Contents

Clause 69, as amended, agreed to.
Clause 70 disagreed to.
Clauses 71 to 92 agreed to, some with amendments.
Schedule 8, as amended, agreed to.
Clauses 93 to 97 agreed to, one with an amendment.
Schedule 9, as amended, agreed to.
Clauses 98 to 106 agreed to, some with amendments.
Schedule 10, as amended, agreed to.
Clauses 107 to 112 agreed to, some with amendments.
Adjourned till Thursday 24 March at Nine o’clock.
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Saturday 26 March 2011

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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
Public Bill Committee

Tuesday 22 March 2011

[DR WILLIAM McCREA in the Chair]

Health and Social Care Bill

Clause 69

DESIGNATION OF SERVICES

4 pm

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

Grahame M. Morris (Easington) (Lab): It is a pleasure to serve under your chairmanship, Dr McCrea.

At the last election, my experience was that members of the governing coalition parties made great play and political capital of campaigning against any hospital or acute service closure, or even possible closure. Does the Minister have anything to say to the experienced and dedicated staff who will face the full impact of his plans for upheaval and disruption? Will he describe market failure to them? There seems to be a reluctance to describe it to the Committee.

Many questions on the future of the bureaucracy in the NHS still need to be answered. Great play has been made of the fact that the Secretary of State has promised that this is not a top-down reorganisation of bureaucracy, but the abolition of it, and the Prime Minister said last Wednesday at Prime Minister’s questions:

“We are not reorganising the bureaucracy of the NHS... We are abolishing the bureaucracy of the NHS.”—[Official Report, 16 March 2011; Vol. 525, c. 292]"

In that case, how would the Minister describe the two thirds of the Bill that set out the rules for competition? Will he venture a guess or an estimate now of the cost to the NHS of the proposals both for failure regimes and for designation?

If Committee members are not minded to support my arguments, perhaps they might want to listen to the arguments being made by the hon. Member for Totnes (Dr Wollaston), a former GP who serves on the Select Committee on Health and who I understand wished to serve on this Committee. She said that the plans would result in the NHS going “belly-up”, not “top-down”.

She went on to say that “if Monitor, the new economic regulator, is filled with competition economists with a zeal for imposing competition at every opportunity, then the NHS could be changed beyond recognition. It is no use ‘liberating’ the NHS from top-down political control only to shackle it to an unelected economic regulator.”

We have not seen anything in the Bill that would rein in Monitor, and I hope that the Minister will look again at making significant changes to the current approach, which will result in service failures, a bureaucratic nightmare and an over-powerful economic regulator dictating local service closures—not based on quality or local needs, but on economics and competition.

John Pugh (Southport) (LD): It is a pleasure to serve under your chairmanship, Dr McCrea.

I was not able to pick out from fairly wide-ranging contribution of the hon. Member for Halton whether he opposes the principle of designation or whether he objects to the lack of apparent clarity in the designation process.

Derek Twigg (Halton) (Lab): Both.

John Pugh: Okay. May I take him up on the first issue of the principle of designation? Presumably, if he is against the principle of designation, he is in favour of a system whereby all services, regardless of their value to the community or their indispensability, are judged by, broadly speaking, the same criteria when people make decisions on whether to use those services or not. I thought that we were all genuinely uncomfortable with that, and the legislation seems to indicate that most of us on this side of the Committee would be uncomfortable with that because we feel that some services in a special category ought not to fall due to any sort of market failure or commercial competition, and that other services are in a rather different category. I think the general public feel like that.

One has to visualise what the situation would look like if we were to take away designation per se. I think it would look similar to what it is now. As I understand it, there is no process of designation at the moment. If we compare, for example, the Co-operation and Competition Panel with Monitor, we see what Monitor would look like without designation.

Derek Twigg: If I have misunderstood the hon. Gentleman, I apologise, but I understand that the Liberal Democrats were opposed to the proposals for competition in the Bill. [Interruption.] Will he let me finish? As we are opposed to the proposals in terms of competition, pricing and Monitor, why would we support the proposal for designation, which all fits into that mantra for the Bill, which I understand that his party is opposed to?

John Pugh: Basically, my argument is that if the hon. Member for Halton is opposed to competition, why in the previous Parliament did he support so many of those requirements that were put into health legislation and demanded competition? We have an organisation somewhat similar to Monitor, existing today, called the Co-operation and Competition Panel, which does similar sorts of things. It has to balance collaboration and competition. As far as I know, it was not tasked by the previous Government to do anything about health inequalities. It has similar functions to Monitor, although Labour wants Monitor to do something about health inequalities. It has to consider the impact and availability of choice and competition, which Monitor has as a parallel function.

Owen Smith (Pontypridd) (Lab): I go back to the point I made this morning. Are there not fundamental differences between the Co-operation and Competition Panel and Monitor, such as the extent to which competition law will apply and how the Co-operation and Competition Panel is not charged with promoting competition? It is charged with striking a balance between collaboration and competition, rather than promoting one at the expense of the other.
John Pugh: That is a fair point about stress. I acknowledge that European competition law and how competition law will apply is unfinished business, but if the hon. Gentleman will allow me to park that issue, I will develop my argument.

The Minister of State, Department of Health (Paul Burstow): There is one other distinction of which the Committee should be aware. When the Co-operation and Competition Panel was established, it was not subject to any form of parliamentary scrutiny.

John Pugh: We will accept that there has been a degree of mission creep in what it does. We are debating what Monitor can and cannot do. I am not aware that there was any parallel debate with regard to the creation of the Co-operation and Competition Panel, although it impacts in all our constituencies. Apparently, we cannot even abolish it, because officially it is not a statutory body. It is something that has emerged and been implemented by the previous Government; presumably it was implemented because the Secretary of State at the time thought that there was a purpose to it.

Most of the criticisms that the hon. Member for Halton has made of Monitor in this debate—there are others to be made, which I might share with him—are also criticisms that could be made of the Co-operation and Competition Panel. It is unaccountable. There is a huge issue about accountability, particularly of those organisations that are making important judgments with a balance of considerations, which have a strategic impact. There is a question mark over whether an organisation such as that is strictly speaking just a regulator, or whether it is more of a strategic body. None the less, I think he would accept that both bodies are unaccountable. I have never written to the Co-operation and Competition Panel, nor have I found a way of doing so, but it has impacted in my constituency. My hospital, to make ends meet, because it has a fairly substantial deficit, has had to work with other hospitals in a collaborative way and share pathology services throughout Merseyside. Before it could do that, however, it had to go to the Co-operation and Competition Panel to satisfy it that there was sufficient competition around.

Derek Twigg: I want to clear up one point, so that I have no confusion in my mind. I am listening to what the hon. Gentleman is saying and I understand his arguments, but can he explain whether he is in favour of the proposals in the Bill for Monitor and the extension of competition?

John Pugh: I know that. If the hon. Gentleman looks back through Hansard, part of his critique of Monitor doing its designation process was that it cannot do that properly because it is not in touch with the local scene. I do not know how far the Co-operation and Competition Panel is in touch with what goes on in the Southport and Merseyside health economy, but I doubt that it is not more in touch than Monitor would be.

If hon. Members look at the provisions of the Bill dealing with what Monitor will do, they will see that the additional clauses in the Bill make it fairly explicit that although the panel does not have to take on board financial aspects and consequences, Monitor will have to do so. In a sense, it is an attempt to finesse a model that already exists. That said, however, I take the point that if Monitor is to perform a series of complex processes—balancing considerations and working out what is designated and what is not—there is a genuine issue about accountability.

I accept the point made by the hon. Member for Oldham East and Saddleworth that the remit of the two organisations is not exactly identical, but the functions that they will perform within the health system have similar consequences. Members should not content themselves with the belief that there is a bad world ahead, and that the sort of things that they complain about are not happening now. In the past 24 hours, I have discovered that the dermatological unit at the local hospital in my constituency will be deprived of a contract, because Assura Medical has bid for and got it—presumably on price competition. It has got the unit although it does not have a consultant urologist, or a base to work from. That is what is happening.

There is a case for defining more clearly in legislation than we have done so far what fair competition is, because appalling things have happened. To cite another example from my constituency—I am not shy of citing examples, unlike the Minister—the urologists in my local hospital are working partly in a private hospital that also gets patients who are referred from the local community. In effect, they are using their talents and abilities to worsen the budget of the local hospital and create a financial problem. Simultaneously, they are paid by the NHS and getting NHS pensions. One hospital picks up their pension bill, and the other picks up the reward for their services, through the commissioning that the PCT gives it. That does not strike me as fair competition.

Both of my examples are current today; they are live at the moment. We have to recognise that, if we accept that there has to be a degree of competition, it has to be framed so that the competition is fair. The Bill must do that; simply leaving things alone is not an option. The Bill will not get rid of cherry-picking, because that is happening today in Southport.

Liz Kendall (Leicester West) (Lab): Does the hon. Gentleman think that one key issue is to manage the consequences of competition? There is a debate about whether the evidence suggests that competition improves health outcomes, and the Committee has discussed that to some extent. There is also a debate about whether, in any system with competition, there are real consequences as patients and money move. One of the arguments that we have so far is that there will be no ability to manage those consequences under
the new systems proposed in the Bill. Does the hon. Gentleman think that that is more important than having a more “pure” market?

**John Pugh:** I have heard the arguments made by the hon. Lady several times. It is a perfectly valid point—

**The Chair:** Order. May I say to hon. Members that, as you know, I am new in the Chair? Nevertheless, I am led to believe that you have already debated the subject of competition, so we have to stick strictly to the clause that we are dealing with at the moment.

**John Pugh:** I will conclude very briefly, Dr McCrea. I accept the point that the hon. Lady has made about a managed environment. It is a perfectly valid point that demands and requires further investigation. All I have to say is that, when times are hard and PCTs and acute hospitals are trying to cut their budgets, it does not look like a managed environment. It looks like dog eat dog.

**Owen Smith:** It is lovely to serve under your chairmanship today, Dr McCrea. Designation is another of the Orwellian phrases in the Bill.

**The Minister of State, Department of Health (Mr Simon Burns):** Orwellian?

4.15 pm

**Owen Smith:** Designation does not feature anywhere else in health legislation, as far as I can tell. We have not seen it previously used, although it has been used in the context of energy regulation and some other such aspects—much of the regulation framework in the Bill comes from the energy sector, and so too does “designation”. It is a crucial term in the Bill and it is intimately connected to competition, because the reason we have that Orwellian term, “designation”, is precisely the degree of competition to which we are about to open the NHS.

Unlike my extremely experienced right hon. Friend the Member for Rother Valley, I understand absolutely what designation means. The Minister has told us on several occasions, effectively, what it means: it is about protectionism—a permissive protectionism within the NHS. It is identifying those areas of NHS services that are not too big to fail, but that are too important to fail, and therefore need to be protected from competition.

**Mr Burns** indicated dissent.

**Owen Smith:** The Minister is shrugging his shoulders, rolling his eyes and looking exasperated, but that is precisely what he has said on a couple of occasions today: that designation is about affording protection—[Interruption.] With respect, I am precisely mirroring the context. He said that it was about affording protection to vital services which need to be protected. The question therefore is: protected from what? Clearly, the answer is: protected from the impact of being competed with and competed out of the market; the impact on patients of a service either not having competition at all, and therefore needing to be preserved because it is the only service available to patients in that locale, or having other competitors coming into the market and potentially eroding and undercutting that service. [Interruption.] I am not going to go into price competition, no. We know precisely what the measure is about: competition, the interrelationship between designation and competition, and allowing protectionism within the NHS and ring-fencing certain services so that they are not undermined by competition. That is clear, and I think the public will understand it as well.

What is much less clear is how designation will work. We have already heard a lot of questions about how designation will work. We read in the Bill and the explanatory notes that local knowledge will be the key driver of designation. I assume that local clinicians who are commissioners, and the commissioners they employ, whether private sector or transferees from the primary care trusts and strategic health authorities, will be the people with the local knowledge to determine which services ought to be protected—in other words, designated.

The problem with such a system is that, as far as Monitor is concerned, the key criterion for allowing designation is whether there is competition—alternative providers. I understand how a commissioner and a clinician locally can judge whether his service is so intrinsically valuable to his patients that it absolutely ought to be designated, but I cannot understand—I ask the Minister to explain—how those local commissioners in their local hospital or GP consortium will have sufficient knowledge of the nature, type and availability of alternative providers out in their local marketplaces such that they can deem that their service need to be protected. I cannot see how that could be the case.

Also, in the Minister’s comments to date, I cannot see an answer to what he means by “local”. In a world where there are multiple entrants into the health care market, how are we to determine whether a service—radiotherapy or pathology services, or technical assays, which are vital to determining whether a patient ought to be given medicine x or y—that is being provided by a multinational corporation, or one operating on a pan-UK basis, but at a local level, constitutes the competition that means a service cannot be designated? If so, local knowledge will seriously be called into question, because it will not have sufficient insight into pan-UK issues.

Secondly, we have heard repeatedly from the Minister that quality will be the key arbiter or determinant of decisions—not price, but quality. How on earth can we expect local commissioners, who are the people who have to determine whether a service ought to be designated, to understand and to have sufficient insight into the quality of the alternative providers’ offers such that they can determine that the provision will not be sufficiently robust, safe or worthy while for their patients, and therefore ought not to be allowed to compete for the delivery of that service? I cannot see how they would have any insight into the quality of the alternative providers’ services. Monitor, too, from its lofty heights in London, will likewise have very little insight into the relative qualities of the local provider and the new competitive entrant into the marketplace.

Thirdly, why are all of the changes happening? The language is absolutely clear. Most of the phrases in the Bill and in the mouth of the Minister today, including about inefficient providers being bailed out wholesale, market mechanisms not working properly and poor
providers being subsidised, would be more familiar in the mouth of the Chancellor or the Secretary of State for Business, Innovation and Skills in the context of economic regulation than they are in the mouth of a Health Minister. They reveal the economic drive behind all the changes—the financial drive and the drive to see competition delivering quality and improvements in the NHS. The Minister has not persuaded us that quality is the key driver. He has not persuaded anyone that the Bill is well thought through, because in this instance as in so many others, there are more holes in it than a Swiss cheese.

Jeremy Lefroy (Stafford) (Con): It is a pleasure to serve under your chairmanship, Dr McCrea.

I have two brief points about the definition of words in the clause, and I would appreciate the Minister’s help. First, it is extremely important to have clarity on what constitutes a service. Services can be salami-sliced down to very small items or, as others have said, they can be an agglomeration. One could say that, in an acute hospital, a service is not only the accident and emergency, but some—not necessarily all—of the other wards associated with it. That might constitute a block of service or, under other definitions, several services. How will Monitor interpret that word?

Liz Kendall: As a first step, does the hon. Gentleman agree that not only is it the GP commissioners who need to say whether a service is essential and cannot be allowed to fail, but that, to determine that, they need to understand what the knock-on effect of the failure of one service would be on other services? Not only Monitor, but GPs must have that understanding. Does he believe that GP commissioners fully understand the integrated nature of all the available services?

Jeremy Lefroy: That is a good point. In most cases, GP commissioners probably do, and clause 69(1) states that the “commissioner of a health care service for the purposes of the NHS may apply to Monitor”. The ball is therefore very much in the GPs’ court and I expect them, particularly as they grow used to the idea of commissioning services, to pick that up quickly. Certainly, in my experience, local GPs have a very good understanding of the need for a core block of services. What that block constitutes might differ from a district general hospital to a major teaching hospital, but it is extremely important that Monitor appreciates that and does not take a nit-picking approach to what constitutes a service. I would welcome the Minister’s comments.

My second question—apologies for being tedious about this—is on the definition of “alternative providers”. To take an example from my own area, stroke services used to be provided by what is now the University hospital of North Staffordshire, by New Cross hospital in Wolverhampton and by Stafford hospital. Stroke services are no longer provided by Stafford hospital for various reasons—not only economic but quality reasons, I understand—although I hope those services will return at some point.

As all Members will know, what is vital in providing a stroke service is how quickly the patient can be got to where the service is provided. The location, the road network, the density of traffic and whether there are constant traffic jams—as there are in certain parts of the west midlands, so that it can take half an hour to travel two miles—and all extremely important in defining who is a willing provider. A hospital 10 miles down the road may be a willing provider, and on the map it may look to Monitor as though it is an extremely good provider, but in realistic terms a patient would not have a hope of surviving a stroke if it was the local provider because all those road transport factors would mean that the ambulance service, as the hon. Member for Leicester West will know, would not be able to guarantee to get the patient to that hospital in time.

I am looking for some assurance from the Minister on both those points. Can he assure me that Monitor will not take a desiccated accountant’s—I am an accountant myself—approach to what constitutes a service, but will take a realistic approach, informed by local commissioners, to what a local alternative provider is and what constitutes a block of services that makes sense for an area?

