HEALTH AND SOCIAL CARE BILL

Twenty-third Sitting
Thursday 24 March 2011
(Morning)

CONTENTS
Written evidence reported to the House.
Clause 113, as amended, under consideration when the Committee adjourned till this day at One o’clock.
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not later than

Monday 28 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  

Thursday 24 March 2011  

(Morning)  

[Mr Mike Hancock in the Chair]  

Health and Social Care Bill  

Written evidence to be reported to the House  

HS 113 General Medical Council  

HS 114 Association of Directors of Public Health  

9 am  

The Chair: Good morning, Members. Before we start our debates on clause 113, I must comment on the rather radical step taken by Mr Lefroy in moving to another seat without the Chair's permission. Given that Members all agreed to stay where they were for the duration of the Committee, Mr Lefroy, you might have a job being called today.  

The Minister of State, Department of Health (Mr Simon Burns): He has man flu and does not want to spread it.  

The Chair: Then he is doing the Committee a service and I apologise. Mr Lefroy, your courage in moving is to be applauded.  

Clause 113  

Application of Insolvency Law to NHS Foundation Trusts  

Amendment made: 519, in clause 113, page 102, line 4, after ‘of’ insert ‘, and Schedule 9 to,’.—[Mr Simon Burns.]  

Derek Twigg (Halton) (Lab): I beg to move amendment 615, in clause 113, page 102, line 12, at end insert ‘if Monitor so decides.’.  

I hope that the Minister will be a little more forthcoming with information today. We think that we have been asking pretty succinct and relevant questions, but the right hon. Gentleman is now becoming known as someone who gives only name, rank and serial number; occasionally, if he is feeling generous, he might talk about his football team, but knowing who that is, I have decided that it is probably best not to raise the subject. However, we hope that he will give us more information today, because the Bill makes the most profound change in the national health service since it was set up and we must have more detail. He keeps saying that the detail is being worked up or that someone else is dealing with the detail, but because of that profound change, it is important that we have a chance to scrutinise the Bill with the facts before us, and that is not the case at the moment.  

The insolvency clauses fit with the present Government’s approach to the health service of putting competition first and of having the private sector much more involved and undermining NHS services. That is embodied in the drafting of the clauses. Under the National Health Service Act 2006, the application of insolvency law was voluntary; in the Bill, we have a whole new way of dealing with the law on insolvency, which becomes mandatory. The Minister might want to give us more information about that.  

Under clause 113, failing foundation trusts that go bust will become subject to commercial insolvency law. The aim of our amendment is twofold: first, we want to voice strongly our opposition to a measure that is dangerous to the national health service; and secondly, we want the Minister to provide some clarification about the regulations that the Secretary of State will impose with regard to foundation trusts entering insolvency.  

The clause has been written to serve the needs of profit making, the market and the private sector. It represents a reversal of the governing principle of the NHS—the principle that puts patient care first and profit margins second. Today, we will return regularly to the theme of the profit margin, rather than the patient, being put first as a result of the Government’s changes. The change between the existing policy and the future one is clear. At present, foundation trusts can voluntarily be placed in insolvency by the NHS through Monitor in its current guise—I stress, in its current guise—but that is a last resort measure that, to date, it has never been necessary to implement. Changing that is the point of the additional powers given in the Bill for competition and for greater involvement of the private sector.  

Important to us—I shall come back to this again and again—are early intervention in and support for hospital trusts or other services that get into trouble. The Minister keeps talking about inefficient trusts and services that are not up to the job, but there is a difference between that and wanting a better failure regime. Trusts may get into financial difficulties, but that does not necessarily mean that they are providing poor clinical services. That is a big difference, but under the Bill if a trust becomes insolvent, it goes. Basically, that is what the Bill is saying.  

The 2006 Act contains a thorough procedure for early intervention when trusts are struggling financially. It was Labour’s policy when in government that insolvency should be the very last resort, taken only after multiple attempts have been made to reform trusts and return them to financial stability. We are interested to see how the Government want to prevent it from happening in the first place. We see hospitals as part of the wider NHS family, but the Government seem to see them as independent business entities, almost celebrating the fact they are putting a failure regime in place.  

We want to ensure that the provisions we put in place in 2006 remain to support hospitals that might get into trouble financially, but still provide good clinical services—indeed, that will be true in most cases. Under our system, even if financial failure ensued it would be dealt with in a planned and careful way to ensure the best solution for the local population. I am not sure how many people in the constituencies of Committee members are aware of how insolvency law applies and how the rules regarding the finances of foundation trusts will impact on the local hospital.  

