Written evidence reported to the House.

Clause 69, as amended, under consideration when the Committee adjourned till this day at Four o’clock.
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Saturday 26 March 2011

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

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The Committee consisted of the following Members:

**Chairs:** Mr Jim Hood, Mr Mike Hancock, † Mr Roger Gale, Dr William McCrea

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

Chris Stanton, Mark Etherton, Committee Clerks

† attended the Committee
I raise that because back in 1983, only 55% of people were happy with the NHS. Why are we having such an upheaval, and why is there this major clause? We have had a lot of debate about Monitor, pricing, accountability and competition, but there has not been much focus outside on the issue of designation, which has just as great an impact on the future of the national health service in terms of competition and the greater involvement of private providers.

We would be grateful if the Minister explained designation to us as part of his response, as I am sure he is about to. Funnily enough, some people who are much more knowledgeable about the national health service than I are having difficulty completely understanding what designation means. We will explore that in our debate this morning, but, fundamentally, we disagree with the clause’s provisions.

The amendments seek to express our opposition to the notion of designated services. As we will no doubt discuss the wider concerns in the stand part debate, amendments 474 and 475 are specifically targeted to remove the most damaging principle of this clause: the principle that, unless an application is made otherwise, services are assumed to be non-designated. In effect, the amendments seek to mitigate the damage that such a designation regime will cause.

Amendment 474 would alter the Bill so that all services were classed as designated in the first instance. The onus would then be on the commissioners to apply to undesignate a service. We believe that it should be for commissioners to prove that competition will be of benefit to a service, not the other way round. Manufacturing competition for a service should not be the default position. I will repeat that point time and again during this debate.

People have been commissioning services for years on the basis that they are essential, so why should that suddenly change as a result of this provision? That represents an important structural difference between us and the Government. I stress that we are opposed, although we are trying to help the Government. Our approach in government was to give targeted support for limited competition in specific areas where there was clear evidence that it could bring demonstrable benefits to patients within a managed system. Strategic decisions were taken based on merit and patient need. I am struggling to find any sign of how strategic decisions will be made—not only under this clause, but throughout the Bill.

We are interested to hear what the Minister has to say. We will explore the issue further in the clause stand part debate. In contrast, I would also be interested to hear how the Minister believes allowing a range of non-designated services to be shut down by providers, or stopped as a result of a provider’s failing without being helped, could be presented as having a specific or demonstrable benefit to patients. Again, the issue is about promoting competition, not promoting the interests of patients. That is a theme that we will continue to come back to during the debate on designation.

There are many services that, if removed, would have a significant adverse impact on the health of patients. It is clear from the conversations that all Members regularly have with their constituents that the vast majority of services are important to the local population; as I said before, if they were not, the commissioners would not
commission them in the first instance. That all comes back to the point that we will debate later, which is that the provision’s purpose is to allow failure to become easier, to cut services and to open them up to competition; it is not to promote the best interests of patients.

As it stands, the clause will ensure that the smallest possible number of services will be designated. Does the Minister have any idea about that number?

The Minister of State, Department of Health (Mr Simon Burns) indicated dissent.

Derek Twigg: I am sure that the Minister does not want to get into how regional and consortia boundaries will impact on such decisions. That is the problem. There is so much detail that is not in Bill, but we are being asked to make an important decision today, which is a great worry.

A commitment to competition is put before patient care and choice. I remind the Minister that it is simply not enough to say that competition will provide a better service and better health outcomes for patients, and we will explore that further. The measure will lead to mass fragmentation and volatility in the provision of services, and, of course, it wagers too much on the success of under-regulated market forces. Every service that a patient uses is important to them, and, as such, there should be no system of first or second-class services. This group of amendments aims to ensure that if such a regime of designation is implemented, it is done with the intention of undesignating services only in exceptional circumstances where there is a clear body of clinical evidence to show that it is not detrimental to patient service.

We would be interested in what patients’ views would be in such instances and what consultation would take place. The Government have made a great play of stating that this is about putting the patient first and about consultation with local populations and providers, such as healthwatch and local authority scrutiny, but we have seen little of that in this particular proposal. It would be interesting to hear from the Minister how important patients’ views will be.

The Government believe that decisions should be made locally by those who know best, because they are clinical professionals, local authority members or even a member of the public or a patient. However, Monitor is the king in that respect—not the local clinicians or GP consortia, and not the local population or patients. It is, again, about Monitor.

As my hon. Friend the Member for Leicester West exposed last week, putting patients first is not at the centre of the Bill; Monitor; regulation and promoting competition are at the centre. It is not surprising that we want to explore that further in the clause stand part debate. Our view is that patients, not competition, should remain at the heart of the Bill, and I hope that my hon. Friends will join me in supporting the amendments.

The Chair: Before we embark, let me set down the ground rules for those who perhaps do not understand the process. I am relaxed; I do not mind if we have a stand part debate at the beginning or at the end, but we cannot do both. The shadow Minister has indicated that he wants to have a stand part debate. That being so, I intend to glue this debate down to the amendments, and I do not expect a ramble round the shires in between.

Mr Burns: Mr Gale, may I surprise you by saying that I would like to begin on a consensual note? I am in total agreement with the hon. Member for Halton about it being a pleasure to have you temporarily chairing our proceedings. I know that your wisdom will prevail, as it already has done with your announcement of the ground rules on the stand part debate. I had assumed, because the hon. Gentleman asked me to explain designation, that that would take place at the beginning of my comments on the amendments.

The Chair: Order. That is fine, because designation is referred to in amendment 474, but we must not have a broad Second Reading-style debate on the whole clause now.

Mr Burns: If it is in order, Mr Gale, I will help the Committee and the hon. Member for Halton by starting with some introductory comments about the overall, overarching system of designation, because the hon. Gentleman has a number of misconceptions about it. I will then go on to the specifics of the amendments, if that finds favour with you.

The Chair: That is fine.

Mr Burns: Thank you; I would not say that too often.

Before going into the detail of the amendments, I thought that it would be helpful to remind the Committee of the purpose of designated services. Our aim is to give providers the freedom to thrive and succeed, and to develop high-quality services for NHS patients, but in doing so we must recognise the possibility of failure.

Failure is not new; it happens in all sectors and all health care systems, as a result of factors such as overcapacity, poor management or inefficient service delivery. Failure has always existed at times in the NHS, but rather than being acknowledged and dealt with openly it has too often been covered up. Poor-quality, inefficient providers have been propped up through covert subsidies at the expense of patients and taxpayers. Our aim is to create a robust and credible failure regime that will deal with failure fairly if it happens, and will act as a deterrent to make failure far less likely in the first place.

Under our proposals, commissioners will have the primary duty to ensure the continuity of an NHS-funded health service to all patients in England through effective contracting and oversight of their providers. However, as we set out in “Equity and Excellence: Liberating the NHS”, Monitor will have an additional role in supporting commissioners by ensuring the continuity of designated services, which are essential local health services where there is no alternative provider. Monitor can do so through additional regulation and intervention and, in extreme circumstances—where a provider becomes insolvent or is at risk of becoming so—by triggering a special administration regime.

Due to the variety of the health care needs of different communities and to significant differences in the provider landscape between communities, it is likely that the services that need additional regulation will vary across
the country. As a result, we feel that it is essential for local commissioners, rather than a national body such as Monitor, to lead the process of defining which services would be designated. Knowledge of local health needs and the local provider landscape will be critical in determining whether additional protection from Monitor would be required.

Derek Twigg: If the Minister is coming on to this, I apologise, but can he explain how Monitor will have any local knowledge?

Mr Burns: I will be coming to that point, if the hon. Gentleman will bear with me.

The Bill sets out high-level criteria for commissioners to follow when considering whether a service should be designated. Those criteria will require commissioners to demonstrate that the services are necessary to meet the health needs of their populations, and that no alternative providers of those services exist. The default position will be that a service should not be designated unless commissioners can demonstrate that the principles set out in the Bill have been met.

It is important at this stage to make it clear that just because a service is not designated, that does not— I repeat does not—mean that commissioners plan to close that service. I hope that that blocks off any scare stories emanating particularly from the hon. Member for Leicester West, who is very good at them.

Derek Twigg: Again, if the Minister is about to answer this I apologise, but can he tell us how Monitor will do that?

Mr Burns: The hon. Gentleman anticipates me. I will be coming to that point.

I repeat that just because a service is not designated, that does not mean that commissioners plan to close that service. Rather, it means that the commissioner is confident that a range of other services exist in the locality, and that it has contracts in place with other providers to provide the same service. Should one of the providers fail due to inefficiency or low demand, those other providers could be scaled up to replace the lost capacity. Additional regulation would, therefore, not be required to protect patient services. Commissioners would have a duty to consult providers, local authorities, HealthWatch England and other key stakeholders, in determining which services should be designated.

10.45 am

When they could demonstrate that the criteria were met, commissioners could apply to Monitor for designation of services. Monitor would be obliged to approve the designation when, in turn, it was satisfied that the criteria were met and consultation had taken place. Knowledge of local health needs and the local provider landscape will be critical in determining whether additional protection from Monitor would be required.

In the new regime, Monitor will have a number of tools to minimise provider failure in three stages: first, in advance of a failure; secondly, in the event of provider distress; and thirdly, if an organisation reached the point of failure.

Owen Smith (Pontypridd) (Lab): I thank the Minister for giving way, because he is moving beyond the point at which I wanted to intervene.

If I understand the Minister, he is saying that the principal criterion against which designation will be judged is whether there are alternative providers in the local health care economy. If those alternative providers exist, the service might not be designated, might not need to be protected through designation. Does the Minister imagine that, as we have more entrants into the health care market, just as with competition applied to a great degree, there will be greater pressure to de-designate services? If so, how often does he imagine we will see services being reviewed and de-designated, as more entrants come into the market?

Mr Burns: First, as I just said, there will be guidance for criteria, which will be published in due course. When published, that will provide greater detail. Secondly, I am not going to fall into the trap of answering the question about numbers; as I said earlier, with Opposition Members what might seem an innocent question at the time gets misinterpreted and sometimes misrepresented. However, I will say very broadly that it might happen in some circumstances. The crucial point is that with non-designated services—by definition, they are not designated—there is a plurality of the supply of that service. However, I do not wish to go further than that and interpret precisely how it might look on the ground, to avoid a repetition of a rather unfortunate incident during our second or third sitting.

I return to the new regime. Monitor will have a number of tools to minimise provider failure at three stages. In the first stage, in advance of a failure, Monitor’s licence for providers will contain a number of continuity of service conditions that will seek to restrict risky behaviour among providers of designated services. For example, those could include restrictions on the disposal of assets or financial requirements, such as a ban on cross-subsidies between regulated and unregulated services.

At the same time, providers of designated services will be required to contribute to a provider risk pool, which will create incentives for providers to reduce their financial exposure. In comparable schemes, such as the Pension Protection Fund, those mechanisms have proved to be effective in reducing the overall risk of failure of organisations.