Mr Burns: It is a pleasure to serve under your chairmanship this afternoon, Dr McCrea. You will not be aware of it, but this is probably the longest debate we have had on a clause; it certainly seems to have been the longest. I will speak swiftly and deal with the questions that have been raised. I fully understand that we need to make progress because there are some other important clauses that need to be discussed tonight.

Derek Twigg: As long as you answer our questions.

Mr Burns: I will do that, too.

Clause 69 provides for commissioners to make an application to Monitor for services to be designated. Commissioners can be GP commissioning consortia, the NHS commissioning board or the Secretary of State exercising his powers under new section 13V of new chapter A1 of the National Health Service Act 2006. The provision is intended to be similar to other engagement processes run by other regulators in other sectors, such as the energy sector, and has been modified for the health sector to effect the role of commissioners.

The clause provides that commissioners may apply for a service to be designated only if, first, the commissioners can demonstrate that the service is necessary to meet the health needs of their populations and that there is no alternative provider of that service. [Interruption.] The hon. Member for Leicester West looks at me in that smiling way, but the reason I am saying this is because I think there has been a misconception—the word I originally used was “misconception”—of what the clause will do, and I think it would be helpful to the Committee if I reiterate it.

Derek Twigg rose—

Mr Burns: May I make a little progress? All I am doing at this stage, before I reach the hon. Gentleman’s questions, which he is anxious to hear me answer, is explaining exactly what the clause will do. Hopefully that will clear up some of the misunderstandings.

Secondly, commissioners must have consulted providers, local authorities, healthwatch and other key stakeholders before determining which services should be designated.
In practice, that will mean the commissioners have to show that they have made an assessment of patient needs and local provision. Commissioners will be expected to share that evidence with Monitor when applying for a service to be designated and will be required to provide copies of consultation responses they have received on the question whether to designate a service.

In addition to commissioners’ overarching duties on effectiveness, efficiency and continuous quality improvement, the clause requires commissioners, in deciding whether the criteria for designation are met, to have regard also to the current and future need for the provision of the service; whether the removal of the service would significantly reduce equality of access to the service; and any other matter that may be specified in Monitor’s guidance.

4.30 pm

The clause requires Monitor to grant an application for designation if it is satisfied that the criterion in subsection (3) is met, and if the commissioner has consulted as required under subsection (2). The clause then requires Monitor to give notice of the designation of the service to the commissioner and every person who has been consulted on the application, and to explain the right of appeal.

Derek Twigg: What does “future needs” mean in that context? Does it mean future need over a year? There are time scales of one year and 10 years in the Bill. Is that over a year, over 10 years or more?

Mr Burns: The future needs of the local health economy are just that—one cannot set a time scale on that. The hon. Gentleman refers to time scales of “not until after the first year of designation” and “within 10 years of designation”, but that relates to the requirements to review the designation decision taken. What he was talking about just now is future needs in a generality of what should be designated, which is slightly different. I do not think there is much further we can go on that.

Derek Twigg: There is actually. It is a very important point. I do not know whether the Minister has been given any inspiration yet, but he said that a lot of the detail will be drawn up by Monitor—

Mr Burns: Guidance.

Derek Twigg: Is the Department giving no advice or guidance to Monitor about the time scale on future needs? Is that entirely left to Monitor?

Mr Burns: The requirement on the reviewing of designation after the first year and within 10 years is in the Bill, as the hon. Gentleman knows, but if we are talking about what services specifically are to be designated where, by definition there has to be the flexibility for Monitor; and particularly the commissioners who will be driving the process, to be able to do that as and when relevant. I do not understand the difficulty with that; it seems common sense. No doubt, he disagrees.

Let me try another tack and start answering some of the hon. Gentleman’s questions, starting with a series of questions on the designation process: how it would happen, how much it would cost and how long it would last.

Derek Twigg: And when it will start.

Mr Burns: I will take the hon. Gentleman’s word for that. My response will reflect what I have already said. It will not be for Ministers to define how and when the designation processes will be run. It will be for Monitor to give guidance on the process, based on the clear criteria in the Bill and building on best practice in other sectors. Monitor will be required to run a full consultation on its guidance, on the designation process and on the methodology to define how much designated services providers will pay into the risk pool. In that, as in other functions, Monitor will be under a duty to promote the economic, efficient and effective provision of health care services and to avoid imposing unnecessary burdens.

The hon. Gentleman asked whether GP consortia will have the skills required to run a designation process. Anything that is relatively new to some GPs will of course offer some challenges, although they will be aided by Monitor’s guidance. However, we believe that GPs are ideally placed to make decisions on which services need additional regulation, as they have the hands-on clinical knowledge and expertise regarding the needs of their patients. The designation process will be a key part of the commissioners’ role, which they should be gearing up from the start to deliver effectively.

Derek Twigg: Again, that differs from what the hon. Member for Southport has said. Monitor is in charge of the whole process, not the Government—the Minister says it will be up to Monitor to decide. Will he put on the record that the Government, who are putting the Bill through Parliament, have no idea when the process of designation will start, how long it will take, or how much it will cost? [Interruption.]

Mr Burns: The right hon. Member for Rother Valley laughs, but it is out of frustration, I think, because I have dealt with the hon. Gentleman’s questions. When we started answering his questions we said, in effect, how much the process would cost, how long it would last and how it would happen. I do not want to sound like a record going round and round, but it will not be for Ministers to define how and when the designation process is run; again, it will be for Monitor to give the guidance based on the clear criteria in the Bill and building on best practice in other sectors. Monitor will be required to run a full consultation on its guidance on the designation process.

Liz Kendall: Will the Minister give way?

Mr Burns: No. I want to deal with these matters or we will be here all night. I do not see the problem, unless it is that the shadow Minister does not want to understand.

Derek Twigg: You still have not answered the question.
Mr Burns: I think I have answered it twice, consistently. He may not like my answer, but that is a different matter.

Let me try the next lot of questions. The hon. Gentleman has asked whether GP consortia have the required skills to run the designation process. As I have said, that will be challenging, but aided by Monitor’s guidance and that of existing PCTs in the run-up to the changeover, GPs will have the relevant expertise or will develop it. I do not share the hon. Gentleman’s doubts. As he will appreciate, the designation process will be a key part of commissioners’ roles, which they should gear up to from the start to deliver effectively. Help from the PCTs, guidance and some GPs’ experience of commissioning will enable an effective and efficient system of commissioning for patients.

The hon. Gentleman suggested that designation would lead to some kind of free-for-all for management consultants. On the contrary, Monitor will learn how best to design the process from the experience of other regulated industries. I would be happy to get into a debate on management consultants with him, given the previous Government’s record of using them and the fact that this Government have introduced a moratorium on public sector use of management consultants; however, I would not like to fall foul of you, Dr McCrea, by straying beyond the remit of the clause.

The hon. Gentleman asked about separating designated and non-designated services in a provider, as the same equipment could be used. There is no reason why equipment cannot be used by both designated and non-designated services, as designation is not about closing services but about deciding which ones require additional regulation. It will be for providers to decide how best to use their staff and equipment. In doing so, they can build on the experience of other sectors: health services are different from other services, but there is valuable experience to draw on in other areas. I get the feeling that if we had not looked at the strengths, weaknesses and relevance of other areas from which to draw best practice, or anything that would help to make the proposals far more effective and efficient, we would be criticised for not having done so, so in that respect, where the hon. Gentleman is concerned, it is a lose-lose situation, because he will not accept anything that does not fit into his criteria.

The hon. Gentleman asked why some essential services may not be designated. I shall repeat a point I made earlier, as it is at the heart of this debate. Whether a service is designated is not the same as whether it is essential. Non-designation simply indicates that alternative providers are available. Where services are not designated, the mechanism for securing service continuity will be led by commissioners through legally binding contracts.

The hon. Members for Halton and for Easington raised concerns about how others will be involved in the designation process. As I have said, to run a full consultation on what services they wish to designate, as services, there is significant scope for local involvement in the designation process. The hon. Member for Halton suggested that service designation would be a top-down exercise imposed by Monitor. On the contrary, the decisions will be made locally by commissioners in consultation with local patients and communities. Monitor’s role—is I hope the hon. Gentleman listens to this—is simply to ensure that the criterion for designated services is met and that there have been proper consultations.

It is, to my mind, somewhat ridiculous to suggest that Monitor would somehow become omnipresent, as the hon. Gentleman implied. The Bill opens up decisions about services to an unprecedented degree of transparency and democratic scrutiny, and it ensures that those decisions are made locally. I have to tell the hon. Gentleman that that is a huge improvement on the current situation in which an unaccountable, hierarchical bureaucracy is free to intervene in local decisions with very little transparency at all. Let me be clear: our proposals will put an end to the hidden subsidies that have been used in the past to prop up failing and inefficient providers taking money out of the budgets of successful providers or forcing commissioners to pay artificially high prices to reward poor management elsewhere.

Derek Twigg: Just for the record, so that I am absolutely clear—who will draw up the guidance?

Mr Burns: Monitor will issue guidance. I also have to tell the hon. Gentleman that we will not force patients to use or taxpayers to subsidise poor-quality, inefficient services or providers.

Liz Kendall: On that point, will the Minister give way?

Mr Burns: May I make some progress, please? Rather than propping up failing providers, there will be a transparent mechanism for managing provider failure that protects essential services and allows commissioners to replace services with higher-quality or better-value options.

The hon. Gentleman asked how major reconfigurations would be handled in future. My fellow Minister, the hon. Member for Sutton and Cheam explained that to the Committee in detail when we debated clause 175, and I do not propose to re-open that debate. Dr McCrea. I will simply add that I entirely agree with the point made that reconfiguration will not happen if left to market forces alone, as I think the King’s Fund recently argued. The Government have never suggested that approach. Consortia will be able to work together and with the commissioning board to make strategic decisions about services across large areas where that is necessary. Where there are interdependencies between services or a need for integrated care pathways, that is something that commissioners will be able to plan for.

The hon. Member for Easington asked why we have not estimated the likely failure rates of providers. As I said earlier, to give accurate failure rates is not possible. International comparisons are not suitable, as there are no international health systems that are the same as our NHS system.

Liz Kendall: On that point, will the hon. Gentleman give way?

Mr Burns: I will give way in one minute. Let me finish the point raised by the hon. Gentleman. Bandying about failure rates in America is, as I said to him previously, misleading and likely to be highly inaccurate because of the huge difference between the two systems.
4.45 pm

Liz Kendall: I am delighted that the Minister has given way. He says that services will not be propped up any longer. There is not a single member of this Committee who does not have a service in their constituency that at some point has been in debt or deficit or—not my words—"bailed out" by primary care trusts. Is he saying that that will no longer happen?

Mr Burns: Let me repeat what I said, so that there will be no misunderstanding. The hon. Lady is a serial offender in that respect. What I said was that we will not force patients to use, or taxpayers to subsidise, poor quality, inefficient services or providers. Rather than propping up failing providers, there will be a transparent mechanism for managing provider failure that protects essential services and allows commissioners to replace services with higher quality or better value options.

Grahame M. Morris: Will the Minister give way?

Mr Burns: No, I will not.

Put in context, that is somewhat different from the abridged intervention from the hon. Member for Leicester West. I will now move on to the number of other questions that were asked, starting with the hon. Member for Pontypridd, who will have to wait a minute.

Derek Twigg: I am sorry if I missed what the Minister said, but one of my questions was on whether GP services would come under the designation.

Mr Burns: I will provide the answer to that as I get through the pile of questions.

The hon. Member for Pontypridd asked a number of questions. One was on how often services would be reviewed for redesignation. We will deal with that in later amendments, as I said earlier. It would be sensible to wait until we get to that part of the Bill, which will be soon. The hon. Gentleman raised the perfectly valid point of what counts as local. It is simple. The local population is that which a commissioner is responsible for. Local services are those available to the local population to meet their needs. In that way, commissioners would review the availability of services to meet the needs of their population and would apply to Monitor where additional regulation was needed to secure continued access to services in the absence of alternative providers. The hon. Gentleman also said that designation is the protectionism of services that are too important to fail. I would not altogether agree with that. Designation is about the protection of services that are provided by a sole provider in that locality. If such a service should fail, and the impact of that failure would cause significant harm to patients, that service needs additional regulation to ensure the continuity of that service.

My hon. Friend the Member for Stafford asked what the definition of services was for the purposes of designation. I hope I can reassure him on that point. It is built into that guidance. Monitor will run a full consultation on its guidance, and it will seek responses from the Care Quality Commission to ensure that quality is built into that guidance.

The hon. Member for Pontypridd asked how quality will be built into the designation process. Monitor’s guidance will be key in explaining to commissioners how quality should be built in. Monitor will run a full consultation on its guidance, and it will seek responses from the Care Quality Commission to ensure that quality is built into that guidance.

The hon. Member for Easington asked how many organisations will fail. I suspect that the hon. Gentleman can anticipate from past experience what my answer will be. I will most certainly not speculate on what may or may not happen in the future. However, it is beyond doubt that the previous Administration presided over a system in which successful organisations were forced to bail the same failed management out year after year. The evidence is for all to see in the published NHS accounts. Apart from not being transparent, the problem with the old system was that it maintained the wrong incentives. Successful organisations were penalised, failing organisations could duck difficult decisions, and patients and taxpayers ultimately lost out.

Grahame M. Morris rose—

Mr Burns: May I just finish giving the hon. Gentleman the answer?

Our proposals would put that right by strengthening incentives for improvement and removing the bail-outs for failed management, while protecting patients’ interests and securing continuity of essential services. I will give way to the hon. Gentleman, but I will then make some progress, because otherwise we will be here all night.

Grahame M. Morris: If that is the assessment, why is it that the west Cumbria practice-based commissioning model, which has been wheeled out numerous times by
the Government Front Bench, is in fact running at an £11 million deficit and had to be bailed out by the SHA. If that is a model of good practice and a harbinger of what is going to happen as other practice-based commissioning units come on stream, it is a recipe for disaster.

Mr Burns: To all intents and purposes, the hon. Gentleman is actually describing the previous Government’s system. Through the Bill, we are trying to bring in a system that will avoid the problems that I have just mentioned, so that we can move forward and ensure that good quality commissioning leads to enhanced health care and outcomes for patients. That is the purpose of the Bill, and, as I said, I will now make some progress.

The hon. Member for Southport mentioned that there should be greater control over Monitor’s competition duties to safeguard patients’ interests. The Bill provides the legal framework within which Monitor must operate. It must promote competition only where appropriate in exercising its functions. It must have regard to the need to maintain the safety of people who use the NHS. Importantly, Monitor may promote competition only when it is in patients’ interests.

Finally, one hon. Member asked if bail-outs would stop under the new system. Forgive me, because I cannot remember which hon. Gentleman it was.

Liz Kendall: Or Lady.

Mr Burns: Was it the hon. Lady?

Liz Kendall: I cannot remember if it was among the many questions that I asked.

Mr Burns: To be fair, the hon. Lady has not asked that many questions during the course of this particular debate, but I have taken interventions from her, and it is always a pleasure to do so. I could not take too many, however, because we have spent a considerable amount of time on what, to my mind, is a straightforward, sensible clause.

Our proposals would protect patients’ interests by securing the continuity of NHS services in the absence of alternative providers. The Bill makes express provision for funding to be given to sustain provision of designated services under clause 111, but the payments would be transparent, in the form of grants or loans. What we will not do is continue the practice of paying non-transparent bail-outs that may reward failed management at the expense of successful services. For those reasons, I strongly believe that clause 69 should stand part of the Bill, and I urge my hon. Friends to support it.

Derek Twigg: I will take only a few moments to make a couple of points. We have asked many questions about the fact that, continually, the Minister will not give examples to back up his arguments, which is really poor. If the Minister has an argument, and he feels that there are plenty of examples of where things have failed, have not been done properly, are not being supported, or where guidance is not being followed in terms of procedure and support, he should say what they are. Interestingly, on designation and non-designation, he says that Monitor will stick to what the guidance says. It is Monitor, however, which draws that guidance up. That will be crucial in terms of how this process works, and we have no sight or idea of it, which is frankly, appalling. I hope that the Minister will look again at whether he can give us more information.

The Minister also does not know how long the process will take, when it will start, or when it will end. There is no guidance on that, which is incredible. This is a major change to the health service, but we do not have that information. Finally, perhaps the Minister will write to me, because he did not answer my question about whether designation in the clause applies to GP services.

Mr Burns: Sorry, I did forget that. I apologise—I had forgotten initially, but I have the answer now. Will GPs be designated? In principle, they could be, but I do not want to go into too much detail on what services will or will not be designated, because it will be for the commissioners to decide—[Interruption.]

The Chair: Order. If Members want to intervene or make a speech, they can do so, but if we have exhausted debate on the clause, we will move on.

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

The Committee divided: Ayes 13, Noes 10.

Division No. 69]

AYES

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

NOES

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

Question accordingly agreed to.

Clause 69, as amended, ordered to stand part of the Bill.