Under the clause, that will no longer be the case; it is no longer Government policy. Had an FT failed under Labour, it would of course have been regrettable and upsetting but it seems that this Government will celebrate it as a success of market function. That is a big change. On Tuesday, the Minister kept speaking about the failure...
they see the services their hospital provides and they
People do have an emotional attachment to their local
because he does not know what the Bill’s consequences
Alternatively, will he once again duck the question
have been forthcoming with details, which are important if
That goes back to the fact that the Minister has not
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State is competent enough to deal with our concerns?
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setting out the as yet undefined regulations under the
the detail of what the Bill entails or that the future of
local hospitals. We believe that people do not yet understand
about the future of local hospitals. Many hon. Members
surprising that more and more people are becoming
at the profit line rather than what might be in the best
interests of patients.
To avoid the unacceptable prospect of seeing foundation
trusts enter insolvency proceedings, with publicly financed
assets being sold off at a much reduced price in an
insolvency fire sale, our amendment seeks to ensure that
the final decision on whether a trust enters insolvency
remains with Monitor. As it stands, the clause operates
in the interests of creditors. With our amendment, it
would operate in the interests of patients.
Throughout, the clause talks about creditors. That is
the difference: we talk about patients, the Government
talk about creditors. If that is the reality, it is not
surprising that more and more people are becoming
worried about the privatisation of the NHS, and particularly
about the future of local hospitals. Many hon. Members
on both sides of the House have spoken about their
local hospitals. We believe that people do not yet understand
the detail of what the Bill entails or that the future of
local hospitals is under threat because of the changes.
The Secretary of State will have responsibility for
setting out the as yet undefined regulations under the
clause. Is that yet another example of our being asked
to vote on a clause and to trust that the Secretary of
State is competent enough to deal with our concerns?
Can the Minister provide evidence showing that we
should simply trust the Secretary of State to come up
with regulations sufficient to address our concerns?
That goes back to the fact that the Minister has not
been forthcoming with details, which are important if
the Committee is to make the decisions it must make.
Alternatively, will he once again duck the question
because he does not know what the Bill’s consequences
will be or, worse, because he is afraid of exposing them?
I return to what Monitor’s chairman said about
people’s emotional attachment to their local services.
People do have an emotional attachment to their local
hospitals. That is not based on a lack of logic; rather,
they see the services their hospital provides and they
support the hospital. Under the plans in the Bill, however,
that does not matter, because hospitals are now much
more vulnerable to closure and to having their assets
transferred. We will explore that further as we go through
the coming clauses this morning and this afternoon.
For the avoidance of doubt, Mr Hancock, let me add
that, depending on what the Minister says, we may want
a short clause stand part debate.
Mr Burns: I listened with great interest to the hon.
Member for Halton. At the beginning of his remarks,
he said he was being deprived of information. I think he
is being a little unfair.
Derek Twigg: Only a little?
Mr Burns: I was being polite. At every stage of the
Committee’s proceedings, we have sought and we will
continue to provide as much information as we can
to answer the points made by Opposition Members.
The fact is, however, that sometimes they do not like the
answers they get, so they take that as not having had an
answer. In other cases, it is a fact of life in Committee
that a number of the issues that flow from the Bill will
be dealt with through regulation and guidance. Much
of that guidance will be open to consultation before its
implementation, and it would be premature at this stage
to give the information the hon. Gentleman seeks.
The hon. Gentleman spoke as if that were unprecedented
or surprising, but it is not, as I have said on numerous
occasions. The previous Government’s practice was
completely different from that demonstrated in the Bill.
The primary legislation they produced was a skeleton;
all the powers in terms of what was to be done flowed
from that primary legislation and through secondary
legislation, which, for valid reasons relating to the cycle,
we did not have at the time in Committee. We have
sought to redress that problem by putting far more in
the Bill, where appropriate. However, secondary legislation,
regulations and guidance will still flow from our Bills,
just as they did from the Labour Government’s. There is
at least the reassurance that there will be consultations
before many of the regulations and pieces of guidance
are drawn up. I hope that that clarifies the point without
stimulating an intervention from the hon. Gentleman.
Let me broadly explain what clause 113 does before
moving on to some of the specific points the hon.
Gentleman raised in moving the amendment. The clause
provides for the Secretary of State to make regulations
to apply relevant parts of insolvency and company
legislation to foundation trusts for the purposes of
rescuing an insolvent foundation trust as a going concern
or ensuring an orderly winding-up of its affairs in the
best interests of creditors as a whole.
Such proceedings would used only ever as the last
resort, and it is important to bear that in mind. The
hon. Gentleman asked what will be done to prevent us
from getting to the last resort. As is my habit, I will give
him great detail in answer to that question.
9.15 am
Derek Twigg: I look forward to it.
Mr Burns: Good. Such proceedings will be used only
as the last resort when pre-insolvency intervention has
not succeeded, and only after continued provision of
designated services have been secured through special
administration. I emphasise that those procedures will be the last resort when intervention by FT governors, commissioners and Monitor has not succeeded in turning around the affairs of a failing provider, and will apply only in relation to non-designated services.

Derek Twigg: The Minister mentions governors. Will he tell us exactly—it is not clear in the Bill—what Monitor’s intervention procedures will be before insolvency? What powers will it have?

Mr Burns: I will, but will the hon. Gentleman let me make a little more progress, because the answer will be part and parcel of my explanation of how we will ensure that action is taken to avoid the last resort of insolvency?

We think that such powers are vital to ensure that patients should no longer be forced to use, or taxpayers to subsidise, poor-quality, inefficient services or providers. Instead of propping up failing providers, as under the current system, there will be transparent mechanisms for managing provider failure to protect essential services, and to allow commissioners to replace services with high-quality or better-quality options.

The clause binds the Secretary of State to making regulations. We believe that that is the right approach, particularly as long-standing powers to apply insolvency procedures to foundation trusts, which the previous Government introduced, have never been exercised. It would be wrong for the Secretary of State to be required to secure Monitor’s permission to introduce secondary legislation, as the amendment suggests. Indeed, that would undermine Parliament’s role. Moreover, we are not aware of any precedent that would require the Secretary of State to need permission from an arm’s-length body such as Monitor before making secondary legislation in the health care sector. It will therefore not surprise the hon. Gentleman that I do not think the amendment would add anything relevant to the clause.

I will flesh out my argument. The hon. Gentleman referred to insolvency being the last resort, and I totally agree with him: it must be the point of last resort. We expect commissioners to work constructively with providers to try to resolve problems to avoid failure. Monitor will also provide support and intervene before failure, as discussed during our debate on designated services, which I am sure the hon. Gentleman remembers.

I shall give some examples of providers’ actions to prevent failure. A provider will always have a range of actions, including: improving management capability and expertise, appointing directors with experience of turning around health organisations, benchmarking its services and costs against comparable providers, reducing costs and increasing efficiency through targeted cost improvement programmes, and working in partnership with other organisations to share back-office functions and services.

Derek Twigg: I suspect we are heading down the same road as we did the other day in trying to obtain answers. The Minister referred to designations. So that the Committee knows and there is no doubt, will he tell us why the intervention powers under the 2006 Act need to be changed, and what can Monitor do under its powers in law to make the foundation trust take action before it goes into insolvency? Will he tell us exactly what those powers are and why they must be different from the 2006 Act?

Mr Burns: I certainly will. That is what I am trying to do.

Derek Twigg: With respect, the Minister is referring to providers. I am asking specific questions about Monitor.

Mr Burns: The hon. Gentleman has asked specific questions about Monitor. He also asked what will be done to try to prevent a situation of last resort arising. It is for the benefit and interest of the Committee and those who are following our proceedings to hear the whole package. I am concentrating on actions that can be taken within organisations to try to prevent them from getting to the last resort. When I have finished that section I will move on to Monitor’s regulatory powers, which I think will address the hon. Gentleman’s second point. I have chosen to do it that way around, rather than the other way around, which I get the impression is the way that the hon. Gentleman would like it, but we will get there in the end, so whichever way around it is does not matter. It is important, however, to give the Committee some idea of what we expect will happen to help to ensure that that is a position of last resort.