Secondly, if a designated service provider became distressed, Monitor would have the ability, through a combination of licence conditions and the threat of special administration, to increase the basic level of surveillance and advice and to require action from providers to address particular issues. It is only likely to be in exceptional circumstances, therefore, that a provider would reach the third stage and need to be placed into special administration. Nevertheless, it is crucial that special administration should exist as a possibility. The more credible the failure regime, the stronger the incentive will be for providers to take action to tackle their problems, and the less likely failure will be.
Grahame M. Morris (Easington) (Lab): I have pursued this issue on a number of occasions to try to determine what the estimated failure rate is likely to be under the new arrangements. I can give a couple of examples—not least the west Cumbria practice-based commissioning model, which is being held up as an exemplar. As I understand it, that is about £11 million in debt, and it is being bailed out by the strategic health authority, which, of course, will not exist under the new arrangements. If that is typical of what we can expect, my anticipation is that the failure rate will be very high. Does the Minister share that view?

Mr Burns: Most certainly I do not. Given the three steps that I have outlined, I think that it will be exceptional and unusual for that to happen. I can appreciate, however, that because the hon. Gentleman is a pessimist, he always wants to look at the downside. I am a realist, so I want to look at the range of a situation. [Interruption.] The hon. Gentleman is trying to derail the Bill.

The Chair: Order. If the hon. Member for Easington wishes to intervene, he may, but he may not do so from a sedentary position.

Mr Burns: Thank you, Mr Gale. I do not think that we shall pursue that any further. We got the message from the hon. Member for Easington. Amendments 474 and 475 amend the clause to change fundamentally the policy of designated services, from being one where commissioners have to opt in services for designation and additional regulation, to one where commissioners have to opt out services from such measures. Where no application is received to opt out, the assumption would be that all services would be designated, as per the amendments.

I understand why the hon. Member for Halton tabled the amendments; I think that they are an attempt to protect NHS services from closure, due to a misconception of designated services policy that has been repeated in recent reports beyond the Committee. That is why I tried to help by providing a general overview of the whole designation system at the beginning of my remarks.

Just because a service is not designated does not mean that commissioners plan to close that service. In fact, it means that the commissioner wants the service to continue and is also confident that it is not the only provider of that service for the locality. Therefore, the service will continue. I repeat that from my earlier remarks, so that there can be no misconception among Labour Members. The commissioner would have to be confident that the service had contracts in place with other providers of that same service, and should one of the providers fail due to inefficiency or low demand, the other providers could be scaled up to replace the lost capacity. That means that additional regulation is not required to protect patient services.

Grahame M. Morris: Will the Minister explain the evidence base for that assertion? Evidence about the failure regime presented to the Committee by Dr Jennifer Dixon from the Nuffield Trust suggested that it was expected to be very high. Based on modelling in north America, it might be as high as 90%.

Mr Burns: The hon. Gentleman has asked for evidence, to which I simply say that it is self-evident. It is all right for the hon. Gentleman to pray in aid a witness at the beginning of the Committee, who referred to the United States, but as I have mentioned before, it is most unwise to compare the American system with the British national health service. The fundamentals of the two systems are poles apart, and they are totally different. Personally, I think that such comparisons are a non sequitur.

I return to my original comments. The amendment would mean that the vast majority of services would be designated, and therefore additionally regulated. It is important that I explain the impact of a high level of designated services, because significant negative implications to patient care will arise as a result of designating services that do not require it. If a commissioner designates a service, they effectively lock that service provision into one provider. That means that the benefits of competition—greater quality, innovation, reduced inequalities, efficiency—are missed, and renders any willing provider policy and increased patient choice ineffective.

Preventing competition would also run counter to Monitor's duty to promote competition where appropriate, and might lead to market investigation references for the Competition Commission about anti-competitive features of the market. As a result, the opposition amendments would subject almost all providers of NHS care to a high level of regulatory burden, giving Monitor additional powers to intervene where it is not necessary—for example, in physiotherapy or podiatry services.

Providers and commissioners would have to pay for the protection that designation offers by paying into the financial mechanisms that cover the cost of ensuring continuity of service in the event of failure. The amendments would lead to a higher amount of designated services than necessary, and therefore higher costs than necessary for commissioners and providers. Patients would not receive the best quality of care if we missed out on these benefits. If there is less cash for commissioners to spend on services, that is clearly not in the best interests of patients.

Amendments 474 and 475 would also degrade commissioners' responsibilities by removing their responsibility for the continuity of services. The Government believe that commissioners, as those closest to patients and the needs of their populations, should have the primary duty of ensuring continuity of services. Ironically, the amendments would move that responsibility to Monitor. I therefore ask Opposition Members to withdraw the amendments.

I move on to amendment 476, which seems to remove the requirement of commissioners to consult while designating services. I am unsure why the hon. Member for Halton has tabled the amendment, as it would remove the ability of the local population, local authorities, the Care Quality Commission, healthwatch and other local stakeholders to contribute to the designation process. From the Government perspective, that would remove local accountability from the process and disfranchise patients and the public. I think we all agree that that would be a retrograde step, so I ask the hon. Gentleman to withdraw his amendment.

The hon. Member for Halton asked how Monitor would have local knowledge. Local commissioners would determine which services should be designated, based
on local knowledge and consultation with the local partners that I mentioned. Monitor’s role is to approve applications where the criteria set out in the legislation are met—in other words, to ensure that due process is followed and that the legislation is applied properly. It is right that commissioners, armed with extensive local knowledge, should lead on the application of services for designation.

Liz Kendall (Leicester West) (Lab): The Minister keeps referring to the fact that commissioners must consider whether there are any alternative providers to deliver local services, and that that is the key criterion. What counts as “local”?

Mr Burns: I am slightly surprised by that question. “Local” is the local health economy covered by the GP consortium, or consortia if they are providing the same service for a local population. The local area will meet the needs of local consortia.

Mr Burns: No, about this point.

Mr Barron: I do not have any misconception about the Bill; I just want to know what it means. [Interruption.] Again, the Minister is shaking his head. Responsibilities given to Monitor in the Bill involve three key functions. One is to promote competition. It was initially to be competition full stop, but now it is to be competition on quality, though we are not sure what that means at this stage. Monitor is also to set prices, and we will move on to that later today, I hope. The third function is to ensure continuity of essential services.

The Minister has just described what that means. However, “designation” is confusing to me. I took notes as he spoke; he talked about a service not being designated. To take the example of a GP surgery would be a bit harsh, but there could be a local health service provider that was not designated by an economic regulator. The Minister said that that would not mean that it would close, but he went on to say that that the service it provided would be provided by others. What does that mean? A provider will not close, but the service it had provided will be provided by somebody else.

What does that provider do? Does it just hang around in the ether? What does that mean? I have just conveyed what the Minister said, although I will crawl over it when we get Hansard. I do not know what it means. I have looked through the explanatory notes for clause 69, which explain what the economic regulator has to do, but frankly I am confused.

With regard to how an economic regulator would make the clinical judgment, the Minister outlined three areas. The licence for providers would apply if someone were involved in risky behaviour, which would obviously have to be put right. Financial exposure would have to be reduced. Secondly, if the designated provider became distressed, Monitor would have to make it improve, or it would have to go into special administration if necessary. What does that all mean?

When talking about licence for providers, risky behaviour and reducing financial exposure, where does quality come in? The Minister keeps throwing in the issue of quality now and again. Where is quality in what Monitor has to do? It is an economic regulator that, we assume, is going to designate parts of the private and public health service and social care. It is going to designate whether that can provide or not for local commissioners to commission from.

We ought to ask which criteria will be applied. The Minister mentioned local knowledge and local commissioners, and the need for the people designated to maintain, improve and meet criteria where necessary. Which criteria will they have to meet? All we have in clause 69 are criteria laid down by an economic regulator, not by a body that includes clinicians looking at standards and quality. That is what I want to come round to.

Liz Kendall: Does my right hon. Friend recall that, in the evidence given to the Committee, David Bennett, the new chairman of Monitor, said that it had not figured out the process or the guidance for designation and that it did not know how often it would happen and who would do it? We are being asked to agree to a big change without seeing any real details.

Mr Barron: My hon. Friend is absolutely right. We are on clause 69 this morning, but we could go through the Bill and say that it is ill thought out on many occasions. The very people who have responsibility, such as David Bennett, do not know what the Bill means either. It all right for the Government to put down amendments to take out competition on prices and put in competition on quality, but I do not know what that means—and I do not think that members of the Committee know either.

The Government have been explaining to us how a service could not be designated, and the Minister has mentioned reducing financial exposure, but I want to know about reducing risk to patients. If we are going to designate services, we should ensure that those services are of the quality and have the skills to be able to look after patients in an appropriate way. Financial risk is not something that will impact on a patient if they have a need.

Derek Twigg: On exactly that point, did my right hon. Friend notice the Minister use the phrase “keeping more services than is necessary”? Is that not really what this is about?

Mr Barron: I do not want to return to last week’s debate; there was a situation where, if Monitor wanted it, any merger in a local health authority would have to
be agreed by the Office of Fair Trading and the Competition Commission. Quite frankly, that is alien to our national health service.

Mr Burns: The right hon. Gentleman talks about Monitor and its general duties, and, yet again, I draw his attention to clause 52. He mentioned guidance, and he is right. As I said, guidance will be published, which will then be consulted on to move forward.

Given that the right hon. Gentleman supported the creation of foundation trusts and the Health and Social Care (Community Health and Standards) Act 2003, I thought that it was a little rich for him to refer to a lack of detail in the Bill. The modus operandi of the previous Government was to provide primary legislation that was a skeleton. All the powers flowed from that skeleton through secondary legislation.

When I opposed the 2003 Act in Committee, we did not have any draft statutory instruments or draft guidance—we were left to buy a pig in a poke. Opposition Members have complained about the length of the Bill, but we have sought to redress the lack of detail, where feasible, by putting far more detail in the Bill. Inevitably, however, some of it will flow from secondary legislation.

Mr Barron: So the criteria on whether a service will be designated are something that we will see a few months down the road. As has been said all along in the Committee, the Minister says that this is a seamless move from what the previous Government were doing; the Minister’s defence is always about what the previous Government did or what a previous Minister said six years ago. I want to know why the Bill has nearly 100 clauses that introduce competition, so that the OFT or the Competition Commission can designate what services will potentially be like for my constituents.

It is all right to say that the criteria will be published further down the road, but when I asked the Minister last week about the issue of monopolies having to open their doors for third-party access, he used one example to say that that would be in a limited way only. How are we to know that? Those are just words that he keeps coming out with. It seems ill thought through.

We know that the Bill was put together after the coalition agreement was published, but it is at odds with much of what that contained. There seems to be a running dialogue in the media about changes that might come in the future, because people on the other side seem to be dissatisfied with some aspects of the Bill. The country, never mind the House, deserves to know what the criteria will be.

