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Clauses 113 to 153 agreed to, some with amendments.
Schedule 11 agreed to.
Clauses 136 to 164 agreed to, some with amendments.
Schedule 12, as amended, agreed to.
Clause 165, as amended, agreed to.
Adjourned till Tuesday 29 March at half-past Ten o’clock.
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not later than

Monday 28 March 2011

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

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The Committee consisted of the following Members:

*Chairs: MR JIM HOOD, † MR MIKE HANCOCK, MR ROGER GALE, DR WILLIAM McCREA*

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

Thursday 24 March 2011

(Afternoon)

[MR MIKE HANCOCK in the Chair]

Health and Social Care Bill

Clause 113

APPLICATION OF INSOLVENCY LAW TO NHS FOUNDATION TRUSTS

1 pm

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

Owen Smith (Pontypridd) (Lab): This morning, I was explaining that the purpose of clause 113 is clearly to introduce insolvency and company law into the NHS, to allow a more efficient entry and exit from the marketplace for NHS providers. I suggested that a legitimate interpretation of that was that it would allow—albeit as the last resort, after all the appropriate interventions had been followed—hospitals to close more efficiently.

I was going to say that the second critical piece of evidence—of information—required to interpret the clause in that manner is in paragraph B114 in the Government’s impact assessment for the Bill. It says that to address the weaknesses in the current system, this insolvency-based regime will be introduced so that “The taxpayer will be protected from political pressure to rescue providers—public funds will not be used to support unviable providers.”

That is extremely clear. The Government are being very open and transparent about the issue, and it is because they have been so open and transparent and the clause is so clear that we are very worried. That worry has been compounded by the Minister’s remarks to the Committee on Tuesday, because it is clear not only that under the clause and the new regime it will be easier to close hospitals, but that the Minister believes that in the past too many hospitals have been propped up when they were unviable.

The Minister of State, Department of Health (Mr Simon Burns) rose—

Owen Smith: Before I allow the Minister to intervene, I would like to quote the words from his own mouth on Tuesday. He said:

“In contrast, too often under the current system have inefficient and poor quality providers”—

I presume that we mean hospitals—

“been bailed out wholesale and at too great a cost. We want regulation to protect services for patients, not...the institutions that provide them.”—[Official Report, Health and Social Care Public Bill Committee, 22 March 2011; c. 916.]

If I am wrong and the Minister does not feel that too many institutions in the past have been unviable but propped up, and if I am wrong and the future provisions will not mean that hospitals are able to close, he should please put me right. However, I suggest that I am right and I ask the Minister to reassure us by telling us which institutions in the past he thinks have been unviable and propped up.

The Chair: A quick response please, Mr Burns.

Mr Burns: Absolutely, Mr Hancock. I will not drift on to other subjects. I just want to reassure the hon. Member for Pontypridd because he does not understand, or does not want to understand, that the whole purpose of the Bill and the clause is to protect, not close, essential services. I say to him, in the nicest possible way, that if he persists with that student debating style, he might end up, at 65, still travelling on his student bus pass.

The Chair: It would not be in order to discuss that, so stick to where we are on clause stand part and try not to go back over the closures or the unviability of things in the past. The Bill is looking to the future.

Owen Smith: I am grateful to you, Mr Hancock. Of course I would not dream of going back over the issue. I have made my position clear. I will merely say in response that it does not do the Minister great service to offer such a cheap jibe. I have come to expect better of him.

Opposition Members are worried. I fully accept the position of the Minister and other hon. Members that it is not their intention to close hospitals. I fully accept that it is their view that safeguards are being placed in the system that will militate against the closure of hospitals. All I am suggesting is that closure becomes more possible with competition, because some hospitals and providers will be deemed unviable. Under the clause, the insolvency regime makes it physically easier for such hospitals to be closed and such providers to exit the market.

Paragraph B149 of the impact assessment makes it crystal clear that that is precisely what is under consideration. It simply says: “In the new regulated market, providers will succeed or fail based on their ability to offer high quality, efficient services. Successful providers will be able to expand as they attract new patients to their services or win new contracts. However, some providers will struggle to attract patients to their services or win contracts. These providers will need to restructure their services and those who are unable to improve the quality and efficiency of their services may fail.”

Therein lies the issue at the heart of this morning’s debates and, in many respects, the issue at the heart of the Bill. The Minister believes that competition, in effect, allows resources to be allocated more efficiently in the NHS, as in other markets; that is the Bill’s underpinning ethos. The flip side of that is that in a market where some bits see resources efficiently allocated, other bits fail, and the option for those inefficient bits is exit. That is what will happen, and this insolvency clause makes it easier.

John Pugh (Southport) (LD): I have three brief points. The first is on consultation. The Minister legitimately said that, after the previous Government, consultation has a poor name; the fact that there is consultation gives nobody any reassurance, given its political history. The consultation on the White Paper did not necessarily improve the name of consultation, because it was a consultation about how to do things, not whether to do them. However, we will pass over that.
Secondly, when the hon. Member for Halton discussed the clauses, his key point was that they offer a shell that will be followed by secondary legislation. The Minister adroitly replied that such provisions were exactly what the previous Government had. That is like the argument that we have when an Opposition Member tables a rational amendment, and we say that we are doing exactly what the previous Government did. However, repeatedly doing what the previous Government did is not necessarily a good basis for forward-looking policy. I might be ploughing a fairly lonely furrow, but I think we can do just a wee bit better.

There is quite a good example of that. In the Committee that considered a previous, very contentious bit of legislation—the Mental Health Act 2007—it was clear that a lot of clauses would lead to secondary legislation, which would clarify what those clauses were all about. In Committee, Members pressed for some kind of draft regulation by Report to clarify where the legislation was taking us. That does not strike me as a bad precedent to follow, and the Minister might comment on whether such an arrangement is a distinct possibility, because it would be helpful.

Thirdly, I was grateful to the Minister for setting out the errors in the explanatory notes, because we could all have gone down a sidetrack talking about level playing fields and the intention of the clause being to put Bupa hospitals on the same footing as other hospitals. Clearly, that is obviously nonsense, and the Minister has revealed it as such. There never can be a level playing field, because the Government or some state agency—Monitor or whoever—will, presumably, interfere when a foundation trust starts to get into trouble. We will not do that at all with a Bupa hospital.

In any case, there should not be a level playing field, because a Bupa hospital and an acute hospital are different entities; one is paid for by taxpayers, and we have a public interest and investment in it, while the other is purely a private venture. In any case, the Bill will not treat the two sorts of hospital evenly.

The Minister of State, Department of Health (Paul Burstow): I am listening closely to my hon. Friend. His argument and I want to make sure that he is clear about the designation regime, which we have discussed. Designation does not apply simply to state-funded and state-based organisations; it also applies to any provider providing a designated service, and a Bupa hospital could have a designated service.

Mr Kevin Barron (Rother Valley) (Lab): I cannot remember when it was, but I have spoken before about mergers. Mergers are made not only with foundation trusts, but with other organisations. It would be interesting to discover what those other organisations are.

John Pugh: I am indebted to the Minister. I did not realise that; I thought that designation was only for traditional A and E departments. It seems that, for example, private-sector establishments can also be designated for whatever purpose. That is an interesting addition to my understanding.

Mr Kevin Barron: I cannot remember when it was, but I have spoken before about mergers. Mergers are made not only with foundation trusts, but with other organisations. It would be interesting to discover what those other organisations are.

John Pugh: I clearly need to listen more carefully to the right hon. Gentleman and the Minister in order to put the various pieces together. I would have been enormously assisted if the explanatory notes had been of some help, but sadly they were not.

Owen Smith: Is the hon. Gentleman as surprised as I am at what the Minister said? Was he saying that a private hospital could have part or all of its services designated—that it will be protected from further competition?

The Chair: Order. Dr Pugh, may I draw your attention to the fact that you are taking the Committee to matters not covered by the clause? The question of private hospitals is not relevant. I hope that you will speedily return to our debate.

John Pugh: Indeed, Mr Hancock. I was talking about the Minister’s clarification of the explanatory notes about the clause, so I think that I am in order.

The Chair: You might, but I don’t.

John Pugh: I bow to your superior judgment, Mr Hancock, but if I am out of order, so are many other members of the Committee—possibly including the Minister. If the same regime for decommissioning hospital foundation trusts is to apply to Bupa hospitals, there will be knock-on consequences in further legislation. However, I do not want extend the argument, because in addition to having independent hospitals we are now going to have independent state schools, and presumably similar rules will apply to those at some point.

I return to the key point. The Minister sensibly explained that the Bill will give us a serviceable and manageable regime for closing hospitals in place of an outdated, inapplicable and almost unworkable regime. One does not need to be terribly bright to draw the logical conclusion that it will be easier to close hospitals as a result. That is the inevitable conclusion. In supporting the clause, one has to go with the inference, and I see no point in pretending different. However, that is not necessarily the intention; the intention is to put in place a regime.

The Minister is on record as saying that the present scheme is unworkable and outdated, and that it cannot be applied when closing foundation hospitals. The Government are putting in place a model that can be used. Moving from a model that cannot to a model that can will make the process easier, and the fact should be acknowledged.

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

The Committee divided: Ayes 13, Noes 9.

Division No. 81]

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
Twigg, Derek

Question accordingly agreed to.
Clause 113, as amended, ordered to stand part of the Bill.

Clause 114

HEALTH SPECIAL ADMINISTRATION ORDERS
Amendments made: 407, in clause 114, page 103, line 18, leave out ‘designated’.
Amendment 408, in clause 114, page 103, line 20, after ‘imposed’ insert ‘in respect of that activity’.—(Mr Simon Burns.)
Clause 114, as amended, ordered to stand part of the Bill.

1.15 pm

Clause 115

OBJECTIVE OF A HEALTH SPECIAL ADMINISTRATION

Derek Twigg (Halton) (Lab): I beg to move amendment 618, in clause 115, page 104, line 21, leave out ‘licence holder’ and insert ‘foundation trust or the Secretary of State’.

The Chair: With this it will be convenient to discuss the following:
Amendment 619, in clause 115, page 104, line 24, leave out ‘licensure holders’ and insert ‘foundation trusts or the Secretary of State’.
Amendment 620, in clause 117, page 106, line 15, leave out ‘to another licence holder’ and insert ‘to either another NHS foundation trust or the Secretary of State’.
Amendment 621, in clause 117, page 106, line 19, at end insert ‘to another NHS foundation trust or the Secretary of State’.

Derek Twigg: I do not intend to take long on this amendment; I just want some more detail. The provision refers to the transfer of a going concern to another licence holder. The Bill changes the current legislation by allowing a transfer to any licence holder, which could mean a private sector organisation.

We have a number of concerns, including how Monitor will view such a transfer. I know that its view could depend on the scale and size of the services involved, but will Monitor try to get an NHS foundation trust to take over the work? That may not be possible, of course, because there might not be a NHS foundation trust nearby, but that probably does not matter in this day and age, in that the management could be done elsewhere. Does the work have to go out on a tender basis to both private sector and NHS providers, and what would be the criteria behind such a decision?

If the local accident and emergency unit and its supporting services were designated—we would want to protect them from bankruptcy—they could be handed over to a private sector provider. The buildings, the estate, the accommodation and the equipment would obviously be being paid for by the taxpayer; they were run by the foundation trust and they would be part of the wider NHS family. How would the ownership system work with regard to such property if the work was transferred to a private sector licence holder? What would be the consequences of that? Is it right—the Opposition do not think so—that state-owned property and equipment should be transferred out in such a way?

If a failed foundation trust is handed over, it appears that a private company would physically own the hospital. I am sure that not many of the public are aware of that or would support that. I come back to the point that I made in the previous debate about the wider NHS family, which all work together to support each other and put in different management systems, although it all still remains under NHS ownership. Will the Minister expand on that and tell us how the system will work and whether there is a difference between designated and non-designated services in respect of this clause?

Mr Burns: The objective of any health special administration would be to ensure the continuity of designated services, and would be achieved either by turning around a failed provider so that it was able to exit health special administration as a going concern, or by transferring designated services and associated assets to another provider or a number of different providers. As we have already discussed, the priority would be to achieve the former, but if that was not possible it might be necessary to transfer essential services and associated assets to another local provider to ensure continuity of care.

Amendments 618 to 621 would mean that when a provider of designated services — a foundation trust or a private company — failed and a going-concern rescue was not feasible, the services could be transferred only to a foundation trust or to the Secretary of State. That would not be in the patient interest for two reasons. First, if there was no alternative foundation trust within easy reach, the service would close, even if a local willing provider or voluntary sector provider that was providing high-quality care was prepared to take on the delivery of the designated service. I cannot see how it would be in the patient interest to prefer closure over the continuation of the service.

Derek Twigg: It does not necessarily follow that the other foundation trust would have to be nearby. There is a hole in the Minister’s logic. He seems to say that all the services have to be transferred to another foundation trust rather than be managed on the present site by that trust. Will he clarify that?

Mr Burns: What I am saying is that if it was not possible for another foundation trust to provide the service on the failing concern’s premises, it would not be viable to have it carry it out on its own site, if that was too far away geographically.

Derek Twigg: I just want to be clear. Part of our concern—I am sure that the Minister will come on to this—is about who ends up owning the estate, the equipment and the buildings. Is it clear that Monitor should consider allowing the services to continue at the present site, even if they are managed by a foundation trust some distance away, and should that be a first priority?
Mr Burns: No. The overarching priority is to guarantee the continuation of a designated service, because services are designated for the sole purpose of ensuring the continuity of their supply. Another foundation trust could provide the designated service, but it would be more in the patient interest to find a local provider rather than simply to box the service into another FT, which might be some distance away. The service could either move physically to another provider’s site, or another provider could come to the failing FT’s site to provide the designated service. The crucial thing, in the best interest of patient care, is the continuity of the designated service. I hope that that has helped the hon. Gentleman.

Secondly, the amendments would mean that another foundation trust or the state might have to take on designated service provision when a private company had failed. That would represent a nationalisation of failed private providers, could be an incentive to private providers to take excessive risks, and would not be a good use of taxpayers’ money. That might well be an unintended consequence of the amendments, but it is important to consider it.

The hon. Gentleman asked how Monitor would determine—on what criteria—to whom the assets were transferred. It would be for the special administrator, working with Monitor, to determine whether assets would be transferred, and to whom, to protect patients’ interests, because it is those interests that are paramount. For those reasons, I hope the hon. Gentleman will consider withdrawing the amendments.

Derek Twigg: I want to be clear. The answer that came back from the Minister’s civil servants implied that it would be preferred if a local provider took over. The point was made earlier and we fully understand the argument on that. My point related to a situation where there was no local NHS foundation trust, so clearly the only people able to take over would be in the private sector or a social enterprise.

Mr Burns: Or another foundation trust.

Derek Twigg: I am saying if there was not one locally. Does the Minister want to clarify? He said to me that the preference is to have a local provider. I was making the argument that it is not crucial that a NHS foundation trust has to be local to be able to manage the site. My point is about how much effort there is on keeping the service and providing it in the current buildings and estates, rather than transferring it somewhere.

The Chair: I am happy with what the Minister said. He did give an explanation, and I am sure Hansard will bear that out. It would be helpful, however, if he repeated it.

Mr Burns: I do not think that there is any difference between us. We would not want the designated service to be transferred to another FT miles away, but there would be nothing to stop another FT miles away providing the designated service on the site of the failing FT. That is what I have been trying to say, and I hope that that has helped.

Derek Twigg: I thank the Minister. I want to be clear because this is an important point. We have a view that the Government want to take capacity out of the NHS and would like to see private providers given the responsibility. Again we do not have an answer, although the Minister mentioned that the administrator would have to make a decision. Will he clarify the following? Due to insolvency law, the administrator can transfer the whole estate and equipment to a private provider, if that is the decision. That private provider would then own it, rather than the state or the NHS.

Mr Burns: The answer to that straightforward question is that that would happen only if it were in the best interests of continuity of services in the interests of patients.

I want to make something clear, so it is not misunderstood. The estate and equipment would have to be sold, not given. That is fundamental, particularly in the light of past representations of what I have said by Opposition Members.

Dan Byles: [North Warwickshire] (Con): May I intervene, Mr Hancock?

The Chair: You have the floor.

Dan Byles: Some of the mutterings from Opposition Members are interesting. The Minister made it clear: only if it is in the best interests of patients. The mutterings seemed to suggest that, even if it is in the best interests of patients, the very idea is abhorrent. That makes me wonder whether ideology is being put ahead of the best interests of the patients. Surely the best interests of patients must be the No. 1 priority for all of us.

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

Amendment, by leave, withdrawn.

1.30 pm

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

The Committee divided: Ayes 13, Noes 9.

Division No. 82]

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Question accordingly agreed to.

Clause 115 ordered to stand part of the Bill.
Clause 116

HEALTH SPECIAL ADMINISTRATION REGULATIONS

Question put, That the clause stand part of the Bill. The Committee divided: Ayes 13, Noes 9.

Division No. 83]

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)

Emily Thornberry: Thank you, Sir, for your indulgence. I am afraid that amendment 161, although it is very important, does not deserve the melodrama that I have just built around it. I apologise to the Committee for that. [Laughter.]

The point of these amendments is clear to everyone who reads them. They would explicitly enable health special administration regulations to include provision for the transfer of staff, at the same time ensuring that staff transfers under those regulations are covered by the Transfer of Undertakings (Protection of Employment) Regulations 1981 and 2006 protection. That would bring the clause more in line with the protection that may be given to primary care trust staff. These are extremely important amendments and it would be surprising if the Committee were to oppose them.

Mr Burns: I agree with the hon. Lady that these are important considerations. While I am not able to agree that the amendments should be made, I hope that I can explain why they are not necessary. Amendments 161 and 162 seek to provide for health special administration regulations to include provisions for the transfer of staff from an NHS FT, or company in special administration, to another licence holder. We agree that that is an important issue. As I have said, our preferred outcome of a special administration would be to rescue the organisation as a going concern. Staff transfers would be required only where that was not possible and would be subject to TUPE regulations wherever applicable.

We do not, however, consider the amendments necessary, because the Bill already makes provision for the transfer of the undertaking of an FT, or part of that undertaking, in clause 115. Clause 117 makes further provision about those transfer schemes, which include the powers to transfer rights and liabilities, which can also cover those under a contract of employment. The important protections for staff, including TUPE regulations, are already provided for under employment law. As a further safeguard, the regulations to be made to implement the health special administration regime, including transfer provisions, would be subject to consultation. Furthermore, the regulations would be subject to affirmative resolution. Both Houses of Parliament would have an opportunity to consider specific proposals for regulations, including any provision that might be made in the regulations for staff transfers.