As I said, we expect providers to work in partnership with organisations and share back-office functions and services. We expect them to improve service quality to attract more referrals. We expect them to apply to Monitor for a local subsidy to the tariff to cover excess costs of delivery in designated services when, despite being demonstrably efficient, they cannot recover their costs—for example, where a provider is serving a very rural community where it is unable to generate sufficient economies of scale. The regulator may also encourage the provider to reduce its costs in designated services where that is practical and possible.

That is the generality of what one would expect providers to be working on if they were beginning to detect problems. The hon. Gentleman asked: what will Monitor do? Monitor, as he knows, has a role in pre-failure with regard to designated services. Monitor will be responsible for supporting commissioners in meeting their duty to preserve access to essential health care services for patients. It will do that through a range of activities, some of which will happen in advance of a failure, some of which will happen as an organisation enters the pre-failure phase, and some as an organisation reaches the point of failure. The provider licence will contain a number of continuity of service conditions that will seek to restrict risky behaviour among designated service providers. The provider risk pool will place financial incentives on providers through the provider levy to reduce their financial exposure by taking steps to reduce their risk of failure. Looking at the operation of other comparable schemes, such as the Pension Protection Fund, those mechanisms have proved to be effective in reducing the overall risk of failure of organisations.

The designated service licence conditions will require providers of designated services to provide information that will allow Monitor to develop a distress regime that tracks providers’ financial well-being and compliance against licence conditions. Should a provider of a designated
service breach a licence condition or fall below a certain credit rating. Monitor will be able to trigger a higher level of regulatory scrutiny and intervention by taking enforcement action, through the licensing regime, as set out in clause 90. That could include advice to providers on how to rectify their situation and the ability to require action from providers to address specific issues. It is important to know that such enforcement action is unlikely to include fines, as that would only heighten the financial failure.

The hon. Gentleman went on to ask what role the community has in insolvency proceedings. The regulations that will be published will spell out the details of the regimes. However, without wanting to pre-empt the regulation, I can confirm that there will be a consultation stage in special administration where significant changes to designated services are planned. Parliament will have the chance for scrutiny and debate through the affirmative procedure.

**Derek Twigg:** Just to be clear, will Parliament get the chance to debate measures on each individual foundation trust?

**Mr Burns:** No, Parliament will have the opportunity to debate, subject to the affirmative procedure, the regulations that will flow from this part of the Bill to deal with that area of policy. I am glad to clear that up.

The hon. Gentleman said that a trust could be providing high-quality care but still face financial difficulties and go bust. Trusts providing high-quality services would be much less likely to fail, as funds follow the patients. We expect commissioners and Monitor to work with them to control and reduce costs to avoid failure.

The point that the hon. Gentleman made more than once—it was obviously the buzzword message that he wanted to get across—was that the clause puts profit first, which is ludicrous. He does not really mean that, but I understand that he has to go through the motions.

**Derek Twigg:** I wonder if the Minister can confirm that providers will have the chance to rectify their situation and the ability to require action from providers to address specific issues.

**Mr Burns:** The clause does, and the amendment seeks to rectify, is to introduce a new mechanism for insolvency. The hon. Gentleman is clearly the buzzword message that he wants to get across—was that the clause puts profit first, which is ludicrous. He does not really mean that, but I understand that he has to go through the motions. However, it is palpable nonsense to suggest that. The previous Government proposed to apply insolvency law to foundation trusts. Our Bill recognises that pure insolvency law would not be appropriate for the NHS, which is why we are proposing a tailor-made special administration regime to protect the interests of patients. Despite the prejudices of some Opposition Members, we are talking about the interests of patients and not of profits.

**Liz Kendall:** The Minister says that the trusts will be getting lots of guidance before they fail, but who will provide that guidance? If Monitor is an economic regulator and no longer responsible for regulating foundation trusts, who will provide guidance to the hospitals and trusts to stop them from failing?

**Mr Burns:** I came in for an element of criticism from the hon. Member for Halton on this because I decided to do it in the opposite way to the way in which he wanted, but I thought that I had gone into considerable detail as to how help and assistance would be given. I explained what we expected providers to do during the whole process. I gave a whole list of ideas and courses of action that providers could take to seek to minimise the problems.

**Liz Kendall:** The Minister says that the trusts will be getting lots of guidance before they fail, but who will provide that guidance? If Monitor is an economic regulator and no longer responsible for regulating foundation trusts, who will provide guidance to the hospitals and trusts to stop them from failing?

**Mr Burns:** The hon. Lady is trying to intervene without even hearing the end of the answer to her previous intervention. Let me just finish answering her first question.

**Emily Thornberry:** The hon. Gentleman said that a trust could be providing high-quality care but still face financial difficulties and go bust. Trusts providing high-quality services would be much less likely to fail, as funds follow the patients. We expect commissioners and Monitor to work with them to control and reduce costs to avoid failure.

**Mr Burns:** No, not tetchy. I just want to ensure that, in answer to the hon. Gentleman’s opening remarks, I put it on the record that we are seeking to give as much information and answers to questions as possible. The hon. Member for Leicester West asked about Monitor—its role and what we expect it to do. The role of Monitor—this might anticipate her next intervention—as she knows from our earlier discussions is in ensuring continuity of services, and that applies to all providers and not just foundation trusts. On that basis, I ask my hon. Friends to reject the amendment if it is put to a vote.

**John Pugh:** This makes me quite glad, in a way, that I did not vote for foundation trusts in the previous Parliament, because it is clearly a dangerous road. The Minister of State, Department of Health, my hon. Friend the Member for Sutton and Cheam, might not have voted for foundation trusts in the previous Parliament either, because what we have now are foundation trusts but no choice for a hospital as to whether it does become a foundation trust. Now we have legislation applying to all hospitals across the board, whether or not they have made that rather strange choice.

9.30 am

**Liz Kendall:** Did I hear the Minister say that if this Bill is passed under the Government’s new regime, providers will be less likely to fail?