We ought to know what is going to happen to the NHS as a result of the changes proposed in the Bill. On that basis, I will keep coming back to these issues and asking what criteria an economic regulator will use to say whether a service—it might be a GP practice or a local clinic; it could be anything—is a designated service that serves people such as those in my constituency.

Mr Burns: Why does not the right hon. Gentleman look at clause 69(3)?

Mr Barron: I understand that that is about cause of failure, and I accept that entirely. I am looking at clause 69(3)(b) now, but I will not sound off on the hoof.

Mr Burns: It is clause 69(3)(a).

Mr Barron: I say to the Minister that this is a leap into the dark in terms of the future of the NHS. As I said to the Secretary of State for Health when he first gave evidence to the Committee, I believe that the proposals were hastily put together. We have changed competition to competition on quality, but I do not know who within Monitor will be able to determine the quality of a local service or how it will be designated. I would like to see those criteria.

I would like to know that my local health service, which serves the people in my constituency, is all right and that it is protected as far as it should be. It should improve—absolutely; I do not have any problem with that whatever. It has been improving over many years now. Health care has improved not only during the past 10 years, but during the years before that.

I want to know where this leap in the dark takes us. Quite frankly, every time the Minister gets up and speaks about a clause, more questions are raised than he actually answers.

John Pugh (Southport) (LD): The Government have made clear something that is going on, which Labour Members may not be aware of. They protest too much about this clause because there is a body called the co-operation and competition panel, which the previous Labour Government set up. It has a similar remit to Monitor’s, in so far as it is supposed to take into account the securing of the best provider, regardless of the status of that provider.

Graeme M. Morris: Does the hon. Gentleman recognise that under the Bill, structures such as the strategic health authorities, which have traditionally brokered the co-operation part of competition and co-operation, will disappear? The new approach is fundamentally different from the one that the previous Government envisaged.

John Pugh: The whole trick with getting this legislation right is achieving the right balance between integration, collaboration and competition. I have not seen anybody row back totally from all those objectives.

It might be interesting for Committee members to consult the website of the co-operation and competition panel, because it says things similar to what we are putting in the legislation now, but in a vague, airy-fairy way. The panel makes real-time decisions about our local services. I imagine that few Committee members know that the panel exists or can name anybody on it, but it makes crucial decisions. Its current cases include a claim from Midlands Psychology that south Staffordshire and Shropshire NHS foundation trust “has acted inconsistently with the Principles and Rules for Cooperation and Competition.”

Circle Health Ltd is currently applying to the panel to ask whether NHS Wiltshire has acted inconsistently with the principles and rules for co-operation and competition.

The co-operation and competition panel is, in a sense, free to make up its mind about how it interprets the rules; very little is explicit. It is, none the less, perfectly possible for any private organisation currently to apply
to the panel and say that competition has not been fairly embodied in the decisions that have been made. I admit that that must be balanced against integration and collaboration—and the Bill to some extent also tries to square that circle. We ought not to run away from the fact that all this is currently being done, and that these are real-time cases.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): Will the hon. Gentleman comment on the scope of the work that the co-operation and competition panel is involved in? Is it not primarily to do with elective care? It does not cover the whole range of services that will be covered by the proposals, such as maternity services, emergency care and cancer care.

John Pugh: There is genuinely a substantive issue about what the scope of a regulator should be. In part, the legislation endeavours to address that through the concept of designated services, which we are debating now. It also looks into issues, such as financial risk and stability, that are not currently taken on board when decisions are made, but which ought to be.

In some ways, the Government are trying to flesh out something that is already there and currently running. Although there is a clear distinction between elective and non-elective care, the Government are working towards a distinction between designated and undesignated services. Fundamentally, we are all trying to carry out the very similar task of ensuring that lazy providers do not continue to provide poor services and that there is collaboration and integration. The real issue is not the objective, but whether the legislation actually captures it.

11.15 am

Owen Smith: Does the hon. Gentleman agree that the CCP has investigated PCTs and found substantial evidence of anti-competitive practice throughout the NHS? Is that not why the Bill seeks not just to create a level playing field for competition, but to improve the competitiveness of services around quality?

John Pugh: I should correct the right hon. Gentleman, because I do not think that his understanding is right. The co-operation and competition panel does not look solely at deficient services—if he looks at the cases on its website, he will find that it is looking at services that are up and running. Many hospitals are trying to reconfigure, amalgamate and merge to achieve quick savings. They are referring the related issues to the co-operation and competition panel, not because they are deficient services, but, for example, because they are mergers that seem anti-competitive.

Margot James (Stourbridge) (Con): Does my hon. Friend agree that the CCP has investigated PCTs and found substantial evidence of anti-competitive practice throughout the NHS? Is that not why the Bill seeks not just to create a level playing field for competition, but to improve the competitiveness of services around quality?

John Pugh: I thank the hon. Lady for that point, but I think we need to define very clearly what we mean by anti-competitive behaviour. My concern about the CCP is that, in a sense, it is left to make up its own mind about that. There is a case—particularly where the issue of cherry-picking emerges—for defining anti-competitive behaviour in a very precise way, and not leaving it open.

The Chair: For the clarification of all Members, particularly those who might not have sat on a Committee before, I should say that one or two people have indicated that they want to take part in the clause stand part debate. We will work through all the amendments. When they are out of the way, we will have the clause stand part debate. At that point, it will be proper for any Member to seek to catch my eye in order to take part in that debate. I have let things run just a little, but we have started to stray into stand part territory; I must ask the hon. Member to seek to catch my eye in order to take part in that debate.

Derek Twigg: Thank you, Mr Gale. We do want that stand part debate, so I will try to be as brief as possible. However, the Minister did raise a number of interesting issues. The first thing that must go on the record is that we are obviously discussing a system different from the current one. Let us look at how commissioning will be done.

There is a view, which I do not think is unreasonable, that if commissioners are commissioning services today, they are doing so because those services are needed. The Bill is about markets and about having to go through the Monitor process. Why do we have to have such upheaval in the health service as a result of designation?
The proposed system is different from the current system—no matter what the hon. Member for Southport says, it is different. The Bill’s proposals might relate to parts of the current system, but it is actually about having open competition in the health service, not the limited competition that we introduced. It is about designating only certain services—in other words, protecting them—and leaving lots of services undesignated and, therefore, unprotected. That will make it easier for those services to be closed, changed or reconfigured.

I know that the Minister will not go into boundaries, integration and how the system fits in with other services, but designation is an important part of the Bill. The Minister has not addressed those issues in any way. The key thing is that he said that there is no need to keep services that are not necessary. That suggests that today we have lots of unnecessary services. I do not know how many, because the Minister has not said. Perhaps he would like to intervene and give me an example of such a service.

The Minister has not intervened. That goes back to the real issue, which we will explore in the clause stand part debate. This is a recipe—an agenda—for cuts in the health service, underlined by the Minister’s comment about keeping more services than are necessary. That is what designation is really about. [Interruption.] The Minister—I wrote this down—did mention keeping more services than necessary. That is the key issue.

We will explore the issue again in much more detail, but I have lost count of the number of times the Minister mentioned failure. The phrase was, “This will make failure easier”. Because the criteria will make failure easier, it will be easier to close services or hospitals. As I have said, this is an agenda for closing hospitals. We will explore that later.

The Minister did not mention the pressure on those who are commissioning services and who have to make recommendations to Monitor about those services. To some extent, amendment 476 is about the bureaucratic nature of the provision. We can consult if someone wants to designate a service, but I suspect that not many people would be opposed to designating a service. They have to go through the same bureaucratic procedure to do that. People will feel pressure; perhaps sometimes they will think, “Oh well, it’s not worth it.” We do not know the pressures of their day-to-day work and it is quite a bureaucratic system that does not exist today. Failure, failure, failure is continually mentioned by Ministers—and, of course, by the Bill.

The Minister talks about local knowledge, but the commissioners use that today. What we do not have today is Monitor sitting on their shoulders making the final decision. The Minister is trying to dress it up as if all Monitor will do is ensure that commissioners follow the rules. Unfortunately, as we have heard from the Minister, the Government are not prepared to give us the details of the criteria. We have no details. That runs through the whole Bill. We are being asked to make decisions about the future of the national health service without knowing the details of how things will apply. That is appalling.

John Pugh: This is not a picky point, but, presumably, co-operation and competition panels are also devoid of local knowledge. If the hon. Gentleman supports such panels, talking about local knowledge seems almost to be engineering an issue.

Derek Twigg: I am surprised at the hon. Gentleman.
Mr Burns: Yes, because it does not fit your agenda.
Derek Twigg: It does, actually. The Bill is changing what we have in the sense of control, involvement of the private sector and competition. It is basically implementing a competitive system—I am conscious of your ruling, Mr Gale, and I do not want to stray—to which, as the Minister has said, European and UK competition law will become increasingly applicable. That is the big difference.

There are lots of issues that we need to explore, and we will explore them later. The clause and the Bill will enable NHS services that seem essential under the current criteria to be dropped because the new system will be profit driven. That is the situation that we face. Commissioners will have to think carefully about whether they put a service in a certain place, because they may not be able to make as much money out of it. “Should I not do that?” they may think. That is what the issue is about. I would like, however, to hear more evidence from the Minister to suggest that my view is wrong.

The Chair: Does the hon. Gentleman wish to press the amendment to a vote?
Derek Twigg: Yes, Mr Gale.

The Committee divided: Ayes 10, Noes 13.

Division No. 67]

AYES

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

Turner, Karl

Wilson, Phil

NOES

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

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

Question accordingly negatived.

The Chair: I am looking straight ahead of me, so that I do not embarrass any particular Member. The Procedure Committee is conducting an inquiry at present into the use of electronic devices in Committee Rooms. The current ruling by the Chairman of Ways and Means is that electronic devices should not be used. Until and unless that situation is changed, I advise all Members that such devices are not permitted in the Committee Room.

Emily Thornberry (Islington South and Finsbury) (Lab): On a point of order, Mr Gale. I gave evidence to the Modernisation Committee in 2006 about the use of mobile telephones. I thought that the rules had now changed and that as long as such devices are on silent and are used only by screen, we are allowed to use them in the Chamber and in Committee. It may well be that that has not been extended to electronic devices in general.
The Chair: The hon. Lady is partly right. The use of hand-held devices—the term was intended to allow such devices as radio pagers—was, and still is, permitted. What is under consideration is what constitutes a hand-held device—in other words, whether hon. Members are allowed to use tablets or laptops. As things stand, that is not the case. The situation may well change, but that is a matter for the House. For the moment, I must enforce the ruling by the Chairman of Ways and Means, which is that only hand-held devices may be used.

Mr Burns: Further to that point of order, Mr Gale. Does your ruling mean that hon. Members are not allowed to tweet during the proceedings?

The Chair: That, again, is the subject of investigation. I do not want to get drawn too far down this road, because it will be the subject of a very comprehensive report to Members, and the House will have the opportunity to vote on it. The specific intention has been—and I understand that this is Mr Speaker's view—that machines should not be used for communication with the outside world.