Clause 70

APPEALS TO THE TRIBUNAL

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

5 pm

Mr Burns: On this occasion, and I alluded to this in our previous debate this morning, I wish that the clause does not stand part of the Bill. We have already discussed Government amendments 504 to 508 and new clauses 10, 11 and 14, and we will discuss Government amendments 510 to 515 and new clauses 12 and 13 shortly. They make a series of changes that will ensure that the process
of designating services operates effectively and that there is greater transparency on the way in which Monitor makes decisions in relation to the designation of services.

Clause 70 will be replaced by five more comprehensive clauses on complaints and appeals, namely new clauses 10 to 14, which clarify and extend the rights of providers and potential providers to appeal to the first-tier tribunal should they believe that Monitor’s decision on the original designation request or on an application for removal of designation was based on an error of fact, or was wrong in law or unreasonable. Therefore, clause 70 is no longer needed, and I urge my hon. Friends to join me in voting against it standing part of the Bill if the Opposition decide to press it to a vote. I must say that, if they do press it to a vote, it would be a supreme irony.

**Derek Twigg**: To save the Government any embarrassment, we shall not press the clause to a vote.

**Question put and negatived.**

**Clause 71**

**REVIEWS AND REMOVALS OF DESIGNATIONS**

**Mr Burns**: I beg to move amendment 510, in clause 71, page 75, line 10, leave out ‘the relevant’ and insert ‘each review’.

**The Chair**: With this it will be convenient to discuss Government amendment 511.

**Mr Burns**: The amendments allow Monitor to set the regulatory periods for which services will be designated. As drafted, the clause provides that commissioners must conduct reviews of designated services, to ensure that they continue to meet the criteria for designation, at some point between one and 10 years after the previous review. These amendments will enable Monitor to specify when in that period the reviews should take place. Having regulatory periods for designated services set by Monitor would ensure that the system on designation and the review of designation were clear and transparent to all. It would also enable Monitor to properly manage the financial mechanisms that would provide financial assistance to providers in health special administration and ensure the continuity of designated services in the event of failure.

Monitor would have the power to require commissioners and providers of designated services to contribute to those financial mechanisms. Being able to set the regulatory periods for designated services means that Monitor would be able to properly calculate the contributions that commissioners and providers must pay into the financial mechanisms. It is likely that the contributions would be measured by some element of risk of failure and, in order to allow a risk measurement to be included, it is necessary to establish the time period to which that risk applies.

**Liz Kendall**: Can the Minister explain on what basis I would decide between one and 10 years if I were a GP commissioner?

**Mr Burns**: The starting period is after a year, because we believe that before that would be too short a period and could be disruptive. The maximum time is 10 years, because we think that is a reasonable time scale for the system.

**Liz Kendall**: Why 10 years? On what basis is 10 years a reasonable time scale? The Minister has referred to some economic issues in relation to that being a reasonable period. Where has the 10-year figure come from?

**Mr Burns**: The 10-year figure has come from the fact that we believe that that is a reasonable maximum time scale for a review because it will provide stability for that period without creating a disjointed or potentially disruptive system.

**Liz Kendall** rose—

**Mr Burns**: No; I think the hon. Lady has laboured the point now. We believe that that is a reasonable time scale and that is why it is in the Bill.

If Monitor were able to set the regulatory periods for designated services it could properly calculate the contribution that commissioners and providers must pay into the financial mechanisms. It is likely that contributions would be measured by some element of risk of failure and in order to allow a risk measurement to be included, it is necessary to establish the time period to which the risk applies. Allowing Monitor to set the regulatory periods would also help Monitor to manage the size of the fund needed to cover the risk and to decide what level of levies would be needed for the next regulatory period to ensure that the fund met that risk. In its written evidence to this Committee, the Foundation Trust Network argued for the need for designated services to have set regulatory periods. I therefore ask hon. Members to support the amendments.

**Derek Twigg**: My hon. Friend the Member for Leicester West made an important point when she asked the Minister why it was 10 years and in fairness, I do not think he explained the rationale behind that. What if a mistake were made with the non-designation of a service in the first six months and so outside the first year? Does he think the levy payment to the risk fund will influence commissioners’ decisions to commission services? I am not sure whether the money would come directly from the designated service provider or whether the commissioner would have to pay for it. It would be useful to know that.

**Owen Smith**: Was that the moment, I asked myself, when the Minister would tell us how often services would be re-designated or have their designation status reviewed? I did not feel that I got an answer to my question. If the key determinant of whether a service ought to be designated is whether there is adequate competition for that service, will there be further reviews of designation between that one and 10-year period when new entrants come into the market? If it is not the moment when he will answer the question, then I have no further questions.

**Mr Burns**: The hon. Member for Halton asked what would happen if there was a mistake over non-designation within six months. Applications for designation can be
made at any time so there would not be a problem in the first year. He also asked how the decision between one and 10 years is made. I will repeat the point: it has been considered that 10 years is a reasonable time limit for an upper limit. It would be for Monitor to determine, having regard to the nature of particular services and the contents of the evolving health economy. However, Monitor’s powers would be to set the timetable for reviews when the criteria are met. There is no arbitrary limit on duration of designation per se.

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

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

### Division No. 70

#### AYES

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

#### NOES

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

*Question accordingly agreed to.*

**Amendment 510 agreed to.**

*Amendment made: 511, in clause 71, page 75, line 14, leave out subsection (2) and insert—*

(2) The first review period is a period which is of such duration as Monitor may by direction specify but which—

(a) must not begin before the expiry of the period of one year after the date of the notice under section 69(7), and

(b) must end before the expiry of the period of ten years after that date.

(2A) Each subsequent review period is a period which is of such duration as Monitor may by direction specify but which—

(a) must not begin before the expiry of the period of one year after the date on which the previous review under subsection (1) was completed, and

(b) must end before the expiry of the period of ten years after that date.

(2B) For the purposes of subsections (2) and (2A), Monitor may specify—

(a) the same period in respect of all designated services, or

(b) different periods in respect of different designated services or designated services of different descriptions.’.—

(Mr Simon Burns.)

**Mr Burns:** I beg to move amendment 512, in clause 71, page 75, line 35, leave out ‘must grant an application under subsection (3)’ and insert ‘may grant an application under subsection (3) only’.

*The Chair:* With this it will be convenient to discuss the following: Government amendments 513 to 515.

**Government new clause 12—Complaint about grant of application for removal of designation.**

**Government new clause 13—Complaint about refusal of application for removal of designation.**

**Mr Burns:** These Government amendments and new clauses make a series of changes that will ensure that the process of designating services operates effectively, and will provide greater transparency in how Monitor makes decisions in relation to the designation of services.

Amendment 512 is a minor, technical amendment that clarifies the drafting of clause 71 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 only agree to the removal of a designation if the criterion is no longer met.

Amendments 513 and 514 are consequential amendments to clause 71 to reflect new clauses 12 and 13, which enable complaints to be made against Monitor’s decision following an application under clause 69. Amendment 515 removes subsections (8) to (10) of clause 71, which detail how Monitor must handle complaints on decisions to designate. These provisions will be replaced by four new, more comprehensive clauses that will extend the right to complain and will provide greater transparency on how Monitor must respond to complaints about its decisions on designation. They will, for example, require Monitor to explain the reasons why it has refused an application for the removal of a designation.

Government new clauses 12 and 13 are similar to new clauses 10 and 11 in clarifying the appeals process with regard to designated services. They will govern how complaints could be made in response to Monitor’s decision to accept or refuse an application from commissioners for the removal of designation under subsection (3) of clause 71. Clause 71(3) allows commissioners to apply to Monitor for the removal of a designation of a particular service if they believe the criterion for designation is no longer met. That might be, for example, because the commissioner has been able to introduce new providers locally and therefore the additional protection that designation offers is no longer needed.

Government new clause 12 will allow the provider of a designated service to complain against Monitor’s decision to remove the designation. The new clause will require Monitor to re-examine its original decision and decide whether the designation should be removed. It will also allow the provider or the commissioner to complain to the first-tier tribunal if it believes that Monitor’s decision on the complaint was based on an error of fact, was wrong in law or was unreasonable.

New clause 13 would allow the commissioner or provider of the designated service or a potential provider of NHS services to complain against Monitor’s decision to refuse an application to remove the designation. The new clause would then require Monitor to re-examine its original decision and decide whether the designation should be removed. It will also allow appeals to the first-tier tribunal on the grounds that Monitor’s decision about the complaint was based on an error of fact, wrong in law or unreasonable. New clause 13 provides an important check to ensure that services are not
unnecessarily designated. As I have mentioned, that would be undesirable due to the missed benefits and additional costs that designation incurs.

5.15 pm

Owen Smith: I have a simple question for the Minister. He described a situation in which a provider—I presume that he meant an NHS provider—might complain about the removal of the designation of a service by Monitor. Will he confirm that the complainant about a designation might also be an alternative provider, whether it is an alternative hospital or a private provider intending to offer the service in that local health economy? Might such providers complain to Monitor that the service ought not to be provided? If so, it speaks to the question that I asked earlier—perhaps I was not clear—about whether the complaint would then trigger a re-review by Monitor of the designation. How often in that period between the first and 10th years might re-reviews of designation occur, and is it not most likely that fewer and fewer services will be designated as more and more entrants come into the market, reducing the rationale for designation under the Bill?

Mr Burns: The answer to the hon. Gentleman’s first question is yes. The answer to the second is that after a period has been set, Monitor cannot force a review within that period. Commissioners can apply for services to be un-designated if they feel that that is appropriate, but I remind hon. Members that it is commissioners who lead the process.

Amendment 512 agreed to.

Amendments made: 513, in clause 71, page 75, line 40, leave out from beginning to ‘to’ in line 41 and insert ‘Monitor must give notice of its decision on an application under subsection (3)’.

Amendment 514, in clause 71, page 75, line 43, at end insert—
( ) Where Monitor grants the application, a notice under subsection (7) given to a provider of a service for the purposes of the NHS must explain the rights conferred by section (Complaint about grant of application for removal of designation).
( ) Where Monitor refuses the application, the notice under subsection (7) given to the commissioner must—
(a) give the reasons for the refusal, and
(b) explain the rights conferred by section (Complaint about refusal of application for removal of designation).

Amendment 515, in clause 71, page 76, line 1, leave out subsections (8) to (10).—(Mr Burns.)

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

Liz Kendall: Sorry, Dr McCrea. It is a great pleasure to serve under your chairmanship. I have not had the pleasure of doing so before.

From our discussions today, the process of designation seems technically complex. It will require commissioners to determine what local services are essential by judging and measuring outcomes and travel times. Those are complicated issues that the national commissioning board, civil servants and primary care trusts already find extremely challenging to determine. The commissioners will have to assess future health needs and the links between different services. If one service is designated but another is not, what will be the knock-on effect on providers? They will have to consult relevant stakeholders, draw together all the evidence and put it to Monitor, who will then judge by guidance that has not yet come out. The Minister said in a previous discussion that Monitor’s annual budget will go up to £140 million from £20 million at present; no wonder, when it has all that to do. What estimate has he made of the costs of that technically complex and politically challenging process for GP commissioning consortia?

Mr Burns: I will answer the hon. Lady in two ways. First, there is the cost of the modernisation programme as reflected in the White Paper and the Bill, and which is in the impact assessment. As we have discussed before, it is a one-off cost of £1.4 billion. I will spare her and the Committee the other side of that, which is the savings that will be made.

Secondly, it is premature to give a figure on the cost of the designation process to GP consortia. As the hon. Lady knows, we have pathfinders at the moment, which we are looking at carefully. At the appropriate time, we will have to reach a decision on the sum that we will provide to consortia for their management costs. We have taken no final decisions on that because of the pathfinders, and we will not do so until the appropriate moment in the light of those pathfinders. There is some other information that may help the hon. Lady with regard to the skills of consortia, but I will save time now because the she does not need that.

Liz Kendall: Will the Minister clarify whether the pathfinders are looking at the cost of the process of designation? Will the cost of designating a service have to come from the admin costs that the Government said they have capped to, I think, £35 or £40 a head?

Mr Burns: On the first question, I would reverse the process. With the pathfinders, GP consortia will be learning a lot, and so will we, by watching the example of the development of the pathfinders and their operations, so that we will be able to reach decisions—

Liz Kendall: Are the pathfinders going through a trial process of designation to determine how much it would cost nationally?

Mr Burns: No, not specifically. The pathfinders at the moment are, as the hon. Lady knows, voluntary bodies of GP practices joining to form consortia so that they can begin the process of developing the full range of GP consortia when the modernisation is fully implemented. They will work with a number of people, such as the PCTs, and look to employ people with experience and expertise where they wish, to help them with their commissioning. We will study what they do, their experiences and the pros and cons of what emerges from those pathfinders so that at the appropriate moment we will be able to reach realistic decisions on questions such as the cost of management. The hon. Lady used the figure in the public domain; it may be somewhere between £25 and £35 per patient per year. At this stage, however, it is a little premature to say what the costs will be and how much money will be made available for management and administration. We will have to wait and see.
Mr Burns: The hon. Lady is never simple. The tasks that will be placed on commissioners in designating services are core tasks, as I am sure she appreciates. This will help them to properly plan the commissioning of services in the future.

On the admin budget and the money that will flow from that, I have sought to explain that we will learn from the pathfinders what the amount for the administration budget should be. Of course we will need to work with them and others to estimate the total amount of money that they will require, including designation. It is all part and parcel of the process, and we will have to take decisions when we have more information and experience as to how much is a realistic amount of money to make available for each consortia, which I think is the right word.

Liz Kendall: So the Minister is saying that the figure that the Government have publicly stated as the cap of admin costs is not actually set—as the Secretary of State and the chief executive of the NHS have said—but will be determined on the basis of the pathfinder experience, which could include this huge, technically complex designation process. Is he saying that that is not the cap?

Mr Burns: The figure that the hon. Lady used, which was between £25 and £35 per patient per year, is not fixed. We said that we expected that the figure would probably be in that range, but we have taken no final decision and will not at this early stage.

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

The Committee divided: Ayes 12, Noes 10.
Division No. 71]

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

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

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

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

Question accordingly agreed to.

Clause 71, as amended, ordered to stand part of the Bill.

5.30 pm

Clauses 72 to 75 ordered to stand part of the Bill.

Clause 76

EXEMPTION REGULATIONS

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

Derek Twigg: The Minister may or may not be pleased to hear that we will not spend a lot of time on licensing as we are conscious that have to move on to other things, not least pricing, which is of particular interest to the Committee.

This links to the previous question about the impact of this Bill on GP services. Paragraph 607 of the explanatory notes states:

“The intention is to ensure that regulatory burden would not be imposed where it was not needed, keeping the system targeted and proportionate. For example, GPs providing only traditional primary care ‘gatekeeper’ services might be exempted as, initially at least, they might not require sector-specific competition regulation or additional regulation to support the continuity of services.”

The Minister may recall I asked before whether designation would apply to GP services and the Minister said that it could. Here we have another part of the Bill which says that, in terms of licensing—this comes under Monitor again—gatekeeper services might be exempted initially, therefore they could be. This could apply to them in the future. Also, would he like to say whether there are other services GPs provide which would be subject to this licensing procedure?

My point, which we have not had a chance to discuss in this Committee, is that not just hospital services but also GP services could be accountable to Monitor through the system of designation, licensing and competition.

Mr Burns: So that we all know where we stand, what does the hon. Gentleman mean by “accountable to Monitor”?

Derek Twigg: If they are a provider or commissioner, they have a responsibility to some extent to Monitor. They have to abide by the guidance that Monitor puts out. What I am trying to get across is that just as the designation may apply—

Mr Burns: Could.

Derek Twigg: —could apply to GPs, we now find that licensing procedure could also apply to GP services—certainly gatekeeper services. There are other services that GPs provide as well. Does that exclude the other services or just gatekeeper services? This is important because we are finding now that GP services can be subject to competition. I do not know whether GPs are aware of this, but they might have quite an interesting conversation with their representatives.

Mr Burns: The clause allows the Secretary of State to make exemptions from the need to hold a licence. The exemptions can be for a type of provider or a type of activity, conditional or unconditional and temporary or permanent. The conditions that might attach to an exemption could include requirements, nevertheless—that is notwithstanding the exemption—to comply with certain directions from Monitor, or to do or not do certain things, or refer certain matters to Monitor’s determination.
We want to ensure that regulation is necessary and proportionate. The clause allows the Secretary of State to make exemptions from the general requirement to hold a licence. Exemptions are important to avoid creating an unnecessary burden on providers where it is not necessary or proportionate to impose price controls and other economic conditions on their operations, over and above contractual requirements.

Respondents to the Government’s consultation expressed support for a transparent and proportionate system with no exceptions for large providers and a test of materiality for smaller providers. Regulations would create exemptions in respect of individual providers, types of provider or the provision of particular services. For example, they could provide an exemption for GP practices or providers of general medical services.