**Mr Burns:** No, I am not saying that at all. We anticipate failure because no one can predict what will happen in the future. We see failure as the last resort. We see failure as the last resort. Every assistance will be given to avoid the last resort regime. What I would say to the hon. Lady is that if a provider is providing high-quality care, there is less likelihood of failure.
It would be useful for the Committee to have a note—from somebody, not from the Minister—as to how insolvency law currently applies to foundation trusts and how this set of arrangements differs. We are making a change, and I would like to look at what that change is. All of us are obliged to look at that change. We have to scrutinise legislation, so we have to know what the situation is today and what it will be when the legislation is applied. If we do not know that, we are failing in our duty to scrutinise the legislation.

We have here a new mechanism for insolvency, and there has to be a rationale for it. Again, by default and lacking any better guide, I went to the explanatory notes. They say:

“This would assist in ensuring a level playing field between foundation trusts and other providers.”

There is a change that I do not understand, because I have not had it explained to me, but I have a clear rationale for the change: to ensure a level playing field. It is there that my doubts begin. Clearly, there are two sorts of hospital: private hospitals and public hospitals including foundation trusts and others. We are trying to ensure a level playing field between foundation trusts and other providers.

**Mr Burns**: Will the hon. Gentleman give way?

**The Chair**: I will allow the Minister to intervene, because he suggests he has something helpful to say. It will be longer than a normal intervention, but I think it will be appropriate to help the debate.

**Mr Burns**: The hon. Member for Southport mentioned what is happening now and what the Bill does. The Committee might find it convenient and helpful if I explained that briefly.

The Bill will replace the failure regime provisions for NHS FTs set out in sections 53 to 55 of the 2006 Act, introduced under the previous Government. Those provisions, which deal with voluntary arrangements, winding up and dissolution, are workable, as the necessary secondary legislation has never been made. Those earlier provisions are also largely outdated, given that the provisions were repealed in part by the Health Act 2009. The effect of the repeal is that the provisions apply only to FTs that were not formerly NHS trusts. In practice, no such bodies exist, as all existing FTs were formerly NHS trusts. In their place, the Bill would create an obligation for the Secretary of State to make regulations to apply relevant parts of insolvency and company legislation to FTs, for the purposes of either rescuing an insolvent foundation trust as a going concern, or ensuring an orderly winding up of its affairs, in the best interests of creditors as a whole.

We think it right to set out a broad range of mechanisms that may enable the rescue of a troubled provider, since they may be applied, where appropriate in particular circumstances, to protect the interests of patients, creditors and, importantly, British taxpayers. Applying normal insolvency procedures would not only provide a range of mechanisms for dealing with failure but provide incentives for management to avoid failure in the first place, since they would lose overall control where an insolvency practitioner takes charge and reckless management may be held to account for their actions.

We went into great detail earlier about how we see the role of providers in earlier stages and the role of Monitor. I hope that is helpful to the hon. Gentleman. He also asked whether insolvency law applies to FTs. I can come back on that.

**John Pugh**: I am grateful for that detailed intervention. To be fair, later in the explanatory notes they mention introducing “an effective failure regime,” and I will check with *Hansard*, but I think the Minister said that the current failure regime is either outdated, inapplicable or needs modification. I do not know how people read things, but most paragraphs have a kind of topic sentence that states what the paragraph is about, and the second paragraph in the explanatory notes on clause 113 states:

“This would assist in ensuring a level playing field between foundation trusts and other providers”.

**The Chair**: We are talking about the Bill, as opposed to the explanatory notes, and the Minister has clarified what the Bill says.

**John Pugh**: Absolutely; I will restrain my arguments until we reach the clause stand part debate.

**Derek Twigg**: I thank the hon. Member for Southport for shining some light on the problem that we keep raising, which is that we cannot find out the details. Not only did we find that the explanatory notes on price competition—I will not go into that—actually clarified that the Government were in favour of price competition, even though they said that they were not, but we now find that the explanatory notes on the important area of insolvency do not actually explain it. It is bizarre that we have had a succession of explanatory notes that are supposed to inform the Committee, to make possible the tabling of amendments, debate and scrutiny of the Bill, but the Minister has had to step up to explain what areas of the Bill mean, because the explanatory notes do not. I do not know whether a concern has been raised with you, Mr Hancock, but it is important to do so. In fact, perhaps the hon. Gentleman and I think alike on that. We have highlighted the same areas as those that were raised in the debate.

I want to raise several other issues that I am not sure that the Minister will be able to answer. On consultation, I think he said that the details of regulations for the consultation will be drawn up at a later stage by Monitor.

**Mr Burns**: The Secretary of State.

**Derek Twigg**: Oh, the Secretary of State; I am sorry. Therefore we do not actually know what the details will be. The Minister has made a big thing, particularly during the early stages of the Bill, about how the Government have improved scrutiny and consultation, but that is no good if it does not change the decision. The Government can go on all they like about what they have done. If the Minister’s constituents were clearly overwhelmingly opposed to a local hospital or service going into insolvency, what weight would that have on Monitor’s decision? People care about their local hospitals, so they need to know what that means. Whatever local patients might think, what would the key factor be in Monitor making its decision on insolvency?
Mr Burns: On the question whether responses to consultations, in whatever shape or form they take, would be listened to, I am tempted to answer in a flip way and say that they will be listened to as much as the previous Government listened to consultations, but I will refrain from that. Of course, responses to any consultation, on any issue, are always listened to carefully. Where they are relevant and make a positive contribution, they are taken on board. We saw that with my right hon. Friend the Secretary of State and the consultation responses that we received to the White Paper, where we subsequently found that we could strengthen and enhance the legislation that flowed from it. The hon. Gentleman has been in the House long enough to know that I cannot prejudge any consultation and give a blanket commitment now that whatever response comes in from a consultation process will affect the decision.

Derek Twigg: I am not sure it was advisable to go down that road. Let me return to what I was saying, which is crucial, because the Government made a big thing about how they are having greater scrutiny and consultation. The chairman of Monitor let the cat out of the bag when he used the words “emotional attachment” to local services. I might be misinterpreting, but he may mean an emotional “irrational” attachment, so we know that Monitor will ignore the wishes of local people because their views are made on an emotional not a rational basis. If the Minister wants to put on record that there will be no closure of hospitals under this Government, I am happy for him to do so, but I suspect that he will not. What the Government are doing will make the closure of local hospitals much easier. Monitor made its position clear—there is an emotional attachment to local services. That is important.