I can sympathise with some of the principles behind amendments 163 and 164. It is right that the interests of NHS staff should be represented within NHS FTs and that staff should have an opportunity to have their say in decisions that affect them and to contribute their ideas. However, the NHS FT model already achieves that. Staff members are an integral part of the governance of each and every NHS FT in the country, and the Bill builds on that mutual approach. It actually strengthens the voices of staff members and governors by giving them the ability to contribute to the deliberations of the council of governors greater powers and by promoting the transparency of NHS FTs to the people that they serve. The Bill both retains the existing statutory powers of and implicit duties on governors and gives them new powers. Such powers include powers to approve mergers, acquisitions, separations and other significant transactions, to approve amendments to the constitution and to call a director to attend a special general meeting to obtain information about a trust’s performance. At the same time, the NHS constitution pledge to involve staff in...
decisions that affect them remains in place, and, of course, employment law already applies to staff of all providers offering NHS care.

As the amendments are unnecessary and could have the unintended consequence of imposing needless and excessive requirements on FTs, I ask the hon. Lady to withdraw them.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): We have already discussed the potential process for speeding up the winding up of a foundation trust hospital that goes under, and the Minister has said that the preferred option is to bring someone else in to take over that trust and run it. In the gap in between, the terms and conditions of workers, if they are made redundant following the trust’s becoming insolvent, are vulnerable, and we could be getting rid of people on reduced terms and conditions until the preferred person comes in. I just wanted to highlight a certain element of employment law, particularly as FTs could be treated as enterprises.

Mr Burns: If the hon. Gentleman is referring to our recent debate, I was discussing how another FT could continue to provide the designated services on the failing FT’s premises. That was the debate that we had. On his second point, I do not share the hon. Gentleman’s analysis of the situation, because what I said during my remarks is watertight, gives assurances and, in effect, backs up what the amendments are seeking to do by showing that the protections are already there.

Emily Thornberry: I have listened to what the right hon. Gentleman has said and appreciate that this is a technical area of the law. I do not want to put the matter to an unnecessary vote, but the Hansard report of his comments will be read carefully and the matter may be brought back in another place. I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Clause 117 ordered to stand part of the Bill.

Clauses 118 to 127 ordered to stand part of the Bill.

Clause 128

Amendments to consultation

Amendments made: 410, in clause 128, page 112, line 35, leave out ‘and 5(6)’ and insert ‘, 5(6) and 6(6)’.

Amendment 411, in clause 128, page 112, line 38, leave out paragraph (b).—(Mr Simon Burns.)

Clause 128, as amended, ordered to stand part of the Bill.

Clause 129

Amount payable

Derek Twigg: I beg to move amendment 622, in clause 129, page 113, line 35, leave out ‘a financial year’ and insert ‘the two financial years immediately’.

I will be brief. Subsections (8) and (9) require Monitor to recalculate the amount payable where providers request a recalculation because they believe that the amount has been miscalculated as long as the request relates to the current year. We think that may be too narrow. In view of the changes that have taken place as a result of the Bill, the last financial year should also be taken into account to ensure longer-term financial arrangements. For example, if Monitor levies an incorrect amount on a provider on 20 March 2015, the provider may only realise that one month later, in April 2015. Why is it so narrow, given that a new system is being brought in?

Mr Burns: I will be as brief as I can, as I know the Committee wants to make progress. Part 3, chapter 7 of the Bill would give Monitor the power to establish effective financial mechanisms to support the operation of the health special administration regime, which has the objective of ensuring the continuity of designated services in the event of a provider insolvency. It would enable Monitor to collect money from providers of designated services and commissioners of those services to invest in those financial mechanisms.

A health special administrator appointed to a failing provider of designated services would be able to apply for additional funds from the financial mechanisms to help cover the costs of ensuring the continued provision of designated services until the failing provider was restructured or a new provider could be found. Funds from the financial mechanisms could only be used by the health special administrator to cover operating costs during health special administration associated with ensuring the continuity of designated services. That includes any indemnities for the health special administrator and other relevant persons in respect of liabilities incurred, or loss or damage sustained in connection with the exercise of the health special administrator’s powers and duties; any costs associated with ensuring the continued operation of designated services; and the costs associated with restructuring the provider to ensure a sustainable future for the designated services. Those restructuring costs might include, but are not limited to, renegotiation of service contracts and restructuring of debts or payments that are made to a new operator to establish a viable provider.
Amendment 622 applies to that recalculation provision. I believe that the amendment is an attempt to improve the provision by increasing the restriction on providers’ ability to go back to previous financial years’ levies and ask for recalculations on levies that they have already paid. The amendment is not necessary, however, as the current drafting of the clause already restricts the application for recalculation to that financial year’s levy. For that reason, I ask the hon. Gentleman to consider withdrawing his amendment.

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

Amendment, by leave, withdrawn.

Clause 129 ordered to stand part of the Bill.

Clause 130

INVESTMENT PRINCIPLES AND REVIEWS

Mr Burns: I beg to move amendment 413, in clause 130, page 114, line 33, leave out ‘in its opinion’.

I will be brief, because this is a minor and technical amendment to sharpen the drafting of the legislation. The words “in its opinion” in subsection (6) (b) are not necessary, because the subsection already requires Monitor to make a determination on what it must exclude from a review.

Amendment 413 agreed to.

Clause 130, as amended, ordered to stand part of the Bill.

Clauses 131 and 132 ordered to stand part of the Bill.

Clause 133

SERVICE OF DOCUMENTS

Amendment made: 414, in clause 133, page 116, line 27, at end insert—

‘( ) This section is subject to paragraph 4(3) of Schedule 7 (delivery of notice from Secretary of State of suspension of non-executive member of Monitor).’—(Mr Simon Burns.)

Clause 133, as amended, ordered to stand part of the Bill.

Clause 134

ELECTRONIC COMMUNICATIONS

Amendments made: 468, in clause 134, page 116, line 34, after ‘Monitor’, insert ‘or the Competition Commission’.

Amendment 469, in clause 134, page 116, line 36, after ‘Monitor’, insert ‘or (as the case may be) the Competition Commission’.

Amendment 470, in clause 134, page 116, line 41, after first ‘Monitor’, insert ‘or the Competition Commission’.

Amendment 471, in clause 134, page 116, line 44, after ‘Monitor’, insert ‘or (as the case may be) the Competition Commission’.—(Mr Simon Burns.)

Clause 134, as amended, ordered to stand part of the Bill.

Clause 135 ordered to stand part of the Bill.

Schedule 11 agreed to.

Clause 136

GOVERNORS

Liz Kendall (Leicester West) (Lab): I beg to move amendment 639, in clause 136, page 117, line 28, at end insert ‘and instead insert—

‘(3) At least one member of the council must be appointed by a Commissioning Consortium for which the corporation provides goods or services.

(3A) At least one member of the council must be appointed by the appropriate local Health and Wellbeing Board.”.

We are now moving on to the changes to foundation trusts. The clause concerns the changes to the role and appointment of foundation trust governors. Subsection (2) removes the requirement that at least one member of the board of governors, or council of governors, as the Government intend to rename it, should be appointed by the primary care trust, because the Government intend to abolish primary care trusts.

The amendment seeks to ensure that at least one member of a council of governors is appointed by a commissioning consortium to which the foundation trust provides services, and that at least one member is appointed by a relevant health and well-being board. The purpose of the amendment is clear. If we want to support the integration of services across community, primary and secondary health services and across health and social care, it would be extremely beneficial for foundation trusts to have a governor appointed by one of those bodies, just as foundation trusts currently have to have someone appointed by a primary care trust. We ought to see such improved collaboration and joint working.

The appointment of at least one member of the council by the local health and well-being board would help to improve democratic accountability. There would be accountability not only to patients, but through the democratic process. I am sure the Minister will say that that is something that the Government are keen to achieve.

Paul Burstow: So that I do not begin by disappointing the hon. Lady, she is absolutely right, the Government do want to achieve that. Through the Bill we will further strengthen the system to encourage integration across health and social care and between community, secondary and tertiary services. This is an essential part of how we ensure that patients’ experience of health and social care is improved, and that we drive the continuous improvement that we wish to see in the NHS.

Looking at amendment 639, which relates to the composition of the council of governors of an NHS foundation trust, I certainly sympathise with the intention behind it, and I support greater transparency and accountability in the governing of foundation trusts. That is why the Bill includes robust provisions to increase the transparency and accountability of foundation trusts to their governors, staff members, patients and the public. That is why we have proposed that foundation trusts should be free to include any organisation they choose on their council of governors so that they can tailor their governance arrangements to suit local circumstances.
Foundation trusts are not homogeneous; community foundation trusts or ambulance trusts may wish to have different people on their council of governors than acute trusts. We need to ensure flexibility so that they can tailor their governance arrangements. Rather than specify more and more compulsory governors, we feel that, beyond the absolute minimum requirements, decisions on the composition of the council of governors are best left to local discretion. Some foundation trusts may wish to invite voluntary sector partners on to the council of governors, others may want one or more commissioners on the council; in any case, public and patient governors would remain the majority.

As the hon. Lady knows and has indicated, health and well-being boards are part of the local authority. Placing a duty on them to make an appointment to the foundation trust council would duplicate an existing local authority duty, which will continue, and which gives the local authority flexibility over the most appropriate representation. It is also important to recognise that health and well-being boards are about influencing commissioning decisions, rather than supervising individual provider organisations. As we discussed when we debated part 5 of the Bill, while individual commissioners would remain responsible for their commissioning plans, the role of health and well-being boards would be to create an overarching framework within which the plans are developed.

Requiring health and well-being boards to make appointments to foundation trusts would require the board to be involved in the governance of some providers while not having that type of influence over others—for example, any provider that is not a foundation trust. That could involve community interest companies of the sort established as part of the spin-out of community services from PCTs, which started under the last Government and continues under this. The requirement would therefore raise questions of fairness and equity between providers, and also go significantly beyond the original role of health and well-being boards, which were widely supported during the consultation.

Clearly foundation trusts should continue to engage commissioners; the hon. Member for Leicester West is absolutely right about that. That relationship is very important in order to understand what commissioners want, so that they can respond in the best interests of patients. Consortia have influence by virtue of their commissioning decisions and contractual arrangements, and it would continue to be in the interests of foundation trusts to involve commissioners appropriately. We have not imposed foundation trust representatives on consortia, nor do we seek to impose consortia representatives on foundation trusts. If foundation trusts decide that they want representation from other bodies in their governance structures it is up to them; the Bill provides for greater autonomy in the way that foundation trusts operate.

Mr Steve Brine (Winchester) (Con): Is it the Minister’s view that there is a good likelihood—that let us put it that way—that the council would wish to involve commissioners from the GP consortia that it wants to sell services to? Given that it wants them to be interested in buying its services, does the Minister expect that it is likely it would put them on the council?

2 pm

Paul Burstow: The clause—as do those which we will discuss shortly—makes the responsibilities of governors much clearer and more transparent. It clarifies the purposes of these organisations and makes them visible to both the communities they serve and the governors, so that what they are meant to do is much clearer. The clause also clarifies what they are meant to do in terms of framing their constitution. This matter will not be left to one side, unconsidered. In future, as part of the process of reviewing constitutions, governors would have to consider whether they wanted to include the possibility of membership of commissioners in the constitution. However, the question of commissioners being involved with providers on the design of appropriate care pathways is not necessarily best solved by membership as governors of the body. It is dealt with in a host of other ways and through other relationships, not least the clinical relationships between clinicians in the trust and clinicians in the consortia. I hope that the hon. Lady is reassured, and that she will not press her amendment to a vote.

Liz Kendall: I also hope that foundation trusts will seek to involve GP commissioning consortia and health and well-being boards in a host of ways, not least, as I hoped they would, through the council of governors, because that is the overarching body with responsibility. There is a strong argument to say that it would be in the best interests of foundation trusts to ensure that the body that has overall responsibility for that trust includes the people it has to work with. I only wanted to have those statements put on the record, so I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Liz Kendall: I beg to move amendment 640, in clause 136, page 118, line 4, at end insert—

‘(2) The Care Quality Commission must make provisions to ensure that the governors of a public benefit corporation are equipped with the skills and knowledge they require in their capacity as such.’.

Subsection (5) requires foundation trusts to ensure that governors are equipped with the skills and knowledge they need to carry out their duties. Such duties are set out in subsection (4):

(a) to hold the non-executive directors individually and collectively to account for the performance of the board of directors, and
(b) to represent the interests of the members of the corporation as a whole and the interests of the public.

Those provisions are welcome, because they provide clarity and spell out, in detail, the role of governors, showing that the line of accountability goes from the council of governors to non-executive directors, who themselves have to hold the board of directors to account. It is useful to have such details in the legislation.

The Foundation Trust Governors Association represents about 3,000 governors across England. It believes that the provisions do not go far enough in establishing how the effectiveness of governors will be assessed on an ongoing basis. As hon. Members know, I have raised the point several times that, as Monitor loses its responsibility for foundation trusts, the governors of foundation trusts are where the buck stops in terms of responsibility for them. Ensuring that governors are
inducted and trained by their foundation trust is absolutely critical to the overall effectiveness of their governance, so that needs to be assured on an ongoing basis. The amendment would give the Care Quality Commission a responsibility to assess the effectiveness of foundation trust governors, as Ofsted assesses the effectiveness of school governing bodies as part of its school inspection regime. The amendment attempts to provide some kind of proportionate outside check or balance on foundation trusts. Organisations go through a rigorous process to become a foundation trust and to ensure that they have the governors in place. Anyone who has worked with such trusts as they do that knows that it is a rigorous process. The argument, however, is that assessment needs to happen on a continuing basis. It does not need to be over-burdensome—Ofsted, at least once every five years, I think, looks at the effectiveness of how school governors run their schools. The amendment allows for the CQC to take on a similar role for foundation trusts. It is an important and not over-burdensome requirement, which would be helpful for foundation trusts. Without removing their independence, it would provide some reassurance to patients and the public that the body responsible for running these trusts is, at the very least, effectively trained and has the right skills.

Paul Burstow: I certainly have some sympathy with the points made, and I welcome the hon. Lady’s point about the need for good induction and ongoing training.

We agree that foundation trust governors must have adequate support to fulfil their role. Governors already play an important role, and it will be even more important in the future. They will be responsible for holding their board of directors to account as representatives of their foundation membership—the public and staff of the foundation trust.

It is equally important that there is clarity about who in the system is responsible for ensuring that governors are fully equipped for their role. If the same responsibility is placed on the Care Quality Commission, which is the effect of amendment 136, we run the risk of having a situation in which it is no longer clear where responsibility lies and we end up weakening rather than strengthening the responsibilities. We want it to be beyond doubt that this is a responsibility of the organisation itself—that it sits with the directors to ensure that they are providing the necessary support and ongoing development so that governors can fully discharge their responsibilities. It would be a great pity if this clear responsibility on foundation trusts, as set out in clause 136, were to be diluted. Foundation trusts themselves are best placed to identify the skills and knowledge of their governors and to make the arrangements to achieve that—whether by providing training or information themselves or by buying it in from other suppliers—and supporting governors to take up the opportunities available to them. Transferring this responsibility to the Care Quality Commission would allow foundation trusts, effectively, to blame someone else if things go wrong.

Foundation trusts are best placed to help governors focus on specific issues affecting their own organisations. Governors will continue to need information from a variety of sources and on a wide range of issues, including governance, clinical quality and finance and local priorities and needs. Foundation trusts will be able to help them access that.

I understand the wish to involve the CQC. There will be increased emphasis on quality of patient service, but CQC’s important role as a quality regulator of providers of service is to provide assurance that the care is being delivered safely to patients and people using the services and meets the standards set out in registration regulations. The CQC should not be distracted by being drawn into discussions about the governance of boards or organisations.

The hon. Lady talked about the Foundation Trust Governors Association. We are certainly aware of the need to provide support for foundation trust governors. We are working with the Foundation Trust Network, the Foundation Trust Governors Association and Monitor, in its current role as foundation trust regulator, to see how best that can be achieved. Although the intention is one that we share and understand, the means that the hon. Lady is suggesting is not the right way to achieve that, so we resist the amendment.

Jeremy Lefroy (Stafford) (Con): I shall be extremely brief. I support the idea behind the amendment, which is that it is vital that foundation trust governors have training. Our experience in Mid Staffordshire clearly shows what an important role governors have, and they must be supported. They are elected and may have great skills, but not necessarily all the skills that such groups might need. It is vital that they obtain skills by the most professional means possible. The Minister says that we would not want to constrain how it is done or make it too bureaucratic. Perhaps the Department could consider some kind of qualification or specific course for governors that is of a higher order than what is currently available, such as that mentioned by the hon. Lady, so that they are trained in the best possible way. I note that the impact assessment mentions provision for funds to be made available for such training. Will the Minister assure us on that point?

Paul Burstow: As I said, we are working closely with the Foundation Trust Governors Association, the FT network and Monitor on these issues, and I would be happy to update the Committee as work progresses.

Jeremy Lefroy: I am grateful for that reassurance.

The role of governors of foundation trusts is extremely important. As the hon. Lady said, the buck stops with them. Society should value that role, supporting all who undertake this responsibility as best we can.

Liz Kendall: The Minister is right to say that we want to be clear about the responsibility of foundation trusts to ensure that governors are trained effectively and have
the right skills and experience, and I would not want any amendment to muddy the water. In all seriousness, however, my real concern is that we need some kind of periodic outside check, not one that is over-burdensome, to be sure that the governance of foundation trusts is effective. The amendment tries to ensure that the matter is dealt with in the same way as Ofsted deals with the governance of schools. It is an important outside check and balance.

The wording of the amendment may not be as tight as it should be, but I shall press it to a vote because I want to record the Opposition’s concern. I ask the Minister to think again. I shall say more about the subject on clause stand part, but I hope that we are not faced with another situation like that in Mid Staffordshire in years to come. If it happens, members of the Committee will have some responsibility for not taking the opportunity to put these checks and balances in place.

2.15 pm

Question put, That the amendment be made.

The Committee divided: Ayes 7, Noes 13.

Division No. 84]

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

Smith, Owen
Thornberry, Emily
Twigg, Derek

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

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

Question accordingly negatived.

Amendments made: 522, in clause 136, page 118, line 10, at end insert—

( ) In paragraph 23(4) of that Schedule (persons eligible for appointment as auditor by governors), in sub-paragraph (c), for “the regulator” substitute “the Secretary of State”.

Amendment 523, in clause 136, page 118, line 17, after ‘33(4)(a)’ insert ‘(in each place it appears)’.

Amendment 524, in clause 136, page 118, line 19, after ‘in’ insert ‘section 60(2) and (3) and’.—(Paul Burstow.)

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

Liz Kendall: I wish to make some points that follow on from comments made during our discussion of amendment 640.

There are real concerns about removing Monitor’s role in regulating the foundation trusts. It currently has the ability to step in if a foundation trust does not have the necessary governance arrangements to prevent or deal with a whole range of problems: it can direct trusts to do things, stop them from doing things and require them to add individuals to or remove individuals from trust leadership. All NHS trusts have to become foundation trusts by April 2014, and although Monitor will retain some regulatory powers over some of the most challenged trusts during a transition period, from 2016 all foundations trusts will be on their own. That is a major change, and it is important that we discuss it.