The clause provides sufficient flexibility for exemptions to be temporary or permanent and conditional or unconditional. For example, regulations could exempt a provider from the general requirement to hold a licence on condition that the provider would nevertheless be obliged to comply with certain directions from Monitor. Such flexibility would enable the Secretary of State to provide for the wide variety of circumstances that might arise.

However, the details of the exemption regime will be of key importance and interest, which is why the clause provides that before making regulations, the Secretary of State must consult Monitor, the NHS commissioning board, the CQC and HealthWatch England. He must also publish notice of the consultation, which must last not less than 28 days. The provisions ensure proper transparency and accountability in relation to the exemptions regime.

The hon. Gentleman mentioned GPs and exemptions. Certain services that GPs provide could be licensed if appropriate, and exemptions could be made if it were not appropriate. He asked what services must be licensed—potentially, any or all NHS services. However, we anticipate that there will be cases for exemptions that will be the subject of regulations under clause 76.

Question put and agreed to.

Clause 76 accordingly ordered to stand part of the Bill.

Clause 77

Exemption regulations: supplementary

Mr Burns: I beg to move amendment 382, in clause 77, page 79, line 24, at end insert ‘;

() where the Secretary of State is proposing to give a direction under subsection (3)(b) or (c), give notice of the proposal to the person from whom the Secretary of State proposes to withdraw the exemption.’.

The Chair: With this it will be convenient to discuss Government amendment 449.

Mr Burns: The amendments fit the classic definition of minor and technical. They are designed to increase the transparency of the system by which the Secretary of State will be able to grant exemptions to providers from the need to hold a licence from Monitor to provide NHS services.

Amendment 382 inserts a new provision stating that the Secretary of State must give notice to providers if he plans to withdraw an exemption that has been granted. It will bring the clause into line with provisions elsewhere in clause 77 and this part of the Bill requiring the Secretary of State or Monitor to give providers notice of any proposed changes in their regulatory status.

Amendment 449 would modify clause 77 to require the Secretary of State to give a minimum of 28 days’ notice before giving a direction withdrawing an exemption from a person who belongs to a group of exempted persons. The 28-day period would start on the day after that on which the person received the notice stating the Secretary of State’s intention to withdraw the exemption. It is stipulated elsewhere in this part of the Bill that notice periods should last for 28 days beginning on the day after that on which the notice is received. That is a standard approach in line with regulatory best practice. Clause 133(2) makes provision about when a notice is to be treated as having been received. To give providers clarity about regulatory requirements and avoid confusion about regulatory processes, we believe that it is important to standardise the provisions relating to notice periods throughout the Bill. The amendment proposes to make the provisions in clause 77 consistent with those elsewhere in the Bill.

Amendment 382 agreed to.

Amendment made: 449, in clause 77, page 79, line 30, at end insert—

‘( ) The period so specified must be not less than 28 days beginning with the day after that on which the notice is received or (as the case may be) published.’.—

(Mr Burns.)

Clause 77, as amended, ordered to stand part of the Bill.

Clauses 78 to 83 ordered to stand part of the Bill.

Clause 84

Notice of decisions

Amendments made: 383, in clause 84, page 81, line 16, leave out ‘of 28 days mentioned in’ and insert ‘for bringing an appeal under’.

Amendment 384, in clause 84, page 81, line 18, leave out from ‘after’ to the end and insert ‘that period’.—

(Mr Simon Burns.)

Clause 84, as amended, ordered to stand part of the Bill.

Clauses 85 to 88 ordered to stand part of the Bill.

Clause 89

Limits on Monitor’s functions to set or modify licence conditions

Mr Burns: I beg to move amendment 450, in clause 89, page 84, line 5, leave out ‘or accountability’.
Clause 89 will establish limits to Monitor’s ability to set or modify licence conditions. The limits have been put in place to ensure that Monitor may use its licensing powers only for the purposes intended and not expand its role beyond its parameters via regulatory creep.

The clause as originally drafted will give Monitor the ability to use its licensing powers “for purposes connected with the governance or accountability of persons providing health care services for the purposes of the NHS”.

We propose to remove the reference to accountability from the clause to avoid confusion and clarify the role of the economic regulator. To be clear, we absolutely recognise the need for accountability throughout the health-care system. Regulated bodies should be accountable to their regulators, directors and governors of foundation trusts to their members, and providers and commissioners to the patients and members of the public whom they serve, just to highlight a few examples.

However, the examples that I have just given illustrate the complex system of accountability that is needed if the NHS is to function correctly. Many different groups and individuals need to be held accountable by many others if patients are to be protected and quality of service to be improved. Therefore, we felt that it would be unhelpful and potentially confusing to place a single duty on Monitor to set licence conditions designed to ensure accountability, as it would not be the sole responsibility of Monitor to bring that about. Instead, we propose in the clause to allow Monitor to set licence conditions related to governance, which is for an economic regulator to oversee. Monitor is then given powers elsewhere in the Bill to ensure that the regulated bodies that it oversees are accountable to it—for instance, the ability to take enforcement action against bodies that do not comply with licence conditions or the requirement to hold a licence.

Amended in the manner proposed, and taken alongside the other provisions in this part of the Bill, the clause will more clearly establish the role and remit of the regulator and will ensure that there is no confusion among regulators and regulated bodies as to who is responsible for what.

Amendment 450 agreed to.

5.45 pm

Mr Burns: I beg to move amendment 516, in clause 89, page 84, line 13, at end insert—

( ) Monitor must not exercise a function to which this section applies in a way which it considers would result in a particular licence holder or holders of licences of a particular description being put at an unfair advantage or disadvantage in competing with others in the provision of health care services for the purposes of the NHS as a result of—

(a) being in public or (as the case may be) private ownership; or

(b) some other aspect of its or their status.

On Second Reading, some hon. Members expressed concern that Monitor’s licensing regime could unfairly skew the competitive balance between different types of licencee when it came to competing for NHS services. This amendment is there to reassure those hon. Members. It clarifies that Monitor’s use of licensing functions could not unfairly advantage or disadvantage particular providers or types of provider on the basis of their ownership status or other organisational characteristics.

The amendment does not mean that Monitor could not regulate different types of providers in different ways. For example, elsewhere in the Bill we have proposed that Monitor could exercise transitional powers over foundation trusts for a two-year period, and these are powers that it could not exercise over independent providers. However, the amendment does mean that Monitor will have to examine its proposed regulatory regime and ensure that any differences in the way it treats providers based on their ownership or status are fair and can be justified. It will sit alongside subsections (3), (4), (5) and (6) of clause 87, which limit the ability of Monitor to set differential conditions across different types of provider. I hope this clarifies the position to the satisfaction of hon. Members who have concerns about this.

Derek Twigg: I apologise, Dr McCrea, I should have said that it is a pleasure to serve under your chairmanship. I am sure you will continue to ensure the good order of the Committee.

I want to explore the issue of differentials, which will be coming up later. I suppose this comes back to the issue of the so-called distortions in the market, as opposed to the so-called advantages that the NHS providers have against private providers. From what the Minister said I am not sure I fully understand what the amendment will do. If it cannot make differing conditions how will that fit in with the Bill’s impact assessment? That document states at B108 on page 52:

“Once the net distortion facing different provider types is better understood, the tariff methodology could be developed in such a way as to move towards a fairer playing field by setting different prices for different providers in order to recognise different levels of implicit subsidies. (Note that to avoid compromising the fair playing field from a commissioner perspective, these charges need not be reflected in the charges faced by commissioners of care.).”

I am not quite sure how that fits in with setting different conditions for different providers.

Mr Burns: The amendment responds to concerns expressed by some hon. Members on Second Reading, and seeks to reassure by ensuring that the licensing regime would not inherently favour private providers. That was the concern expressed by some hon. Members. The effect of the amendment is to ensure that Monitor’s licensing regime cannot tilt the competitive playing field towards a particular type of licensee—for example, away from NHS organisations and towards independent providers—in a way that is unfair. We are seeking to be helpful and make sure that there is no doubt, and that Monitor is not able to play the system—for want of a better expression—to advantage one sector over another. We hope that that point reassures those people who raised this issue on Second Reading.

Grahame M. Morris: I am grateful for the Minister’s reassurance that there will not be any apparent disadvantage to the in-house NHS provider, but will he clarify something? I have already referred to paragraph B107 of the Bill’s impact assessment. It says that the regulator will be able to require the incumbent, which is assumed to be an NHS foundation trust, to provide operating theatres and diagnostic scanning at predetermined prices. The Government anticipate that NHS hospitals will be forced
to share operating theatres, brain scanners and, presumably, any other facility, with private health care providers, perhaps on a rota system. Does that remain the intention, or will the amendment take it away?

Mr Burns: Sorry, what?

Grahame M. Morris: Well, paragraph B107 of the impact assessment refers to the incumbent—the NHS foundation trust—and suggests that, in order to address the issue of a level playing field, and the NHS having advantage over a private provider, as assessed by Monitor, the private provider would have access to the facilities in an NHS hospital on a rota basis. The paragraph specifically refers to scanning facilities and operating theatres, and says that NHS hospitals will be forced to share them.

Mr Burns: We will deal with part of what the hon. Gentleman is talking about when we come to clause 90. I do not want to make heavy weather of this, but may I clarify and put on the record the purpose of this amendment? It is about clarifying that Monitor, in exercising its licensing functions, cannot favour public, private or voluntary providers to the disadvantage or advantage of any of those groups. It is about having a level playing field. We have tabled similar amendments to chapter 5, which we will address later. The amendment is meant simply to provide reassurance and meet concerns that were expressed on Second Reading.

Amendment 516 agreed to.

Clause 89, as amended, ordered to stand part of the Bill.

Clause 90

CONDITIONS: SUPPLEMENTARY

Mr Burns: I beg to move amendment 451, in clause 90, page 84, line 23, leave out from 'things' to second 'in' in line 24 and insert
‘or things of a specified description (or to do, or not to do, any such things in a specified manner) within such period as may be specified’.

The Chair: With this it will be convenient to discuss Government amendment 452.

Mr Burns: The clause lays out an illustrative but not prescriptive list of the major types of licence conditions that Monitor may wish to include in its provider licences. One type of condition that Monitor might wish to include would be conditions designed to ensure that licensees, when required to by Monitor, take actions to promote competition in the provision of NHS services.

It is important that Monitor has the clear legal authority to require providers to take those actions, and to take them in an appropriate time scale. To that end, we believe it is appropriate to strengthen and clarify clause 90(1)(c) to make it clear that Monitor can require licensed providers to take specific actions and to take actions of a general type or in a manner specified by Monitor, and that Monitor can define the period in which such actions can be taken. Without this provision, licensees could seek to avoid complying with the requirements of the regulator by arguing that the scope of appropriate regulatory action was not defined in the Bill, or that the Bill did not give Monitor the power to stipulate that providers should comply with requirements within a certain period. Amendment 451, therefore, prevents licensees from making that argument.

Turning to amendment 452, one type of condition that Monitor might wish to include would be one designed to ensure that licensees, when required to by Monitor, would take action to ensure continued provision of designated services. Monitor being able to make those requirements via its licence is crucial, because the licence will be the vehicle through which Monitor can operate a distress regime, reducing the risk of disruption to designated service provision in the instance of provider failure.

For instance, Monitor might wish to require providers of designated services to submit accounts and business plans and to refrain from taking certain actions that could compromise the integrity of designated service facilities. It is important for Monitor to have the clear legal authority to require providers to take such actions, in an appropriate time scale. To that end, we believe that it is appropriate to strengthen and include the proposed provision, to make it clear that Monitor could require licensed providers to take specific actions, actions of a general type or actions in a manner specified by Monitor, and that Monitor could define the period within which to take such actions.

Without the provision, licensees might seek to avoid complying with the requirements of the regulator by arguing that the scope of appropriate regulatory action was not defined in the Bill, or that the Bill did not give Monitor the power to stipulate that providers should comply with the requirements within a certain period.

Derek Twigg: Can the Minister give me any examples of where such powers exist in a regulator? One example might be a utility regulator.

The measure obviously gives Monitor a massive amount of power. I apologise if I have in any way misinterpreted what the Minister said, but Monitor could, basically, write the rules itself. Given the Minister’s explanation, Monitor seems to have no parameters, with the Government saying, “There’s your role, get on with it. You set the rules.” However, if providers or commissioners think a decision based on a power given to Monitor in the amendments unreasonable, what is their redress?

Mr Burns: I will write to the hon. Gentleman. Question put, That the amendment be made:—

The Committee divided: Ayes 13, Noes 9.

Division No. 72]

AYES

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Grabb, Stephen
de Bois, Nick
James, Margot
Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Soubry, Anna
Sturdy, Julian
Obviously, the provision will be biased towards NHS making such changes. What if there is no spare capacity before the Government decided to go down the route of whole of a hospital trust? We touched on that matter to a range of services; for example, throughout the assessment been carried out on the proposal's application and whether there is a definitive list of them. Has an I shall be interested to see what services that applies to, scanning) at predetermined prices."

"special licence conditions on individual providers to promote competition. For example, where an incumbent provider has significant market power, require the incumbent to grant access to its services to other providers (e.g. operating theatres, diagnostic scanning) at predetermined prices." I shall be interested to see what services that applies to, and whether there is a definitive list of them. Has an assessment been carried out on the proposal's application to a range of services; for example, throughout the whole of a hospital trust? We touched on that matter when we discussed designation, but the Minister needs to say more about any such assessment. An example or model for a hospital trust must surely have been considered before the Government decided to go down the route of making such changes. What if there is no spare capacity in a trust when a provider wants to use its facilities? Obviously, the provision will be biased towards NHS services.
to the holder’s facilities—that does not include staff; it refers to facilities—Monitor must consider whether the other provider could install its own facilities; whether it is practical to provide such access; the investment that the licensee has made to create the facilities; and the need to secure effective long-term completion. The conditions should ensure that providers in the system have the right incentives to invest in their own facilities but that some competition can be introduced when facilities are monopolistic by nature.

The clause also specifies that Monitor can require only foundation trusts or bodies used to be NHS trusts to notify the Office of Fair Trading of their intent to merge, and that a condition of this type can be in place for only five years. The other example conditions in the clause are of the type that may be required for Monitor to carry out the functions that are set out in other parts of the Bill, such as the charging of licence fees, conditions to protect patient choice and requiring providers to charge in accordance with the national tariff.

The hon. Member for Halton asked a number of perfectly reasonable questions. I have answered his question about whether the proposal applied only to facilities, or whether it covered staff as well; it applies only to facilities. He asked what would happen if there were no spare capacity. If there were no spare capacity, it would not happen—that is obvious—because there would be no spare capacity to enable it to happen. He asked about access to facilities. That is consistent with previous Government policy, as set out in the principles and rules for co-operation and competition—principle 7—published in March 2010. I think that was under the previous Government, so it is not that new or foreign a concept.

The hon. Gentleman asked about patients and competition. Once again, a key misconception rears its head. Monitor’s role is to act to protect and promote the interests of patients, through competition where appropriate. The hon. Gentleman also talked about redress: how do licence holders object to conditions? Modifications of licence conditions must have the agreement of providers. In the case of standard conditions, clause 91 provides a process for objections to be made. If sufficient objections are made, Monitor cannot adopt the modification without referring the proposal to the Competition Commission for consideration under clause 92.

Directions to licence holders under licence conditions, to do or not to do certain things, could be challenged by an application for judicial review.

I think I have answered all the hon. Gentleman’s questions. I would like to place one thing on the record, as it may reassure him. If anyone does use another provider’s facilities, whether it is the NHS using private providers of vice versa—of course, it is a two-way process—they would have to pay for the use of those facilities. For those reasons, the clause should stand part of the Bill.

Jeremy Lefroy: I have a short question about clause 90(1)(g), which refers to the requirement on licence holders to charge for the provision of health care services in accordance with the national tariff. My question is about patients who are not entitled to NHS services, in effect not UK citizens, but citizens of the European Economic Area or beyond. Will there be a requirement on service providers to inform when they provide services to such citizens? As the Minister may be aware, the amount of money that the UK spends on paying for UK citizens overseas to have treatment within the EEA is about £130 million a year, whereas only £25 million is charged by the NHS to citizens of EEA countries. Is there an opportunity to make it a condition for providers to inform when they provide such services? We might see the takings of the UK increase through that.

Mr Burns: I can give my hon. Friend an answer, but it may not reassure him. The provision does not deal with that type of issue. However, he may be reassured by the work that the Under-Secretary of State for Health, my hon. Friend the hon. Member for Guildford (Anne Milton) has been doing in that area, and the consultation document that she published last week.

Derek Twigg: I may have missed it, but in the Minister’s comments did he say anything about access to GP services? Will he cover that point? It is an NHS service. Will he say whether access provided to GP services will be included?

The full capacity issue is interesting. The King’s Fund knows a lot more about the health service than I do, and, I suspect, the Minister does.