The reason is that there is a grave concern that Members, both in the Chamber and in Committee, might seek to receive advice, instructions and comments from people outside the Committee Room, or outside the body of the Committee. I am not prepared to discuss this matter any further. I have ruled on the subject. As long as I am in the Chair, I must enforce the ruling by the Chairman of Ways and Means.

Derek Twigg: Thank you for that helpful advice, Mr Gale. I shall refrain from tweeting, of course.

I beg to move amendment 477, in clause 69, page 73, line 31, at end insert—

'(c) increase or fail to decrease inequalities between the people of England with respect to their—

(i) health needs,

(ii) health outcomes, or

(iii) access to health services.'.

The Chair: With this it will be convenient to discuss amendment 478, in clause 69, page 73, line 39, at end insert—

'(ba) the potential impact on other services in the organisation or region'.

11.30 am

Derek Twigg: Amendments 477 and 478 seek to ensure that proper consideration is given to the wider effects that designation of a service may have on the services received by patients and to the important issue of the inter-dependency of services, which we have briefly touched on; we will do so in more detail later.

A key area of concern generally is a lack of strategic leadership in the Bill. The Government propose to remove strategic health authorities and primary care trusts. SHAs have had a strategic, regional and inter-boundary view and involvement on a range of services and configurations. We have not heard from the Government how that strategic leadership will be provided, other than on a local basis, for those areas where consortia and inter-regional and inter-hospital services come into play.

The amendments seek to strengthen and clarify the strategic aspect of the criteria for designation and explore how the Government envisage them being applied. Amendment 477 would put in place a statutory requirement for commissioners to consider health inequalities among the criteria for applying for designation of service. As it stands, clause 69 does not include such a requirement, as we believe it should. As the process of designation would be local, the effects of the clause may vary on a geographical basis. As such, it is vital to include a provision that refers to a duty to tackle inequalities across the whole of England, not just within the commissioning area.

The consequences of commissioning decisions on different areas will be an important part of the Government’s proposals, which we are still trying to clarify as part of the designation issue. The amendment would help ensure equality between regional services offered to and received by patients in Devon, for example, and those offered in my constituency of Halton. At an earlier stage of the Bill, the Minister made a big play of a commitment to reducing inequalities across the country. He commented on the postcode lottery. [Interruption.] The Minister is looking quizzical. Does he not oppose a postcode lottery?

Mr Burns: No, I was being cautious and listening carefully, in case I was about to be misrepresented again.

Derek Twigg: I am not sure where the Minister feels he was misrepresented. [Interruption.] He is pointing at my colleagues. I cannot believe that happened. I will not stray down that path. It is never our intention to misrepresent what hon. Members say. We listen exceptionally carefully to the right hon. Gentleman and his colleagues.

The Government have made much of a notional desire to reduce health inequalities. In one of our first sittings—I hope I am not misquoting the Minister—he claimed that the Conservative-Liberal Democrat coalition Government are doing something about inequalities, and instead of just “talking the talk” are “walking the walk”. That is an interesting phrase, given the context of the decision on services and designation, and I am sure we will explore it.

Clause 69(4)(b) states that commissioners must have regard to “whether ceasing to provide the service…would significantly reduce equality between those for whom the commissioner arranges for the provision of services”.

That is a key provision. If a service is designated, it is designated; but if it is not designated, we are not clear how that will be applied. Maybe the Minister can enlighten us.

Although we welcome the inclusion of at least a nod to ensuring that health inequalities are not created within a commissioning area, that commitment is not sufficient to meet the Government’s and Secretary of State’s commitment outlined in clause 3. Equality must refer to equality for all people, across all regions, not simply equality within one commissioning area, depending on how good that commissioning service is, or how good it is at co-operation. The hon. Member for Southport, who is not in his place at the moment, made an important point about integration and co-operation.
Amendment 478 would require a commissioner to have due regard to the impact applications for designation may have on the other services in the organisation or region. That comes back to strategic need and oversight, which is very important. We are waiting to see whether the national commissioning board will have regional offices, or even regional input, or whether it will all be run from London. That applies equally to Monitor. I mean no disrespect to my hon. Friends with London constituencies, but we have a slight problem with that back in the regions.

The amendment is brief, but it recognises the interdependent nature of services in a region. It highlights regional factors that will have an impact on the designation of services and explores how the Government envisage the application of designation. The Minister should give careful consideration to that point, because genuine concern has been raised by several people.

The amendment is designed to remedy the lack of strategic planning in the clause. Some services are highly interdependent—in hospitals, for example, one service often relies on several others to function safely. The Minister and the Government have said that patient safety is a primary concern in the Bill. Our argument, and a source of increasing concern to us, is that the proposals in the Bill will lead to greater fragmentation, to a lack of co-operation between providers and to misunderstandings. We are worried about safety: if one service is designated, several others may require designation for it to remain at a full and safe working capacity. It will be interesting to hear the Minister explain that, because, as he explained before, a service will designated because it is essential and it needs support, but other services will not be designated because there are many players out there that can provide the service. How would that work in a hospital where one service was designated but others, because of competition, were not? How would that work in practice to ensure continuity and support for designated services? We do not know the answer because the Minister has not given us any idea about the details of the system.

Mr Burns: The reason why the service in that example would not be designated is that there would be no need for designation, because there were other providers providing the same service in the local health economy.

Derek Twigg: Of course, they may never get to the point of failure. That is the issue. The process could be complicated and could prove hugely bureaucratic and expensive to administer. Cost is a big issue. It would be interesting to find out how many management consultants will be brought in to ensure that the process gets under way; I am not sure where the expertise will come from otherwise.

Splitting services between designated and non-designated also leads to problems with the staff and equipment used in the provision of multiple services. [Interruption.] The Minister shakes his head, but we are trying to find out how the Bill will operate on the ground. That might be obvious to him, but it is not obvious to us, and we are not the only ones; there are people out there with much more NHS experience who are having difficulty getting to grips with the details. As he has said, much of the detail will be published at a later date, and that is part of the problem. I am sorry if he thinks that we should not be asking these questions, but we need to ask them to hold the Government to account.

Returning to the splitting of services, if a piece of equipment or a member of staff is used in part for designated and in part for non-designated services, are there any issues about how those services will be provided? What is to be the process if the provider of both services becomes insolvent? We need to understand that. It is all very well for the Minister to say that non-designated services will have several providers, but they could go out of business. The Minister has talked a lot about failure. The cost of administering that complicated eventuality on a wide scale could be vast.

During Prime Minister’s questions last Wednesday, the Prime Minister claimed that his and the Health Secretary’s reforms were “about cutting bureaucracy and improving patient care”.—[Official Report, 16 March 2011; Vol. 525, c. 292.]

Will the Minister tell us which part of the clause will achieve that? The whole idea of designation is formed on the basis that it would be easy to break up a provider, such as a hospital, into individual services. That is something that the Minister may want to look at. Has he any idea how many services in a hospital would be designated—an accident and emergency unit for instance? I am interested to hear what he says. In many cases this is neither possible nor desirable. At some level there should be significant strategic leadership within the designation of service.

My final point is that there is so much detail missing from the Bill in an area that will have a profound impact on the future delivery of services in the NHS. We need answers, because we have been asked to make decisions without the knowledge that we should have.

Mr Burns: I am afraid that I will have to disappoint the hon. Gentleman and say that I believe the amendments are unnecessary, and I will not be advising my hon. Friends to vote for them to be made.

Amendment 477 would require commissioners to designate a service if the outcome of that service failing would mean an increase in, or failure to decrease, inequalities. I understand precisely why the Opposition have tabled the amendment: they seek to place a requirement on commissioners to consider inequalities when designating services, and in many ways the amendment flows with their previous proposals on tackling inequality. As I did when dealing with earlier parts of the Bill, I agree that issues of equality and inequality should be considered as part of the designation process. That is why subsection (4)(b) of the clause already requires commissioners to have regard to “whether ceasing to provide the services for those purposes would significantly reduce equality”.

The divide between us is on whether equality should be in subsection (3) as one of the main criteria, or in subsection (4) as a matter that the commissioner should have regard to. I feel that the appropriate place is subsection (4).

Debbie Abrahams: Are this Government serious about reducing inequalities or not? By suggesting that that cannot be included in the criteria, the Minister is implying that it is not a priority for the Government.

Mr Burns: The answer to the hon. Lady’s straightforward question is yes, of course we are passionately determined to seek to reduce inequalities. As I have just said, we believe that it is more effective and appropriate to have
the measure in subsection (4). If the hon. Lady’s question had been “Why do the Government not refer to inequalities at all?” I would have a greater understanding of why she intervened. Our earlier debates showed that we are determined to reduce inequalities, and I hope we will demonstrate that during this debate. Reducing inequalities is not an issue that divides the Committee, and I am saddened that the hon. Lady does not accept that we are determined to reduce inequalities as she and her hon. Friends are.

Liz Kendall: The Minister said in the discussion on the previous amendment—as do the explanatory notes to the Bill—that Monitor will publish guidance on the criteria it will use to judge whether commissioners have looked at all of the necessary issues concerning designation of services. Why should tackling health inequalities not be part of that?

11.45 am

Mr Burns: Let me explain to the hon. Lady, and I hope she will not only accept this but appreciate it. In the previous debates and this one, Opposition Members have quite rightly raised for more action against inequalities. There are, we are united: we all want to reduce inequalities. However, it is this Government who through the Bill are putting in place the first ever legal duties to tackle health inequalities. During the 13 years of the previous Labour Government, no legislation was introduced that would reduce health inequalities.

In this atmosphere of co-operation and consensus, what I find rather churlish is that rather than giving the Government the credit for doing this innovative thing, we are being criticised. Opposition Members are suggesting that we are not doing anything about inequalities. I say to them: by all means, oppose, probe and question, but I advise them not simply to oppose and be contradictory in their approach for the sake of it, because I am afraid that that diminishes credibility. The shadow Minister looks hurt. He is an intelligent man and I think he knows what I am getting at.

That very welcome intervention from the hon. Member for Oldham East and Saddleworth has allowed me to put on the record that it is this Government—the Conservative-Liberal Democrat coalition Government—who, for the first time in our history, have put a requirement to reduce health inequalities into primary legislation.

Liz Kendall: We have heard this before.

Mr Burns: The hon. Member for Leicester West has been rather quiet today, but I welcome that sedentary intervention. She says that I have already said that and yes, I have, but our experience is that with this Committee, one has to—

The Chair: Order. The Minister is standing with his back to the Chair. He knows very well that if he were in the main Chamber, he would be in serious trouble about that.

Mr Burns: As well I know, Mr. Gale. The advice I got to rectify that problem was slightly confusing, but we will not go there.

Margot James: In addition to enshrining the health equality duty in the legislation up front, does my right hon. Friend agree that the other two fundamental changes we are making—the transition of responsibility for public health to local authorities and increasing the accountability of the health care service through local authorities—will enable a far greater commitment to public health through the integration of health and social care, local authority involvement and the uprating of public health? All those things will improve health equality.