I gave the Minister two examples: the burns unit in the north-west and my local hospital trust, and the Secretary of State or Ministers got involved. They listened to the public view, and, certainly in one case, the public were in favour of what happened and we managed to get a compromise in the other case. The fact is that the Secretary of State will not be involved. My hon. Friend the Member for Southport has also raised some interesting points about that regime.

The Minister mentioned the help given to foundation trusts by Monitor, and made a point about subsidies. I have read the Bill, but again, we are not clear about the details. Can he say more about the criteria for the subsidy, or is it down to Monitor to draw up the criteria? The difficulty is that we are, again, being asked to decide a crucial part of the element to help avoid insolvency on the basis that part of that help might be a subsidy, but we have no idea what the criteria will be. There may be more information elsewhere in the Bill, but I suspect that it will probably be up to Monitor, and we need to know that.

A letter from the Minister putting in black and white the difference between the system under the 2006 Act and now would be useful, so that there is no mistake. Given the pro-competition position and the fact that providers can bring challenges if they think that competition has been interfered with in any way, will the help that Monitor will give to foundation trusts will be challengeable by a provider? Will they be able to challenge the subsidy as being anti-competitive? Is that the case? The difference is that this regime is more pro-competition and pro-market. The Government have introduced lots of clauses that, frankly, are a lawyer’s paradise in terms of challenge. Can the Minister explain? He may be able to give some reassurance that Monitor’s help, including the subsidy, will not be open to legal challenge. I suspect that I know the answer, but it will be useful to hear what he says.

The Minister says that Monitor will develop a distress regime. We are not sure what a “distress regime” will be exactly. Again, it is the lack of detail that concerns us. If he goes away and gets further information about what it will be and will entail, it would be useful if he would write to us about it. He talked about credit rating; here we go again—the market, credit rating, failure and creditors. That is what the Bill is about, not patient interest, local health services and what the public want. My hon. Friend the Member for Leicester West made an important point on market failure. The Minister may correct me, but I think he said that judgments will be based on whether it is less likely to be a market failure in terms of a foundation trust getting into difficulty. It may be useful for him to confirm that.

I will finish this part with the point that a poor trust will not necessarily get into financial difficulty. To go back to the Government’s view of the world, it might have a greater monopoly in its area. Members who represent urban constituencies may wish to explore this matter further, but the Minister mentioned that rural areas may receive additional support because they do not have as many services around, and as a result there may well be a monopoly, or there will become one. The fact that a hospital trust is financially sound does not necessarily mean that it is a good provider of services. It is a little simplistic to argue that that is the case, and the Minister may want to respond to that point, too.

We have many questions on that subject, and the hon. Member for Southport has also raised some interesting points about that regime.

Grahame M. Morris (Easington) (Lab): I have a couple of questions for the Minister, which come from our discussions about level playing fields and market distortions, in terms of the failure regime. I am interested to know whether, at least in part, a driver for the related clauses in the Bill is either EU procurement law or EU competition law.

Mr Burns: I am more than happy to answer the hon. Gentleman’s question quickly. The straightforward answer is no. First, there is nothing in the Bill that changes existing UK or EU competition legislation. Secondly, common causes of financial distress among health care providers relate to such factors as poor management, and/or poor control of costs, and/or poor quality services resulting in fewer patients choosing to use them, and/or insufficient provision. The application of competition law is not a factor. Our proposals create much stronger incentives to address such problems and, in the event of failure, they provide robust safeguards for patients.

The Committee divided: Ayes 11, Noes 13.
Division No. 80]

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

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

Question accordingly negatived.

Derek Twigg: I beg to move amendment 616, in clause 113, page 102, line 35, leave out ‘Before’ and insert ‘Whilst’.

The Chair: With this it will be convenient to discuss amendment 617, in clause 113, page 102, line 36, after ‘must’, insert ‘have regard to the need for early intervention procedures and’.

Derek Twigg: The lead amendment is a probing amendment, because it may only be about tidying up language. “Before” implies an arbitrary cut-off point for consultation, which could lead to bureaucratic delay in making decisions about regulations for insolvency applications. It is a matter of opinion, but replacing “Before” with “Whilst” makes provision more realistic by ensuring that the consultation and decision-making process go hand in hand—in other words, so consultation happens not only before, but during the process. We would like more information about what the provision means. Again, it is obviously about prevention, but in terms of ongoing consultation, there should not be an arbitrary cut-off point, and nothing more.

The clause states that
“the Secretary of State must consult—
(a) Monitor, and
(b) such other persons as the Secretary of State considers appropriate.”

What will be the extent of that consultation and who will be involved in it? There is genuine concern about having a cut-off point for consultation. If someone followed the letter of the law, that could be the end of discussion.

As we have said before, we do not believe that a hospital should be allowed to go bust without a serious pre-failure regime being gone through to try to turn it around. We have a difference of opinion about the 2006 Act and what the Minister has said. As the Bill stands, hospitals without designated services could just fall over. The first we will hear about them going wrong is when they enter insolvency. The Minister talks about a procedure that could take place, although the detail has not been drawn up by Monitor, but at what point will local people get to know that the hospital is in trouble?

The Minister has said that the local population will be consulted, but at what point will they be involved in consultation?

We believe that the Bill will result in too little protection for services. Successful providers will be able to expand as they attract new patients to their services or win new contracts, but some providers will struggle to attract patients to their services or win contracts. That will not necessarily be because they are poor clinical providers; there may be other factors involved. The Minister already used the example of a hospital or services in a rural area, and demographics could play a particularly important part. Such providers will need to restructure their services, and those that are unable to improve on the quality and efficiency may fail. We want to explore the contrast between financial failure and the quality of services.

There is a risk that the proposals could lead to inequalities in access to services or disruption to the continuity of essential services. People may have to travel further to access services. If there is a problem with the delivery of services because of insolvency, we do not know whether there will be a nearby provider that would be able to take over those services or take over the premises of the current provider. We do not have the detail. We believe that the clause reveals the ruthless, sink-or-swim, survival-of-the-fittest competitive economics that is being thrust into the NHS. That was confirmed in Tuesday’s sitting, when the Minister said that the taxpayer will no longer prop up failing or inefficient providers. We explored the thinking behind that under the previous clause.