The need to ensure that foundation trusts have governors with the necessary skills and experience will be even more important in the future. The NHS faces its tightest ever funding period, and will be under huge pressure to maintain and improve quality of care at the same time as making efficiency savings worth £20 billion. If the Bill is passed, the NHS will have to do that within a much more competitive environment, with many more providers challenging foundation trusts and the services that they offer. Also being abolished are the strategic health authorities, which have the ability to step in and help to prevent trusts and foundation trusts from starting to fail. Many hon. Members will know that.

We also need to be aware that there will have to be many more governors, because all hospitals, mental health trusts, ambulance services and community services will become foundation trusts, and they will all need governors with the necessary skills and experience to have the ultimate responsibility for very complex organisations. As we all know, Dr David Bennett is the new head of Monitor. He told a recent meeting of the Westminster health forum:

“It is a very, very major step up for the governors of these trusts and one thing we would say is that we think a lot of thought and effort needs to go into how we make the governors of these foundation trusts ready to take on that extra role.”

I want to illustrate that point by giving an example. Government members of the Committee are not concerned about using specific examples and I hope that the hon. Member for Stafford will bear with me, as I realise that he knows far more about these issues than I do. Nevertheless, I want to highlight some of the key issues and challenges that have emerged from both the independent inquiry and the public inquiry into Mid Staffordshire, although the public inquiry has not yet reported. I have very carefully read the evidence that has emerged from both inquiries so far and it is important that we are aware of some of these issues about governance, because they are very pertinent to the clause.

I want to use these examples not because I want to suggest that the problems in Mid Staffordshire are widespread. Far from it—I know that there are a huge number of foundation trusts with very strong governance arrangements, and excellent working between governors, directors and non-executive directors, with rigorous scrutiny and challenge. Nevertheless, it is important to understand what can happen if the governance of an FT is not strong or effective, and I want to highlight just a few points from the Mid Staffordshire case.

The independent inquiry, which took place before the public inquiry, clearly found that the governors of the Mid Staffordshire trust struggled to provide effective oversight of the trust. Witness M11, as she is referred to, had been a chaplaincy volunteer at Cannock for several years. She stood for election as a governor after there had been some very poor care of her father before he died. She told the inquiry that, despite the very high volume of paperwork involved in the role of governor, it was not clear to her what the position involved. That is why I am grateful that there is some more clarity in the Bill about the role of governors.
Witness M11 said that, in her view, the information that was provided to the meetings of governors was “not truthful”—that was the phrase that she used. On mortality figures, for example, she said the governors were simply told by the directors that there was a coding problem and that it was a very complicated situation. She said that the directors did not go through those figures in detail with the governors. She felt that governors were not encouraged to express their views or opinions, or to challenge the board. She also said that the governors were often told, when they asked questions about something, that it was an operational, not a strategic matter. But of course, if someone is going to understand strategic challenges they often have to understand the operational detail.

It was hard for the governors of the Mid Staffordshire trust, but the non-executive directors also said that they experienced problems in getting the right information from the directors of the trust. The executive summary of the independent inquiry into the trust said:

“It was noted that the non-executive directors recruited by the Trust were on the whole inexperienced in NHS board positions. While this may be inevitable in a relatively small trust”

We should not forget that, as we move forward, it is the smaller trusts that are becoming foundation trusts—“it does give rise to a need to call on more training or outside assistance.”

My final point is about what the public inquiry into the Mid Staffordshire trust has said about GPs so far. Although the Minister has not yet made this argument, one of the arguments for GP commissioners is that they will hold foundation trusts to account for the services that they provide. It is obviously at the heart of the Bill that GP commissioners will drive those changes. I want to read the opening statement, dated 9 November, from Tom Kark, the counsel to the public inquiry:

“The inquiry team has made repeated attempts to engage the local GP consortium with the work of this inquiry. The inquiry team has written directly to local surgeries. Unfortunately, until last week that effort had produced very little response, even from those who frequently referred patients to the trust and who must have something relevant to say of their own and their patients’ experiences, both of care and complaining…In short, the serious and global nature of the concerns about the trust do not appear to have been picked up by the surgeries…The extent to which general practitioners are in a good position or not to identify concerns at the local hospitals is of particular significance to this inquiry, bearing in mind the proposals for GP-based commissioning to take a far more front line role in the NHS.”

I do not think that the oversight of foundation trusts can be left simply up to governors themselves, when we know it is a huge challenge with all NHS trusts becoming foundation trusts—or to GPs. Dr Ian Wilson, one of the GPs who gave evidence to the public inquiry, said on 18 January that,

“committed GPs are very, very busy people and to try and keep a grasp of all of the changes that are going on and to make sure that you are on top of all aspects of what you should be doing as a professional is very, very difficult.”

I urge the Minister to think again about how we ensure effective governance over trusts to make sure that the very real problems in Mid Staffordshire are not repeated.

Jeremy Lefroy: I thank the hon. Lady for that good summary of a lot of the evidence from both the independent inquiry and the ongoing public inquiry. Clearly, as there is a public inquiry, we cannot draw too much until Robert Francis has published his report. I want to come to that later. Hard cases make bad law. If it were simply one instance of a trust that had problems with its governance and all other trusts around the country were in good shape, we could say that it was a problem for Mid Staffordshire and not something that we should be too concerned about from the legislative point of view. However, I do not believe that is the case. The hon. Lady is perhaps too generous to trusts around the country as I think there are more hard cases than we realise at the moment. Therefore it is important that, as legislators, we look closely at this.

I want to highlight the danger of the transition, which the hon. Lady has already mentioned. As I understand it, and the Minister will correct me if I am wrong, once the Bill is enacted, Monitor will no longer be responsible for the monitoring of existing foundation trusts. It will still have the responsibility for the approval of new foundation trusts, but not for the monitoring of existing foundation trusts.

Paul Burstow: Just to be clear, all foundation trusts will come under the licensing system that we have been discussing, so they will be subject to the same conditions that would apply to any provider. So there will be monitoring in the context of their licence obligations.

Jeremy Lefroy: I am most grateful for that. It gives some comfort although I suspect, given the number of providers compared with the rather small number of foundation trusts at the moment, the extent to which Monitor will be able to oversee that and the amount of work that it will be able to do on each one will probably be less than at the moment. That is not necessarily a bad thing, but it means that the onus is very much on the board, as many Members have already pointed out.

At the moment we have this transition between the consideration of the Bill and eventually, if Parliament wills it, its enactment, and the Francis inquiry, which is an incredibly significant inquiry. It is probably one of the most significant inquiries into the health service in decades. I welcome the fact that the Minister has already given an assurance that all the recommendations made by the inquiry will be taken fully into account and, where necessary, put on a statutory basis.

2.30 pm

We do not know how long that interim period will last, but what transition arrangements will there be? The proposals and recommendations of the Francis inquiry could be quite radical. I know that Sir Robert Francis is taking a particular interest in both the independent and public inquiries. Is there a way in which the recommendations—particularly on governance, as that is key—can be brought forward, or indicated, so that they could even be incorporated into the Bill? If that is not possible, will the Minister give an assurance that there is a way in which they could be very rapidly implemented? As we know, waiting for a second Session Bill could take a couple of years, and I do not think we have that amount of time.

That is all I wish to say. I believe the question of timing and transition is very important, particularly in the area of governance, where we place so much emphasis on foundation trusts.
Paul Burstow: I thank my hon. Friend the Member for Stafford and the hon. Member for Leicester West for their important points. They go to the heart of how we ensure that the system put in place by the Bill is entirely about delivering the best possible results for patients: safe, quality care. That is at the heart of the vision and purpose of the legislation.

I will try to address several of the key points. First, I will reflect quickly on the objective of moving NHS organisations to foundation trust status. This is not the first time that such an objective has been set, but it is the first time that it has been set so clearly in statute. It was set by Alan Milburn in 2003, when the aspiration was to achieve it by 2008. That was revisited in 2007, with the view taken that it should be achieved by 2010. Those dates have been missed. We have been ensuring that we learn from the experience of the previous Government in not achieving those deadlines, and that we proceed in a way that secures the patient interest, which is to have well delivered quality care that is value for money for the taxpayer. That is in a context, as the hon. Lady rightly said, of a tight but none the less significant financial settlement for the NHS, which the Chancellor confirmed in yesterday’s Budget statement. That, alongside what is now called the Nicholson challenge, provides an extra year for the NHS to respond to the quality, innovation, productivity and prevention programme initiated by the previous Government, which this Government are committed to carry through.

That programme is about ensuring that health care resources are allocated to delivering the best possible results for patients. It is about asking whether we are necessarily delivering care in the right place. For example, it is about ensuring that care for people with long-term conditions and co-morbidities is increasingly delivered in community settings. It is also about ensuring that unscheduled care is reduced and that more appropriate interventions are provided. There are inevitable changes to the way in which services are provided to deliver that agenda, which is one shared throughout the Committee. Both this Government and the previous one see this as essential to changing the services that are there to meet patient need.

In response to the challenge about governance rightly made by the hon. Lady and my hon. Friend, the clauses try to elevate the status and profile of a governor’s responsibility, and make that clear to governors, directors and others with an interest. That is a very serious and important responsibility. As the legislation is enacted, we will see that responsibility become even clearer. That is why the clause does a number of things. First, the clause defines the role of the council and the governors more clearly than ever before. They will have a duty to hold the directors of the foundation trust to account and to represent the interests of the membership and the public. Secondly, it gives governors a new power to challenge and question directors about the performance of the organisation at a special general meeting.

While the new duty and power will be a relatively small legislative change, it has a big cultural impact. The hon. Lady referred to the inquiry, and recommendation 9 identified a cultural issue. It is partly about training, but it is also about attitude and behaviour. The Francis report highlighted several failings of the board of directors at Mid Staffordshire, including the recruitment of inexperienced non-executive directors, who failed to fulfil their role. Directors were complacent and isolated themselves from outside influences. The provisions in the clause aim to open the board up to greater influence from outside, not least from governors and the membership. Our reforms ensure that directors cannot hide away from those outside influences. That is an important assurance that I can give to my hon. Friend and the hon. Lady.

The hon. Lady also asked about the role of GPs, but if we talk about it solely in terms of “GPs” and not GP commissioning consortia, we would be misdirecting ourselves. We are discussing the role of a public body—a commissioning consortium—that is led by GPs. That body will have clear responsibilities about its contractual relationships with providers, including foundation trusts, which it must ensure that it is fully and completely undertaking. The NHS commissioning board will be undertaking assessments of such consortia to ensure that they are discharging their functions properly.

Dan Byles: I am not saying more than what other hon. Members have already said, but this is a hugely important issue. When I sat on the board of the mental health trust, in the aftermath of the Mid Staffordshire events we regularly discussed how we could be sure that something like that was not happening at our trust. The Mid Staffordshire board sat down every month and looked at all its indicators, at its dashboard, at all the targets that it had been set and whether it had ticked all the boxes, but we know what was happening out in the wards. As a board, we fundamentally reassessed how we gathered information and how we interacted with our partners, both within the trust and externally. This is a hugely important issue, and I am reassured greatly by what the Minister has said.

Paul Burstow: Indeed, one of the points made in the report was that there had been a corporate focus on process at the expense of outcomes. That was a key failing, which the Bill is trying to change. We want to shift the focus more decisively on to outcomes.

We are placing the onus on governors, but we are not excluding other actors, such as GP commissioning consortia. Taken together, the provisions significantly strengthen the internal governance of foundation trusts. They make them more accountable to their governors, and as a result foundation trusts will be more responsive to the interests of their members and the communities that they serve. The provisions respond to the feedback that we received during the consultation on the White Paper, particularly from our discussions with the Foundation Trust Governors Association and the Foundation Trust Network. For those reasons, I hope that the hon. Member for Leicester West and my hon. Friend the Member for Stafford are reassured.

We are obviously in the middle of an inquiry at the moment. It is entirely right that hon. Members are following it closely, as are the Government, but until the inquiry has ended, drawn its conclusions and made its recommendations, we cannot respond and cannot commentate as it goes along. That could misdirect the Committee and result in our making poor judgments.

Question put and agreed to.

Clause 136, as amended, accordingly ordered to stand part of the Bill.
Clause 137

DIRECTORS

Liz Kendall: I beg to move amendment 642, in clause 137, page 118, line 32, after ‘maximise the’, insert ‘health and other’.

The amendment is straightforward and seeks that other benefits, as well as health, are taken into account when directors determine whether a foundation trust is a success. That would ensure that the key determinant of the success of a foundation trust could not be interpreted as its financial success.

Paul Burstow: I sympathise with the intention behind the amendment. The Government fully support a focus on improving health care outcomes, as I have said, which is at the heart of what we are trying to achieve in the Bill. That is why we are making foundation trusts more autonomous and removing existing constraints, leaving them free to focus on innovation and improving health care outcomes for patients.

The principal purpose of all foundation trusts, set out in existing legislation, is:

“When directors determine whether a foundation trust is a success. That would ensure that the key determinant of the success of a foundation trust could not be interpreted as its financial success.

Liz Kendall: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.

Liz Kendall: I beg to move amendment 641, in clause 137, page 119, line 30, at end insert—

18D (1) The board of directors must meet in public.’.

Clause 137(4) requires the board of directors to send a copy of the agenda of a board meeting to the council of governors before they hold the meeting, and to send the minutes to the council as soon as is practicable afterwards. That is a welcome legislative change as a way of trying to provide more information for governors. As I have said, that is extremely important because it is not possible to hold the board of directors properly to account without the information that is needed to scrutinise its work. However, as the Foundation Trust Governors Association says in its written evidence to the Committee, it is

“unclear how this information will be shared with governors if Board of Directors’ meetings are held in private as in many trusts this sort of information is not shared on the grounds of confidentiality.”

The amendment would ensure that the board of directors meets in public.

The Foundation Trust Governors Association understands that there will be confidential and sensitive matters that will need to be discussed by the board of directors in closed sessions, but the association believes that that could be addressed by splitting board meetings into a part 1 and part 2 arrangement. In part 1, the board of directors would meet in public, and part 2 would be held in private. The scope of the part 2 meetings would need to be carefully assessed to ensure its appropriateness and foundation trusts would need to establish a process for reassuring their governors that the items in the private, part 2 sessions really need to be there and to provide an outline of why they are there.

The Foundation Trust Governors Association believes that that could be done through the work of the lead governor and says:

“it is important for the probity and local accountability of the FT that the Part I of the meeting is clearly the discussion and decision-making forum for the Board of Directors... If FTs are to fulfill their remit of being accountable to their communities rather than Whitehall, public scrutiny of the Board of Directors’ meeting is essential.”

The association cites the Local Government Act 1972 as a precedent, and states in its memorandum to the Committee that section 100 of that Act says:

“A meeting of a principal council shall be open to the public except to the extent that they are excluded”

under an arrangement similar to a part 1 and part 2 meeting. The majority of the association’s approximately 3,000 members agree with that, and feel that without access to their directors’ public meetings, they cannot properly discharge their duties.

2.45 pm

Paul Burstow: Again, we share the intention behind the amendment, which flows logically from some of the findings and recommendations of the Francis inquiry in that we need to foster a culture of openness and a general belief in the practice of transparency in FTs’ operations. My concern about the amendment is that its approach is to add to the Bill a provision about having meetings in public. The hon. Lady referred to the equivalent situation in local authorities. I will refer directly to Mid Staffordshire by way of example.

Starting with the local authority context, I do not know how many colleagues on the Committee have served in local authorities over the years, but those who have and have been members of majority groups will
know that those groups often have meetings before a public meeting in which they discuss the business and come to a collective view on how to proceed. That is a part of local authority practice that goes back many years. They then discharge the formal part of their business in a committee. A concern that emerged during the Francis inquiry and led to its recommendation 8 echoes that: the inquiry report highlighted the lack of openness in the Mid Staffordshire NHS Trust as a contributing factor to a culture there that was not conducive to providing good patient care. However, that lack of openness predated Mid Staffordshire becoming a foundation trust.

At the moment, foundation trusts are not under a statutory obligation to meet in public. In the past eight years and on the three occasions when health legislation has been before the House, Governments have not taken the view that there is a need to open up the committees of foundation trust boards in that way, so the hon. Lady’s proposal is novel. It is important to bear in mind that the Mid Staffordshire organisation was an NHS trust, and although such trusts are under a statutory duty to meet in public, discussions and meetings there took place in private so, in that sense, the statute does not give the comfort that the hon. Lady seeks. We have to find other ways really to ensure that governors have the ability to scrutinise, call to account and do everything we discussed under clause 136.

Emily Thornberry: I am interested to hear the Minister’s argument about why bodies that make important decisions on behalf of the public should not meet in public. Although there might always be canvassing in advance of meetings, just as justice needs to be seen to be done, so does proper democracy. That major decisions can be made behind closed doors when there is no reason to do so is an odd position for the Minister to argue, given his party’s history and its commitment to local democracy.

Paul Burstow: I am almost stunned. The hon. Lady was, of course, a member of the previous Parliament and, therefore, would have been in the House when the 2009 legislation was considered. There would have been ample opportunity for that concern to be addressed at that time, but it was not. The view seems to have been that it was entirely appropriate for such matters to be dealt with in a way that was considered by the organisation itself to be appropriate. The point, which we discussed under clause 136, is that we want to ensure that a foundation trust’s governing document, its constitution, is the place where such issues are worked through.

On behalf of the FTGA, the hon. Member for Leicester West asked how governors would find out there is a meeting and how they could obtain the papers. Directors must send governors the agenda in advance of a meeting, and if governors are not told of any meeting, they can challenge the directors at a special general meeting. There is, therefore, a transparent route by which the material, the papers, the agenda and the minutes are sent to governors. There is no way that that would be hidden simply because directors do not meet in public.

Mr Brine: I have listened carefully to the arguments of the hon. Member for Leicester West and the Minister. Although the Bill does not state that directors must meet in public, does he agree that it does not state that they must not?

Paul Burstow: Most certainly it does not. It is permissive: it allows the foundation trust to organise its governance arrangements in the way provided for in the Bill.

Mr Brine: The Minister may not be able to answer this, but is it his experience that existing foundation trusts, on the whole, do so?

Paul Burstow: The practice varies. There are foundation trusts that meet in public and there are foundation trusts that do not. The Bill makes it much more in the purview of governors to challenge and debate such issues with their director colleagues and, if necessary, call directors to account on them, too. The Bill moves the arrangements significantly in the right direction toward a framework that is much more transparent and accountable than the one we have inherited.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): Does the Minister agree that there are certain issues, perhaps to do with commercial sensitivity or staffing, that may require a certain amount of confidentiality, at least at some stages of discussion, and that flexibility is needed on whether meetings are held in public or in private; but that overall we are moving towards much greater transparency and, ultimately, there is transparency at the end of all of the processes?

Paul Burstow: Yes. That was a perfectly formed question, and I am happy to give a clear, straightforward yes in answer. Those are the reasons we do not think the amendment is necessary. We believe the changes we are making to the governance arrangements of foundation trusts are a significant step in the direction that all Members want to see. We should not be attempting to fetter the organisations that we want to be more autonomous, as we would by making the amendment.