Mr Burns: My hon. Friend is absolutely right and I am extremely grateful to her for reiterating that point, so that it has been made in our proceedings. We are determined to tackle inequalities in health meaningfully. I do not want to detain the Committee, so I shall make progress.

As I said before the intervention, it would not be appropriate to include the provision in subsection (3) because doing so would reduce the benefits of competition, quality and so on to patients. That takes us back to the purpose of designation and the benefits to patients that are brought about by having providers that are not subject to the additional regulation that being designated requires. The greater the proportion of services that are not subject to additional regulation and that are undesignated, the greater the benefits to patients that competition can bring—namely, greater quality, innovation and efficiency.

Under the Bill, only health services for which there are no alternative providers will be subject to additional regulation to secure continued access to those services in the event of insolvency. Non-essential services—in other words, those services that would have less of an impact on the health outcomes and equality of patients—will not be subject to additional regulation, rather it will be the responsibility of commissioners to have plans in place to ensure the continuity of those services through using alternative providers.

Derek Twigg: Will the Minister give way?

Mr Burns: For the last time.

Derek Twigg: I am deeply hurt that the Minister will accept only one more intervention from me—he is usually quite generous. Could he give us some examples of non-essential services?

Mr Burns: The straightforward answer is, no. I will tell the hon. Gentleman why not—

Liz Kendall indicated dissent.

Mr Burns: The hon. Member for Leicester West shakes her head, but I am afraid she is the author of my reluctance to go down that road. Mr. Gale, you did not have the pleasure of chairing our Committee at the time. I thought we were having a grown-up discussion on designation earlier in the Bill, and was trying to be helpful—

Liz Kendall: Will the Minister give way?

Mr Burns: How can the hon. Lady intervene when I have not finished the sentence? I was trying to be helpful by using an illustration to make the point, when
suddenly I heard the hon. Lady saying that I was confirming the closure of a number of A and E departments, which I certainly was not. In the light of that experience, I am being cautious and careful, so that I cannot be misrepresented when I am trying to be helpful.

**Liz Kendall rose—**

**The Chair:** Order. Before we go too far down that route, I would like a grown-up discussion on the amendments under consideration at the moment. If the hon. Lady wishes to refer directly to the amendments under discussion, that is fine. If not, we should progress.

**Mr Burns:** Thank you, Mr Gale. I think that the hon. Lady’s not rising again might suggest that the intervention was not going to be grown-up. [Interruption.]

**The Chair:** Order. The Chairman is seeking to drive the business forward. I expect all Members of the Committee to be grown-up.

**Liz Kendall:** You may rule me out of order, Mr Gale, but in his comments the Minister questioned what I said before. We are asking for clarification of non-essential services because that is what patients, the public, our constituents want to know. There cannot be a Bill that does not describe what that will mean for people and patients on the ground. That is what scrutiny is about; that is why I was elected as a Member of Parliament, to stand up for my constituents; and that is why we are asking for an example of a non-essential service.

**Mr Burns:** The principle of what the hon. Lady says is absolutely right. I will get round to a number of answers to a number of questions. The point I am making is that in certain areas, the nature of the question invites me to speculate on something prematurely, and I am reluctant to go there—

**Emily Thornberry:** On a point of order, Mr Gale. I understand that your ruling was that we should move on with the clause. Having ruled that her hon. Friend was in order, I have unfortunately heard a great deal of this train of thought from the Minister over the past few weeks, and I fear he may be about to go off on a frolic of his own, rather than move on with the clause.

**The Chair:** With respect to the hon. Lady, it is up to the Chairman to decide whether something is in order. Having ruled that her hon. Friend was in order, I have to allow the Minister to respond. The alternative would be to rule her hon. Friend out of order and I did not think that was what the Committee desired. I would, however, like to return to the normal courtesy and good humour and see if we can take matters forward.

**Mr Burns:** Absolutely, Mr Gale, I will make progress. I agree that amendment 478 is important with regard to inequalities, but it is unnecessary, as subsection (4)(a) already provides for a very similar effect, in that commissioners would have to consider “the current and future need for the provision of the service for the purposes of the NHS”.

The hon. Member for Halton asked what would happen if one service within a hospital is designated and others are not? That would be an important question for commissioners generally in securing high-quality, efficient and sustainable services. Equally, it would be an important question for commissioners to consider when consulting on applications for designated services, because it is integral to consideration of whether the withdrawal of a particular service would impact on the health of the population in the absence of alternative providers. Designation of some services but not of others provided by the same provider would mean that some services would be subject to additional regulation while the others would not. That would mean that the provider would have greater freedom as to how it delivered its non-designated services than it would in relation to designated services.

The hon. Gentleman also asked how the equality consideration would work. When designating a service, commissioners would have regard to the equality of access in terms of distance travelled or the impact on particular sections of the population—patients with anaemia, for example. That would be part of the commissioner’s considerations when applying for designation.

The hon. Gentleman also made a possibly dubious suggestion that designation will be bureaucratic. He is worried about that, and I will seek to convince him that he need not be. On past practice, given his mindset, it might be an uphill battle, but it is worth the try.

If used appropriately, designation is a targeted and proportionate system that focuses regulation where it is needed. It ensures that the extra cost of protecting a particular service is paid only where necessary. In contrast, too often under the current system have inefficient and poor quality providers been bailed out wholesale and at too great a cost. We want regulation to protect services for patients, not for the institutions that provide them.

**Owen Smith:** Will the Minister give way?

**Mr Burns:** No. I want to deal with a number of questions because we want to make some progress today.

The hon. Member for Halton also raised the question of equality across the country. As the Prime Minister has made clear, our proposals would put key decisions in the hands of family doctors. GP consortia would decide how best to improve the quality of services for their patients and how to make best use of NHS resources. That is the very opposite of a postcode lottery.

The hon. Members for Leicester West and for Halton both asked which services will be designated. At this stage it is simply not possible to answer that question. The whole point of our Bill is to ensure that decisions are made locally, not by Ministers in Whitehall. It will be more appropriate at the local level when the system—[Interruption.] The right hon. Member for Rother Valley keeps saying that Monitor will do it. Tomorrow morning, the *Hansard* for this sitting will have been published. He not usually recommend that people read my addresses to the nation in this House, but I certainly recommend that he reads it tomorrow. I think he will then get it.
Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): On the postcode lottery point, does my right hon. Friend agree that individual GPs and health care professionals will be making decisions on a case-by-case basis for the benefit of patients, rather than, as at the moment, applying blanket rules that are arbitrary and inconsistent across the country?

Mr Burns: My hon. Friend is absolutely spot on. He has hit the nail on the head with the hammer. I hope that Opposition Members will benefit from that.

Finally, a number of Opposition Members asked what is a non-essential service. As I said earlier, I am not going down the route of specifying different services against others, because it is a recipe for misrepresentation or, if I am being generous, misunderstanding. Designation is not about what is essential; it is about where additional regulation is necessary to secure continuity of NHS services. I would have thought that Opposition Members would warmly welcome it for that alone. It is for those reasons that I urge my hon. Friends to reject the amendment, if it is pressed to a Division.

12 noon

Derek Twigg: It will not come as a surprise that we will be pressing the amendment to a Division.

I am not sure how to put this, but, in some ways, the Minister seems to underestimate the importance of his speeches. I assure him that we follow what he says word for word in Hansard, and what is said by his right hon. Friend, the Secretary of State for Health. In particular, we look at times where their views might not be compatible, so the Minister should not underestimate the importance of his words.

It is as though the Government do not want to accept any Opposition amendment in this Committee, full stop. There seems to be a mantra, “Under any circumstances, do not accept an Opposition amendment.” The Minister did not advance a logical argument for rejecting our amendment on reducing inequalities and making that an important part of the commissioner’s role. What was telling, and the reason why we will be reading the Minister’s comments, was his point that it would reduce the benefits of competition. That was his argument for not accepting our proposals. Again, that comes back to our main point, which is that the Bill is driven by competition and not by what is in the best circumstances, do not accept an Opposition amendment.”

Mr Burns: Can I help the hon. Gentleman, because I do not think he quite gets it? If there are two providers of a service in a local community, competition will work because patients have choice, and they will be the driving force in choosing which of the two providers they use. That will drive up quality, because both providers will want the patient to choose them to provide their health care. It is simple, if only the hon. Gentleman would get it.

Derek Twigg: That is a nice little theory, but the Minister seems to forget that the service will have to take account of the massive pressures on the NHS, the underfunding that the Government are putting into it, and the demand. What we will see is cost being even more of a driver.

Mr Burns: Will the hon. Gentleman give way?

Derek Twigg: I will, but if the Minister is going to intervene, may I ask him a question? He keeps saying that because my hon. Friend the Member for Leicester West was so terrible to him in misquoting what he said, he will not give another example in his arguments. I have been around the House for a while and I have served on a number of Committees, but I have not seen a situation where the Minister will not give an example to back up his arguments. Will he therefore give some examples of the services in question?

Mr Burns: The hon. Gentleman has slightly moved on. I want to correct this before it becomes a fact, because he keeps repeating the point about underfunding. We are the only party that is giving a real-terms increase—however modest—to the NHS, which will ensure that we move forward with all these services being provided. The Labour party policy is not to give a real-terms increase, and the Institute for Fiscal Studies has suggested that over the lifetime of this Parliament such a policy would result in a £5 billion funding cut for the health service, rather than the £10.7 billion increase that we are giving it.

Derek Twigg: I know that you do not want us to get into a funding argument, Mr Gale, but funding is an important aspect of the debate. I refer the Minister again to The Daily Telegraph today and the impact that Labour’s massively increased funding for the health service had in terms of massive patient satisfaction. When we talk about funding, that is what we did, and we are waiting to see what happens with this Government’s funding.

Dan Byles (North Warwickshire) (Con): That is very interesting. My understanding was that a memo came out from the shadow Chancellor forbidding Opposition Front Benchers from making funding commitments. Is it now a Labour funding commitment to real-terms NHS increases for the lifetime of this Parliament?

Derek Twigg: Nice try—

Hon. Members: Answer!

The Chair: Order.

Derek Twigg: We can talk about what Labour has achieved for the health service. If the Minister wants to guarantee that waiting lists will not increase under his Government, or that there will be no closures of hospitals and reconfigurations because of funding problems, I am happy to give way to allow him to do so. He will not do so, however, because the Government will not give that guarantee. That is the issue that we are discussing today.

The Minister has talked about not bailing out failing services, which is what will change as a result of the Bill. Our argument is that the Bill makes cuts and closures easier. The Government are trying to say that failure is happening all around us and that the proposals will deal
with it, but will the Minister give us some examples of
failure that we did not deal with? Can he give us more
than one example? Can he give us three, five or six? He
refuses to give examples.