The Minister has said that the Labour Government did not deal with inefficient and poor providers. We have repeatedly asked him for examples, but he has not been able to provide any, so perhaps he might like to think again. Perhaps Chase Farm hospital might be an example, but lots of hospitals have issues. If we do not have examples, we cannot draw any conclusions about whether what he says stands up to scrutiny.

Page 123 of the explanatory notes states that
“Introducing an effective failure regime would allow for orderly market exit.”

It would be legitimate to ask for whom it is orderly. For the managers? For hospital staff? For patients’ interests? What does the Minister mean by that? What does he mean by an orderly exit? That is another example of the market-oriented language that runs through the Bill.

The purpose of the clause is to facilitate provider exit, by which the Government mean hospitals, departments or other NHS services going bust and closing and private companies coming in instead. That would all happen according to the rule of the market rather than being democratically decided by local people or patients or their elected representatives. People do not like the idea of their local hospital being treated in that way. Although an exit might be orderly for economic purposes, it might not be for clinical purposes. That goes back to the question of the point at which local people will be involved.

We have talked about the health and well-being board and the council scrutiny committee; what role will they have in the process? At what point will they be informed and brought in? The Minister has talked about what a hospital may do and what Monitor may and may not do, but we have not yet seen the details. Monitor will
not have the market, if I may use that phrase, on good ways of dealing with the problem and helping the choice. There may be others in the local community with a great deal of health experience, including the health and well-being board and the council scrutiny committee, both of which should be involved. That fits in with the Government’s oft-stated position that the Bill extends scrutiny and consultation procedures. It is important to explore what that means.

I am involved with a foundation trust hospital, and we have always had a great deal of involvement with the local authority. The chief executive attends the scrutiny board meetings and there is quite a lot of openness about issues in the hospital itself. I have mentioned the reconfiguration issues in my local hospital before it was a foundation trust, but it would be useful if the Minister were to address that. For those of us with concerns about the Bill, it is important that the best talent is involved when a hospital is at risk of failure.

The risk of indefinite expensive provision funded from the risk pool needs to be mitigated by obliging the administrator to find an efficient solution quickly, such as working with commissioners to invite tenders from possible substitute providers to find the most cost-effective alternative. Does the Minister have any idea of the time scales? How long will such administrations take? I do not know whether the administrators will have any health background or knowledge, or any knowledge of the health market. It would be useful if the Minister gave us some information on that.

How will the regime be enforced and implemented? To be precise and effective, early intervention has to be at the heart of the regime. Paragraph 737 of the explanatory notes talks about “ensuring a level playing field between foundation trusts and other providers”.

The hon. Member for Southport raised that important point, too. The Government’s logic is similar to the alleged problems and solutions related to fair playing fields and market distortions in the pricing clauses. To allow private competitors into the market, existing NHS providers have to be downgraded. That is to treat NHS foundation trusts like private companies that can just go bust if they cannot compete in the market. NHS foundation trusts are not private companies. They are NHS bodies and people do not want their local hospital to go bust and be flogged off to satisfy the creditors. We see a lot about creditors in the Bill.

Private hospitals will be allowed to undercut NHS services, taking the most profitable patients and, therefore, putting NHS hospitals at risk. The stability of foundation trust hospitals is important because cherry-picking undermines foundation trusts. It would be useful if the Minister set out which provisions in the Bill stop cherry-picking in the health service. We introduced a safety net to prevent FTs from failing and, if necessary, there was a deauthorisation regime to return an FT to being an NHS trust.

The strategic approach is the big issue. Now, strategic health authorities and primary care trusts take a leading role in planning what health care is needed in a community, which services to close and which to maintain. In last night’s debate in the House, we heard one of the Minister’s colleagues talking about a centre being downgraded. I think, to a minor injuries centre. Obviously the PCT was involved in that decision, which I think was taken yesterday. It is important that such changes are planned and co-ordinated, but instead the market will bankrupt failing hospitals. Under the Government’s proposals, the market will replace a planned and strategic approach.

10 am

NHS providers that get into financial trouble, including by building up debts, will not be subject to the proper level of scrutiny or provided with any support. I do not believe that there will be scrutiny—the Minister tried to explain the situation to us earlier, but we are not convinced. The risk of financial failure is no longer a widely shared responsibility within the NHS, which is another big change. There will be no PCTs and no SHAs, and it is accepted that hospitals will go bust and that a court-appointed official will then act as a commercial administrator. GP consortia will also be allowed to collapse financially. It is important that the Minister gives us some information on that.

The Government will let hospitals go bust and services shut down before intervening to keep the hospital going in some form or before breaking it up. Ministers will not intervene in the process; it will be down to Monitor and the market. The Minister might say that Monitor had a role in the previous Government’s system, but the difference is that this Government’s proposed system is market oriented and there is much more risk. A competitive market means more risk, so the Minister needs to address that.

Earlier action to stop disruption to services is essential, and we have discussed that to some extent under the previous clause. Services that are not designated could be shut down by a court-appointed administrator, who will not be required to consult. I am not a competition or insolvency lawyer, so will the Minister tell me what administration of the health service a court-appointed administrator might do? Court-appointed administrators will make decisions on financial grounds, but what will they know about the health service and how it and other health service providers are run?

There is no detail on the failure regime for GP commissioners. It would be interesting to know how the provisions would apply to a failing GP consortium. It could cause serious uncertainty or disruption in commissioning groups that routinely fail. Foundation trusts are an issue, but what will be done about failing GP consortia? We have already discussed GP consortia, but will the Minister say something about them in relation to the clause?

Mr Burns: I will do so now, if it is in order, Mr Hancock.

The Chair: Let Mr Twigg finish first and then we will discuss it.

Derek Twigg: Will the Minister confirm whether GP consortia will be subject to the insolvency regime? We need to know. If the answer is no, which is what has been indicated, will he explain why?