Mr Burns: I do not think that the situation would arise with GPs. The proposal is about the use of facilities not services.

Derek Twigg: GPs have facilities.

Mr Burns: Yes, but I cannot envisage why anyone would want to use their facilities in the way that providers might want to use someone else’s facilities to provide health care in a hospital setting of certain types.

Derek Twigg: With regard to GP services, there are different sizes and types of provision, some quite significant, so I am surprised by what the Minister said. It would be easy for him to put on the record that he is confident that no way will GP services or surgeries be included.

Mr Burns: I am happy with what I said.

6.15 pm

Derek Twigg: The Minister did not say that, though; if he wants to say it, let him put it on the record. Basically, this could apply to GP facilities—that is what he is actually saying. We can talk about the difference between services and facilities.

The Government have a great commitment to open up the health service to competition, but there is no way that a very large hospital trust that is at full capacity could be competed against, because there would be no capacity for the other providers to use.

Grahame M. Morris: Perhaps the Minister can clarify the issue of facilities, not personnel. It is a practical consideration. Imagine that an NHS foundation trust
had invested in a major diagnostic piece of equipment, such as an MRI or CT scanner that cost £1 million; it is inconceivable that a private sector provider would hire that facility without hiring the specialist diagnostic staff who operate it. It seems bizarre. There are major inconsistencies between the impact assessment, the clauses in the Bill and what the Minister is telling us.

As a number of hon. Members have said, including my hon. Friend the Member for Leicester West, it is notoriously difficult to make an assessment of the tariff, for example; it has a very complicated formula. If Monitor addresses the issue of creating a level playing field, and Ministers have previously ruled out giving the private sector tax breaks or a differential pricing system to get new entrants—private sector health companies—into the markets, I find it difficult to understand why this mechanism is being used.

There is a risk, despite the Minister’s earlier assurances, that the private health care provider could effectively be profiting from the NHS by using its facilities without paying for the wider costs that the NHS foundation trusts would have to bear, because of the complicated pattern of cross-subsidies for overheads and all the other things that go into the mix to determine the cost of a particular service.

**Mr Burns:** So that hares do not start running all over the place, I will answer the hon. Member for Halton, who is a past master. On the question of GP surgeries, which was his example, I repeat what I said earlier, because I stand by that. I will not be tempted down the road on which the hon. Gentleman wants me to go. What I will say, as I said then, is that it would be extremely unlikely that what he described would happen with regard to a GP surgery, not least because a GP surgery is not categorised as a specialist facility. That is what I am putting on the record, not what the hon. Gentleman is trying to tempt me to say.

*Question put and agreed to.*

Clause 90, as amended, accordingly ordered to stand part of the Bill.

Clause 91

**Modification of standard conditions**

Amendment made: 386, in clause 91, page 86, line 31, leave out ‘licences’ and insert ‘all licences or (as the case may be) licences of that description’.—(Mr Simon Burns.)

Clause 91, as amended, ordered to stand part of the Bill.

Clause 92

**Modification references to the Competition Commission**

Amendments made: 387, in clause 92, page 87, line 37, after ‘applicant’ insert ‘or licence holder concerned’.

Amendment 388, in clause 92, page 87, line 41, after ‘applicant’ insert ‘or licence holder concerned’.

Amendment 389, in clause 92, page 87, line 44, after ‘applicant’ insert ‘or licence holder concerned’.

Amendment 453, in clause 92, page 88, line 5, at end insert—

‘( ) Where the standard conditions applicable to all licences or (as the case may be) to licences of a particular description are modified pursuant to a reference made under subsection (4), Monitor—

(a) may also make such incidental or consequential modifications as it considers necessary or expedient of any other conditions of a licence which is affected by the modifications,

(b) must make (as nearly as may be) the same modifications of those conditions for the purposes of their inclusion in all licences or (as the case may be) licences of that description granted after that time, and

(c) must publish any modifications made under this subsection.’.

Amendment 390, in clause 92, page 88, line 6, leave out subsection (7).—(Mr Simon Burns.)

Clause 92, as amended, ordered to stand part of the Bill.

Schedule 8

References by Monitor to the Competition Commission

Mr Burns: I beg to move amendment 391, schedule 8, page 285, line 33, leave out paragraph (b).

The Chair: With this it will be convenient to take Government amendments 410 and 411.

Mr Burns: I hope that I can be brief, so that the Committee can make progress. The Bill will require Monitor to notify sector bodies, including the commissioning board, of any reports received from the Competition Commission following references that Monitor makes to the commission seeking modification of provider licence conditions.

Two parts of the Bill place an obligation on Monitor to carry out the notification—clause 92(5)(a)(ii), which will introduce and establish the power for Monitor to make a notification, and schedule 8, which presents details of the reference process. To ensure clarity and to establish a single notification requirement, amendment 391 will remove the duplicated and unnecessary provision from schedule 8. There are similar amendments to clause 128, to update references to the notification process in that clause.

With regard to the amendments to clause 128, the removal of subsection 6(b) will not mean that Monitor will no longer have to notify the objecting providers, because those same providers would be covered by subsection 6(a)(ii). The amendments, taken together, will mean that appropriate processes for notification of references to the Competition Commission are established in the Bill, ensuring that appropriate bodies will be informed of and able to scrutinise the referrals made by the regulator. I trust that my hon. Friends will join me in supporting the amendments.

Amendment 391 agreed to.

Amendments made: 392, page 286, line 20, after ‘day’ insert ‘after that’.
Amendment 517, page 288, line 19, leave out ‘and (6)’ and insert ‘, (6) and (8) to (11)’.
Amendment 518, page 288, line 34, after ‘(7)’ insert ‘to (11)’.
Amendment 393, page 288, line 35, leave out ‘7’ and insert ‘8’.
Amendment 394, page 289, line 44, leave out ‘offences and’.—[Mr Simon Burns.]
Schedule 8, as amended, agreed to.

Clause 93

MODIFICATION OF CONDITIONS BY ORDER UNDER OTHER ENACTMENTS

Amendment made: 395, page 89, line 6, leave out ‘licences’ and insert ‘all licences or (as the case may be) licences of that description’.—(Mr Simon Burns.)

Clause 93, as amended, ordered to stand part of the Bill.

Clauses 94 to 97 ordered to stand part of the Bill.

Schedule 9

FURTHER PROVISION ABOUT ENFORCEMENT POWERS

Amendments made: 454, page 290, line 14, at end insert—

‘( ) explain the effect of section 96.’.

Amendment 455, page 291, line 1, after ‘period’, insert ‘(“the payment period”)’.

Amendment 456, page 291, line 1, after ‘made’, insert—

‘(i) any discount applicable for early payment of the penalty;’.

Amendment 457, page 291, line 5, at end insert—

‘( ) The payment period must be not less than 28 days beginning with the day after that on which the final notice is received.’.

Amendment 458, page 291, line 29, at end insert—

‘Monitor may by notice to a person on whom a discretionary requirement has been imposed—

(a) withdraw the discretionary requirement,
(b) in the case of a variable monetary penalty, reduce the amount of the penalty or extend the payment period, or
(c) in the case of a compliance requirement or a restoration requirement, extend the period specified for taking the steps specified in the requirement.’.

Amendment 459, page 291, line 41, at end insert—

‘(i) state any discount applicable for early payment of the penalty.’.

Amendment 460, page 292, leave out lines 6 to 8 and insert—

‘( ) Monitor may by notice to a person on whom a non-compliance penalty has been imposed reduce the amount of the penalty or extend the payment period.’.

Amendment 461, page 293, line 4, at end insert—

‘( ) But Monitor must not under sub-paragraph (1) publish any part of an enforcement undertaking which contains commercial information the disclosure of which Monitor considers would or might significantly harm the legitimate business interests of any person to whom it relates.’.

Amendment 462, page 293, line 33, leave out ‘the person is to be treated’ and insert ‘Monitor may treat the person’.

Amendment 463, page 293, line 35, leave out ‘accordingly’ and insert—

‘if Monitor decides so to treat the person’.—(Mr Simon Burns.)

Schedule 9, as amended, agreed to.

Clause 98 ordered to stand part of the Bill.

Clause 99

PUBLICATION OF ENFORCEMENT ACTION

Amendment made: 396, page 92, line 7, leave out ‘licence holder’ and insert ‘person’.—(Mr Simon Burns.)

Clause 99, as amended, ordered to stand part of the Bill.

6.30 pm

Clause 100 ordered to stand part of the Bill.

Clause 101

DESIGNATION OF NHS FOUNDATION TRUSTS DURING TRANSITIONAL PERIOD

Amendment made: 397, in clause 101, page 93, line 13, leave out ‘for the time being published’.—(Mr Simon Burns.)

Clause 101, as amended, ordered to stand part of the Bill.

Clause 102

IMPOSITION OF LICENCE CONDITIONS ON DESIGNATED NHS FOUNDATION TRUSTS

Mr Burns: I beg to move amendment 464, in clause 102, page 93, line 33, leave out ‘within a specified period’ and insert—

‘(or to do, or not to do, any such things in a specified manner) within such period as may be specified’.

The Chair: With this it will be convenient to discuss Government amendments 465, 466 and 467.

Mr Burns: The amendments make minor and technical changes to the provisions relating to Monitor’s power to impose additional licence conditions on certain foundation trusts temporarily—and to intervene, if necessary, to enforce them. They do not make any substantive changes to the clause; they simply make necessary changes to clarify the language used and make it consistent with a related provision in clause 90(1)(c).

The amendments do not alter the purpose of, or rationale for, the clause.

The clause addresses responses to the White Paper consultation suggesting that not all foundation trusts will be ready to manage their own affairs without external oversight when the licensing regime begins. New foundation trusts will need time to develop their governance arrangements, and governors will need to learn how to use their powers effectively.
Some existing FTs whose governors have not been fulfilling the role defined for them in part 4 of the Bill might need time to adapt and develop the effectiveness of their governance arrangements. During the transitional period, Monitor will have the power to impose additional licence conditions on new and identified existing FTs if it is satisfied that there is a significant risk that an FT will fail to fulfil its principal purpose of providing goods and services for the purposes of the health service in England.

Liz Kendall: What assessment has the Department made of how many foundation trusts will be included in that description?

Mr Burns: My answer to the hon. Lady is one that she already knows. The figure that Sir David Nicholson, the head of the NHS, gave to the Public Accounts Committee was 20.

The first of the amendments simply brings the wording of clause 102(5)(a) into line with the language used in clause 90(1)(c). Clause 90 deals with requirements that might be included in a provider's standard or special licence conditions. As we have discussed, it makes it clear that such conditions could require a licence holder to do or not do certain things and specifies how those things should be done and in what period.

Amendment 464 makes it clear that licence conditions can not only require a foundation trust to do or not do certain things but specify the manner in which those things should be done. It is important that the two clauses be consistent. Amendment 465 is similarly minor and technical, as are amendments 466 and 467. For those reasons, I urge the Committee to accept the amendments.

Amendment 464 agreed to.

Amendments made: 465, in clause 102, page 93, line 41, leave out ‘the trust’ and insert ‘a person’.

Amendment 466, in clause 102, page 93, line 42, after ‘(5)’, insert ‘(a)’.

Amendment 467, in clause 102, page 93, line 45, leave out ‘that subsection’ and insert ‘subsection (5)’.—(Mr Simon Burns.)

Derek Twigg: I beg to move amendment 611, in clause 102, page 94, leave out lines 15 to 20.

Our rationale is that clause 52 of the 2006 Act allows Monitor to intervene in foundation trusts before they become insolvent. For example, where there is a risk of failing to comply with requirements, Monitor can remove the entire foundation trust management. It is about the early intervention duty and powers, and our amendment would effectively keep Monitor’s existing role, in relation to ensuring compliance and financial risk ratings. We want the type of monitoring and early intervention that is set out in the 2006 Act, which is why we seek to keep section 52 of that legislation.

It is straightforward for the Minister to respond to those points. I will not spend too much time on the subject this evening, because we will return to it when we debate insolvent and foundation trusts. It is important, however, because we believe that the Government have shifted away and talked a lot today about failure regimes, and about dealing with failure. Our original Bill, which became the 2006 Act, talked a lot about early intervention, and about helping foundation trusts. The amendment would do that, but as I said, we will return to the subject.

Mr Burns: I understand the hon. Gentleman’s concerns, and I sympathise with the underlying purpose of the amendment. I am confident that we agree that failure should be the last resort. Where providers find themselves in difficulty, there should be robust measures to ensure that, above all else, the interests of patients are protected and the continuity of essential services is maintained. The Bill, however, already achieves that. It contains a wide range of provisions to ensure that patients’ interests are protected in the event that a provider gets into difficulty. One of Monitor’s core roles would be to support commissioners in ensuring the continuity of essential local health services, if a provider became insolvent. Not all services or providers are equally successful.

The Government will not force patients to use poor-quality, inefficient services or providers, nor will it force taxpayers to subsidise them. Whereas in the past, the response to failure has usually been to prop up the provider as an institution, in future, there would be a clear and transparent mechanism for managing provider failure, which would protect services for patients, but not ineffective management or poor-quality care. That would enable commissioners to replace existing services with higher-quality or better-value options smoothly, and without the risk of interrupting patient access to services.

The Bill gives Monitor a broad set of legislative intervention powers to ensure the continuity of essential services, including, in exceptional circumstances, powers to direct an organisation to take specific actions in order to prevent failure. If any provider breaches its licence conditions, Monitor would be able to intervene to enforce compliance under clauses 95 and 96. Its powers in that regard include: the power to require a provider to take action to ensure that the breach does not recur; the power to take action to restore the situation to what it would have been, had the breach not occurred; and the ability to fine providers in breach of their licence conditions. Those would be permanent enforcement powers, which Monitor would have at its disposal to protect patients’ interests.

We are also putting in place robust measures to ensure that the transition to the new system is managed effectively and smoothly. We are, therefore, giving Monitor transitional intervention powers on a strictly time-limited basis to intervene, if necessary, in foundation trusts that have yet to develop effective internal governance, in the event that serious failings have developed, or that a foundation trust has encountered difficulties that threaten its ability to provide services to NHS patients.

Monitor’s transitional intervention powers would be exactly the same as the set of powers that it has now in relation to failing foundation trusts under section 52 of the 2006 Act. Those powers include: the power to require a foundation trust to take, or refrain from taking, certain actions; the power to suspend or remove a foundation trust’s management; and the power to disqualify such people from holding office again. Those powers would only apply to foundation trusts that require additional oversight. Foundation
trusts that have effective governance and perform well would not be subject to the transitional intervention powers.

The hon. Gentleman seems to want Monitor to retain its ability to intervene in foundation trusts on a permanent basis. I hope I have made it clear that that is unnecessary, because Monitor would have the ability to intervene in any provider that breaches its licence conditions. That applies not only to foundation trusts, but to independent providers, including private companies, charities and social enterprises. That strengthens Monitor’s ability to protect patients’ interests.

Whatever the hon. Gentleman’s intention, his amendment simply would not protect patients’ interests, nor would it help to minimise the risk of provider failure, because it would preserve a power for Monitor that, in practice, it would be unable to use. The amendment would retain section 52 of the 2006 Act, which allows Monitor to intervene in a foundation trust to enforce compliance with its terms of authorisation. The terms of authorisation would cease to have effect when the licensing regime begins. While Monitor would have a nominal legal power, it would in fact be redundant. Monitor’s enforcement powers need to be based on licensing and that is precisely what the Bill provides. This amendment is therefore not only unnecessary but unworkable. For those reasons I ask the hon. Gentleman to withdraw it.

Derek Twigg: I wish to divide the Committee on the amendment.

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 73]

AYES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)

Smith, Owen
Thomberry, Emily
Twigg, Derek
Wilson, Phil

NOES

Brine, Mr Steve
Burns, Mr Simon
Burstaw, 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.

Clause 102, as amended, ordered to stand part of the Bill.

Clause 103

PRICE PAYABLE BY COMMISSIONERS FOR NHS SERVICES

Mr Burns: I beg to move amendment 550, in clause 103, page 94, line 27, leave out ‘the price’ and insert ‘(subject to sections 110 and 111) such price as is determined in accordance with the national tariff on the basis of the price (referred to in this Chapter as “the national price”).’
large body of evidence shows that it is detrimental to quality. It is worth noting that our general concerns—and the public’s—about price competition have been expressed by many experts from whom the Committee has heard. Dr. Clare Gerada, who is chair of the Royal College of General Practitioners, said:

“All the evidence appears to show that if you base competition on price you drive down quality. That is what we are concerned about.”—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 50, Q102.]

Mr Burns: I do not want to interrupt unnecessarily, but the hon. Gentleman seems to be talking about the issue of maximum prices. Will it not be more appropriate to discuss that on the next group of amendments?

Derek Twigg: My understanding is that it is relevant to this group, Dr McCrea.

The Chair: I think it is the next group.