Liz Kendall: I thank the Minister for his reply. I tabled the amendment because the majority of the FTGA’s 3,000 members believe that it will help them to do their job. That is not an argument that I have created from thin air—not that I create any of my arguments from thin air. It is what the FTGA’s members have said they want to help them do their job properly.

The Minister used the phrase that I am somehow seeking comfort that everything would be fine. That is not what I am doing. I absolutely believe that the way to change the culture of an organisation is through building relationships and trust and by working with common values towards a common goal, so that scrutiny is seen as helpful, not an attack. The FTGA has said that the amendment help to change the culture. Although some foundation trusts might meet in public at the moment, it does not happen everywhere.

Mr Brine: I have a lot of sympathy with the hon. Lady’s argument. I understand that the FTGA said to her that the amendment would help its members to do their jobs, but there nothing to stop them doing what the amendment states to do their jobs. I am sure that that the members of the new FT in my Winchester constituency will be putting a great deal of pressure on governors, who will also be members of the FTGA in due course, to hold their meetings in public—their Member of Parliament will certainly be doing so. There
is nothing to stop them doing what they need to do and I do not know why the FTGA is asking Parliament to, dare I say it, lead them by the hand down that path.

Liz Kendall: The hon. Gentleman makes a good point, and I am sure that governors up and down the country will make a similar point, strongly, to their trusts. In response to the point made by hon. Member

The Chair: With this it will be convenient to discuss the following: amendment 644, in clause 141, page 121, line 32, at end insert—

Liz Kendall: Amendments 643 and 644 are designed to make it clear to FTs that they need to have clear and separate accounts relating to the income derived from charges for private patients, and the income derived from NHS services. In a later clause, we will discuss removing the cap on private patient income, and I am sure that there will be a vigorous, lively discussion then. The amendments seek to place a clearer, more formal requirement on trusts for their accounts to be kept separately for the two pots of income, which is often best practice in some foundation trusts. The proposals would ensure that foundation trusts are very clear about how much money is coming in from the private sector and how much from the NHS, and clear about not allowing any subsidy between the two.

Amendment 644 would ensure separate reporting in an annual report of transactions relating to private patients and NHS patients. If the Government want a level playing field, I am sure that they would agree to the proposal.

Amendment 645 is on a different topic, so I am not sure why it has been placed in this group, but I shall speak to it anyway. It would remove subsection (3) which would give the Secretary of State the ability to determine the content of foundation trusts’ annual reports, and importantly, the power to repeal a foundation trust’s obligation to detail in its annual report the steps that it has taken to ensure that its membership is representative.

A number of questions arise. If the Government believe in the independence of foundation trusts, why does the Bill give the Secretary of State the ability to determine the content of their annual reports? It seems very peculiar that the Government want to set them free in many aspects, apart from determining the content of their annual report.

John Pugh: Regarding amendment 643, I would have thought it would be quite natural, in decent accountancy terms, for foundation trusts to give the different sources of income, although I grant that NHS accounts are not as transparent as one might wish. If the Government had this power they could—paradoxically—insist that the private and public revenue streams are separately accounted for.

Liz Kendall: Now, of course, the grouping of the amendments becomes clear. There is a series of issues here. What is the best way to require foundation trusts to have very clear accounting arrangements? Is it to give the Secretary of State a power to determine the content of the annual report that he does not have to exercise? Or is it to put the requirement clearly on the face of the Bill, as the Government say they are doing with many other aspects of their reforms? It is important that foundation trusts show that they have taken steps to ensure that their membership is representative of the people that they serve. That is a basic requirement. I would like the Minister, at the very least, to explain the anomalies in the approaches that the Government are taking on these points, and I look forward to hearing him.

Paul Burstow: I will start with amendment 643. We agree absolutely with the hon. Lady’s point that there should be separate accounts for private income. However, the amendment is not necessary to achieve our shared goal, and indeed it could prove to be ineffective or unduly restrictive. Monitor already requires separate reporting and, as we said in the Command Paper response to the consultation on the White Paper, we accept the arguments for requiring foundation trusts to produce separate accounts for their NHS and private services. We consulted, listened, understood, acted, and we are now fulfilling that in this legislation.

As hon. Members know, clause 150 repeals the private income cap for foundation trusts, who tell us that the rigid and arbitrary cap is in fact damaging the NHS. We
want to release the creativity and innovation of foundation trusts to benefit NHS patients. In short, we want foundation trusts to be able to earn additional income to improve services, like other providers. We will come on to some of the arguments about the cap when the hon. Lady speaks to her amendments on that, but when it comes to the issue of separating the two items we are at one.

Liz Kendall: I am glad that we agree on the principle. Could the Minister tell me where the Bill requires those two separate funding streams to be accountable? I may well have missed it in this large Bill, but if he could tell me where that is I would be very grateful.

Paul Burstow: In effect, we copy over the existing power that Monitor has into this legislation, and provide for it to be exercised by the Secretary of State.

Liz Kendall: I do not understand. Monitor is to lose its powers to regulate foundation trusts, so how will it ensure that they keep these separate accounts?

Paul Burstow: I was about to say that the ability to direct or issue guidance about separating accounts remains; it is who exercises it that changes. The ability to issue that direction remains within the legislative framework that we are providing. It is simply that Monitor will not be the body that exercises that in future. If the hon. Lady wishes, I can provide her with further clarification. That is the purpose. There is provision and it is maintained: it is just who exercises it that changes.

I can understand why amendment 644 was tabled. The ambition is to ensure that we have a fair playing field for providers so that we can deliver the best possible results for patients in terms of services. While the ethos and the values of foundation trusts provide a powerful protection for NHS services, I want also to see clear reporting on private income and to ensure that foundation trusts can be held to account. Amending clause 141 would not have the intended effect of increasing transparency about the impact of private patient work on the NHS.

The first part of amendment 644 would require the annual report to duplicate information contained in the annual accounts; the accounts and report are published together so that is unnecessary. As I have said, clauses 139 and 140 will allow requirements on separate accounting for NHS and private income to continue and we are committed to ensuring that that happens. This information would be available to foundation trust governors and our proposals to strengthen the role of governors would give them the power to take steps if private income was not helping the trust to fulfil its principal purpose. I will later highlight some of the benefits of that.

The second part of amendment 644 is unnecessary and again, due to the precise definition, potentially unhelpful and restrictive. Foundation trusts are likely to want to use the opportunity of their annual report to explain the role played by any private income, but we do not dictate that or set out the details in the Bill. As I have said, the principal purpose of a foundation trust is already set out in primary legislation. It is to provide goods and services to the NHS in England. The governors’ role, therefore, is to hold the board of directors to account for its performance and that is being made more explicit. The board’s role will be clearly defined as promoting the success of the organisation in the interests of its members and the public. So governors should hold the board of directors to account for fulfilling their principal purpose.

It is right that the Secretary of State should not have any kind of operational control over foundation trusts. That is a view that has developed in policy terms over a number of years. Such interference would run entirely counter to the purpose of our reforms on the provider side. Our reforms give foundation trusts greater autonomy so that they are free to focus on improving outcomes and being more responsive to patients and to innovate. Before I say why amendment 645 is not needed, let me briefly explain the important role of annual reports. Annual reports will be increasingly important as a way of providing summary information to governors and to the public about foundation trusts. It is important that in the short term the contents of annual reports are able to evolve and develop so that they can be of most use to governors of foundation trusts and the public.

Amendment 645 misunderstands the purpose of a provision in clause 141. The Secretary of State would only take on the power to determine the contents of foundation trusts’ annual reports if and when greater certainty about them could be provided by setting them out in secondary legislation. That is the point. It is only at the point that we think there is clarity and certainty and we have a perfect annual report that such a power would be taken. Then it would be dealt with through the processes of secondary legislation. Our intention is that this power for the Secretary of State would not be commenced immediately or, indeed, in the near future. For the moment we think that Monitor’s role in specifying the content requirements of foundation trusts’ annual reports is very important. It helps to ensure that the annual report can continue to become ever more useful to governors and the public. The powers proposed for the Secretary of State could not be used arbitrarily to impose operational controls on foundation trusts. For those reasons I hope that the hon. Lady has been reassured and will withdraw her amendment. If not, I will urge my colleagues to resist them.

Liz Kendall: I am grateful to the Minister for his reply. There was one bit of it that I did not understand. Would he therefore write to me to clarify that the Secretary of State has the power to require foundation trusts to keep those separate accounting streams? I raise that because any foundation trust that does not, could be subject to challenge from competitors in the independent sector, who may think that they are not facing a fair playing field, if a foundation trust is using its private patient money to subsidise its NHS services. That is a real risk. Having very clear accounts that show that there is not that cross-subsidy would be important to protect those FTs.

Paul Burstow: Perhaps I can save the ink on a letter, and give the answer now. Monitor currently has the power to require that clear separation. With the Bill, we are repealing Monitor’s role in that regard. That responsibility will come back and sit with the Secretary of State. The assurance that I have given the hon. Lady
and the Committee is that we intend to exercise that power in the same way, so as to ensure that accounting of private income is separate from that of the taxpayer.

**Liz Kendall:** I would urge that requirement to be used possibly more than Monitor has done. I am not sure that every FT always does that. If there is a suggestion of cross-subsidy between private and public, FTs could open themselves to challenge from the private sector. I would urge the Secretary of State to use that power more often than Monitor has in the past. On that point, I beg to ask leave to withdraw the amendment.  

*Amendment, by leave, withdrawn.*

**Dan Byles:** On a point of order, Mr Hancock. I do not think you were in the Chair at an earlier sitting when concern was expressed as to whether tweeting and the use of iPads were allowed. The Committee might be interested to know that an hour ago, the Procedure Committee announced that iPads are allowed and that tweeting is permitted from the Chamber, provided it is done with decorum.

**The Chair:** Order. Unfortunately, the decisions of the Procedure Committee only have effect if they have been endorsed by the whole House. Until they have, nothing changes.

**Derek Twigg:** Further to that point of order, Mr Hancock. The Minister might want to make quite a lot of tweets about what his leader has just said on a microphone. There might be quite a lot of tweeting at the moment, given what has just come over the wires regarding what the leader of the Liberal Democrats and Deputy Prime Minister has said that was picked up by a microphone.

**The Chair:** We all eagerly await that.

**Emily Thornberry:** Further to that point of order, Mr Hancock. I am concerned about a possible misunderstanding about the use of hand-held mobile phones. I cannot quote chapter and verse, although I am prepared to look it up, but I am sure that the rules have been changed so that mobiles can be used. I gave evidence and that was the effect of it. I remember speaking to the Speaker who said he would change the rules.

**The Chair:** I read with interest the comments made by the Chair on Tuesday. That seemed to be a fractious meeting for some reason. The situation is clear: you can use them but they are not to be used as aid during the presentation of a speech. That is quite clear. I personally use them but they are not to be used as aid during the meeting for some reason. The situation is clear: you can leave out from ‘paragraph’ to end of line 33 and insert ‘in paragraph (b)—

(a) omit “once it has done so.”, and (b) at the end insert “within such period as the regulator may direct.”.—(Paul Burstow.)

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

3.15 pm  

**Liz Kendall:** I have an important point regarding clause 139, which makes changes to the accounting requirements of foundation trusts. As the explanatory note outlines, from 2011-12—the financial year starting in two weeks’ time—foundation trust accounts will move within the Department’s accounting boundary...and will be fully consolidated into the Department’s resource account.”

It continues:  

“As the Department must produce its accounts in accordance with HM Treasury guidance...foundation trust accounts would also continue to be consistent with HM Treasury accounting guidance.”

As a result,  

“the requirement for foundation trusts to lay accounts before Parliament independently” will be removed, and  

“the route of accountability for the spending of these organisations will be through the Department’s resource account.”

**Paul Burstow:** The group of Government amendments that we moved earlier reinstate the duty of foundation trusts to lay a copy of their accounts, and any auditor’s report, before Parliament.

**Liz Kendall:** I thank the Minister for that, but I want to make a point on the bigger issue of accountability to Parliament for the spending of public money. I want to alert hon. Members to the fact that there is still a degree of confusion around how Parliament will, in the phrase often used by the Public Accounts Committee, “follow the pound.” I refer hon. Members to the meetings of that Committee on Tuesday 18 January and Tuesday 25 January, when evidence was given by David Nicholson, the chief executive of the NHS and future chief executive of the NHS commissioning board, and Una O’Brien, the permanent secretary at the Department of Health.

On Tuesday 18 January, the Chair of the Public Accounts Committee, my right hon. Friend the Member for Barking (Margaret Hodge), asked Sir David:  

“So in the new world, when they’re all foundation trusts, where will the buck stop?”

He replied:  

“The buck stops in the foundation trust.”

On Tuesday 25 January, when asked to clarify again the accountability for finances in the new world, David Nicholson said:  

“Well, I’ll be accountable for the totality of the commissioning spend.”

Una O’Brien said:  

“I have...overall stewardship of resources voted by Parliament to the Department of Health.”

The Chair then asked:  

“Where does the buck stop?”

Una O’Brien replied:  

“It absolutely stops in the Department.”

As a member of that Committee said, this is all a bit confusing. I want to ask the Minister who is responsible for taxpayers’ money, so that Members of Parliament...
can hold them to account for the money that we vote for the NHS to spend. Are FTs responsible, or is it the NHS commissioning board, or the Department of Health?

Paul Burstow: Perhaps I can start by setting out what the clause is about. Following the changes in the Constitutional Reform and Governance Act 2010, foundation trusts will move to within the Department’s accounting boundary under the cross-Government clear line of sight initiative, so that it is easier for Parliament to understand Government accounts. The clear line of sight initiative requires that foundation trusts’ annual accounts are consolidated into the Department of Health’s accounts from 2011-12. The Department needs, therefore, to be able to specify the form, content and timing of foundation trust accounts. We have discussed some of that already.

The direct answer to the hon. Lady’s question about who accounts for the use of public money is, as we indicated in discussion on the amendments that we moved earlier, that foundation trusts will continue to be responsible for laying their own accounts before Parliament. Their accounting officers, therefore, will be accountable for those accounts. The NHS as a whole, through the NHS commissioning board and its accountable officer, will be accountable for the moneys for which it is directly responsible and for which it accounts to the Department. The Department will be responsible, with its accounting officer, for accounting for the consolidated accounts. I hope that that has answered the hon. Lady’s question; it is the most direct answer, I hope, that she has had for a while—[Interruption.] Sorry, I did not mean that. I withdraw that unreservedly, and I have said so on microphone, Mr Hancock. That was a regrettable comment; I meant from me, of course, not from any of my right hon., or hon. Friends in this Committee.

I hope that the hon. Lady has the answer that she wanted. I will not read out the rest of the script, because I do not want to delay the Committee.

Mr Barron: I do not want to delay the Committee, but I thought that I ought to try to ensure that we clarify the intention of clause 143 regarding the

“Power to make provision about voting”.

The explanatory notes for clause 143 state:

“This clause inserts a new paragraph into Schedule 7 to the NHS Act. This would give the Secretary of State, in light of new decision-making powers for foundation trusts in subsequent clauses, a regulation-making power to alter the associated voting arrangements for directors, governors and members of foundation trusts provided for in this Bill.”

Two examples are then given:

“the Secretary of State could, for example, change the size of a majority required for approving mergers or for making changes to the constitution of a foundation trust, or specify that such a majority should be of those eligible to vote as opposed to those actually voting.”

That seems pretty clear on the face of it, but the powers could presumably ensure the opposite of what is suggested in those two examples. I am not saying that that is the case, and I do not want to scaremonger in any way, but we ought to give the Secretary of State such powers only if we really deem it necessary.

I want to draw the Committee’s attention to clause 153, which would be affected by clause 143. Clause 153(2) states quite clearly:

“An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant.”

I do not know exactly what that means, because we are giving massive powers to the Secretary of State to move the majority around, which may be very necessary in mergers and acquisitions—I would probably argue that that is the case; maybe two thirds ought to be able to take such decisions—but we are saying in the Bill that it has got to be a majority. Will the Minister tell us exactly where the power lies: in regulation or in what is in the Bill? I hope that he can clear this matter up. If he does not, it seems to me that if we take the wording in the Bill, which states that it is a simple majority—not even of those in attendance, according to the explanatory note—at least we know where we stand. If regulation can ride roughshod over the simple majority mentioned in clause 153, maybe we should not give the Secretary of State the power under clause 143 to determine the matter by regulation.

We have been talking most of the afternoon about foundation trusts: their shape, who should be on them, what powers they should have. The Government consistently talk about the localism of decisions in the Bill, but they are leaving powers in the clause for the Secretary of State to bring in by regulation something—we know not what—that will affect mergers, acquisitions, separations and dissolutions. I hope that the Minister can reassure the Committee. The power that we are about to give the Secretary of State could ride roughshod over what many of us thought was to be the real decision making in our health service, done by GP consortia and the local trust delivering the services.

Paul Burstow: I hope that I can give the right hon. Gentleman all the reassurance he seeks. He has perfectly described what we intend to do—that is, to create increasingly independent organisations, able to focus on the interests of their patients and the public and deliver ever better services.

It is worth saying that the regulations in the clause are given effect only by affirmative order, open to a lot of scrutiny by the House. The clause enables the Secretary of State for Health to amend the new voting arrangements—just the new voting arrangements—provided for in the Bill. That is to ensure that the arrangements could be modified if necessary in the light of how they are working in practice. Part 4 introduces a range of new voting arrangements for members, governors and directors of foundation trusts. Those arrangements are important measures to strengthen,
quite rightly, the internal governance and to place genuine responsibility on foundation trusts to enable them to become more autonomous and accountable to their local population. I will get to the point, but I think it important to develop the argument first, if the right hon. Gentleman will forgive me.

The Bill would allow a foundation trust to change its constitution if a majority of the governors and directors voted to approve the amendment. Governors would have the power to approve mergers, acquisitions and separations on a majority vote. Members could approve certain constitutional amendments on a majority vote. The power in the clause will enable the Secretary of State to modify the provisions if necessary. For example, he could make regulations changing the size of the majority needed to change the constitution from a simple majority to a two-thirds majority—I think the right hon. Gentleman suggested that might be in order—or he could require a majority to be a majority of all those entitled to vote, as opposed to a majority of those actually voting.

We are confident from our discussions with stakeholders that the voting arrangements we have provided for in the Bill are robust and would prove effective in practice. They strike a balance between the appropriate accountability and not having unnecessary bureaucracy that could impede the organisation's operational effectiveness. We do not, therefore, expect to use the power. However, it is prudent to ensure the necessary changes could be made to respond to unforeseen or exceptional circumstances. In order to ensure proper parliamentary scrutiny, these matters will be dealt with by an affirmative resolution of both Houses of Parliament. I hope I have reassured the right hon. Gentleman that the provisions are necessary.