We are concerned about the way the provisions will seriously destabilise many hospitals, because their activity levels will be subject to increased volatility over short periods. That could undermine the financial position of local hospitals, leading to service lines or entire hospitals
shutting, because it takes far longer to reduce costs in line with reduction in activity. Part of the problem with foundation trusts and hospitals is that the fixed costs in hospitals are great; they represent a large part of the hospital costs, so it is more difficult, particularly in response to short-term problems, to reduce them. I am not sure what consideration will be given to the financial stability of foundation trusts and the difficulties involved in reducing their fixed costs. Will the Minister give us some more information about that? Local people are concerned that the Bill’s proposals mean that their hospital could be closed down much more easily than at present.

**The Chair:** Let me say from the Chair that I think that part of that contribution was appropriate to the clause stand part debate, although the amendment does not refer specifically to it. We must deduce that we have had that part of the debate when we get to clause stand part. I will not permit us to go back to it if we discuss it now.

**Mr Burns:**—

**The Chair:** Bear in mind what I said. If Members go further than the amendments, those aspects of the discussion will be taken out of the clause stand part debate.

**Mr Burns:** Thank you, Mr Hancock. That is very helpful.

Although I understand some of the concerns expressed by the hon. Member for Halton about the provisions and I am sympathetic to some of them, the amendments are unnecessary. As I explained in relation to amendment 615 in the previous debate, clause 113 provides for the Secretary of State to make regulations to apply relevant parts of insolvency and companies legislation to FTs. That is for the purposes either of rescuing an insolvent FT as a going concern or of an orderly winding up of its affairs in the best interests of creditors as a whole.

As I understand it, the amendments are designed to ensure that the Secretary of State would not make regulations without having had regard to the need for the other options available—for example, the need for early intervention procedures. I can reassure the hon. Member for Halton that of course the Secretary of State would consider all other options. As I have mentioned on other occasions, such proceedings would only ever be used as the last resort where pre-insolvency interventions had not succeeded, and only after continued provision of designated services had been secured through special administration. We will come to that point in greater detail in relation to a later clause.

A range of other mechanisms are available that could be used to try to ensure that foundation trusts would not reach a state in which the proceedings would be necessary. For example, as we discussed in earlier debates, under chapter 4 of part 3 of the Bill, Monitor will operate a licensing regime for all providers of NHS services. One of the core functions of the licence would be to provide a vehicle for additional regulation to secure continued access to designated services. We expect that to include requirements to minimise financial risk and controls on key assets. Monitor would have the power to intervene in response to risk and to require a provider to take remedial action to address risk and prevent failure, as I said in relation to amendment 615.

Before making regulations under the clause, the Secretary of State would be obliged to consult Monitor and other persons. That would include the health care sector and such other persons as he considered appropriate. At this point, I would like to make it clear that it is our intention that this important secondary legislation will be subject to full public consultation, as I have said before. As a further safeguard and as I have also said before, the regulations will be subject to a parliamentary resolution by way of the affirmative procedure.

When the hon. Gentleman was discussing amendment 616, he said that the word “before” applies an arbitrary cut-off. I hope that I can reassure him on that by saying that no, it does not. What the word “before” means and what it means in parliamentary drafting terms is that it is a standard procedure that consultation happens before regulations are made. I hope that that helps him.

We think that to ensure that the final regulations are robust and appropriate for the health care sector, it is very important for the legislation to be subject to extensive consultation before it is made, rather than during the course of laying and making the regulations as suggested by the amendment. Given the requirements to consult before making regulations, and as ordinary insolvency procedures would only ever be called on as the last resort and once continued access to designated services had been secured, I consider the proposed changes to the clause unnecessary.

The hon. Gentleman raised a number of valid points, which I will address. He asked at what point local people would know that a hospital was in trouble. It is my belief that that will be at an early stage. Through the reports and the meetings of the board of the provider, its governors and commissioners, the new system will be more transparent, so there will be more opportunities than there are under the current regimes for people to be aware at an earlier stage.

The hon. Gentleman also asked what local communities could do in such a situation. Local commissioners can apply to designate services. That might, for example, be likely in rural hospitals where there is no alternative provision. In applying, commissioners will have to consult, as we have discussed at length. The decision about what services are protected by Monitor is locally led, as we have also discussed.

The hon. Gentleman was concerned about whether the process would be orderly, and asked what “orderly” meant. It means that the process must be orderly for patients. It means protecting essential services, delivering realistic available alternatives and making sure that the process is orderly for staff. To recap, it must be orderly for patients, so that we protect essential services, and it must be orderly for staff, so that it is managed well.

The hon. Gentleman asked what the time scale for administration will be. It is always difficult to give definitive time scales, because they can, by their very nature, be nebulous. However, I hope I reassure him by saying that there is an obligation on insolvency practitioners to act quickly and efficiently. They will consult on whether special administration should be
The hon. Gentleman asked whether GP consortia will be covered, even though the provisions specifically deal with FTs. The answer is no, simply because this regime applies only to providers, and, as the hon. Gentleman knows, GP consortia are commissioners. He might have gone on to ask how a failing GP consortium would be dealt with. In anticipation of that question—and to save time, because we are making relatively slow progress this morning—let me tell him that the NHS commissioning board would be responsible for assessing the performance of GP consortia. The Bill includes clear powers to enable the board to intervene where a consortium is failing to discharge its functions or where there is a risk that it will do so.

The hon. Gentleman might also ask what powers the NHS commissioning board will have in relation to failing GP consortia. To forestall a further intervention from him, let me say that its powers will include the ability to request information, explanations and documents relating to the discharge of consortia’s duties or the appropriateness of the areas consortia cover; to direct a consortium as to how it should carry out its functions; to arrange for the board or another consortium to carry out some functions on behalf of a failing consortium for a set period; to appoint a new accountable officer; to vary the constitution; and to dissolve the consortium. I will stop talking about consortia, because you, Mr Hancock, might feel that I am beginning to stray.

Let me now answer the hon. Gentleman’s questions on one final issue, so that he has a full range of answers. He raised a number of issues relating to the role of an insolvency practitioner and he asked who would be an insolvency practitioner, and I think I can be helpful here, too. An insolvency practitioner is a person who is qualified to act as such under insolvency legislation. They are authorised by a range of recognised professional bodies, including some that are authorised directly by the Secretary of State for Business, Innovation and Skills. In general, practitioners are accountants or solicitors who are qualified in examinations, practice requirements and specialised insolvency matters.