Derek Twigg: I accept your ruling, Dr McCrea, but I understand that it applies equally to this group.

The Chair: I certainly do not want to stifle debate, but maximum price relates to the next group.

Derek Twigg: We will leave it to the next group. If the Minister wants to have the debate, I am happy with that.

Amendment 550 agreed to.

Mr Burns: I beg to move amendment 187, in clause 103, page 94, line 27, leave out from ‘service’ to end of line 30.

The Chair: With this it will be convenient to take Government amendments 188 to 191 and 193 to 203.

Mr Burns: I am delighted that Labour Front-Bench Members have seen the merits of these Government amendments and have added their names to them, in a show of consensus, so that we can move forward to get the Bill properly drafted without any misunderstandings. The intention of these amendments is to deal with misunderstandings from some quarters that the Bill introduces price competition. Let me state very clearly that I do not want to interrupt unnecessarily, but the hon. Gentleman seems to be talking about the issue of maximum prices. Will it not be more appropriate to discuss that on the next group of amendments?

Mr Burns: I do not want to interrupt unnecessarily, but the hon. Gentleman seems to be talking about the issue of maximum prices. Will it not be more appropriate to discuss that on the next group of amendments?

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Grahame M. Morris: Will the Minister comment on the award of the north-east prison health contract, which was apparently awarded on the basis of price?

Mr Burns: The hon. Gentleman has been a delight in this Committee. [Interruption.] Excuse me, I am trying to help the hon. Gentleman. He knows that I do not go down cul-de-sacs to address individual examples because of the problems that can flow from that. On this occasion, in a spirit of generosity, I will say that although I do not know whether he has portrayed the contract accurately, he will be perspicacious enough to know that it was all done under the system installed by his party’s Government.

Margot James (Stourbridge) (Con): Is my right hon. Friend concerned that there might be a rash of these private providers coming in to try to compete on price to get in quick before this Government’s legislation outlaws the practice?

Mr Burns: My hon. Friend raises an intriguing point, which we could probably debate for hours. In deference to hon. Members I will resist the temptation, but my hon. Friend makes a valid point that is on the record.

These amendments remove Monitor’s ability to set national tariff prices as the maximum. This means that for all services covered by the tariff there can be no competition on price. The provisions for Monitor to set maximum prices were never to be used to introduce price competition. Competition should be based on quality, and wherever possible the price must be fixed before beneficial competition can take place. The use of maximum prices was included to allow Monitor to regulate price increases for non-competitive services, again, among monopoly providers. However, Monitor’s competition powers are sufficient to deal with any abuse of the dominant position and we are able to remove the references to maximum. Let me remind hon. Members that for the first time the Bill introduces a framework in primary legislation to govern the use of the tariff in the NHS. That is a very significant change, which Labour Members can appreciate and support—although they did not legislate for it when they were in power.

Where a service is covered by the national tariff, competition should only ever be on the quality of care that the provider can provide to its patients. Being covered by the tariff means not only that we can be certain that competition is focused on quality, but that the risk of cherry-picking is mitigated by the setting of accurate prices that fairly reflect costs. As hon. Members will be aware, the setting of the tariff is a complex process, which must take into account a wide range of considerations. That has contributed to the current situation where the tariff is not comprehensive and many clinical areas that would benefit from having a national tariff are not covered. That is not good enough.

Mr Steve Brine (Winchester) (Con): I welcome the amendments wholeheartedly. Many of the representations made to me revolve around the misrepresentation on so-called price competition and so-called cherry-picking. I welcome the Government’s listening mode on this. Does the Minister agree that this goes to the very heart of addressing some of the criticisms of the Bill? Does he accept that the measure will stop the creeping privatisation and price competition that we inherited from the previous Government?

Mr Burns: My hon. Friend makes an excellent point. I wholeheartedly share his view. Does he agree that one should always welcome a sinner who repenteth? I will take the fact that Opposition Front Benchers have signed up to our amendment as a sign of a sinner repenting, and I will give them forgiveness.
Mr Burns: No, because of the time. As I said, hon. Members will be aware that the setting of the tariff is a complex process, which must take into account a wide range of considerations. That has contributed to the current situation where the tariff is not comprehensive and many clinical areas that would benefit from having a national tariff are not covered. Because of that, at a later stage we will bring forward amendments to put an express duty on Monitor and the NHS commissioning board to develop the tariff into a comprehensive system of national pricing.

The Chair: Let me say to Mr Twigg that I certainly do not want in any way to stifle the questions that he wanted to ask previously and that he has the freedom to ask them.

Derek Twigg: Thank you, Dr McCrea.

It is interesting that the Minister is denying it was the intention to have price competition. The explanatory notes state on page 117:

“it allows for those services to provided at a standard price or a maximum price, with flexibility to negotiate below that price.”

That is in the Government’s explanatory notes. How can they deny their own explanatory notes? As usual, the right hon. Gentleman tried to make a good fist of his Government’s appalling policies. I am sure that he will look back with fondness on some of the things he has had to say, and perhaps cringe at some of the others. The fact is that competition was—I am going to explore whether it still is—the purpose of the Bill.

We believe that outright competition on price is unacceptable. There is a large body of evidence to show that such an approach is detrimental to quality. It is worth noting that in addition to their own and the public’s general concerns about price competition, many of the experts we heard from during the Committee’s evidence sessions expressed concerns. Dr Clare Gerada of the Royal College of General Practitioners said:

“All the evidence appears to show that if you base competition on price you drive down quality. That is what we are concerned about, that it will be a race to the bottom.”—[Official Report, Health and Social Care Public Bill Committee, 8 February 2011; c. 50, Q102.]

Dr Gerada’s concerns were echoed by others during the evidence sessions, but I will not go into that because we were all there. In particular, however, it is clear from the evidence of experts that there is a real danger that price competition will be damaging. We were not the only ones who felt that we were moving towards price competition; lots of experts outside did, too. I do not know how the Minister can deny it.

7 pm

The Minister is fond of claiming that my right hon. and hon. Friends somehow misunderstood the Bill or have sought to misrepresent it. I refer him to the explanatory notes and to the other representations. Last week he declared himself

“saddened by this philosophy that if someone repeats something that is not factually correct often enough, it might become a fact.”—[Official Report, Health and Social Care Public Bill Committee, 17 March 2011; c. 869.]

I am unsure what is the best evidence for that that I have heard during this Committee, but perhaps we have just heard it now. Just this morning the Minister said with exasperation that, given my mindset, it would be an uphill battle to convince me of the arguments. Well, he certainly has a big uphill battle to convince us.

In this instance it is lucky that I was not convinced by the right hon. Gentleman’s previous arguments on price competition. He has said numerous times to the Committee that there will be a genuine market, but he has never said that there will be a genuine market in quality. It is lucky that we were not convinced by what the Government have said, and it is lucky that the medical professionals and the public have not been convinced by the plans. As a result, would he like to take this opportunity to apologise for his previous comments and accept that, in this case, it is he and the Government he represents who appear to have failed correctly to understand their own Bill? That is quite remarkable.

As we have noticed quite a few times during this debate, Ministers lack understanding of what is in the Bill and how it works, not least in terms of competition. I am sure you will not let me go down that road, Dr McCrea, but it is a very important point. In the light of that, I can only hope that the Government take the opportunity to reread some of the evidence we have received, particularly on the role of Monitor, to see whether there are other policy shifts that might be in the best interests of the national health service. I feel that, in the Minister’s words, it might be “an uphill battle”. Despite the Government’s talk of having regard to price competition, which is a deviation from their original position—I use that word carefully—we remain unconvinced that they will go far enough to ensure that price competition cannot and will not take place in the NHS.

During the Opposition day debate last Wednesday, the Health Secretary said

“we have amended the Health and Social Care Bill on an important point, which greatly concerned the BMA, and clarified that the measure supports competition on quality, not price.”—[Official Report, 16 March 2011; Vol. 525, c. 387.]

Earlier in the day, the Prime Minister went further, stating categorically

“we have ruled out price competition in the NHS.”—[Official Report, 16 March 2011; Vol. 525, c. 292.]

If we are to believe that is truly the Government’s position, will the Minister explain where he sees the need for a new and hugely expanded Monitor? It is the economic regulator, but why do we need it? If there is no price competition, why do we need a huge regulator such as Monitor? The evidence does not stack up in the Government’s favour.

I do not wish to appear to be seeking to revisit the ground we covered on Monitor last week, so I think the best approach is to ask the question everyone is thinking: if there is to be no possibility of price competition in the NHS, why do we need this remodelled economic regulator? Where is the need for reorganisation on such an unprecedented scale? If the Government truly want to rule out price competition, why not simply introduce an amendment that states, perhaps on Report, that competition on price is not allowed and that anyone who believes that such a practice has occurred may lodge a complaint with the NHS commissioning board, Monitor in its current form, or any other body that the
Government create? Why will the Government not make it plain and clear in the Bill that price competition is not allowed?

Even after the amendments were tabled, the future head of Monitor said in an interview with the BBC:

"I wouldn’t go so far as to say you can never have price competition. I think over time it will probably emerge."

That is the regulator! Is the Minister going to sack him? Quite frankly, it completely contradicts the Government’s policy. Could the Minister confirm whether, in his opinion, the new head of Monitor is incorrect, and what is he going to do about it? If he will not, will he accept that there is a need for the Government to consider tabling further amendments? They need to clarify their position beyond any further doubt, not least to offer some clarity to the head of their new economic regulator.

On cherry-picking, the Government are trying to confuse the issue with that around cherry-picking on price, rather than dealing with other issues, which I want to come on to. May I quote the Prime Minister last week? We will probably all enjoy his full quote, so we can understand what he is saying. He said:

"First of all, let us be clear about the fact that the reforms are about cutting bureaucracy and improving patient care. They were drawn up by us as a coalition to improve the NHS. Let me answer the right hon. Gentleman’s question very directly. We have already made some real strengthenings to the Bill” —

I do not think that we have seen many of those.

"First, we have ruled out price competition in the NHS” —

but, obviously, not told the regulator.

"Secondly, there is the issue raised by the Liberal Democrats, with which I completely agree: we must avoid cherry-picking by the private sector in the NHS.” —[Official Report, 16 March 2011; Vol. 525, c. 292.]

Yet again, the Prime Minister’s promises do not match his actions. Nothing in the Bill rules out cherry-picking. Let us be clear what we are talking about with cherry-picking, and it is important to separate the various comments of the Minister and his hon. Friends. It is about bidding only for services that present less complex problems—in other words, healthier patients—and about private providers choosing certain profitable services or people to compete over; taking away activity from existing providers and so undermining the financial stability of NHS trusts, which have to provide unprofitable services, so endangering local hospitals. We have, again, a charter for putting hospitals—I hate to use the phrase —out of business. One of the consequences could be that NHS trusts stop providing services that they cannot make a profit from, and do not want them designated.

I could go on, but we clearly have the Government denying that they want price competition, while all the facts point in the opposite direction, including their own explanatory notes. We have the chairman of Monitor completely contradicting what Ministers are saying. The whole system is chaos, a mess and going nowhere whatever the Minister and the Government say, it is about competition on price.

Amendment 187 agreed to.

Clause 103, as amended, ordered to stand part of the Bill. 

Clause 104

The national tariff


Amendment 188, in clause 104, page 94, line 40, leave out ‘, or maximum prices.’.—(Mr Simon Burns.)

Derek Twigg: On a point of order, Dr McCrea, I thought that we were going to have a debate on clause 103 stand part. I did not hear the question on clause 103 being put.

The Chair: The Committee has agreed to clause 103. It was called before Government amendments 551 and 188 were made. It was clearly put after the debate on Government amendment 187.

Derek Twigg: None of my colleagues heard it being called. I thought that the clause stand part came at the end of the debate.

The Chair: The question was clear that clause 103, as amended, stand part of the Bill, and that was after the debate and decision on Government amendment 187. I am sorry, but it certainly was called, but we have to move on to amendment 612 now.

Derek Twigg: I accept your ruling, Dr McCrea, but I assume that, as clause 103 is affected by the rest of the clauses in this part, we can have some debate on it under clause 104. I have put it on the record that Opposition Members did not hear clause 103 stand part being called. I have to accept your ruling, Dr McCrea. [Interuption.] If hon. Members want to doubt what we did and did not hear that is fine, but we did not hear it. We heard amendments being moved, but we did not pick up that clause 103 was being dealt with and did not hear the question.

The Chair: I have no doubt that the hon. Members are genuine when they make that statement. However, the record will show clearly that it was called. I am advised that we cannot go back on it, but the record will show that it was called.

Mr Burns: On a point of order, Dr McCrea. I wonder if you and the Committee might feel that this would be an appropriate moment for us to have a short break?

The Chair: I agree. I will suspend the Committee briefly.

7.13 pm

Sitting suspended.

7.28 pm

On resuming —

The Chair: When we suspended, we about to debate amendment 612. I would like to make a ruling at this time. I believe that Members genuinely did not hear the question on clause 103 stand part, so when we come to
Derek Twigg: Thank you, Dr McCrea. It was not just me—one or two of my colleagues also wanted to speak in that debate. That was why I was particularly concerned. I will, of course, take your advice, and I thank you for your ruling.

I beg to move amendment 612, in clause 104, page 94, line 40, at end insert

\[excluding how capital costs have been taken into account\].

This is a short amendment, but it deals with an issue that the Minister must address. At present, major investment projects are dealt with through regional planning, and normally require PCT and SHA approval. The funds come from either the private sector through private finance initiative schemes, or through the Department of Health granting public expenditure capital dividends under the market system. It is not clear how that will be achieved in future, so it needs to be allowed for in tariff rates. The amendment allows a debate on this important issue, but it is a probing amendment. Although we have to a certain extent already debated strategic responsibility for capital investments under the board clauses, it would be useful to get further information from the Minister.

Mr Burns: I hope that I can reassure the hon. Gentleman. The amendment makes explicit that Monitor will have to include how it has treated the cost of capital when publishing the pricing methodology. It is unnecessary. As the list of things the pricing methodology will cover can never be exhaustive, it is inappropriate to place in legislation, particularly primary legislation, some of the factors to be considered, as they may be seen as having precedence over those that are not included.

When developing a pricing methodology and agreeing it with the commissioning board, Monitor will have to take into account all factors that may affect the price of delivery; that will include how capital costs have been incorporated. I hope the hon. Gentleman finds that helpful and that he considers the matter has now been probed.

Derek Twigg: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Amendments made: 552, in clause 104, page 94, line 41, leave out

\[for the provision of those services for those purposes\] and insert \[of those services\].

Amendment 553, in clause 104, page 94, line 42, after first \[the\], insert \[national\].

Amendment 189, in clause 104, page 94, line 42, leave out \[or maximum price\].

Amendment 554, in clause 104, page 94, line 42, leave out

\[payable for the provision of each of those services for those purposes\] and insert

\[of each of those services\].
Derek Twigg: I should like to press the amendment to a vote.

Question put. That the amendment be made.

The Committee divided: Ayes 9, Noes 12.

Division No. 74

AYES
Abrahams, Debbie
Blencarn, P. (Oldham, G.)
Kendall, Liz
Morris, Grahame M. (Easington)
Smith, Owen

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

Mr Burns: I beg to move amendment 558, in clause 104, page 95, line 8, at end insert—

'(2A) The national tariff may also provide for rules relating to the making of payments to the provider of a health care service for the provision of that service.'.

I will be brief, so that the Committee can make progress. The amendment allows for the national tariff to include rules on payments for services. The rules will be transparent and legally binding, with enforcement by Monitor, and will ensure a smoother running of the tariff system. The rules on payments will be used to outline how and when payments for services in the national tariff should be made. For example, the rules might include whether the provider is paid in arrears for services delivered or up front for expected activity levels, with the opportunity to reclaim moneys when the patients treated are less than expected. The provision will enforce rules that must be followed by commissioners and providers with regard to services specified in the national tariff.

Amendment 558 agreed to.

Amendment made: 559, page 95, line 10, after '(1)', insert '(ca) and'.—(Mr Simon Burns.)

Mr Burns: I beg to move amendment 560, page 95, line 11, leave out subsection (4).

The Chair: With this it will be convenient to discuss Government new clause 16—The national tariff: further provision.

Mr Burns: To help the Committee, I hope to be equally as brief. Amendment 560 offers clarity over how the services in the national tariff can be specified. It also ensures that commissioners and providers can vary the specification of the service and the price only within a transparent rules-based system. Subsection (1) of the new clause allows the NHS commissioning board the flexibility it needs when specifying the services, or currencies, to be covered by the national tariff.

The NHS commissioning board can, among other things, split a service into its components. It could split rehabilitation from a surgical procedure, for example. It can bundle a service together along a patient pathway. An example of that is the combining of diagnostic testing and treatment to attach one price. The board can group services with similar costs to apply a single price for the group. Therefore, if the treatments for more than one condition are sufficiently similar in cost, they may be grouped and priced together. That is currently done using health resource groups under payment by results. That inclusion makes subsection (4) of clause 104 unnecessary, and amendment 560 removes it.