Mr Barron: Nice try, but as the Minister just pointed out, it is the Secretary of State to whom we are giving the power to alter the voting patterns, not foundation trusts. The Secretary of State will have the power to bring regulations to direct foundation trusts on what they can and cannot do. The Minister has not answered my question. Clause 153, which will be affected by clause 143, refers to a majority, not even the majority in attendance. What takes precedence: something in the Bill, or the voting patterns the Bill provides for in the Bill?

Paul Burstow: Clearly, unless the Secretary of State, on the basis of advice and in the exceptional circumstances I just referred to, believes there is a need to amend the arrangements using the power in clause 143, of course clause 153, which sets out the requirement of a simple majority, would be the operative clause in the future.

Mr Barron: So it could be that foundation trusts, under clause 153, need a simple majority for mergers, acquisitions, dissolutions or separations. On that basis, I am unhappy about giving the power to the Secretary of State. I just do not know where it goes. If the Bill requires a simple majority, why are we giving the Secretary of State the power to alter that? Presumably he cannot alter it, and I am misinterpreting what the Minister has said.

Paul Burstow: I have just given examples of where the Secretary of State might determine that the majority should shift upwards, in light of experience and the representations he might receive at some point in future on how the provisions we will go on to discuss are working, in terms of votes on mergers, acquisitions and separations. That is what the clause will provide for. FTs will be able to specify higher voting thresholds when framing and approving their constitution if they wish to do so; the Bill provides for the minimum amounts.

Mr Barron: I thought the Minister said that what is in the Bill will take precedence, and if there is a simple majority, as stated in clause 153, it cannot be overridden by regulation.

Paul Burstow: The Bill provides, if one likes, the de minimis; a foundation trust, when framing its constitution, could go further. That is the point I made to the right hon. Gentleman.

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

The Committee divided: Ayes 12, Noes 9.

Division No. 85]

AYES

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

NOES

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

Question accordingly agreed to.

Clause 143 ordered to stand part of the Bill.

Clauses 144 to 147 ordered to stand part of the Bill.

Clause 148

Financial powers etc.

Amendment made: 525, in clause 148, page 126, line 20, after 'capital' insert

'(a) in subsection (2), at the end insert "; and the reference to section 40 is a reference to that section as it had effect until the commencement of section 148(2) of the Health and Social Care Act 2011 (which repealed subsection (2) of that section)";

(b) ―'(Paul Burstow.)

Derek Twigg: I beg to move amendment 623, in clause 148, page 126, line 20, after 'capital' insert

'—

(A) in subsection (2), at the end insert "; and the reference to section 40 is a reference to that section as it had effect until the commencement of section 148(2) of the Health and Social Care Act 2011 (which repealed subsection (2) of that section)"; and

(b) ―'(Paul Burstow.)

I am conscious of the time. Obviously, we want to spend some time on some of our amendments, but I will move through them as fast as I can. The clause deletes a safeguard that was included in Labour's National Health Service Act 2006. Under the existing legislation, foundation
trusts are authorised by the regulator. That authorisation directs some of the particular services that a foundation trust will supply as part of the existing planned and integrated health care service. The authorisation, which is an important part of our legislation, also designates certain trust property as protected on the grounds that it is necessary to provide services for which the foundation trust is authorised. That property might, for example, be a hospital building or specialist health facility.

The Bill sweeps away the wider system of authorisation by making all NHS secondary providers foundation trusts and removing the need for authorisation to include specifications of particular services that must be provided. Instead, foundation trusts may provide whatever services are economically viable in the new health care market. Presumably the Government will say that the provision is part of removing the wider system of authorisation.

Under the 2006 Act, the foundation trust could not dispose of any property designated as protected in its authorisation without the permission of the regulator. That measure is a safeguard against, for example, a foundation trust selling off vital assets—which, after all, have been paid for by the public purse to provide public services—to plug short-term deficits or create a surplus. The measure acts as a disincentive for borrowing irresponsibly against publicly owned assets. It is one of a number of asset locks designed to ensure that public or community assets remain in public or community ownership for the use of the wider public.

Unfortunately, that does not seem to be accepted by the Government, who have created numerous ways in the Bill—and in other policy areas for that matter—in which public or community-held assets and services may soon end up being owned and run by private companies, as we discussed this morning. That is driven by profit rather than the public interest, or in this case the interest of the national health service. The wider system of authorisation may have been swept away, but retaining the measure would at least provide a safeguard for foundation trusts that have protected property.

Paul Burstow: I understand why the Opposition have raised the point—we all want to be confident that patients’, taxpayers’ and public interests in foundation trust properties are protected. I hope to reassure the hon. Gentleman that the amendment is unnecessary because there are already strong safeguards built into the new regime that the Bill creates.

Monitor’s new economic licensing regime will ensure that property needed for the delivery of essential NHS services designated for additional regulation will be protected. Clause 69 sets out the Government’s proposals for the designation of services—I recall that we spent a significant amount of time on Tuesday analysing that clause. Monitor will be able to use its licensing powers to protect assets for services that commissioners regard as essential to the delivery of NHS services. The licensing regime will protect patients more effectively than the current legislation. Monitor can protect the property needed for the delivery of essential services by all providers, including foundation trusts, charities—this comes back to the point made by my hon. Friend the Member for Southport—and others in the independent sector. The protection can include Monitor’s approval being required for the disposal of property needed for the provision of essential NHS services.

We also want to protect taxpayers’ investment in foundation trusts in a much more transparent way than has been the case until now. The previous Government gave foundation trusts the freedom to sell their assets—I stress that point. We want to be sure that property sales do not lessen the value of that investment—the interest that we, the taxpayer, have. We propose to create an operationally independent investment management function to protect the taxpayer’s investment. That function will manage the taxpayer’s investment in foundation trusts and clause 148(7) will give it powers that it can use if necessary to prevent a foundation trust from disposing of property.

We are also increasing the local oversight of foundation trusts by legislating to ensure that, for the first time, governors can have a role in approving significant transactions. That would increase public scrutiny and accountability and ensure that transactions have local support. For those reasons, the amendment is unnecessary.

The Bill provides for more explicit and transparent safeguards than those in the legislation passed under the previous Government. There will be strong safeguards in the system that will ensure that the property needed for the delivery of essential services is protected, irrespective of the provider. There will also be strong safeguards to protect the taxpayer’s investment in foundation trusts. Finally, governors will need to be satisfied that significant transactions are in the best interests of their local population. I therefore ask the hon. Gentleman to consider withdrawing the amendment. If he chooses not to, I urge my colleagues to resist it.

Derek Twigg: The difference between this Government and the previous Government is that we are moving towards a market-oriented health service, where competition will be king and profit will have an increasing role to play, not just with private providers but with NHS commissioners, who will need to ensure their viability. That is why I tabled the amendment, but I beg to ask leave to withdraw it.

Amendment, by leave, withdrawn.

Clause 148, as amended, ordered to stand part of the Bill.

Clause 149 ordered to stand part of the Bill.

Clause 150

PRIVATE HEALTH CARE

Derek Twigg: I beg to move amendment 624, in clause 150, page 128, leave out line 20.

Mr Hancock, for the avoidance of any misunderstanding, we want a short clause stand part debate to explore wider policy issues, so I will try to keep my comments to the detail of the amendment and widen them later on.

The clause greatly worries the Opposition. The investment that the Labour Government put in, the massive reduction in waiting lists and the improvement in waiting times that the previous Government is that we are moving towards a market-oriented health service, where competition will be king and profit will have an increasing role to play, not just with private providers but with NHS commissioners, who will need to ensure their viability. That is why I tabled the amendment, but I beg to ask leave to withdraw it.

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We believe it is wrong to lift the private patient cap. The organisations that became foundation trusts are NHS organisations—they have NHS buildings, NHS equipment and NHS-trained staff. Their principal purpose, which the Bill does not repeal, is to provide services for NHS patients. Removing the private patient income cap would lead foundation trusts to change from being NHS organisations that treat some private patients to being the same as a private provider that can also treat NHS patients. That is a key part of our argument: what the Government propose would change the nature of foundation trusts in terms of the number of private patients they treat. That is not what patients or the public want; it is unwise and unnecessary and the Government have no mandate to make such a fundamental change. That is not what any of my constituents voted for—nor yours, I am sure, Mr Hancock.

If the Government presented a cohesive argument for the remedy of anomalies and inconsistencies within the system, we would of course give it our full consideration, but that is not what the clause does. Instead, it makes a wholesale change to the system that Labour introduced. Removing the cap would fundamentally, and perhaps fatally, alter the fabric of the NHS. If the Government truly wished to explore the possibility, they should have at least conducted widespread consultation, first nationally on the principal, and then in every locality where a change is proposed. I am quite sure that local people in areas with foundation trusts would have a very strong view on what the Government are proposing in one line of the clause. The policy, set out in just one line, would make a massive, fundamental change.

If the patient cap was removed, the door would be open for a foundation trust to generate as much income as possible from private patients. When budgets become tight, as they undoubtedly will given the policies and cuts that we will see from the Government and the cost of the reforms, foundation trusts will be encouraged to increase income generation as soon as they become more dependent on private patients. As opposed to being an additional source of income for foundation trusts, that could become the lifeblood of some, particularly when the impact of competition is felt and if the Government give help to private providers to deal with “distortions in the market” as laid out in the impact assessment.

Additionally, elsewhere in the Bill we see the role of European Union competition law. The impact on foundation trusts, whose services will increasingly fall under those rules, must not be underestimated. In the Select Committee on Health sitting on Tuesday, I understand that the Secretary of State was at best unsure how EU law could impact on the NHS. If so, our concern is even more pressing. Without a cap, the nature of foundation trusts begins to shift, and they change from being predominantly NHS providers to being something else. A key part of our argument is that without a cap, they become more like undertakings, which implies that EU procurement law will penetrate far further into the system.

Paul Burstow: Will the hon. Gentleman indicate, for the benefit of the Committee, what percentage of private income might turn FTs into undertakings?

Derek Twigg: Let me put the question to the Minister this way—

Mr Burns: Answer the question.

Derek Twigg: No, this is important. If the Minister can give us evidence that his proposals will not lead to the situation I have just described, I will sit down and listen to what he has to say. The point is that there is no useful information or detail. The obvious logic is that the proportion will continue to creep up, and as the Minister said, as time goes by, EU and UK competition law will become more applicable to the health service in this country—[Interruption.]

The Chair: Order. I do not think it is for Ministers to ask colleagues who are not in government questions. It should be vice versa.

Derek Twigg: I take your ruling, Mr Hancock. What the Minister has not done during the debate—

Paul Burstow: On a point of order, Mr Hancock. I want to be absolutely clear on your ruling. When Members speak to amendments, is it not in order to ask them questions that might help us to interpret and understand the amendment’s purpose?

The Chair: Anything is in order if it helps the flow of the debate. I think, however, that it is a little invidious for you to ask a question and then, when a Member chooses not to answer it, to go on about it with your colleague while the Member is still trying to make a point. You would not like it, I do not like it, and I am sure that nobody else likes it.

Derek Twigg: Thank you, Mr Hancock. Given what the Minister has said, it would have been helpful if he and his fellow Minister of State had also taken that view on the many occasions when we have asked for detail to allow us to consider the implications of their policies. Given that they keep telling us that that information is not available, such comments are a bit rich coming from a Minister.

I look forward to hearing the Minister’s account of the Government’s logic, details of why they are proposing the change, and information on whether the health service will become susceptible to EU law to a greater extent. That is the key point. There is massive concern about that. There are many reasons why my colleagues and I will vote against the proposals if the Minister cannot convince us, and I doubt that he can.

Owen Smith: I offer my hon. Friend my full support for the amendment. The clause is an important part of the Bill, because lifting the cap clearly risks changing the ethos underpinning NHS trusts. They have traditionally been not-for-profit bodies that are not concerned about the bottom line and making money. There is a clear risk that if that cap is removed, the temptation—or necessity in times of economic constraints—might be to look for activities that the trust can perform that are revenue generating, but are perhaps not in the best interests of patients. That may not happen—trusts may not pursue such avenues—but the change raises the possibility that it could be a real temptation, and if it is, it could negatively change the priorities of NHS trusts.
I have one simple question for the Minister. Have the Government, in considering the impact of the change, conducted any sort of assessment or review that gives them evidence of what proportion of the revenues received by NHS trusts in future might be derived from private patients or private activities in public hospitals? If he has not undertaken that analysis and so cannot provide us with some insight into what he thinks the level is likely to be, he should have done.

Paul Burstow: I will start with the point that the hon. Member for Halton started with. According to the Opposition’s emerging narrative, competition will apply to the NHS once the Bill becomes an Act. That is nonsense. The Bill does not apply competition for the first time. Competition has increasingly been applied over many years. Many of the actions, policies and Acts of the previous Government made it more applicable.

Derek Twigg: From what point will competition increasingly apply?

Paul Burstow: The point I have just made, and the hon. Gentleman should read Hansard, is that competition already applies: it has applied in the past; it will apply in future; and under previous Labour Governments it became increasingly applicable. That is apparent in their recognition that the Co-operation and Competition Panel, to which my hon. Friend the Member for Southport has referred, was needed; independent treatment centres; the extensive use of the private finance initiative, and many other examples.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): I wonder whether the Minister has read the article that states that, “to challenge a primary care trust’s decision to restrict the volume of services under the commercial contracts for NHS elective surgery.”

Paul Burstow: The point is that competition law already applies. I need to be careful, Mr Hancock, because I am having a clause stand part debate on a clause that we have already debated, but I want to deal with the initial point raised by the hon. Member for Halton. We reject his narrative: the Bill is not intended to do what he has described.

As for the questions posed by the hon. Member for Pontypridd, he has invited me to walk into a hall of mirrors, with all the distortions one would find there, in the way he has described the Bill. He said that this is such an important change that it surely would necessitate public consultation. The Government agree with him, which is why we consulted in the White Paper. We asked the question and we published the responses from many organisations under the heading “Freedom to earn private income” on page 119 of the Command Paper. To quote one of the respondents, the Royal College of Psychiatrists “argued that mental health FTs need flexibility to provide social care and other health-related services, and that ‘capping [private] income...limits the scope for [Mental Health] FTs to be innovative, entrepreneurial, and address breadth and quality of care in partnerships with others’.”

The college was one of many organisations that responded to say that lifting the cap was necessary, which is why the Bill does that.

We know that the proposal to repeal the private patient income cap has provoked strong views, which have been voiced in Committee. Some people are concerned that foundation trusts would stray from their fundamental NHS purpose, but that concern is misplaced. What we want for NHS patients is the best possible care from the best possible providers. To achieve that, foundation trusts have told us that they must be freed from unnecessary constraints, including the private patient cap.

Removing the cap is about allowing foundation trusts to earn more income to improve, expand or support NHS services. If foundation trusts are to innovate and to drive sustainable improvements in outcomes and efficiency for the NHS they must be free from an outdated, unnecessary and blunt legal instrument that locks them into maintaining income from private charges at arbitrary historical levels.

Under the current arrangements, several NHS trusts have been dissuaded from going into the pipeline to become foundation trusts because of the constraints of the cap, which is an historical cap, imposed at one point in time. For example, Great Ormond Street hospital has private income today of 7.8%; Imperial College Healthcare NHS Trust—4.6%; and the Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust, 4%—the list goes on. There are many NHS organisations that, unencumbered by the cap imposed on foundation trusts, are generating private income, which they are reinvesting into their NHS purpose for the benefit of NHS patients.

I will give one other example of a foundation trust where that frankly bogus argument is exploded completely. The Royal Marsden earns the most income from private patients: it has the highest private patient income cap in the country, fixed at nearly 31% of its total patient income, yet that trust has been consistently rated by the Care Quality Commission and its predecessor bodies as a top-performing NHS provider. It has not strayed from its NHS purpose. It has used that money to deliver better results for NHS patients, which is what our proposal is fundamentally about.

The reasons for removing the cap are compelling. First, the rule is unfair, with a few foundation trusts having much higher caps and hence much more flexibility than the majority. Indeed, all foundation trusts are constrained compared with NHS trusts, which do not have a cap on private income in the first place. Secondly, the cap is detrimental to NHS patients because a substantial and growing part of the NHS provider family is hampered from bringing in additional funding to support their core NHS work. That includes some of our internationally respected providers, which wish to generate overseas earnings.

Thirdly, the cap’s legal definition is highly restrictive and, frankly, absurd. It includes not only treating private patients, but joint ventures and activities such as sales of technological developments and drugs to private health care providers. Foundation trusts have said that the position is highly undesirable as they cannot widen services to the NHS through innovative partnerships with other providers. Fourthly, we do not want foundation trusts to be at a disadvantage relative to other providers to which no such restriction applies.
Let me try to reassure the Committee about the robust safeguards that will ensure that foundation trusts protect and prioritise investment in NHS care and resources. In essence, that is the concern that Opposition Members have about the provision. First, NHS commissioning consortia and the commissioning board will be responsible for ensuring that NHS patients are offered prompt and high-quality care and that good use is made of NHS resources, whoever provides care, through robust contracts and arrangements.

Secondly, the principal legal purpose of a foundation trust is and would remain the provision of goods and services to the NHS. The Bill will put directors under an explicit duty to promote the success of the organisation with a view to maximising benefits for its members and the public. Failure to pursue the principal purpose will mean that a foundation trust is breaking the law and would be liable to face the legal consequences. Thirdly, foundation trusts cannot distribute services externally, so all proceeds from non-NHS work will continue to be reinvested in the organisation. Fourthly, the Bill promotes greater transparency and public scrutiny of foundation trusts, strengthens their governance arrangements and introduces economic regulation.

To support public scrutiny, we will use the powers in the Bill to ensure that the accounts of foundation trusts identify NHS income and private income transparently. We discussed that issue earlier. Governors elected by the public and NHS staff will be responsible for holding directors to account on their duty to promote the success of the organisation with a view to maximising benefits for members and the public. They will have new powers to help them to do that, and they will retain the ultimate power to remove the chair and the non-executive directors.

For all of those reasons, and for the simple fact that Monitor, as the economic regulator, has a duty to promote and protect the patient interest, I hope that Members are reassured and that we can lift the cap so that the improvements to public services can continue along the lines that many foundation trusts have said are necessary.

4 pm

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

**The Committee divided:** Ayes 9, Noes 12.

**Division No. 86**

AYES

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**Amendment made:** 526, in clause 150, page 128, line 25, at end insert—

‘( ) In consequence of subsection (1)(b) and (c), omit section 33 of the Health Act 2009.’.—(Paul Burstow.)

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

**Derek Twigg:** Let me first take the consultation issue raised by the Minister. He might want to tell us when that consultation took place.

**Paul Burstow:** The consultation was on the White Paper, which was published in July last year. It concluded in October and the results were published in the Command Paper in December.

**Derek Twigg:** We know the Bill was published much later.

**Mr Burns:** Obviously.

**Derek Twigg:** That is the point, if the Minister would wait for a minute. I remember the Government saying that all those people agree in principle with the Bill; when the Bill was published, however, they all suddenly melted away—and then lots of concerns and issues were raised, including this one. That is the difference.