**Mr Burns:** May I give the hon. Gentleman one example,
which may surprise him and put the matter in perspective?
Lord Reid, who was Secretary of State for health before
the former right hon. Member for Leicester West, was
asked if he thought that politicians—that meant Labour
politicians, because they were in Government—would
be prepared to see their local hospital close. Lord Reid
said, “This politician is.” He added,

> “The patients will decide. I am not going to force people to
take a third rate service. Patients will get the choice because for
60 years the only choice they have had is to like it or lump it.”

**Derek Twigg:** That is not an example. The Minister is
trying to suggest that there is wholesale failure that has
not been dealt with in the system. We still cannot get
examples out of the Minister. We look forward to the
clause stand part debate, during which these issues will
be explored in much greater detail.

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

*The Committee divided: Ayes 10, Noes 13.*

**Division No. 68**

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**Question accordingly negatived.**

**Mr Burns:** I beg to move amendment 504, in clause 69,
page 74, line 1, leave out ‘must grant an application
under this section’ and insert ‘may grant an application
under this section only’.

**The Chair:** With this it will be convenient to discuss
the following: Government amendments 505 to 508.

**Government new clause 10—Complaint about grant
of application for designation.**

**Government new clause 11—Complaint about refusal
of application for designation.**

**Government new clause 14—Complaints: general
provisions.**

**Mr Burns:** I hope that Opposition Members will
agree that the amendments deal with a fairly straightforward
and relatively narrow issue. In the hope of making
progress I will be brief.

The amendments make a series of changes that will
ensure that the process of designating services operates
efficiently and will ensure greater transparency in how
Monitor makes decisions about the designation of services. Amendment 504 is a minor, technical amendment that
clarifies the drafting of clause 69 to make it clear that
Monitor is able to refuse or accept an application. The
current drafting might suggest that Monitor must accept
an application. The amendment also makes it clear that
Monitor must approve the designation of services only
where the criteria for designation are met. It must also
agree to the removal of a designation only when the
criteria are no longer met.

Amendments 505 to 508 would make changes to
what Monitor would be required to do when it issues a
notice of its decision on an application to designate
a service. If Monitor grants an application, then
amendment 507 would require that notice to contain
details of the right to complain against its decision. If
Monitor refuses an application, amendment 508 sets
out what the notice of refusal must contain. It must
contain the reasons for the refusal and explain the right
to appeal against the decision.

The new clauses will deal with how complaints would
be made against Monitor’s decisions in this chapter,
starting with new clause 10. That would govern how
complaints could be made in relation to Monitor’s
decision to grant or refuse an application under clause 69
for designation. The new clause will allow the provider
of the designated service, or a potential provider of NHS
services, to complain against a designation of a particular
service if they believe that the criterion, as set out in
subsection (3), for designating a service is not made.
The new clause would then require Monitor to re-examine
its original decision and decide whether the designation
should be removed or not.

The new clause will also allow the commissioner for
the provider or potential provider to appeal to the
first-tier tribunal should they believe Monitor’s decision
on the complaint was based on an error of fact, or
wrong in law, or unreasonable. By allowing complaints
against a designation of services by the provider, or
potential provider, in question, new clause 10 provides
an important check to ensure that services are not
unnecessarily designated, which would prevent market
entry and would mean that the benefits of competition—
greater quality, innovation and efficiency—would be
missed out on. Unnecessary designation would also
mean unnecessary additional cost to providing services,
as providers and commissioners would have to pay for
the protection that designation offers, by paying into
the financial mechanisms that will cover the cost of
insuring the continuity of services in the event of failure.

At this point, I would like to clarify a misconception
that has appeared in recent reporting of designated
services. As I have said before—I believe it is important,
so I will say it again—just because a service is not
designated does not mean that commissioners plan to
close that service. Rather, that means that the commissioner
has contracts in place with other providers locally to
provide that same service and, should one of the providers
fail, then those other providers could be called up to
replace the lost capacity.

**Mr Barron:** What happens to the service that is not
being used anymore?

**Mr Burns:** It will be used, because, if a service is not
designated, there could be more than one provider of
the service. That is what any willing provider is about,
so there will be no problem.
New clause 11 introduces measures that will govern how complaints can be made in relation to Monitor’s decision to refuse an application for designation under clause 69. The new clause will allow the commissioner, or the provider of the service, to complain against the decision not to designate if they believe that the criterion, as set out in subsection (3), for designating a service is met. The new clause would then require Monitor to re-examine its original decision and decide whether the designation should be applied or not. The new clause would also allow the commissioner, or the provider, to appeal to the first-tier tribunal should they believe that Monitor’s decision on the complaint was based on an error of fact, or wrong in law, or unreasonable. New clause 11 would also provide an important check to ensure that services that actually need the protection of designation are able to obtain protection.

Finally, new clause 14 introduces general rules to which all complaints under this chapter must follow. The new clause would mean that complaints would only be accepted if they are received no later than 28 days after the decision to which the complaint relates was notified. The new clause would restrict individuals at Monitor, who were involved in the original decision, from being involved in the reconsideration of the original decision. The new clause would also restrict the grounds of appeal to the first-tier tribunal, only if the complainant believed that Monitor’s decision on the reconfiguration was based on an error of fact, or wrong in law, or unreasonable. The new clause provides that the first-tier tribunal may confirm Monitor’s decision, or direct that it is not to have effect. On that basis, I move the amendments and new clauses, and urge my hon. Friends to support them.

12.15 pm

Derek Twigg: I will cut short what I was going to say to save time, because I know that members of the Committee want to move on to the clause stand part debate. We have made clear our position on the Government’s proposals.

I have a few questions about new clause 10. It notes that a provider of a designated service could be one who has a significant interest in the application, but who will judge what qualifies as a significant interest? Benefit providers with significant resources will be able to challenge a decision legally, so we are concerned, again, about the process of opening it up to legal challenge and it becoming a lawyers’ charter for the private sector. We are also not satisfied about bureaucracy continuing to be a problem. If any interested health care provider challenges a decision, Monitor must consult the commissioner who made the original application and, whatever the outcome, an appeal can be made and it will be dealt with by a first-tier tribunal. That might not happen—I accept that it is a matter of judgment—but it might happen repeatedly, which would increase the amount of time spent on challenges.

We believe that new clause 11 will also lead to more bureaucracy. It covers an important area, but the entire process of designation, challenge and appeal could lead to countless lengthy disputes over designation of services in relation to providers, commissioners, Monitor and tribunals.

Mr Burns: The hon. Gentleman asks a specific question about who has a significant interest, so it would be helpful if I give him the answer. Initially, it will be Monitor, on a complaint, but the first-tier tribunal on a subsequent appeal.

Derek Twigg: Finally, on amendment 505 and new clause 12, what is significantly different under the new clause from subsections (8) to (10) of clause 71, which are of such concern to the Government? I understand that the Government tried to table an amendment to delete that part of the clause, but I assume that the Clerks did not accept it. Will the Minister say more about what is different? Clearly, the Government did not like what they put in the Bill originally, so it would be useful to know why they now propose this new way.

Mr Burns: Again, it might be helpful if I clear up this point. The reason why we are adding the new clauses and seeking to remove, in due course, clause 71 is that we want the Bill to be as transparent as possible. The new clauses give greater transparency on an important issue. I would have thought that, rather than giggling, Opposition members of the Committee would find that extremely helpful and a possible way forward.

The Chair: Order. I do not wish to intervene, but, for the benefit of the record, I think that the right hon. Gentleman might find that he means clause 70.

Mr Burns: Sorry—clause 70.

Derek Twigg: Can we assume that clause 70 is transparent as well?

Mr Burns: Yes. The replacement expands and improves it.

Derek Twigg: We will explore transparency to a greater extent during the clause stand part debate, but I have concluded my comments about this group of amendments.

Amendment 504 agreed to.

Amendments made: 505, in clause 69, page 74, line 6, leave out from beginning to ‘to’ in line 7 and insert ‘Monitor must give notice of its decision on an application under this section’.

Amendment 506, in clause 69, page 74, line 10, at beginning insert ‘Where Monitor grants the application,’.

Amendment 507, in clause 69, page 74, line 11, leave out ‘right of appeal conferred by section 70’ and insert ‘rights conferred by section (Complaint about grant of application for designation)’.

Amendment 508, in clause 69, page 74, line 11, at end insert—

(’ ) Where Monitor refuses the application, a notice under subsection (7) given to the commissioner or the provider of the service must—

(a) give the reasons for the refusal, and

(b) explain the rights conferred by section (Complaint about refusal of application for designation).

(Mr Simon Burns.)

Question proposed, That the clause, as amended, stand part of the Bill.
Derek Twigg: I am sure that the Minister wants a debate on this, because my hon. Friends and I still want to explore many matters. As I said in my opening remarks, we are somewhat unconvinced by the Minister’s arguments. These provisions amount to a charter for hospital and service closure, which will be made easier by these proposals, and, given the funding backdrop against which we live, they will be a major driver. Many parts of the Bill will change the NHS as we know it for ever.

We have had a lot of time to discuss accountability, Monitor, competition and giving powers to quangos, such as the national commissioning board and Monitor itself. The clause puts Monitor at the centre of everything that is going on in the national health service and gives it untold powers. We will discuss pricing and why we need an income regulator later.

The designation of services has not received much attention until today and the Minister has tried to explain it to us, but, unfortunately, he has not been able to give us many examples or details. He keeps saying that guidance will be forthcoming some time in the future. We find ourselves in the incredible situation of having to make decisions with lots of information missing. None the less, as I have said before, we will oppose this clause. The fact is that these duties are overseen by Monitor. We have already talked about bureaucracy, but we are placing a massive burden on those who must do this work. It will distract them from the day-to-day running of the NHS.

May I ask the Minister to clarify an earlier matter? At what point will decisions be made about which services are designated? We are interested to know that and how long the process will take. It is unclear how the process will work on the ground. That is crucial. When will the process of designation or non-designation begin and how long will it take? I will come to resources in a minute. If the process is done in the way in which we think it will be done, it will be a massive distraction for many people who are already under great pressure in the national health service.

In its evidence, the King’s Fund said:

“The burden on commissioners making an application will be considerable if it is to be evidence-based. For example, the relationship between travel times and outcomes are not well established in many areas of care.”

We tried to find examples of how this will impact, but we do not seem to be getting very far with the Minister on this, yet it is a crucial point. The evidence continues:

“They may also find it difficult to assess the interdependencies between different services.”

The King’s Fund means the commissioners here.

“It is not clear therefore whether GP consortia will have the technical skills and evidence base to make the case for designation.”

The other thing that we are not clear about—I do not want to go into the arguments about primary care trusts—is how many people will still be around who have the necessary skills to do that. The Minister has said that that is not an issue, but we know that people are leaving. It would be interesting to know how many commissioners have given an indication that they wish to leave the health service and how many have already left. It would be useful to have that information. Commissioners are skilled people; they have a great deal of knowledge.

What about GP-provided services? Are we into designation and non-designation of such services? Later, we will talk about gatekeeper GP services. I am not sure whether GPs and the services that they provide in health centres or surgeries will be part of this grand designation plan. If they are, that will entail even more bureaucracy and involvement. Will the Minister set out the costs of this whole designation process and tell us how long he expects it to take?