Subsections (2), (3) and (4) of the new clause state that a national price must be attached to each specification of the services, as laid out in subsection (1), for use in the national tariff. That is to avoid confusion over the national price that will be paid and over what Monitor will apply a price to.

Subsection (5) of the new clause confirms that the provider cannot vary delivery of a service from the specification in the national tariff unless the varied service is also specified, or is allowed under the rules set out in clause 104(2).

Liz Kendall: I am grateful to the Minister for giving way, as I know that he wants to make progress—as all hon. Members do. Will he say whether the new clause will enable a price to be set across a whole patient pathway?

Mr Burns: The simple answer is yes.

Subsection (5) is necessary as it creates a transparent rules-based system of national pricing. At present, if a provider can vary the specification slightly from that outlined in the national tariff by only delivering some components of a bundled service, for example, it would be outside the national tariff and subject to local price-setting rules. Subsection (5) is necessary to stop that eventuality, while still providing the flexibilities that will improve the quality and/or the efficiency of care.

Amendment 560 agreed to.

Derek Twigg: I beg to move amendment 205, page 95, leave out lines 15 to 19.

Mr Burns: I beg to move amendment 613, page 95, line 19, at end insert—

'(6A) A description for the purposes of subsection (6)(b) may not be framed by reference to—

(a) whether the provider is in public or private ownership,
(b) whether the provider is an incumbent or new entrant, or
(c) some other aspect of the status of the provider.'.

Amendment 614, page 95, line 19, at end insert—

'(6A) A description for the purposes of subsection (6)(b) may not be framed by reference to the costs incurred by a provider in relation to—

(a) taxation, or
(b) access to the NHS pension scheme.'.

Derek Twigg: Depending on what the Minister says, we may push the amendment to a vote, but it is initially a probing amendment. Will the Minister explain how the national tariff will be applied to designated and non-designated services? There may be no difference,
but we want to get a handle on that. Will there be a different rate or different conditions, or will prices be constant irrespective of designation? The Bill sets up a risk pool, and providers or commissioners must pay money into a central fund to deal with risk and problems with stability and perhaps even failure. We are worried that that will be an extra burden on NHS services, but not so much on private providers. Again, I would welcome the Minister’s explanation, because we are not clear about the matter. Does the risk pool apply only to NHS providers, or to providers across the piece? It is important to understand that, and I presume that the Minister wants it on the record.

7.45 pm

Mr Burns: If it helps the hon. Gentleman, I will put it on the record now. It is across the piece.

Derek Twigg: The Minister may think we are suggesting that things might happen that will never happen, but because of the extra cost, commissioners may decide not to commission a particular service because they would have to find the money from their budget. I am not sure of the extent of that in terms of how often and how much—obviously, the Bill does not include the details—but it could be a disincentive to designating a service. Similarly, I do not know whether a provider might decide not to bid for or apply for a service. We would like more information, because the matter is not clear enough.

Mr Burns: I fully appreciate the hon. Gentleman’s comment that this might be a probing amendment, but I accept that in the light of what I say he might wish to press it to a vote.

These amendments are all related to Monitor’s ability to set differential prices for designated services and in relation to different types of provider. Amendment 205 would remove Monitor’s power to set differential prices for designated services and different providers. That would have a disastrous effect on the NHS system. First, Monitor’s ability to set differential prices for designated services is an important tool to ensure the sustainability of designated services. Linked to that, the adjustments will be used to correct unavoidable differences in costs associated with delivery for some providers; for example, to account for geographical variations in wages and the cost of land. We have tabled amendments to make the provision’s use crystal clear.

Similar adjustments are made to tariffs in the current system through the market forces factor to reflect the additional, unavoidable costs that some providers face over others. The provision enables those vital adjustments to continue in the new system. Without that power, Monitor would have to set constant prices across all providers regardless of their cost base. That would lead to huge waste, or a reduction in quality or accessing services. If it is still felt that the power would be used to fund inefficiencies or promote entry among some provider types, I assure the Committee that that is not possible.

For the reasons that I have given, I urge my hon. Friends to resist the amendment if the hon. Gentleman decides to press it to a vote.

Liz Kendall: I want ask the Minister for clarification. In an area with only one provider—perhaps a rural area—there may be many designated services that cannot be allowed to fail. Monitor will be allowed to charge higher costs in those areas because it must have the extra money to keep services going so that they do not fail. There will be price competition under the system. Commissioners in areas where there are high levels of designated services will generally have to pay more, and that is not a fair and level playing field. The Minister looks quizzical in his characteristic manner, but that point was made by the King’s Fund whose briefing says that “it may mean that commissioners in areas with a large number of designated services will have to pay levies to Monitor for designating services and higher tariffs. This seems unfair.” “Seems” is their word, not mine.

Mr Burns: Yes, I was looking quizzical. I would like to try to reassure the hon. Lady, although I am not convinced that I will be successful, because it is not often that I can assure her. Regarding higher prices, the commissioning board will set budgets to reflect the circumstances mentioned by her. I hope that has satisfied her.

Liz Kendall: It was a specific question on that point. The Minister was generous in giving way; I know that is his nature. Will he confirm that budgets in areas with high numbers of designated services will, through the allocation formula, reflect the higher costs? That seems to be what he just said, and I would like to confirm that.

Mr Burns: As I have just said to the hon. Lady, yes. The commissioning board will set the budgets to reflect the points that she has just raised.

Government amendment 192 will make it clear that Monitor cannot set prices based on the ownership of the provider. That means that differential prices can be set based only on other criteria, such as the location of the provision and the complexity of patients’ needs. The amendment does not represent a change in policy intention, only a clarification of our position due to the many misrepresentations that have been made in the area. The amendment on differential prices was thought necessary due to the misconception that it may be used to promote entry by some providers. That is not true, and the amendment will make that clear. The Government have never considered paying certain providers more for delivering the same work under the same conditions, as that would not be a responsible use of NHS resources.

However, we recognise that a one-size-fits-all tariff is not appropriate because there are unavoidable cost differences for providers. The tariff needs the flexibility to pay a higher price for provision in higher-cost areas, such as central London, due to the cost of labour, land and buildings. As I have said, that is an adjustment made under the current system through the market forces factor.

Owen Smith: Will the Minister give way?

Mr Burns: No, I want to make some progress.

The tariff also needs to be able to reflect the legitimate additional costs that specialist providers incur when treating the most complex patients, and it may also need to reflect the differential costs associated with delivery,
such as the need for some providers to train the future NHS work force. Providers should be compensated for those costs, and pricing may be the best way to do that. When prices are set differently, it will be supported by an evidence base and agreed by the NHS commissioning board under its duty to agree the pricing methodology. The amendment will make it clear that although differential prices may be based on evidence of unavoidable differential costs, it cannot be set arbitrarily for certain types of provider.

Amendment 613 would add an additional limitation to the national tariff’s opportunity to set differential prices. I take this opportunity to thank the hon. Member for Halton for his support on amendment 192, and I will concentrate on the difference between the two amendments, which relates to restricting Monitor’s ability to set differential prices for incumbents and new entrants.

First, in practice, it would be difficult to distinguish between a new entrant and an incumbent, so that part of the amendment would be difficult to enforce. However, we agree with the spirit of the amendment. Our intention has never been to set a differential price to entice new entry or to favour particular types of providers. Instead, it is to pay the same price to providers that deliver the same work under the same conditions.

I again reassure hon. Members that the differential prices will be developed by Monitor, but must be agreed by the commissioning board before taking effect. The organisations will have to ensure that the setting of a differential price helps in the delivery of their objectives and acts in the interests of patients and taxpayers. This ensures that the differential prices act in the interests of the system, and are used to reimburse providers that face genuine, unavoidable higher costs. It will not be used to promote new entry for the sake of it; that would be an irresponsible use of taxpayers’ money. For those reasons I am resisting the amendment.

Amendment 614 would remove Monitor’s ability to set differential prices to cover the costs incurred with differences in tax arrangements and access to the NHS pension scheme. The amendment is disproportionate and restrictive. It is not appropriate for the legislation to specify to this level of detail what Monitor and the commissioning board may wish to look at when considering setting differential prices to reimburse providers for unavoidable differences in costs.

Placing such a list in legislation would also be too restrictive. Even if Monitor did not want to set differential prices now, it might need the opportunity to address these issues in the future for the benefit of patients and taxpayers. As I said, the power to set differential prices is only to be used to reimburse providers appropriately for the work that they deliver to take into account differences in costs arising, for example, from location or the complexity of case that they treat.

We have already tabled amendments to ensure that this power cannot be used to set differential prices based on the ownership or status of the provider. To include a further list is unnecessary and disproportionate. There are sufficient checks in place to ensure this ability is used only as intended. The differential prices must be agreed between Monitor and the commissioning board, which ensures that these adjustments will act in the interests of patients and taxpayers. The price differentials will be transparent and evidence-based. They will also be open to consultation as they are included in the national tariff document. For those reasons I am resisting the amendment.

For the record, Mr Chairman, as they relate to the amendments we are now debating, I would like to respond to the comments made by the hon. Member for Easington regarding the Government’s impact assessment, as I believe they misrepresent our position and must be clarified for the record. The hon. Gentleman said that the majority of quantifiable distortions work in the favour of NHS organisations, but he failed to set that in its proper context. It is right that the quantifiable distortions, tax, capital and pensions distortions, work in favour of NHS organisations. However, the impact assessment makes it clear that only some of the fair playing field distortions have proved quantifiable through analytical work, and that some of the distortions identified by stakeholders but not quantified are likely to work in favour of private providers. This reduces their costs relative to NHS providers—

Grahame M. Morris: Will the Minister give way?

Mr Burns: Well, let me finish.

The impact assessment states in paragraph B56:

“There are some distortions that we suspect significantly penalise NHS organisations relative to other provider types, but are very difficult to quantify”.

For example, table B1 states under “Cross-subsidy in tariffs”:

“NHS hospitals treat more complex patients than private hospitals within any Healthcare Resource Group, as they have to accept all elective referrals regardless of cost/complexity whereas private providers can have referral criteria, choosing who they treat...Large multi-product hospitals must take emergency admissions 24/7, which is perceived to be systematically underfunded, so they use tariff for elective admissions to cross-subsidise the large overheads”.

In summary, the work undertaken to date on a fair playing field does not determine, on balance, whether NHS bodies or private providers are advantaged or disadvantaged, relative to the other, because some of the key factors could not be quantified using information held centrally. The Department of Health is now undertaking a wider piece of work to assess the landscape of NHS-funded providers, and to engage with providers and commissioners on how to support further development of the provider landscape across all sectors.

As I said, it has never been our intention to set a differential price to entice new entry or favour particular types of providers. Instead, we intend to pay the same price to providers who deliver the same work under the same conditions.

8 pm

Derek Twigg: I was disappointed that the Minister spoke to my amendments before I had the chance to move them formally.

Mr Burns: I am sorry. I thought they had been moved.

Derek Twigg: No. Perhaps the Minister has a hearing problem. It is not a problem; I know that he would not have done it deliberately.
The Minister has covered part of amendment 613. Part of the argument concerns whether Monitor might pay a higher price for new entrants that, by definition, will not be NHS providers, as specified in the impact assessment. It could be argued that that is in line with the duty to promote competition, which is a stated primary objective when setting prices. Even more glaringly, an analysis of different cost bases could be performed, along the lines of the KPMG study in the impact assessment, and a description of the providers could be framed as those who do—or do not—have access to NHS pension schemes, pay tax and so on. Neither of those arguments would explicitly mean paying private providers more just because they are privately owned, but the result would be the same. The Government amendments do not prevent private providers from being paid more in the manner envisaged by the impact assessment; it would simply make what was going on less obvious.

Mr Burns indicated dissent.

Derek Twigg: The Minister should not be hurt by that. It is important because he seems to have started to try and quote my hon. Friend the Member for Easington. He is deeply aggrieved by that, because he was making an important point. The impact assessment is an important document that the Minister often says we should read. We do, and we have found even more interesting things to debate on Thursday when we discuss foundation trusts and insolvency. Paragraph B108 states:

"Once the net distortion facing different provider types is better understood, the tariff methodology could be developed in such a way as to move towards a fairer playing field by setting different prices for different providers in order to recognise different levels of implicit subsidies."

It notes that,

"to avoid compromising the fair playing field from a commissioner perspective, these charges need not be reflected in the charges faced by commissioners of care."

Will the analysis behind that be published? It would be interesting to read.

Paragraph B55 on page 42 states:

"A recent study of fair playing field distortions was able to quantify the impact of some of the distortions identified. The majority of the quantifiable distortions work in favour of NHS organisations; tax, capital and pensions distortions result in a private sector acute provider facing costs about £14 higher for every £100 of cost relative to an NHS acute provider."

Does the Minister intend to use that figure to subsidise the private sector? He effectively accused us of fixing the markets, and I would be interested to see whether the Government use that figure in terms of private sector business. It is a simple question; the Minister can deny it or not.

Jeremy Lefroy: Would the hon. Gentleman also expect training costs to be taken into account on the other side of the equation?

Derek Twigg: The hon. Gentleman pre-empts what I was going to say. That does not seem too transparent in the impact assessment, and it would be interesting to have more information about how the assessment and the data behind it were made. In the spirit of co-operation and transparency that the Minister talks about and that we want on this Committee, the hon. Gentleman's point is correct. We are concerned that there has been no commitment from the Government to look at the other side of the fence and at the costs of training and education, which are a vital part of the national health service. They are expensive and time-consuming, but essential to providing the service we have. I am interested to hear what the Minister has to say. Will he publish the data behind his assumption, as in the impact assessment? Will the Government rule out paying £14 or thereabouts to private sector providers? The Minister is not replying.

Question put. That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 75

AYES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)

NOES

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

Question accordingly negatized. Amendments made: 561, in clause 104, page 95, line 16, after first ‘different’, insert ‘national’.

Amendment 562, in clause 104, page 95, line 16, after ‘prices’, insert ‘or provide for different rules under subsection (1)(ca)’.

Amendment 191, in clause 104, page 95, line 16, leave out ‘or different maximum prices’.

Amendment 192, in clause 104, page 95, line 19, at end insert—

‘ (c) some other aspect of the status of the provider.’—

(Mr Burns.)

Amendment proposed: 613, in clause 104, page 95, line 19, at end insert—

‘(6A) A description for the purposes of subsection (6)(b) may not be framed by reference to—

(a) whether the provider is in public or private ownership,

(b) some other aspect of the status of the provider.’.—

(Derek Twigg.)

Question put. That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 76

AYES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)

NOES

Brine, Mr Steve
Bums, rh Mr Simon
Burston, 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 negatized.
Department and local authorities will not be subject to health pricing, but services commissioned by the Health from seeking advice from Monitor on public health functions of the Secretary of State, or of a local authority, under the National Health Service Act 2006.'.

Public Bill Committee Health and Social Care Bill

Amendment 400 agreed to.

Amendments made:

Amendment proposed: 614, in clause 104, page 95, line 19, at end insert—

'(6A) A description for the purposes of subsection (6)(b) may not be framed by reference to the costs incurred by a provider in relation to—

(a) taxation, or
(b) access to the NHS pension scheme.'.—(Derek Twigg.)

Question put, That the amendment be made.

The Committee divided: Ayes 8, Noes 13.

Division No. 77]

AYES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)

AYES

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

NOES

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

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

Question accordingly negatived.

Amendments made: 563, in clause 104, page 95, line 20, after first 'a', insert 'national'.

Amendment 193, in clause 104, page 95, line 20, leave out 'a', or a maximum price,'

Amendment 564, in clause 104, page 95, line 20, leave out from 'for' to 'pursuant' in line 21 and insert 'a health care service provided'.—(Mr Simon Burns.)

Mr Burns: I beg to move amendment 400, in clause 104, page 95, line 21, leave out from first 'the' to end of line 23 and insert

'public health functions of the Secretary of State, or of a local authority, under the National Health Service Act 2006.'.

The amendment makes it clear that the national tariff cannot cover public health services, which are the responsibility of the Secretary of State and local authorities, rather than of Monitor and the NHS commissioning board. Committee members will note that nothing in the Bill will stop the Department of Health from seeking advice from Monitor on public health pricing, but services commissioned by the Department and local authorities will not be subject to the national tariff.

Amendment 400 agreed to.

Question proposed, That the clause, as amended, stand part of the Bill.
Grahame M. Morris: This is a really interesting point, and I would like the Minister to explain or elaborate on the status of the impact assessment. It seems that where the Department of Health was explicit about the issues that the hon. Member for Stafford raised a moment ago, I am aware of the Minister’s response, and where there was a mixed bag—

Mr Burns: Give way.

Grahame M. Morris: I am making an intervention.