People now understand what the Bill is about and what it is going to do, through, even to the extent that the Government have got into trouble over their pricing, competition and designation policy. People did not know the consequences. It is against that same background that they are making this change. They are pressing for competition. There will be more competition. I keep repeating that the Minister of State said that the laws will increasingly be applicable to the NHS. So there will be more competition. That is being done differently from how we did it. We did it in a controlled way for particular purposes. The Government eventually want unfettered competition in the NHS. That is what they want.

We can look at some of the detail and refer to the impact assessment—page 61, paragraph B153:

“In removing the PPI cap, it is assumed that FTs wishing to generate additional private sector income can do so from three different sources:

• existing independent sector private patients (privately insured or pay-as-you-go)
• additional non-EEA overseas private patients (whom otherwise would not have been able to be treated in England due to the caps);

That is the one through which they propose significantly to extend the number of overseas patients who can be treated in the NHS. It is interesting that the policy is to try to stop the number of overseas students coming to this country given that now the Government want to increase significantly the number of non-EEA private patients coming from abroad. I do not know where that leaves us in terms of capacity. The impact assessment also states:

“patients who would have otherwise been treated on the NHS but for whom reduced private prices (due to increased competition) now makes private treatment just affordable.”

That is in the Government’s own words. They said before that there would not be more competition—that we were making that up. In brackets they have put “due
to increased competition”, and they say it makes private treatment “just affordable”. That is the difference—in their own words in their own impact assessment, they have been caught out.

On a wider point, we need to look at this in the context of Government funding because that will obviously impact on foundation trusts. There will be a drive to get as much income as possible when foundation trusts lose services and cannot make the income due to demographic changes. That is all because they have to look at waiting lists and times and to delay operations due to financial problems, and what I am saying is all in that context.

This week, the British Medical Association said:

“NHS cuts and the drive for competition will leave hospitals unable to fund entire departments, the Chairman of the BMA’s Consultants Committee has said.”

He went on to say that

“in order for competition to be meaningful, it must be possible and accepted that some organisations will fail…Simple to understand…but devastating in its effects upon a cash-limited health service forcibly opened up to commercial competition.”

That is where the nub lies, and how the situation differs from that of the Labour Government. We put money in to reduce waiting lists and get more people seen and treated. That is not what will happen under this Government’s proposals.

I think that top-down targets are pretty important. The Government keep telling us that they will not have them, so we believe that waiting times will go up. If they go up, it benefits the private health sector and impacts on the hospital. The Minister needs to look at that position. In terms of capacity, why would hospitals not want a vast increase in their share of the private sector in order to maintain themselves? Why would they not want to do that? How would it affect services?

A number of years ago in my constituency, we found that some consultants in my NHS trust spent more time treating private patients than NHS ones. I am not saying that necessarily would happen, but there is a risk that hospitals and foundation trusts might decide to shift the balance to maintain themselves and their stability. That would impact on the resources and facilities that we use for NHS patients. We could have private patients coming in the front door, while NHS patients queue at the back door waiting for operations. That is the concern.

I finish by reiterating the following point to try to get across to the Minister that the difference between when the Labour Government were in power and now is that the Bill promotes competition and brings in private providers to a much greater extent. The policies that the Government are pursuing today put hospitals at risk. We have already discussed the serious concerns during our deliberations on the Bill, and they come not only from the Opposition side, but from the Government side in some areas. There is significant concern among many health organisations, trade unions and representatives of doctors and nurses throughout the health service. It is not only the Opposition who have these concerns.

Mr Burns: I do have some information, but the shadow Minister might not like it. Can he confirm that when the legislation that brought in private use of the NHS was originally introduced in 2002, he supported Tony Blair and Alan Milburn’s proposals as a Minister? He changed his mind and voted in a different Lobby only when a section of the Labour party fought so hard against it that Tony Blair and Alan Milburn were forced to compromise. His view changed only because he went with the payroll to support the revised policy.

The Chair: Mr Twigg, you are probably eager give your side to rebut that, but it has no bearing on what we are discussing. What people did in the past is one thing. It might be a matter for debate, but it is not a matter for analysis this afternoon. Let us move on.

Derek Twigg: I will take your advice, Mr Hancock, but I have to say to the Minister, nice try. What is proposed is nothing like what we introduced. It is on a different scale. I will keep coming back to this: the Minister said, and it is recorded in Hansard, that competition law will increasingly apply to the NHS. The NHS will be changed for ever, and this particular proposal is part of that strategy.

Grahame M. Morris (Easington) (Lab): I want to speak against the inclusion of the clause in the Bill. Essentially, the clause removes the cap on foundation trusts providing private health care. Practically, that means that they will expand their private health business to form as big a proportion of their overall service as they wish. Ultimately, that will have a negative impact on the NHS provision of care.

NHS patients are even more likely to find themselves being second-class patients in their own hospitals. Representations from the NHS Confederation, the Royal College of Nursing, UNISON and Unite have made us aware of the pressures that the foundation trusts are facing. The trusts are already struggling to balance their books with the unilateral tariff reduction, and they will face further pressures under the new system that is set out in the Bill to trade at a profit. If they fail, they could be taken over or even closed.

Opposition Members believe that NHS patients will lose out. Private patients will occupy the beds and use the diagnostic facilities and other services. NHS waiting lists and waiting times might rise while patients will face the option of paying to jump the queue. Indeed it might create a perverse incentive deliberately to do that, cutting against even the Government’s limited concept of the NHS as a health care system provided free and allocated according to need.

The point about lifting the cap and pushing foundation trusts into the private health care market is that care will be based no longer solely on the needs of the patient but on the needs of the financial trust to make a profit and survive. My hon. Friend the Member for Halton has already described the three cases set out in paragraphs B153 to B156 of the Government’s impact assessment. They give an interesting insight into where the Government think the additional activity will come from in the private sector.

Dan Byles: Is it not the case that under the existing regime the trusts are under a legal obligation to break even? When looking at their operations in a wider sense, they have also had to have regard for their budget.
Grahame M. Morris: That is a completely reasonable point. The hon. Gentleman is correct. Under the existing arrangements, there is a cap on private work, apart from on the areas that the Minister identified—the non-FTs. I will come on to the main risks of removing the cap, not least the lengthening of waiting times and waiting lists. How do the Government intend to market such a measure to maximise the benefit?

The new arm’s-length body, NHS Global, was set up by the previous Labour Government. Its aim was to extend NHS services overseas and to play a role in international development by providing a shop front for foreign health tourists to be sold clinical services by NHS foundation trusts in the United Kingdom. Does the Minister intend to go down that particular route?

Paragraphs B154 and B156 of the impact assessment are also instructive. They acknowledge:

“The impact of any such increase in private activity on NHS patients will depend upon how near to capacity an FT is operating and whether: NHS FTs respond to the additional private patient income by creating additional capacity to treat private patients; NHS FTs simply allocate more of their existing capacity to treat private patients.”

That is quite a fundamental point. Paragraph B156 states:

“If the latter, there is a risk that private patients may be prioritised above NHS patients resulting in a growth in waiting lists and waiting times for NHS patients.”

Paul Burstow: The hon. Gentleman is reading and referring extensively to the impact assessment. Will he read on in paragraph B156? He will find that it lists all the things in this Bill that mitigate that risk.

4.15 pm

Grahame M. Morris: I acknowledge that the picture is mixed, but unless there is an increase in capacity the concept is different. Unless we plan to go out and create additional capacity within the FT, surely a choice must be made about how to use the existing capacity.

I will move on. That eventuality—the risk of longer waiting times and waiting lists—caused the previous Government to introduce the PPI cap in the first place, so as to prevent such anomalies. I acknowledge that the impact assessment goes on to present the Government’s case, and that that does not happen despite highlighting other risks that emerge as a consequence.

Dr Poulter: The hon. Gentleman paints a pessimistic picture of how foundation trusts will operate. Does he accept that the private sector takes up more of the strain and generates income for the foundation trust? That money can be pumped into patient services elsewhere.

Grahame M. Morris: I do not accept that analysis. I suspect that the private sector is essentially parasitic in taking resources, facilities and opportunities that should be dedicated to NHS patients.

Dan Byles: I am curious to know what motive the hon. Gentleman thinks an NHS foundation trust would have to invite the private sector to use its resources. If that were going to end up with more resources to spend on patients at the end of the process than it would have had at the beginning, why would it do such a thing?

Grahame M. Morris: There is a simple explanation. It is happening now with the tariff reduction of 1.5% that NHS foundation trusts are facing in the current financial year. For a big trust, that might be £20 million or £30 million. In the new world set out in the Bill, trusts will be under pressure to balance the books, just as they are currently. They were constrained by the cap that was in force, but when that lifted there was an opportunity. Would a director of finance of an FT not seize an easy opportunity to balance the books by taking more private patients? It is a simple choice and the line of least resistance.

Dr Poulter: Is that not the point? The hon. Gentleman calls the private sector “parasitic”, yet it was his Government who used the private sector in the first place. Either he likes the private sector, as the previous Government did, or he does not. Clearly, his party likes the private sector, so the point is difficult to argue. The previous Government were prepared to pay the private sector 11% more than NHS providers. Does he find that acceptable?

Grahame M. Morris: The hon. Gentleman has made that point numerous times during the passage of the Bill. The issue is one of capacity. I will move on in a moment as I do not want to drag the point out, but there are certain key areas that affect quality of life, and life-changing clinical interventions for things such as cataracts, hip and knee replacements. I am old enough to remember people waiting 18 months or longer in my locality. Through using the private sector because we did not have capacity in the NHS, we drove down the waiting times. There should be some acknowledgement of that positive move.

The issue is relevant to the discussion because of the demand for private opportunities and operations. Now that the NHS has capacity, the waiting times and demand for private health care have gone down.

Liz Kendall: Will my hon. Friend acknowledge that the private sector was brought in to treat NHS patients, free at the point of use? We are now talking about charging private sector patients, which is a very different issue, as the hon. Member for Central Suffolk and North Ipswich knows. There would be the ability to charge extra to bring in extra money to balance the books. That is the issue under discussion.

The Chair: That point has been made several times. Can we move on?

Grahame M. Morris: I appreciate that, Mr Hancock. It is extremely helpful and I am pleased that we have had the opportunity to put that on the record.

It seems that the incentive to generate new sources of income will be even stronger in the context of the market in health care created under the Bill; after all, the entire policy is predicated on that. The Department of Health’s chief executive, Sir David Nicholson, has said that the NHS constitution enshrines the 18-week waiting time as a right, so commissioners will need to give due regard to whether providers honour it. The Government are using that argument to say, “Well, although we don’t have an 18-week target, it is enshrined in the NHS constitution.” In practice, however, there is
some doubt about whether its constitution is legally binding—or, indeed, enforceable, unless the Government intend to put it on a stronger statutory footing.

Paul Burstow: To make it absolutely clear, I should say that it is our intention to use a standing rule, which the Bill provides for, to ensure that that right is real and manifest.

Grahame M. Morris: I am grateful to the Minister for that.

We know that Ministers have removed the duty for the Department of Health to pursue the targets, as part of the move away from Labour’s targets. However, I wonder whether even an 18-week limit will be effective over the next few years. I have already mentioned some of the problems with cataract, knee and hip operations; an 18-week wait is too long, given the life-changing interventions that need to be made.

The Government also suggest that patients will choose providers that treat them sooner, and that that will incentivise providers to shorten waiting lists and keep waiting times down. Again, that argument is flawed. In many parts of the country—I am thinking of the north-east and the north-west—there may be only one willing provider within convenient travelling distance. Indeed, we touched on that aspect this morning. Any choice will be illusory. Instead, the choice will be between being an NHS patient at the local hospital or a private patient who can pay to jump the queue.

In the face of financial pressures, commissioners may find providers deliberately lengthening rather than shortening waiting times in order to control costs. I have some knowledge of that, having worked in an NHS foundation trust. Being a non-executive director, I understand that they are sometimes manipulated, for reasons that many of us would question. In financial terms, the loss of income from NHS patients may not be a problem for foundation trusts if private patients occupy the same beds but bring in a higher income. Again, it is a recipe for an even greater share being taken by private patients, while NHS capacity is reduced and waiting times lengthen across the board.

The Government argue that the plans currently being implemented are intended to substitute community-based care for acute provision in many cases, and that it would open up new capacity for the providers. Again, however, there is some scepticism about whether it will happen. Even if it did open up new capacity, it is not a strong enough argument to leave the clause unamended, because there is no provision for limiting the expansion of private provision to fill spare capacity. In short, it is an argument for raising the cap rather than abolishing it.

The Government have advanced another argument. They say that most FTs do not operate to their PPI limit. Evidence suggests that many FTs do not automatically use their ability to earn private income, but the argument that foundation trusts have not maximised their private income ignores the realities of the situation. The planned market expansion relies on a period when demand for private health care was dramatically falling as NHS waiting times went down.

There is strong evidence that reduction of waiting lists and times in the NHS had a knock-on effect on the private sector. People were not compelled to wait long periods so they did not feel that they should pay—where they had the means—for a private operation. That would suggest that as waiting times rise again—as we suspect they will—demand for private health care will rise, creating a completely new context. Furthermore, as noted in the impact assessment, the Government envisage non-EEA foreign patients being a major growth area, so domestic demand may be irrelevant. That could undermine community cohesion, given the likelihood of media stories about health tourists blocking NHS patients, with—potentially—effective taxpayer subsidy in the form of overheads.

In short, the Government plan to create new demand for private health care in NHS hospitals. This is fundamentally different from previous arrangements, where NHS patients were treated in private hospitals for a particular purpose—because the capacity was not there. The argument that previous levels of demand were not high enough to cause a problem obviously does not hold. The Government admit that “it is not possible to predict how FTs will behave with the lifting of the caps”.

To proceed with lifting the cap on the assumption that foundation trusts will choose not to use the power that they are being given, based on very flimsy evidence, is not only illogical but reckless. Combined with the forced opening of NHS facilities to private companies—which we discussed on Tuesday in the debate on clause 89 on licensing conditions—this is another step towards opening hospitals to EU competition law, especially if a major part of their income is private, in which case it might be deemed an undertaking, rather than primarily performing a social purpose.

There is also a legal opinion, although the Minister challenges this and is at pains to say that European competition law will not apply. However, there is a legal opinion from Beachcroft which suggests that expanding private provision would leave NHS foundation trusts open to a state aid case, due to the effective cross-subsidy of private patients given that the wider hospital infrastructure was built and is maintained using public funds. There is every reason to believe that this proposal is fraught with risks at many levels, some of which the Government admit to in the new study, and there are few reasons to accept the reassurances that they have given so far. I believe that this clause is a Trojan horse, driving privatisation into the heart of the NHS, and I urge Members to vote against it.

The Chair: It is my intention to suspend the sitting at this stage for approximately 15 minutes. I understand it is agreed that we will try to complete the business up to and including clause 165 this evening. That gives an indication regarding time to those Members who need to know.

I also have to say that I read in the minutes to Tuesday’s sitting that Mr Gale, chairing, made a point about reading out verbatim long submissions that have been made to members of the Committee. Personally I do not object to that, but I do sometimes find that it could be cut down. On this clause alone we have at least three other Members who want to speak. If we are to get anywhere near to completion of this business we will have to be a little bit briefer. It is now my intention to suspend the sitting until quarter to 5.

4.29 pm

Sitting suspended.
John Pugh: I am hoping that the Minister can persuade me that some of my suppositions about the clause, and in particular about the cap, are wrong. I want to make some of the points made by the hon. Member for Easington, but without the conspiracy theory attached.

My remarks do not apply to any private establishment that is simply hosted by a foundation trust, but exclusively to the occasions when NHS-trained and employed staff drawing NHS pensions and within an NHS asset appear to work as part of a private unit that is in turn part of a foundation trust. I do not have a problem with not putting a limit on the amount of funding that trusts can acquire; as far as I am concerned, they might want to provide expensive operations for people who are prepared to pay over the odds in a limited amount of time, and that would provide an excellent cross-subsidy for the NHS. I do not think that any of us have a particular problem with that, even though we may think that they should spend 100% of their time on their NHS patients.

However, the problem appears to be that the crude financial cap is almost a proxy for other things, although I accept that it was a crude financial cap, and I promise the Minister that I will look carefully at the responses to the consultation. The cap did one thing: it put some sort of limit on the amount of time that could be spent by NHS staff—I will call them that, broadly speaking—and the amount of space that could be given to NHS assets. A financial cap is one way of doing it. I would have a concern where a foundation trust that is a public hospital—despite being called a foundation trust—has no limit on the time that staff spend on or the space that it affords to private medicine. That is a genuine difficulty, and where my difficulty starts; it is not with the cap itself, but what the cap is proxy for.

The Minister was not wholly persuasive. I do not think it was his fault; it was probably my lack of attention. I think he said—he can certainly correct me—that there are various restraints on getting the balance badly wrong, which is where a foundation trust spends too much of its staff’s time and too much of its space dealing with private medicine for profit. I think we would all regret that and do not want to see it happen. However, the restraints appear to be relatively weak.

Paul Burstow: On that very point, the purpose of foundation trusts in the Bill is clear—to provide goods and services for the NHS. Straying from that significantly would break the law and be subject to challenge.

John Pugh: I understood the Minister. The problem with that is that it is almost the nuclear option. If a foundation trust was seen to subvert its function of being an NHS hospital, it would be subject to legal challenge. Quite who would make the legal challenge I am not perfectly sure, because presumably Monitor would have lost some of its role in that respect, although it may come back as an economic regulator.

Commissioners are in a weak position to prevent that from happening. The possibility of getting the balance wrong is clearly left open—and getting it badly wrong in certain circumstances. That might mean diverting traffic from the public sector to the private sector, for reasons that only mean anything to the consultants, or even giving an indirect cross-subsidy to the private sector. That would create some interesting competition issues with the other elements of the private sector—private hospitals and the like.

If we accept that there is a concept of getting the balance wrong, and that we need to have constraints in the process to ensure that hospitals do not get it wrong—they will not get it absolutely wrong; it will be fairly transparent and action can be taken—we need to identify mechanisms for preventing it. We might believe from time to time that a particular foundation trust diverts away from the path of absolute rectitude too much and simply becomes obsessed with profit and doing things that pay—which is the point made by the hon. Member for Easington. If we accept that that is a possibility, we need to identify clear mechanisms for preventing it. The financial cap was, I accept, one very crude mechanism for doing that, but—it is with this condition that I would wish to support the clause—I am at a loss to see whether there is a better restraint.

I am not sure it is good enough to simply say, “Well, they can’t do that, because it’s not their purpose. Somebody at some point in time can take action.” I would much prefer an immediate remedy to something that I would regard as a nuclear option. Will the Minister satisfy me that there are immediate remedies and restraints? We are not getting the balance absolutely wrong, but we are getting it clearly wrong. We are spending too much time using a national asset to promote private medicine. If the Minister could identify a restraint, I would be obliged to support him.