Of course there is also the disruption as well as the pressures and the cost. People are under huge pressure to find unprecedented efficiencies and face not only cost pressures but the massive reorganisation, which the Government had said would not happen but will now happen. How does the Minister expect the commissioners and NHS staff to cope with all that as well as take on other responsibilities? The disruption is very important. A report that was published last week mentioned the real threat to services, to which I may come later.

On page 98 of the explanatory notes, paragraph 588 states:

“The determination as to whether the criterion would be met for a service should in practice be based on an assessment of evidence of patient needs and local provision, and therefore done principally by local professionals with local knowledge. Commissioners would be expected to demonstrate this evidence to Monitor.”

I return to the point that these people are supposed to know everything that is going on locally, but they will have to appear in court before Monitor to demonstrate what they are saying is correct. These people have been commissioning services for years, but under the Bill they have to convince Monitor that they are following the rules, which is remarkable. The explanatory notes go on to say that commissioners would be expected to demonstrate the evidence to Monitor “when applying for a service to be designated and would be required to provide copies of consultation responses”.

It would be interesting to see how far that goes in the light of the time taken to look through various consultation responses. As I said, this has to be done when services are not designated and when they are designated, and we are not quite clear how that will work.

Again, I would put the emphasis on local knowledge. The Government are trying to have it both ways: they say they want GP consortia and local professionals and clinicians to drive everything, but people still have to appear before Monitor, which will make the final decision. The Government try to dress that up by saying that as long as people follow the rules, everything will be okay, but we do not have any details or guidance about how the process will work. That is quite extraordinary, and the Minister might want to say something later on that important point.

Will people increasingly be looking at the profit line in this process? They might want to deal only with services they can make a profit out of, and they might get rid of other services, because they will be focusing on the pressure on them as a result of the drive for increased competition, rather than on promoting patients’ best interests. The Minister might think that this does not require any comment from him, but it has been raised with Opposition Members by several people working in the health service. [Interruption.] The Minister makes some comment, but the fact is that people who work in the health service raised these issues with us, and they have much more knowledge of them than we have.
As I will keep repeating, Monitor is at the centre of all this. The hon. Member for Totnes (Dr Wollaston) made an important point in an interview last week, when she called those working for Monitor “competition economists with a zeal for imposing competition at every opportunity.”

The people running Monitor will not be those who have a patient background or whose primary concern is to ensure integration and collaboration in services and to promote the interests of patients. This will be about economic regulation and driving competition.

To stick to local accountability, the Government often say that local people—professionals, clinicians and patients—will drive this process. Interestingly, paragraph 4.1 on page 27 of the White Paper states:

“The Government’s reforms will liberate professionals and providers from top-down control”—except Monitor, that is. Paragraph 1.10 on page 8 says:

“We can foresee a better NHS that…puts clinicians in the driving seat and sets hospitals and providers free”—although not, of course, from Monitor, which is omnipresent. The Secretary of State talked about top-down forced closures, but if Monitor is not a top-down structure, I do not know what it is—apparently, it will have no regional presence—and I wonder how that fits in with the Secretary of State’s words. We will come back to hospital closures a little later.

At a time of great financial strain and pressure on NHS staff and the service, where will Monitor get the expertise—this comes back to the point about Monitor not having the necessary expertise—to examine and challenge designation proposals from local professionals with local knowledge? Where will that resource come from? How much bureaucracy will be involved in that process? How many people will Monitor have working on it? Those are important questions. The Government say we are cutting bureaucracy and getting rid of management consultants, so we need to know the answers. What will happen?

The Government—not just Ministers in the Department of Health, but Ministers throughout the Government, from the Prime Minister down—have made great play of the fact that they want massively to reduce the cost of management consultants. Will management consultants be employed by Monitor or anyone else to help this process through? How many consultants will Monitor employ? Have the Government set a financial limit on Monitor’s use of consultants, because it will not be able to find enough qualified people? Will the Government prevent the re-employment of former NHS staff who have left with redundancy packages, or left the service, as management consultants? What will the Government say about that?

12.30 pm

The Minister said that we should not be concerned about designating services. I come back to the point that we still do not understand why the Government have a process that involves making a case to designate a service rather than to undesignate it. That goes to the heart of the Government’s proposals. The process lacks scrutiny, how many services need to be considered for designation? I will keep repeating that question because it is about how the process will be carried out, how long it will take, and how many people and how much NHS resource will have to be involved. Why would a commissioner who has been commissioning a service decide it should not be designated all of a sudden? Is it a problematic process because it is changing the Bill; they now have to consider whether a service is designated. We find ourselves in an unbelievable situation.

There are differences among hospitals, GPs and different health providers. As I said in the debate on amendment 478, hospital services are highly interdependent. In the first instance, that means that if one service is designated, a lot of others on which it relies might also have to be, which makes the process messy. An example of that might be accident and emergency, which needs a lot of back-up services to make it safe. Will the Minister guarantee that every A and E will be designated? I will come back to reconfiguration, but I must ask the Minister to give us a guarantee. It is very easy if this is not about cuts.

I make the point I made before: it is difficult to say exactly what in a hospital is designated. What if a doctor works 50% of the time on a designated service and 50% on a non-designated service? What happens to him if the hospital becomes insolvent? What happens if a piece of equipment is used 50% of the time on a designated service and 50% on a non-designated service? Those are important questions.

**Graeme M. Morris:** On the question of designated services and how difficult it is when they are linked to other services, I know that the Minister does not like examples, but it is well publicised that the West Cumberland hospital and its NHS foundation trust are in financial difficulties. It was widely reported in the media that it is running a deficit of £20 million. In such circumstances, under the new arrangements, presumably, Monitor would use its powers to encourage another provider, either an existing foundation trust or a private sector provider, to take it over. If, as the Minister suggests, there are certain key services, and those are essential for the people of west Cumbria, such as A and E, how could A and E possibly be designated without designating all the other integrated services that relate to it?

**Derek Twigg:** My hon. Friend, as usual, makes an important and well thought out point that undermines the idea that we can easily break up hospitals into individual services. In keeping with what he said, we need to look at organisations and groups of services as a whole when making decisions about them.

The Minister might want to correct this, but I get the impression that there will be a determination to break hospital services into different parts and not, for instance, designate a whole service in terms of its inter-reaction. We will be interested to hear what he says. What about the impact of this on the integration of services? Fitting in with regional services will be an important element, as I mentioned before. The King’s Fund makes some important points:

“The Bill does not acknowledge that people (and professionals) outside the immediate local area may be affected by a loss of service. For example, tertiary and specialist services often serve wide catchment areas. It is not clear what happens if no local consortium chooses to designate a service.”

That is an interesting point. What happens in a case where a population, and perhaps some clinical professionals, feel that a service should be designated? Is it really just
down to the local consortia? What impact will others' views have? The King's Fund goes on to say:

"There is provision for NHS Commissioning Board to step in and 'facilitate agreement between commissioning consortia' to decide whether to designate and who should apply, but it is not clear what should happen if that does not work."

We have been asked to make a decision on the clauses when greater clarification is needed, and that returns us to an important point that we have all made. The King's Fund says that there is a need for greater "clarification about the regime for designating services."

We have been asked to make decisions, and the fundamental point that we are trying to make today is that the detail is missing. We are being asked to make fundamental decisions on fundamental changes to the health service and people's lives, and even the King's Fund is raising the issue. It goes on to say that the process is inflexible. What if a mistake is made in the initial designation? What if there is a need to designate a service later on because circumstances have changed? Is it necessary to wait for a year? Under Amendment 511, a review "must not begin before the expiry of the period of one year". We will discuss that when we come to clause 71.

I asked earlier what account the regime will take of travel times for patients. Will the Minister give a clear commitment today that the designation process will not increase the travel times for NHS treatment? That is a key consideration for people and patients.

Both the Prime Minister and the Secretary of State have said that they are ending the top-down driven closures of hospitals and A and E departments, except from Monitor. The hon. Member for Enfield North made a particular point about the situation at Chase Farm hospital in his constituency. It is one of a number of proposed closures that the Opposition latched on to before and during the general election, giving a nod and a wink that things would be okay because there would be no top-down driven closures. However, we have not seen that, and it would be helpful if the Minister gave a guarantee today that there will be no closures of A and E departments, wards or hospitals in London.

Nick de Bois (Enfield North) (Con): If there was a nod and a wink, I must have missed it in the heat of the pre-election campaigning. I do not want to debate all the issues, but I want to set the record straight. We made it very clear that there would be a moratorium after the election, when there would be a review based on four tests. That process has gone ahead, and the issue, as I believe the hon. Member for Halton knows very well, has moved on to another stage. I do not want people who read the record to be drawn to any other conclusions about what is happening at Chase Farm hospital.

Derek Twigg (Halton) (Lab): The Prime Minister promised to protect the NHS. Will the Minister confirm that Monitor's decision as to which services will be designated will not be financially driven—or will we see more broken promises on funding, real-terms cuts to the health service and no top-down reorganisation? Another promise was for 3,000 extra midwives, but that has now been dropped.

The issue is about driving competition and cuts in the health service. The Government think that the regime is a failure, and they want to introduce regulation because they believe that there will be more failure. There will be failure not because of poor quality, but because of what is being driven by the Bill—Monitor and its plans.

It is clear that removing the Secretary of State's ability to intervene in reconfiguration will pass responsibility to Monitor, which is unelected. That will make it easier to allow plans to make unpopular cuts and to close down services. Ministers will then try to wash their hands of that by saying, "Not me, guv; it was Monitor, and that is what Parliament voted for." I still think that there will be a lot of pressure in Parliament, through Adjournment and other debates, on the Secretary of State and other Ministers, but one has the impression that they are trying to wash their hands of the matter and blame everything on Monitor.

The comments of David Bennett, the new chair of Monitor, in The Guardian last Thursday were telling. He said that

"the problem in healthcare was that there was such a strong emotional attachment to a local provider of services."

He was probably referring mainly to hospitals and hospital services. He went on to say:

"MPs will still be allowed to make representations but closures will be possible if 'done in a fact-based transparent way [which] has established what is in the best interests of the patients.'"

Liz Kendall: Unbelievable.

Derek Twigg: As my hon. Friend says, that is an unbelievable comment. It sort of says that things were not done in a "fact-based transparent way." Again, we would be very grateful if the Minister gave us some examples of where that has happened. I may be misreading comments about MPs. The article states:

"MPs will still be allowed to make representations".

We are very grateful. We are most grateful that the chair of Monitor says that we can continue to make representations on the closure of services. We will be doing so.

The fact is that the Secretary of State and Ministers have been taken out of the equation. May I give a couple of examples that might be useful in showing how important the switch from the Secretary of State to Monitor is? There was a review of burns services in the country as a whole. In the north, that review recommended that the most serious burns cases should be centred in Manchester and taken away from the Liverpool designated hospital, which was Whiston and St Helens—one of my local hospitals. There was a great deal of debate and massive public opposition, which ran into the thousands, to the review. There were petitions and much lobbying of MPs took place.