The hon. Gentleman could claim, as I think he did, that an insolvency practitioner will not have appropriate knowledge of the health care sector. Insolvency practitioners are used to dealing with failure in a broad range of industry sectors. If a provider fails and pre-insolvency interventions have not succeeded, the insolvency practitioner will take on overall control of the provider. The insolvency practitioner will be able to retain existing management and clinical expertise where necessary, and to employ additional health care experts if needed. The practitioner will be required to fulfil its obligations and duties under the legislation, and more generally will be obliged to adhere to ethical and professional guidance.

10.15 am

The hon. Gentleman also asked, in effect, why we need an insolvency practitioner to run a hospital. It is important that insolvency proceedings should be under the overall supervision of an insolvency practitioner who is experienced in dealing with failure and turnaround, but as I have said, the insolvency practitioner will be able to retain existing management and clinical expertise, where needed, and to take on additional experts if necessary. To answer his question in the spirit in which he asked it, the insolvency practitioner will not run the hospital; as I have said, he will have clinical and administrative health staff to help him. Given that this is a probing amendment, I hope that the hon. Gentleman will consider withdrawing it, as he has had such full and wholesome answers to his questions.

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

Amendment, by leave, withdrawn.

Amendments made: 520, in clause 113, page 102, line 39, at end insert—

‘(1) In section 57 of that Act (mergers etc: supplementary) (as amended by section 157 of this Act)—

(a) in subsection (3)(a), for “the persons mentioned in section 54(4)” substitute “another NHS foundation trust, an NHS trust or the Secretary of State”,

(b) omit subsection (3)(b), and

(c) in subsection (4), for “any of the bodies mentioned in section 54(4)(a) or (c)” substitute “another NHS foundation trust or an NHS trust”.

(2) In section 64 of that Act (procedure for orders and regulations under Chapter 5 of Part 2 of that Act) (as amended by section 157 of this Act), in subsection (4), omit paragraph (b).’

Amendment 521, in clause 113, page 102, line 43, leave out subsection (4).—[Mr. Simon Burns.]

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

Owen Smith (Pontypridd) (Lab): I apologise for the delay in rising, Mr Hancock; I was musing on the finer parts of the Bill. However, I do not feel that I need to muse terribly long on the clause, because the Opposition understand absolutely clearly what it is about, and the Minister has been extremely helpful in giving it even greater clarity.

John Pugh: Tell us.

Owen Smith: I shall. It is simple: it is about introducing insolvency law and companies legislation into the NHS to make it easier to close hospitals. That is what the clause is about; it is crystal clear. In a moment, I will quote extensively from the impact assessment and other parts of the ancillary documents to the Bill to demonstrate precisely what I mean.

Margot James (Stourbridge) (Con): Does the hon. Gentleman seriously think that we want to close hospitals in our constituencies?

Owen Smith: I do not imagine for a minute that the hon. Lady wants to close a hospital in her constituency. However, I urge her to read the Bill carefully and understand what it is likely to do. The application of competition will make it far easier for hospitals and the services that they provide to be competed out of existence, and the clause will allow those hospitals to be closed far more efficiently, shielding the closure decision—

The Chair: Order. The problem that I have is that when I read the clause, it does not seem to me to be about closing hospitals. If a problem arises, they will be taken over, but there is no specific reference at all in the clause to closure. The implications do not lead me to believe that the clause heads for the closure of a hospital. We must stick to what the Bill says, rather than what we want to interpret for our own causes.
Owen Smith: Having listened to your ruling, Mr Hancock, I must say that I have a different interpretation, and it is not drawn from thin air, but from reading the impact assessment produced by the Government to explain the Bill’s impact to the public. Paragraph B112 relates specifically to the issue of insolvency, and the application of insolvency law to the NHS. It explains the problem with the way the current regime deals with failure. It says:

“For competition to work effectively, less effective providers must be able to contract or exit the market entirely”.

My interpretation is that to exit the market entirely means closure if it refers to a hospital.

Nick de Bois (Enfield North) (Con): I am sure we await the hon. Gentleman’s colourful interpretation with great interest, but may I offer him a little advice? There is great danger in taking one clause in isolation and from that extrapolating a rather vast interpretation of what may or may not happen. At one point, as beautifully and eloquently as he was reading, the way his argument was growing was like listening to “Jackanory”.

The point that must be seriously considered is that there is nothing wrong with having the clauses on insolvency, because the process of reaching any such situation has more provisions and safeguards than any business would have. All the processes are designed to protect; there is not the emphasis on failure that he talks about.

The Chair: Interventions will have to be shorter. My co-Chairmen feel more strongly than I do on that subject, but sometimes we push it a bit.

Owen Smith: I thought that was a very helpful intervention, because it allows me to say that I think there is absolutely nothing fanciful about the way I have interpreted this clause or the risks in the Bill. It is absolutely clear, notwithstanding the Minister’s reassurances this morning that it would be the last resort, that there would special administration procedures and that we would never want to reach the point of failure. I fully concede that there are provisions in the Bill to try to stop things reaching that point, but the risk is clear in both the notes and the Bill that the possibility of services failing because of competition will increase. The application of insolvency law and involvement of insolvency practitioners—or asset strippers as they are known in other contexts—coming in to take over a hospital’s exit from the market are very clear risks.

Mr Kevin Barron (Rother Valley) (Lab): My hon. Friend is absolutely right to pursue this. The introduction of competition law, the Competition Commission and the Office of Fair Trading may have different interactions inside the NHS to those we have had for the last sixty years. He is right to bring this matter up. Government Members should sit down and realise exactly what the legislation they are passing does.

Owen Smith: I am grateful to my hon. Friend. As many people here know, he is a longstanding and expert observer of the NHS, and he deserves to be listened to as well. It is not just in the one paragraph of the impact assessment that we hear the Government say that, to work efficiently, competition must allow market exit—meaning closure, because we are talking about hospitals. They go on to explain why applying an insolvency regime addresses the issue we have with inefficient exits from the market, under the terms of the Bill. The impact assessment says,

“To address these weaknesses, it is proposed that an insolvency-based regime is introduced”.

Then, at paragraph B114 it explains why that makes it easier to close hospitals.

10.25 am

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

Adjourned till this day at One o’clock.