Mr Baron: I do not wish to delay the Committee for too long, but we ought to look at what is in front of us. The hon. Member for Southport has just used the word “crude” to describe the financial cap. I think the Minister talked earlier about this “arbitrary” cap, which is how it was described in the White Paper published last July. I want to put the thesis that it was not an arbitrary cap at all.

Over many years some parts of the national health service have managed and treated private patients. There was a big debate back in the ’80s about private wards and private beds in NHS hospitals. It has been going on for a long time. In 2002-03 the then Government looked at what was happening in the national health service and introduced not an arbitrary cap, nor a crude cap, but a cap on how much could be earned based on what was happening on the ground. [Interruption.] If the Minister will keep quiet, I will give way.

It has been happening on the ground for many years. The Select Committee on Health looked at the introduction of new drugs two years ago, and it has looked at parts of the NHS treating private patients on wards with NHS nurses and doctors. That has been happening for a long time, and the previous Government did not want to disturb it, but there was some concern inside the national health service about the introduction of the independent sector.

The cap was introduced. People might say it was crude or arbitrary, but I would argue it was not. People might say it was static. In 2002-03 there were no private patients in mental health. That came along in 2009,
when a percentage was established for it. The real reason the cap was implemented is that the national health service was concerned about being destabilised. Some hospitals had never had private patients. The change allowed that to happen, which was the greatest worry.

Mr Burns: The right hon. Gentleman is—I am sure inadvertently—seeking to rewrite history. There was no intention to have a cap, but Tony Blair and Alan Milburn gave in to a rebellion by a section of the Labour party. They were fearful that they would not get the Bill, so they imposed the cap. If the right hon. Gentleman does not believe that, why does he not ask the hon. Member for Halton? He was a Whip at the time and was probably one of the enforcers.

The Chair: No, he will not.

Mr Barron: No, I will not. If the Minister wants to know the history, some of it is in paragraph 858 of the explanatory notes. He might want to educate himself a bit and read why the measure was introduced in that way. If the Government wanted to lift the cap, I would have no objection to the percentage by which it was lifted, but people out there are right to be concerned about what is going to happen in the NHS under the Bill. Some people thought that a rise of even 5% threatened destabilisation, but the cap is to be lifted completely. We are going to have competition law brought into the NHS. Some NHS reconfigurations are going to be decided by the Office of Fair Trading and the Competition Commission. That is why people are worried that the cap will be lifted altogether.

The Government could have been a bit wiser in doing what they wanted. I am afraid that by throwing things into the marketplace—real market, real competition, to remind the Minister of what he said a few months ago—the Bill is destabilising our NHS now. The Government are fundamentally wrong. If they wanted to move into areas where the NHS has private patients, as some of them have for a long time, they could have done so, but they should not be throwing away the cap. I hope the Minister is reading that section.

We all know very well that there are an enormous number of private patients in the NHS. Independent sector treatment centres do orthopaedic surgery and if there are any complications post-surgery, patients go to the local hospital. That has been going on for many years. I am not in favour of getting rid of that; that is the reality of what happens on the ground. The reality is that there are private patients in the NHS; they are managed quite well alongside NHS patients and it does not destabilise. I argue that that is because of the cap. By getting rid of the cap, instead of lifting it and maybe giving the NHS time to adjust, clause 150 is just throwing it straight out of the window and bringing in competition law. The Government are fundamentally wrong.

Paul Burstow: We have had a long and interesting debate in which emotion has run high and has perhaps clouded the reality of what we are talking about. I start by responding to the hon. Member for Halton who asked at the beginning of his contribution how things are different now from when his party was in office. The difference is that while in office he and his colleagues crossed the Rubicon and decided that competition had a part to play in the NHS. They made a whole series of changes in the legislation that they enacted and as a result, competition law applied increasingly to the NHS. That is why, as we have said on a number of occasions, competition law already applies to the NHS.

Mr Barron: Will the Minister give way?

Paul Burstow: Let me develop my point a little, then I will be more than happy to take a brief intervention, if the Chair is content with that.

The point about competition law now and how it applies is that we, from the evidence of research, that some of the previous Government’s competition-oriented reforms delivered real benefits for patients—shorter waiting times and other improvements of that sort. We are determined to make sure that we continue to deliver those sorts of benefit.

That is why the Bill makes it absolutely clear that we are not interested in introducing laissez-faire into the NHS. We are interested in giving Monitor a specific responsibility to promote and protect the patient interest. That is the bit of the clause that Members often forget to mention in debates on the Bill. They move to the second bit, the subservient, ancillary part, which says that the regulator does that in some circumstances by promoting competition where that is appropriate. The key task is making sure that the patient interest is always promoted and protected. That is what the regulator’s job is.

Derek Twigg: I am interested that the Minister is trying to make the argument that this is the same as what we were doing, when the other Minister of State says that the Government are introducing a genuine market.

Mr Burns: On quality.

Derek Twigg: No, “a genuine market”. Why do we need all these clauses on changes in competition law, insolvency, the Office of Fair Trading, designated services or licensing; why do we need all those changes if it is exactly the same as we were doing?

5 pm

Paul Burstow: We know that many of those parts of the architecture were in place and were intended to be put in place in the legislation for foundation trusts that the previous Government introduced. The trouble was that they were not complete. That was partly because of difficulties that the hon. Gentleman and his colleagues had with colleagues on their own Benches, which is one of the reasons for the issue around the cap in the first place. The cap was not a considered part of the original vision of the previous Government.

Emily Thornberry: Will the Minister give way?

Paul Burstow: No. I want to develop my point.

The cap was a reaction to the resistance of some Labour Members who were in government at the time. The right hon. Member for Rother Valley has referred to the explanatory notes, but they do not explain the reason why, which was the actions of Labour rebels and the Government’s concessions to them. I give way to the right hon. Gentleman.
Mr Barron: The cap has been described as crude or arbitrary, but it was based on evidence and fact. That is in the notes. That is the truth of the matter. It is no good the Minister trying to deny that. It had nothing to do with opening up the NHS—certainly clinical services—to competition law.

Paul Burstow: The point is that it was a snapshot of the levels of income that organisations had at that point. That was the basis. That is why the cap is arbitrary. It has not changed since then and it has the effects I described during our debates on these clauses.

Derek Twigg rose—

Paul Burstow: I give way once more and then I want to make progress.

Derek Twigg: Could the Minister tell us which way he and his coalition colleague voted on foundation hospitals, and what the Liberal Democrat position was?

The Chair: Order. It is invidious to compare each other's antecedents. I am more inclined to know where we are going. That is what the Bill is about. Can Members on both sides stick to what is before us please?

Paul Burstow: Thank you, Mr Hancock. This is an evolution of policy. I want to answer the questions posed by my hon. Friend the Member for Southport as they are important. Today in the NHS, there is more competition on price than there will be under these reforms because the focus, through amendments that we have already debated in Committee and which hon. Members seem to have forgotten, will ensure that competition is increasingly on the basis of quality. The focus of the Bill is therefore on quality and continuous improvement.

The difference over the impact of lifting the arbitrary cap is that the Government are interested in expanding choice for patients and the Opposition feel that the job was done in their time and does not need to be progressed further. That seems to be the nature of the difference. The Opposition have articulated a reason for not allowing the clause to stand part of the Bill that is a fantasy and not the reality of what the clause does.

The clause lifts the cap. There is a primary purpose in law for foundation trusts. It is to provide goods and services for the NHS. Foundation trusts cannot depart from that purpose and the governors' role, which we have already debated today and which we have strengthened significantly through a number of clauses, is to protect that interest and the public interest as a result. The fact that we are also clear that we need to keep separate accounts for both private and public income is a further safeguard and assurance of transparency.

Then there is the role of commissioners in terms of their contracts and the contract monitoring that would guarantee quality and speed of service. Indeed, the contracts that currently exist—this answers the hon. Member for Easington—already contain a contractual requirement to uphold the rights under the NHS constitution. It is not just a right. It is a contractually enforceable right through commissioners' contracts.

On the concern about balancing the books and the fear that, by not having a cap, NHS foundation trusts will somehow behave differently, it is curious, given the Opposition's anxieties, that there has been no attempt to place a similar cap on NHS trusts. We know that a number of NHS trusts have incomes in excess of the cap that currently applies to foundation trusts, so why was that inconsistency of policy allowed to survive throughout the whole time that the cap has been in place?

My final point is that the purpose of foundation trusts is to provide goods and services to the NHS. If they make any surpluses, including those that arise from private activity, those moneys must be reinvested within the organisation to help to deliver its primary purpose. In every way, the changes are beneficial, and they mean that there will be more resources to meet patient demand. One example of that is the buying of leading-edge technology. Private patient income was the means by which one FT bought such technology and equipment. As its PPI cap remains in place, it makes it more difficult for the FT to do that. NHS patients are, therefore, losing out on that benefit. Buying out private competitors to bring them into the NHS is another example. A mental health FT wanted to expand its capacity and services by buying out a private sector competitor, which was going out of business. While the competitor provided most of its services to NHS patients, it had a private client paying for the service. The PPI cap meant that the FT was unable to take over that business. As a result, it lost the opportunity to develop services that were of benefit to its own patients.

Grahame M. Morris: This is a quick point on surpluses generated by FTs. One clause indicates that they are permitted to pay bonuses and executive salaries at their discretion. Is that not another element that could be used to distribute surpluses?

The Chair: Order. That is nothing to do with the clause.

Paul Burstow: That is a red herring, and I will not respond. If the hon. Gentleman can find the right clause, I will be more than happy to respond.

Owen Smith: I have two simple questions. First, will the Minister accept that there is a risk, even if FTs behave perfectly well, that removing the cap will lead to some trusts potentially shifting their priorities and resources to the disbenefit of NHS patients?

Paul Burstow: That is why the Bill is crafted as it is and why the safeguards that I have outlined several times are in place. That is also why the Royal Marsden, which gets 31% of its patient income from private services, has been consistently found by the CQC to be one of the top-performing NHS providers. Competition is not automatically bad, but that seems to be the notion that the hon. Gentleman and others are advancing.

Owen Smith: Competition is inherently risky in the NHS, because it is not like other markets. Secondly, the Minister mentioned the Royal Marsden’s 31%, so what threshold is acceptable to the Minister? Is it 50%, 60% or 70%? Or is it 30%?
Paul Burstow: I put that question to the hon. Member for Halton, but he declined to answer, so I will not speculate.

Dr Poulter: My hon. Friend was making a very good point about foundation trusts, but such practices are also continuing in other hospitals. Is it not the case that the private sector has helped to keep other loss-leading services in NHS hospitals afloat? The money that was made from the private sector under the previous Government’s policies has been pumped back into those loss-leading services. There is no reason why that would not be the case under these reforms or why it would not be greatly beneficial to patients.

Paul Burstow: I will return to the key point, which is that the principal purpose of those organisations is to deliver goods and services to the NHS. The checks and balances that the Bill puts in place are a good way of ensuring that NHS patients get the best quality care at no disadvantage.

John Pugh: Will the Minister clarify one point? I understand that all the money from private sector enterprises within the FT is ploughed back into the public sector side of the operation, and one assumes that money cannot be put back into the private sector, on the grounds that it would further enhance the public sector. That argument will not work. However, let me ask the Minister about a hypothetical situation: is it possible, within an FT, for a consultant who gets 100% of his pension from the NHS, to spend the majority of his time—51%—doing private work at the same hospital?

The Chair: It is pushing credibility to believe that that question has anything whatever to do with the amendment—[Interruption.] Is a consultant’s pension relevant? I think not.

John Pugh: It is not an irrelevant hypothetical question, and its relevance needs to be explained. It is about how cross-subsidy works in the public and private sector. If we are paying the pension of somebody who is able to work in the private side of the operation—perhaps the FT wishes him to—and earn good money, while simultaneously drawing that pension, I would be distressed to hear it. The Minister is free to contradict me and say that that would not happen.

Paul Burstow: I am grateful for my hon. Friend’s hypothetical question. Something I have learned through the pleasure of serving on the Committee is that when in doubt about answering a hypothetical question because of where it might lead, it is better either not to answer at all, or to be prepared to be helpful and write to the Committee with clarification. On this occasion, I am prepared to write and give my hon. Friend the information that he wants, in a considered way, rather than answering off the cuff during the debate.

With that response, I hope that my hon. Friend, Friends feel that the clause should stand part of the Bill, and that Labour Members’ arguments, many of which are bogus, should be rejected.

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

The Committee divided: Ayes 11, Noes 10.

Division No. 87]

AYES

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

NOES

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

Question accordingly agreed to.

Clause 150, as amended, ordered to stand part of the Bill.

Claue 151

Information

Derek Twigg: I beg to move amendment 625, in clause 151, page 128, line 31, after ‘information’, insert ‘except patient information’.

The amendment ensures that patient information is excluded from the type of information that the Secretary of State may require from foundation trusts. It is a probing amendment, so I will not take too long on it.

The clause gives the Secretary of State very broad powers to require information from foundation trusts, without identifying in the Bill what the exact nature of the information is. The explanatory notes make numerous references to information relating to financial management and reporting, and therefore, the intention appears to be that access to patient information would not be required under the clause. Specifying that fact in the Bill would provide reassurance. If patient information is required by the Secretary of State, the reasons should be specified and the usual rules of confidentiality must apply. That issue has been raised in submissions to us.

Confidentiality plays a fundamental role in the relationship between health professionals and their patients. The requirement for confidentiality allows patients to divulge sensitive information to their doctor, without concern that it will be disclosed to others without their consent, except in limited and exceptional circumstances. Significant damage could be caused to health care in general, if trust between doctors and patients is eroded. Fears that data may be shared with central Government without their consent may result in patients withholding information from health care professionals, which would be to the detriment of their care.

5.15 pm

The BMA’s view is that the default position should be that the disclosure or transfer of identifiable information should require consent from the patient or lawful proxy. The issue of consent has been raised with us by a number of people including the BMA.
Paul Burstow: I have every sympathy with the points made by the clinicians, the BMA and, indeed, the hon. Gentleman. We all want to prevent confidential information about individual patients being given to the Secretary of State. I totally agree that that would be inappropriate, if that were the case. The hon. Gentleman and others do not need to worry in that regard. It is neither necessary nor appropriate for the Secretary of State to receive such information. He does not need it and clause 151 already restricts the Secretary of State to collecting only information appropriate to the performance of his functions for the purpose of the health service. The collection of individual personalised information is excluded and outwith what the clause allows him to do.

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

Amendment, by leave, withdrawn.

Clause 151 ordered to stand part of the Bill.

Clause 152

Significant transactions

Derek Twigg: I beg to move amendment 631, in clause 152, page 129, line 12, at end insert—

'(4) The constitution of an NHS foundation trust shall specify significant disposals of property as significant transactions. Significant disposals of property are disposals of property that—

(a) was designated as protected in the foundation trust’s authorisation, or

(b) the council of governors considers necessary for the foundation trust to fulfil its principal purpose.’.

The amendment is an alternative way of approaching the same issue, of protecting what the public will rightly view as a public asset—that is, their hospitals—rather than simply property to be bought and sold and used for private business, if economic factors so decide. This would take a different approach from the Bill’s very weak protection of significant assets and strengthen it.

Clause 152 allows foundation trusts to determine in their constitutions that certain types of transaction are significant. Those will then require a vote of the governors before going ahead. That might allow at least a minimum level of protection for assets, but as it stands leaves the decision to the foundation trusts themselves, much like the provisions on the conflicts of interest in consortia. It lets the regulated not only regulate themselves but write the regulation. There is a clear case to set up some minimum expectations as to what the significant transactions might be. The Minister might want to explain his own view on that, and how the Government intend to communicate to the foundation trusts and Monitor to take up the provision.

Paul Burstow: The amendment is unnecessary and would not achieve what it intends. Let me try to explain why. The purpose of the amendment appears to be to ensure that the public and staff of a foundation trust are involved in any decision to dispose of important property. As worded, it would not work. The first part refers to property protected in the authorisation. The Bill removes the term authorisation and introduces a system of economic licensing. Clause 144, which we have already debated, removes terms of authorisation and clause 148, also debated, repeals the power to use them to designate property as protected. The key elements behind the amendment would, therefore, no longer exist.

The second part of the amendment refers to property necessary for the foundation trust to fulfil its principal purpose. The property in that context refers not only to land and buildings, but other assets such as equipment and licences held by the trust. Governors would have to be consulted on which property they saw as necessary for the foundation trust to fulfil its purpose. That would mean that they would have to be involved in every decision about property. There is a danger that disposal of any equipment could require governor consideration. Such a heavy-handed statutory requirement is unnecessarily prescriptive and would impact adversely on the governors’ role, potentially even obscuring their responsibilities in other matters. That is why we think it would also have the effect of potentially obstructing day-to-day operations within the foundation trust. Foundation trusts need to be able to decide for themselves what is a significant transaction for that organisation. That will differ between trusts. Some trusts will have assets not used for services, for example. One size does not fit all. Some governors may decide that it is best for their trust to approve the disposal of major items of property. Others may decide that they need to approve smaller property disposals, or disposals of certain pieces of equipment. It will be far better to give foundation trusts the discretion over when governors become involved than to use legislation to put them in a straitjacket. Local discretion and flexibility are more appropriate and effective in such circumstances, particularly because of the changes that we have made to the governance arrangements, which strengthen them and make much clearer the role and responsibilities of governors and directors.

If the amendment is prompted by concerns about continuity of service—I am not certain that that was the main thrust—such concern is misplaced. The regulatory licensing regime would give Monitor powers to prevent the disposal of property essential for the provision of designated services. Clause 90(1)(j) would give Monitor the power to set licence conditions for the disposal “of assets used in the provision of designated services”.

Furthermore, the taxpayer investment would also be protected. The investment management function, to which I referred earlier and that we intend to create, would be able to set the terms of Government investments in foundation trusts. Among its powers, it would be able to prevent the disposal of property where this would have a material detrimental impact on the value of taxpayers’ investments, as set out in the Bill.

For those reasons, the amendment is unnecessary and would not achieve its objective.

Liz Kendall: As the Minister says, the assets of foundation trusts will be under a new banking facility, as I think it is described in the explanatory notes, at arm’s length from the Department. We have not had any details about who will run it or who will be on it. Is it really at arm’s length from the Department? Will the Minister provide details about who will be running that facility, and how will it be at arm’s length from the Department? If the Government have not figured that out yet, it is interesting that we are
being asked to agree it. Perhaps I have missed the proposals, in which case it would be lovely if the Minister could explain.

Paul Burstow: There are other clauses that provide the powers for that agency to be established. They are probably the better place to explore those questions. If we do not have time to discuss them, I will make sure that I write to the hon. Lady with the necessary information so that we have given that clarity. With that, I will resist the amendment.

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

Amendment, by leave, withdrawn.

Clause 152 ordered to stand part of the Bill.

Clause 153

Mergers

Derek Twigg: I beg to move amendment 626, in clause 153, page 129, leave out line 24.