It came to light that the person who had a significant say in transferring that part of the service to Manchester was Manchester based. Through a lot of ground work, done by MPs, we found out that many of the data responsible for the decision being proposed were not adding up. That came about because we could ask the Minister questions. She could make representations on our behalf and intervene on the issue.
At the end of the day, the decision was changed. That was fact-based and pretty transparent. The Secretary of State was able to express a view on the matter, which was translated to the service in the north-west. That intervention meant that there was such an outcome. Monitor does not have to take account of such things. The fact is that we will lose that.

The second example relates to my local trust—Warrington and Halton Hospitals NHS Foundation Trust. Again, there was a great debate and campaign because the trust wanted to transfer its critical care in some medical wards from the Halton site to the Warrington site. There were good arguments for doing that. We listened to those. After meeting the Minister, we asked Professor Sir George Alberti to come along and look at the services, and he did that. Based on his recommendations, the service was transferred, but we managed to campaign to have other services delivered at our hospital in Halton—more operations, day surgery and so on. That was a very important part of the process of seeing the Minister. The Minister got involved and expressed a view on the matter. Again, that was done in a fact-based, transparent way. It was a bit of a slight for the chair of Monitor to be saying that we do not do things in a fact-based, transparent way.

The two examples I gave involved massive public involvement—demonstrations, marches and petitions. If the patients are at the centre of the Government’s proposals, how much weight will be given to them in the reconfiguration of decisions, particularly if the chair of Monitor believes that a “strong emotional attachment” is the problem? How is a strong, emotional attachment to NHS services a problem? Is that not a good thing and a very important part of the process? I can see what he is getting at. He is trying to say that emotion overrides facts and that Ministers are susceptible to that type of influence. I have given two examples where the facts were transparent, the emotion was strong and decisions were taken on that basis. Whose views will win most in these reforms? Will it be patients or will it be others? We keep hearing that patients will be involved, but they will not have the decision. I could go on to give further examples, but I will leave it there.

On the issue of reconfiguration, which is an important part of the process, the King’s Fund has raised some important concerns. It has stated:

“It will also be difficult for GP commissioners to drive major reconfigurations within secondary care. The importance of the system leadership role currently provided principally by strategic health authorities”

the Minister may remember that I made this point in the debate on the amendment—

“is underlined by a new report published by The King’s Fund on the reconfiguration of hospital services. The report shows that essential changes to improve quality and tackle financial deficits in some hospitals are unlikely to happen if left to market forces alone.”

That is a very important point, which the Minister needs to consider. The King’s Fund goes on to state:

“The Bill enables GP consortia to collaborate to address issues across consortia boundaries. However, they may not have the appetite or the skills to tackle large, complex and contentious service changes, with the result that the pressing need to reconfigure hospital provision in some areas may not be addressed quickly enough.”

A classic example is the burns unit issue that I just mentioned, which went across regions. The King’s Fund goes on to state:

“A strong, strategic commissioning function able to look across large geographical areas is needed for these purposes. In a recent radio interview, the Secretary of State indicated that the NHS Commissioning Board may have a role in this, although he did not explain how this might work.”

In light of designation, and other changes, could the Minister tell us how major service reconfigurations will be overseen in future? What about the regional perspective? That is particularly important—and I am glad that the King’s Fund agree with us—because, given the loss of the strategic health authorities, there is a real issue concerning leadership, making or driving forward proposals, and ensuring that there is strategic vision. I would like to hear the Minister’s thoughts.

Designation is time consuming, bureaucratic and costly at best. The Opposition believe that it is a mechanism to allow wholesale cuts in the NHS so as to bring in more competition, with lip service paid to local clinical and professional views and those of patients. There is a complete lack of scrutiny here, and a lack of the detail needed for us to make an important decision. Monitor believes public attachment is a problem, which we find unbelievable. It will be fertile ground for lawyers, legal challenge and bureaucracy. It is a terrible proposal and we will vote against it.

Grahame M. Morris: The clause, as we have heard, provides for commissioners—commissioning consortia, the NHS commissioning board, or the Secretary of State if exercising his powers—to apply to Monitor for services to be designated and put into a special administration regime where there has been a provider failure. Additional regulation will exist to ensure that there is continued provision where a failure regime is initiated. There is an acknowledgement of the need for this regulation to protect vital health services where they fail in the new health market.

We have discussed the importance of Monitor to the new health market, and, in the view of Opposition Members, the over-reliance on this superquango. Monitor’s key concluding function will be to act when patients’ local services are forced to close. A commissioner can apply for a service to be designated only if there is an absence of alternative provision, and when ceasing to provide the service would have a significant adverse impact on the health of patients. The commissioner must also have regard to the current and future need for the provision, and whether losing the service would significantly reduce equality of access.

However, it will be for Monitor—which, we should not forget, is the economic regulator—to decide whether the commissioner has satisfied the criteria to carry out a consultation and demonstrate that clinical need will not be met. That raises the fundamental question of why the economic regulator of health services should make that judgment of clinical need. My hon. Friend the Member for Halton referred to that earlier, and other colleagues have discussed the considerable administrative burden of proof that this will place on commissioners to show that a service is defined as vital.

That is another example of the contradiction between the actions of the Government and their rhetoric. In the way in which the clause is formulated, they seem to have
moved from patients’ champion to defender of bureaucracy. A considerable bureaucracy is being established under the guise of Monitor, which, we discovered last week, will cost half a billion pounds—over the lifetime of a Parliament—with a comprehensive role that runs counter to the rhetoric that we have previously heard from the Government Front Bench. We know that Monitor intends to interpret its power to grant an application for designated services, as set out in subsection (6), but we will not know how until it writes its regulations after the passage of the Bill. That concern was also raised by my hon. Friend the Member for Halton.

In the current financial climate, with pressures for efficiency savings, Monitor can be expected to challenge applications and to require commissioners to jump through hoops. Even with the kind of budget that we have discussed—up to £140 million a year—there are questions about whether Monitor will have sufficient funds to meet its obligations to areas with failing services, because Ministers have not been capable of making any estimation of service failures. That is despite my repeated questions, parliamentary questions, letters and the matter being raised in Committee. There has been no robust or meaningful response about service failures, either commissioner or provider failures, which will be a really big issue for the reorganised NHS.

The Opposition are concerned that Monitor will be given the latitude to decide upon its own guidance under clause 73, which it will then publish and require commissioners to follow. The guidance will cover applying for designation of a service under clause 69, and reviewing of designation and applying for the removal of designation, where it has been granted, under clause 71. The Government are being coy about the necessity of provider failure in the market that the Bill creates, and they have not spoken clearly about it in their vision for the future of the NHS.

Liz Kendall: Does my hon. Friend recall the Minister’s opening comments today? He said that there has always been failure in the system, because of “overcapacity” and “poor management”, and that it has been “covered up” and “propped up through covert subsidies”. Would my hon. Friend find it useful to discover how many providers are forced to contract or exit markets.

Grahame M. Morris: I am grateful for that intervention. If the Minister were to give such examples and figures, it would be very instructive, but there seems to be reluctance and perhaps there is a reason for that.

The coalition agreement recently promised: “We will stop the centrally dictated closure of A&E and maternity wards, so that people have better access to local services.” If the Minister were to give such examples and figures, it would be very instructive, but there seems to be reluctance and perhaps there is a reason for that.

The coalition agreement recently promised: “We will stop the centrally dictated closure of A&E and maternity wards, so that people have better access to local services.” If there are provisions in the Bill that allow Ministers to intervene to prevent the market from reaching that conclusion through the vehicle of Monitor, I will gladly give way, but I see that the Minister does not want to speak. That point was also made by the hon. Member for Southport last week when we were dealing with clauses 56 to 60. Despite Government Front-Bench rhetoric, the Bill will ultimately prevent democratic pressures from affecting decisions on health care provision, replacing them with market forces and unaccountable superquangos.

I have referred frequently to the impact assessment. It is important, and it is illuminating to read. It makes it clear that local hospitals will have to close, and that local MPs, councils and campaigners must not be allowed any influence in that regard. The sweeping powers being given to Monitor to dictate the failure regime are also mentioned in supporting documents to the Bill. The consultation document “Regulating healthcare providers” states:

“These criteria are likely to focus on identifying where a provider is the only provider or one of very few providers in a local area.”

The only justification for additional regulation is the need to maintain patient safety in the absence of other providers.

As the Minister said, it is clear that the failure regime is not there to mitigate significant service failures; in his view, the mechanism will be used only in extreme circumstances. I suspect that the Minister has significantly underestimated the failure rate. At the risk of repeating myself, I believe that the theoretical basis for the Bill is contained in paragraph B4 of the impact assessment. It is important to listen to this, because it gives the guiding principles of the Bill. It states:

“Choice-based competition works best where good providers can expand their service offer and enter new markets, and poor providers are forced to contract or exit markets.”

That will send shock waves through existing NHS providers if it is given the force of law. The document goes on to explain that unless providers are allowed to access the market, the changes made under the Bill will not produce the anticipated benefits—in other words, the Bill anticipates a failure regime, and Government Front Benchers consider that that failure may be a good thing as it could bring about innovation.

Dan Byles: I am curious. Is the hon. Gentleman saying that what he called poor providers should be protected and allowed to continue providing a poor service to patients, who at the end of the day are what the Bill is about?

Grahame M. Morris: I am suggesting that Monitor is being given this primary role as economic regulator, and that the existing structure of strategic health authorities and PCTs that is meant to support providers and identify areas of weakness will be lost. That is genuinely a bad thing.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): In response to that intervention, we understand that Monitor judges by quality and is an economic assessor, so if we are talking about poor providers, what is the context? Is it poor economically or poor in quality?
Grahame M. Morris: In that regard, Monitor's fundamental role is as an economic regulator. It is a good point and well made, but I wish to move on.

Paragraph B149 of the impact assessment is entitled “The proposals for competition jeopardise access to essential services”. It states:

“There is a risk that this could lead to inequalities in access to services or disruption to the continuity of essential services. The Government’s proposals will give Monitor substantial powers to protect access to essential services where they are ‘designated services’. These include the ability to require providers to continue delivering particular services for local populations, the power to require providers to contribute to a risk pool so that funds are available to protect the continuity of these services”.

In the light of that assurance, will the Minister say how it will work in relation to European competition law as it applies to the market in health care? [Interruption.]

The Minister groans, but it is an important question, and those involved in health care want to know the answer, as do Opposition Members.

Will the Minister and Government Members say explicitly that the failure of local health services would be a good thing? Is that their contention? If so, will they undertake not to speak out in future against any clause that affects their local hospital services?

Liz Kendall: Does my hon. Friend agree that is important that Members on both sides should be aware that it is not only poor quality—

1 pm

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

Adjourned till this day at Four o’clock.