Derek Twigg: It sounds as though hon. Members do not want to listen to what my hon. Friend is saying. [Interruption.]

The Chair: Order.

Derek Twigg: My hon. Friend always makes very valid points, and I am disappointed.

I am conscious of the time. I have mentioned before that the Government never intended price competition. I have already quoted from one of the paragraphs in the explanatory notes, and I bring their attention to paragraph 699, which states: “These clauses provide Monitor with powers to set prices for NHS services subject to the agreement of the NHS Commissioning Board, in order to promote competition”.

It does not mention improving quality. I come back to the point that the Minister has raised a number of times that this is about a genuine market and it is about quality; they never said that. I will leave that one there. The evidence, as far as I am concerned—I have now read it on to the record—is that they were intending to do that. I am sure we will explore this with others on Report, but we are not clear on how we can ensure that there is no price competition. We look forward to getting the support of the Government on that, if they are so confident about price competition, although we have seen in the impact assessment that there is already price variation.

I will quote from comments made by the King’s Fund, because it is relevant to other points that we have made. It said: “The Bill requires Monitor to consider future health care needs but it does not explicitly refer to the link between price and new investment.”

I wanted to touch on this before, but the issue of price and new investment has not been explored by the Government in the Bill. The King’s Fund said: “In other industries, ”—

Grahame M. Morris: This is a really good one, this one, because this is not an academic argument about the importance of distortions; this is a Department of Health document called “The Fair Playing Field Project”. It states:

“The existence of these distortions, whether they favour the NHS or non-NHS providers has serious implications for patient experience and patient safety. Distortions lead to inefficient decisions and practices which in turn inhibit the quality of the service provided.”

This is the good bit:

“They expose the government to risk of challenge under local and EU procurement laws”.

It is our old friend EU competition. It is not a moot point; it is absolutely germane to the issue.

Derek Twigg: My hon. Friend makes a powerful point. I hate to repeat the Minister’s comments, but competition law will increasingly apply to the NHS—“increasingly apply” are the words of the Minister himself.

I want to briefly finish on a couple of points. I have not had the time to go through the explanatory notes and see how many references or comparisons there are to the utilities in what the Government are proposing. The Government, upsettingly, say that the NHS will become a utility. The number of references in the explanatory notes to a comparison with utilities is profound. We know which way the Government are going. No matter how the Government try to spin their story on the Bill, it is clear that as time progresses the NHS and its patients will be at the mercy of competition law and the market. There will be price competition and the Bill in no way stops that—it promotes it. It will lead to greater inequalities, a longer waiting list, greater rationing and more of a postcode lottery.

Mr Burns: I will not detain the Committee for long, but there are one or two things that I want to say. First, however much it may disappoint the hon. Gentleman, we do not want price competition and we have never intended it. It may be unpalatable to him, but he will have to live with it. He has also—I do not want to end on a sour note—played that typical game of an Opposition MP, which is to ask for information from a Government that no Government of any political party would be prepared to publish, because they are internal working documents for devising policy. [Interruption.] Oh, the hon. Member for Leicester West has woken up.

The Opposition have kept asking whether we will publish the analysis. We do not accept the £14 figure. Nor, because we do not want price distortions of a deliberate nature that benefit the private sector, do we accept a policy of giving more than the rate we pay for NHS services to independent sector treatment centres, and the Bill will very effectively stop that abuse. We therefore stand by the impact assessment. As I said in an earlier debate on the clause, a more extensive piece of work is ongoing on this issue.

Let me say one thing to hon. Members, because it tickles me. The hon. Member for Halton, no doubt followed by the Greek chorus, has been asking whether we will publish the data and analysis behind the impact assessment, and I have to tell my hon. Friends that that is breathtaking in its gall. The KPMG analysis referred to in the impact assessment was commissioned in 2009, under the previous Administration, which, I understand,
decided not to publish it. The hon. Gentleman shakes his head in disagreement, but to be frank with my hon. Friends, I do not believe he had a clue about that, and it has come as news to him, just as it has to me and my hon. Friends. In conclusion, I urge my hon. Friends to ensure that the clause stands part of the Bill.

Derek Twigg: It was a good try from the Minister, but the KPMG study informed the impact assessment. The Department has had its deliberations and discussions, and it has the data, so the Minister can publish that—it is up to him. [Interjection.] We are not in Government now.

Let me make one final point. On competition and prices, the chairman of Monitor said in a recent BBC interview:

“I wouldn’t go so far as to say that you can never have competition. I think over time it probably will emerge”.

Was he correct? He was also quoted on GPonline as saying:

“I understand why people are nervous about price competition... But over time there will be areas where it is useful.”

There is no doubt that there is a difference between what the chairman of Monitor is saying and the Government are saying in the House.

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

The Committee divided: Ayes 13, Noes 9.

Division No. 78]

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

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

NOES
Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Moris, Grahame M. (Easington)
Shannon, Jim
Thornberry, Emily
Turner, Karl
Twigg, Derek
Wilson, Phil

Question accordingly agreed to.

Clause 104, as amended, ordered to stand part of the Bill.

8.30 pm

Clause 105

Consultation on proposals for the national tariff

Amendments made: 565, in clause 105, page 95, line 40, after ‘determining’, insert ‘the national’.

Amendment 194, in clause 105, page 95, line 40, leave out ‘, or maximum prices.’.

Amendment 566, in clause 105, page 95, line 40, leave out ‘payable for the provision’.

Amendment 567, in clause 105, page 95, line 42, after ‘the’, insert ‘national’.

Amendment 195, in clause 105, page 95, line 42, leave out ‘or maximum price’.

Amendment 568, in clause 105, page 95, line 42, leave out ‘for each of those services that is determined’ and insert ‘that is determined as the national price of each of those services’.

Amendment 569, in clause 105, page 96, line 8, after first ‘the’, insert ‘national’.

Amendment 196, in clause 105, page 96, line 8, leave out ‘or maximum price’.

Amendment 570, in clause 105, page 96, line 8, leave out ‘specified in the national tariff’ and insert ‘of the service’.—(Mr Simon Burns.)

Mr Burns: I beg to move amendment 544, in clause 105, page 96, line 14, at end insert—

‘( ) In exercising functions under subsection (5), the Board and Monitor must act with a view to securing the standardisation throughout England of the specification of health care services in the national tariff under section 104(1)(a).’

The amendment makes it crystal clear that when the NHS commissioning board is developing the list of services to be covered by the national tariff, and agreeing those with Monitor, it must specify the services in standard units to be used in the national tariff document.

Of course, the development of standard currencies for use in the national tariff is very likely to have happened anyway. As Monitor would need a consistent set of services in order to attach a price, it would only agree to interventions organised into standard units of service. This amendment just puts this intention beyond doubt and ensures it happens by placing a duty on the NHS commissioning board and Monitor to develop standard units of service for national price setting purposes. Furthermore, at a later stage we will bring forward amendments to place a duty on the NHS commissioning board to develop and maintain a comprehensive set of national currencies. This will, amongst other things, reduce the opportunity for providers to cherry-pick.

Amendment 544 agreed to.

Amendments made: 197, in clause 105, page 96, line 20, leave out ‘, or maximum prices’.

Amendment 198, in clause 105, page 96, line 21, leave out ‘or maximum prices’.

Amendment 199, in clause 105, page 96, line 25, leave out ‘or maximum prices’.—(Mr Simon Burns.)

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

Liz Kendall: I know that everyone is eager to finish, but how prices are set in the NHS has important and significant consequences. We are whizzing through everything, but price setting is a fundamental driver in
the system. Members of all parties, particularly those belonging to Her Majesty's Opposition, ought to scrutinise the proposals.

I am sure that Ministers know from their discussions with organisations within the NHS, think-tanks and others that people are unclear about the role of the national commissioning board and of Monitor in price setting; that has been a regular theme of discussion since the White Paper was published. The Committee ought to acknowledge the great uncertainty about the subject. I also want to discuss the process for price setting, so let us be clear about what it is, if we can be.

Once the national commissioning board has set a structure for the tariff, Monitor will determine the price. It is supposed to consult with local GP commissioning consortia and providers, and then to come up with a solution. That in itself is a huge task. As the explanatory notes on the clause make clear, there is obviously potential for the national commissioning board and Monitor to disagree, otherwise the notes on page 119 would not state:

“If agreement could not be reached, independent arbitration would be used to facilitate agreement.”

The Minister ought to say who will do that independent arbitration and how it will work.

Monitor then has to notify all the commissioners, licence holders and others it considers appropriate about the national tariff document. Objections can be made within 28 days of publication. As part of the process, other issues arise under clauses 106 and 107, so I need to ask for the Chair's advice if he does not want me to stray beyond the clause. However, I want to keep my comments brief, and I would not need to come back on the later clauses if I mention those issues now. Those clauses allow commissioners and providers to challenge the methodology used to set the prices, while there is also a role for the Competition Commission, to which referrals can be made if GP commissioners or providers do not feel that the price is appropriate.

We have some experience of the wonder that is Richmond house, but setting prices is complicated. Going through that procedure, including consultations with commissioners and providers, and the possibility of objections within 28 days and of Competition Commission references, is an extremely time-consuming and bureaucratic process. Where the ultimate responsibility lies is not clear—the clauses suggest that, ultimately, the Competition Commission will decide the prices in the NHS.

That explanation is in the Minister's own notes for the Bill. I have asked before what experience the Competition Commission has of health care that enables it to know what price would be best. The matter is serious, so I will be grateful if the Minister can say whether the Competition Commission is the independent arbitrator referred to in clause 105. Similarly, does the ultimate decision on the price for an NHS service, if it goes to arbitration, lie with the Competition Commission?

People will be able to voice their views on the services to which prices and rules would apply and on the proposed national tariffs for services. By requiring consultation with both commissioners and providers, the clause would help to ensure that prices did not favour one side over the other. The clause is relatively strong. Subsections (5) to (9) provide for the key elements of the national tariff to be agreed between the commissioning board and Monitor before the consultation. Independent arbitration will be used when agreement is not achieved. I will answer the point made by the hon. Member for Leicester West in a moment.

Those subsections also make clear the need for responsibilities for determining particular elements of the national tariff. The NHS commissioning board will lead on services covered by the national tariff and the rules about when services and prices could be varied by commissioners and providers. The board will be required to seek Monitor's agreement to those elements. Monitor has agreed on the pricing methodology and the price levels, as well as the rules for determining prices outside the scope of national price arrangements.

Monitor will be required to seek the agreement of the commissioning board to those elements. There is a need for clear agreement to each element because pricing is vital to the objectives of each organisation. The board will have an interest in the prices set and the rules governing local price setting because it will be the body that oversees the purchase of NHS services and GP consortia, as well as being the guardian of the NHS budget. Monitor will have an interest in how services are defined, as that will affect the level of competition.

The clause also makes provision for consultation. Subsection (1) requires Monitor to send a notice to each commissioning consortium, each licence holder and other people who it considers appropriate before publishing the national tariff. Subsection (2) requires Monitor to publish the notice, and subsections (3) and (4) set out what the notice must include. Subsection (10) provides for a consultation period of 28 days, following publication of the notice. Those provisions are intended to ensure that there is a proper consultation ahead of each national tariff being's put in place.

The hon. Member for Leicester West mentioned the question of price setting being important and needing scrutiny. She is quite right: price setting is important. That is why our Bill puts price setting on a transparent, statutory basis for the first time ever. Parliament has never before had the chance to debate NHS price setting and agree how the price process should operate; currently, it is simply part of the sweeping discretionary powers of the Secretary of State. In future, there will be a transparent and independent process to ensure that prices are accurate and fair.

The hon. Lady also raised the issue of what Monitor and the NHS commissioning board will do with regard to pricing. That is extremely clear, which I hope reassures her. The NHS commissioning board will develop currencies and Monitor will develop the pricing methodology and set the prices, as I mentioned in my introductory comments to the stand part debate. They will need to agree each product with the other organisation to ensure that it is acceptable to others in the system.

The hon. Lady also raised the question of arbitration, which potentially flows from that. Arbitration will be carried out in accordance with the Arbitration Act
1996. The board and Monitor will agree who arbitrates. If not, each party will appoint a person to arbitrate. Such persons will appoint another person as a third arbitrator. I hope that that answers the hon. Lady’s questions.

Liz Kendall: There is one question that the Minister did not answer. Can he bear to give way? He was very swift in sitting down.

Mr Burns: I have sat down.

Liz Kendall: I will ask the question, but the Minister does not have to answer. We have a list of unanswered questions. The question is: if a reference is made to the Competition Commission, is it the Competition Commission that finally decides the price?

Mr Burns: No, it is referred back to Monitor.

Liz Kendall: It is referred back to Monitor. So Monitor ultimately sets the price, not the Competition Commission. [Interruption.] I see the Minister looking for support. Could he rightly tell me who ultimately has the decision over the price of NHS services?

Mr Burns: If the hon. Lady would find that helpful, I am more than happy to be helpful.

Liz Kendall: I want it noted for the record that the Minister does not have an answer for who ultimately sets the price in the NHS. That is a terrible situation, late though it is.

Mr Burns: No. Now the hon. Lady is spoiling it. I know that it is late; I understand. My offer still stands, but it is a little unfortunate that she should be so ungenerous at this time of night.

8.45 pm

Question put and agreed to.

Clause 105, as amended, accordingly ordered to stand part of the Bill.

Clause 106 ordered to stand part of the Bill.

Schedule 10

PROCEDURE ON REFERENCES UNDER SECTION 106

Mr Burns: I beg to move amendment 403, schedule 10, page 296, line 32, leave out ‘(3)’ and insert ‘(4)’.

The Chair: With this it will be convenient to discuss Government amendment 404.

Mr Burns: The amendment makes a small change to schedule 10, paragraph 7, that relates to the Competition Commission’s power to hold an oral hearing before making a decision, following a reference to it in relation to a price methodology. The amendment is to correct an incorrect reference in the clause and is minor and technical. It effectively makes it clear that if a person does not attend the oral hearing, the Competition Commission does not need to call them to give evidence at the hearing and “may make a determination on the reference without hearing that person’s evidence”.

The paragraph is needed as it closes the opportunity for the reference to be delayed by people not attending the oral hearing. It creates incentive for the persons to attend in order for their evidence to be heard and considered.

Amendment 403 agreed to.

Amendment made: 404, schedule 10, page 296, line 34, leave out ‘that sub-paragraph’ and insert ‘sub-paragraph (3)’.

—(Mr Simon Burns.)

Question put, That the schedule, as amended, be the Tenth schedule to the Bill.

The Committee divided: Ayes 12, Noes 9.

Division No. 79

AYES

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

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

NOES

Abrahams, Debbie
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
Shannon, Jim

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

Question accordingly agreed to.

Schedule 10, as amended, agreed to.

Clause 107 ordered to stand part of the Bill.

Clause 108

CHANGES FOLLOWING DETERMINATION ON REFERENCE UNDER SECTION 106

Amendment made: 405, in clause 108, page 99, line 4, after ‘day’ insert ‘after that’.

—(Mr Simon Burns.)

Clause 108, as amended, ordered to stand part of the Bill.

Clause 109

POWER TO VETO CHANGES PROPOSED UNDER SECTION 108

Amendment made: 406, in clause 109, page 99, line 9, after ‘day’ insert ‘after that’.

—(Mr Simon Burns.)

Clause 109, as amended, ordered to stand part of the Bill.

Clause 110

LOCAL MODIFICATIONS OF PRICES OF DESIGNATED SERVICES: AGREEMENTS

Amendments made: 571, in clause 110, page 99, line 42, leave out ‘specified in’ and insert ‘determined in accordance with’.
Amendment 200, in clause 110, page 99, line 43, leave out from ‘agreement’ to end of line 3 on page 100.
Amendment 201, in clause 110, page 100, line 12, leave out ‘or maximum price’.
572, in clause 110, page 100, line 12, leave out ‘specified for the service in the national tariff’ and insert ‘determined in accordance with the national tariff for that service’.—(Mr Simon Burns.)
Clause 110, as amended, ordered to stand part of the Bill.

Clause 111

LOCAL MODIFICATIONS OF PRICES OF DESIGNATED SERVICES: APPLICATIONS

Amendments made: 573, in clause 111, page 100, line 32, leave out ‘specified in’ and insert ‘determined in accordance with’.

Amendment 202, in clause 111, page 100, line 33, leave out from ‘determine’ to end of line 36.
Amendment 203, in clause 111, page 100, line 40, leave out ‘or maximum price’.
Amendment 574, in clause 111, page 100, line 40, leave out ‘specified for the service in the national tariff’ and insert ‘determined in accordance with the national tariff for that service’.—(Mr Simon Burns.)
Clause 111, as amended, ordered to stand part of the Bill.
Clause 112 ordered to stand part of the Bill.
Ordered, That further consideration be now adjourned.—(Stephen Crabb.)

8.54 pm
Adjourned till Thursday 24 March at Nine o’clock.