The amendment would ensure that the application for merger must describe the goods and services that it is proposed should be provided by the new trust. The clause would change section 56 of the National Health Service Act 2006 so that the application for merger between foundation trusts or between foundation trusts and NHS trusts would not need to describe the goods and services that it is proposed should be provided by the new trust. We believe that a description must still occur.

Paul Burstow: The intention behind the amendment is one that I think members of the Committee will have sympathy with. I am sure we can all agree that it is important to protect patients and ensure that essential services continue to be provided in the event of a merger between two foundation trusts. We also agree that regulation is necessary to ensure continuity of essential services. However, the amendment is unnecessary. The new system will go even further in protecting patients’ interests in relation to mergers than the hon. Gentleman’s amendment would.

In its new role as economic regulator, Monitor will ensure that services designated for additional regulation would continue to be provided in the event of any merger of providers, not just those involving foundation trusts. If a merger were to threaten the provision of a designated service, Monitor would have the power to stop it going ahead. That would protect patients’ interests to a greater extent than do the current arrangements. In the new system, Monitor’s functions in relation to mergers would simply involve ensuring that all legal requirements had been met relating to the merger. After that, it would issue the orders that would give effect to the changes taking place because the foundation trusts remain statutory organisations.

It is not appropriate or necessary for Monitor to have controls over foundation trusts that it would not have over other providers, because that could disadvantage foundation trusts in relation to those other providers; that takes us back to the concept of the fair playing field. It is likely that Monitor, as an economic regulator, would want all providers from all sectors to describe their goods and services when they apply for a licence to provide NHS services, and when there are significant changes to those services. Requiring merging foundation trusts to describe separately what goods and services a merged organisation would provide would place an additional and unnecessary bureaucratic burden on them.

I hope that I have been able to reassure the hon. Gentleman, and I hope that he will withdraw the amendments.

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

Amendment, by leave, withdrawn.

Derek Twigg: I beg to move amendment 627, in clause 153, page 129, line 33, at end insert—

‘(8) National terms and conditions of NHS staff will be preserved.’.

The Chair: With this it will be convenient to discuss the following:

Amendment 628, in clause 154, page 130, line 13, at end insert—

‘(6) National terms and conditions of NHS staff will be preserved.’.

Amendment 629, in clause 155, page 130, line 34, at end add—

‘(6) National terms and conditions of NHS staff will be preserved.’.

Derek Twigg: These are essentially probing amendments, through which we seek assurances. While I am on my feet, I notice that the Minister referred to a bank, and perhaps he would direct the Committee to the relevant clause.

Paul Burstow: It is clause 148.

Derek Twigg: I thought the Minister meant that it was a further clause, which we had not yet debated, later on in the Bill.

The amendments address concerns felt by organisations such as the British Medical Association, which also is opposed to any changes that would undermine the national terms and conditions for staff who deliver publicly funded care. That applies also to the trade unions, which have done a lot of work over the years in negotiating with the NHS and the Government. The concerns are essentially about maintaining an equitable spread of doctors across the UK; safeguarding against variable and substandard working conditions; and avoiding the creation of a market in which doctors move around the UK. The local pay bargain is also very wasteful in both management and clinical time. Local pay bargains produce a huge extra administrative burden for hospitals at a time when the Government claim to want to cut back on bureaucracy. Every time a new pay round takes place, local employers are to be found in negotiations rather than letting such things happen centrally and cascade down.

The British Medical Association’s point about the need for an equitable spread of doctors across the country applies equally to other professions. The Government are taking another step towards removing the “national”...
from the NHS; perhaps the Minister will reassure me about that. The whole point of the agenda for change was to achieve equality and equal pay across the NHS work force. Once employers move away from that, the prospect of equal pay claims escalating becomes a distinct reality. That is further evidence that the Government are taking the NHS down an increasingly litigious route, unless the Minister can reassure me that that is not the case.

These are, essentially, probing amendments, and if the Minister can reassure us we can move on. If not, we may well press amendment 627 to a vote.

Paul Burstow: I hope that I can offer the hon. Gentleman some reassurance, because we have sympathy with the intention behind the amendment. It is not necessary, however. Foundation trusts cannot merge with, or be bought outright by, an independent sector provider whether private, voluntary or social enterprise. The Bill would not change that. The clauses on mergers, acquisitions and separation only allow organisational changes involving NHS foundation trusts and other NHS foundation trust, or NHS trusts, while they remain in existence. They would not allow an independent sector organisation to merge with or take over an NHS organisation.

The effect of clause 153 is simply to enable the NHS organisations to adapt and form anew where governors elected by the public and NHS staff decide that such changes are in the best interests of the public and staff. The amendments are unnecessary, because the organisations that would exist after such organisational changes would still be NHS organisations. Clauses 153 to 155 specifically detail the process that an NHS foundation trust must undertake to effect mergers, acquisitions and separations.

In relation to this group of amendments, the hon. Gentleman mentioned the concerns that staff might have. He spoke about removing the “national” from NHS. We should be clear that the last Government gave NHS foundation trusts freedom on pay policies so that those organisations could decide how best to adapt to local requirements and deliver high-quality health care provision. NHS foundation trusts therefore already have the right to determine pay for their own staff. The Bill will not change that. It is likely that many providers will continue using national contracts as a basis for their local terms and conditions. The position of individual staff after transfer will depend on their existing contracts. In those circumstances, the amendment would make no difference whatever. If he wishes to intervene, I am happy to give way.

5.30 pm

Derek Twigg: No, I am okay.

Paul Burstow: Within such organisational changes, there would normally be a requirement for the transfer of staff to the resulting NHS foundation trust or trusts formed after the change. In such circumstances, the Transfer of Undertakings (Protection of Employment) Regulations may apply.

The clauses on mergers, acquisitions and separations concern organisational changes involving foundation trusts. They address gaps in the legislative framework of public benefit corporations and increase accountability by allowing NHS foundation trust governors to take decisions. They would not allow a foundation trust to merge with or be acquired by an independent sector organisation. I hope that that reassures the hon. Gentleman and that he will not feel the need to press the amendments.

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

Amendment, by leave, withdrawn.

Derek Twigg: I beg to move amendment 632, in clause 153, page 129, line 33, at end add—

'(8) After subsection (11) of that section insert—

(12) With regard to undertaking the duties in this section, Monitor and foundation trusts must consult with the local relevant Health and Wellbeing Board(s).''

The Chair: With this it will be convenient to discuss the following: amendment 633, in clause 154, page 130, line 13, at end add—

'(6) With regard to undertaking the duties in this section, Monitor and foundation trusts must consult with the local relevant Health and Wellbeing Boards.'

Amendment 634, in clause 155, page 130, line 34, at end add—

'(6) With regard to undertaking the duties in this section, Monitor and foundation trusts must consult with the local relevant Health and Wellbeing Boards.'

Derek Twigg: The amendments are useful for putting the Government’s position on the record. I am sure that they will be considered elsewhere and that whatever action is appropriate will be taken, but it is useful to have these matters on record.

Again, in that spirit, the current position before reform is that any mergers of, significant acquisitions by or separations of foundation trusts must have the approval of Monitor. That requires a thorough business case, including setting out the clinical benefits and any consultations done with the public, commissioners and so on. Effectively, the local strategic health authorities and primary care trusts would have been involved centrally, and would almost certainly have had to support the move for it to be approved.

Under the Bill, Monitor’s approval will no longer be needed, so neither Monitor, commissioners nor the health and well-being board will have any power to prevent mergers, acquisitions or separations of financial trusts. If such a move could affect competition significantly, the OFT might investigate, but beyond that it would be left up to the foundation trust governors to decide whether a merger, acquisition or separation should go ahead. We have discussed whether governors are properly able to do that job, so I will not raise that issue again.

Our amendment would require foundation trusts at the very least to consult health and well-being boards when deciding on a merger, acquisition or separation. Health and well-being boards could bring up the concerns of the local population or the fact that the move did not fit in with the joint strategic needs assessment. That would help ensure that the merger benefited local people and fitted in with the joint strategic needs assessment.
The health and well-being board could, for instance, bring up local concerns that a merger might lead to the shutting down of services that local people consider vital, or the provision of which is vital as part of the JSNA. Their input would ensure that local people had a say. Surely the Government would not want to object to that. We are not saying that they would have formal approval powers, but it is important to have the facility for input. Again, the point is to involve the wider public in major changes to hospitals, but the health and well-being boards might be the appropriate way for that to happen. I would welcome the Minister’s comments.

Paul Burstow: Health and well-being boards are rightly acknowledged as an important innovation. They will have an important leadership role in influencing the commissioning of health and social care services. That will include a strong role for local councils in shaping local commissioning. At the same time, councils will have a separate scrutiny responsibility enabling them to scrutinise local health and social care services.

Changes in services affect local people, and we expect health and well-being boards to have a say in such changes. However, in our view, the amendments are misguided. The clauses under the heading “Mergers, acquisitions, separations and dissolution” are simply about changes to organisational form, not to services, and they provide for a range of contingencies that we would not expect to be used frequently. They are, however, the logical progression of a policy initiated by the previous Government to free providers to innovate and deliver better patient care. That policy was not completed, so that is what the legislation does.

Where such organisational changes might have material impacts on the provision of services, safeguards are already in place. As the economic regulator, Monitor would have an interest in such changes in relation to public and patient interest in the continued delivery of services designated for additional regulation. In addition, the amended regulation-making powers will enable the local authority scrutiny function to scrutinise those services that are subject to substantial change and reconfiguration and are designated. As we have discussed, those can be referred to the NHS commissioning board and the Secretary of State, and power exists for the scrutiny function to call on any provider to scrutinise any aspect of its work. The scrutiny is real and ongoing.

Where a foundation trust considers that an organisational change would help it successfully pursue its purpose, it should be able to get on with that change with the agreement of the governors who are, after all, elected by the public and staff and hold the board to account. The public accountability about which the hon. Gentleman wanted assurance is in the system.

Imposing consultation requirements could cause unnecessary delay and is neither necessary nor appropriate. In this case, the role of health and well-being boards is different. It is about giving councils a leadership role on health by bringing together locally elected councillors, public patient representatives and health and social care commissioners to assess needs and develop joint commissioning strategies for which commissioners must have regard. For those reasons, we do not believe that the requirement in the amendment would help if placed in the Bill, and I urge the hon. Gentleman to withdraw the amendment.

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

Amendment, by leave, withdrawn.

Clause 153 ordered to stand part of the Bill.

Clauses 154 and 155 ordered to stand part of the Bill.

Clause 156

Dissolution

Amendment made: 527, in clause 156, page 130, line 39, at end insert—

'( ) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant.'—(Paul Burstow.)

Clause 156, as amended, ordered to stand part of the Bill.

Clause 157

Supplementary

Amendment made: 528, in clause 157, page 131, line 17, at end insert ‘, and

(c) in paragraph (b), at the end insert “or trusts”.’.—(Paul Burstow.)

Clause 157, as amended, ordered to stand part of the Bill.

Clauses 158 to 160 ordered to stand part of the Bill.

Clause 161

Action following Final Report

Amendment made: 576, in clause 161, page 134, line 24, leave out from ‘trust’ to ‘the’ in line 26 and insert—

(i) to another NHS foundation trust or the Secretary of State, or
(ii) between another NHS foundation trust and’.—(Paul Burstow.)

Clause 161, as amended, ordered to stand part of the Bill.

Clause 162

Sections 159 to 161: supplementary

Amendments made: 529, in clause 162, page 135, line 38, leave out paragraph (d) and insert—

‘(d) for “(5)” substitute “(7)”’.

Amendment 530, in clause 162, page 136, line 5, leave out paragraph (d) and insert—

‘(d) for “(4)” substitute “(7)”’.—(Paul Burstow.)

Clause 162, as amended, ordered to stand part of the Bill.

Clause 163

Repeal of Chapter 5A of Part 2 of the National Health Service Act 2006

Amendments made: 531, in clause 163, page 136, line 29, leave out ‘(m)’ and insert ‘(n)’.

Amendment 532, in clause 163, page 136, line 30, after ‘(ab)’ insert ‘, (6ZA)’. 

Amendment 533, in clause 163, page 136, line 30, at end insert—

'(i) in paragraph 28(3) of Schedule 4 to that Act, the words from “or where” to “65I(3)”,

(ii) paragraph 221(1)(g) to (n) of Schedule 7 to that Act,

(iii) in the definition of “NHS trust” in section 206(1) of the National Health Service (Wales) Act 2006, the words from “(including)” to the end,

(iv) section 18(9), (10) and (12) of the Health Act 2009, and.

—Paul Burstow:)

Clause 163, as amended, ordered to stand part of the Bill.

Clause 164

Abolition of NHS trusts in England

Paul Burstow: I beg to move amendment 635, in clause 164, page 137, line 1, after ‘arrangements’ insert ‘(“franchise arrangements”).

The Chair: With this it will be convenient to discuss Government amendments 636 to 638.

Paul Burstow: I was going to speak to the group of amendments briefly and ensure that I gave the Committee some additional information that will help it to understand the purpose of the clause. As I look at the notes that I have been hastily pulling out of my folder to ensure that I am in the right place, I think I may not be in the right place. [Interruption.] On a point of order, Mr Hancock. May I clarify that we are dealing with Government amendments 635 to 638? May I have one of those little time-outs? [Interruption.] My apologies, Mr Hancock. Thank you for your guidance and assistance. The pace at which you moved through those amendments caught me out.

The amendments will make changes to the savings provisions that will enable any NHS trusts in franchise deals to retain their status after the repeal of the NHS trust legislation. They will do three things: first, they will define a franchise agreement more precisely than in the original wording; secondly, they will enable trusts to retain their NHS trust status for a period after the end of the franchise agreement; and thirdly, they will confirm, in the Bill, the key sections of the National Health Service Act 2006 that will be saved.

The Government are committed to all NHS trusts achieving foundation status by April 2014. Such status liberates trusts to focus on improving outcomes in order to be more responsive to patients, and to innovate. As a signal of the Government’s commitment to allowing all patients to benefit from treatment by an autonomous, innovative provider, the clause abolishes NHS trust status from 1 April 2014.

We anticipate that a small number of NHS trusts will not be able to achieve foundation trust status by that deadline. We are therefore developing a range of options to deal with such trusts—some might merge with other trusts to become viable foundation trusts and others may be acquired by an existing foundation trust. A further option is being developed, the concept of which originated under the previous Administration. That option is to develop the notion of a franchise arrangement under which another organisation takes on the operational management—I stress operational management—of an NHS trust.

Franchise arrangements might offer significant benefits to the NHS. They might bring in private sector expertise and dynamism, and might help to address some of the problems in the NHS. Hinchingbrooke Health Care will be the first of what we expect to be a small number of NHS trusts to work with partners, including partners in the independent sector, in successful franchise agreements. These are early days, so we need to see how the franchise market develops. In the case of Hinchingbrooke, the Secretary of State would use his intervention powers under section 66 of the National Health Service Act 2006 to create a unique Government structure for the trust. Similar flexibility might be needed in the future for other franchise deals.

Amendments 635 and 636 will define a franchise deal more precisely than the original wording. They make it clear that the savings provision would apply only to NHS trusts and franchise contracts under which the franchisee performs the main functions of the trust. They would ensure that the savings provision would not catch NHS trusts with only part of their services contracted out, such the NHS trusts with contracted-out laundry services.

Amendment 637 will enable a trust to retain its NHS trust status for up to three years after the franchise contract has finished. That is needed because a trust wanting to apply for foundation status would need to demonstrate to Monitor that it could operate autonomously after the end of the franchise contract to be authorised as a foundation trust. Alternatively, another solution would then need to be found. If there were a situation in which a franchise contract had to be terminated early, the amendment would ensure that a trust could continue to operate while alternative arrangements were being made.

Finally, amendment 638 would make the scope of the savings provision explicit in the Bill. The original wording left some room for doubt about whether certain key sections of the National Health Service Act 2006 would be saved. To avoid doubt in future, the savings provision will be amended to make its extent clear.

Derek Twigg: The reason why I asked the Minister to speak to these amendments is that they are significant. The clause, too, is significant because it deals with the abolition of NHS trusts. The Minister confirmed that 20 trusts were in difficulty.

Paul Burstow: When my right hon. Friend the other Minister referred to that figure, he had in mind the exchange that took place in the Public Accounts Committee involving Sir David Nicholson. He indicated that the current estimate is 20.

Derek Twigg: We are just not clear from what the Minister has said and from the detail in the Bill how this will be done given that there are already 20 trusts in difficulty, what the time scale is and how the consultation will be managed. Perhaps the Minister has some more information. We are concerned about how this process will be managed and what the time scale is. Will it be completed in the proposed timeframe? It is important to know who will lead the consultation and when it will take place. I would be grateful if the Minister could say more on that.
Paul Burstow: I shall try to address that point. This clause makes provision for the possibility of franchise arrangements and for those franchise arrangements to operate and, when they come to an end, for the organisation to move to a foundation trust arrangement. The hon. Gentleman is asking what arrangements we are making to support all NHS organisations move to foundation trust status.

Derek Twigg: There are 120.

Paul Burstow: In all, there are 120, of which 20 have been identified as needing additional support to get them to a point where they can become foundation trusts. This is a difficulty that any Government would have, especially one that had a commitment to move to a position where all NHS organisations are foundation trusts. In the coming year, the strategic health authorities that have a provider support function will continue to do their work, working with commissioners at a local level and with provider organisations.

Emily Thornberry: Will the Minister give way?

Paul Burstow: It is best if I elaborate and then I will give way to the hon. Lady. Strategic health authorities will be working on that and coming back to the Department in the next month or so with detailed proposals, tripartite agreements in effect between the organisations I have just mentioned, to enable views to be formed. No view has been formed yet because that work is in hand and is not concluded. Therefore, the 20 figure is an estimate and not a final figure. It would be wrong for anyone to think that it was.

In addition, once strategic health authorities are abolished, the responsibility for driving the pipeline of foundation trusts would move to a special health authority that will continue delivering support to those organisations. We wish to see NHS trusts achieve foundation trust status by April 2014, and we will take the necessary steps to support organisations moving in that direction. The amendments would deal with situations when there may be a need to bring in additional support from the private sector through a franchise arrangement of the sort envisaged in the past, and which we wish to carry forward.

Derek Twigg: The Minister made a specific point on something that my hon. Friend the Member for Leicester West mentioned. I think he said that he would come back with further information on special health authorities and who will run them. That is important.

If the review is ongoing, who is responsible for it, and when will it be completed? How will patients and the public be involved and consulted—including Members of Parliament, dare I say it? We are accountable people. Another specific problem is to do with SHAs and PCTs. We are getting rid of the SHAs by 2012, so there will be a gap of two years. I would be interested if the Minister has information on that. If it is a problem, I would be happy for him to write. If he has it here, it would be much better.

Paul Burstow: As a constituency MP, I know that the Epsom and St Helier University Hospitals NHS Trust is in that pipeline, and is going through the process at the moment. I and other Members of Parliament in south-west London have already been told of the options being considered.

Liz Kendall rose—

Paul Burstow: Let me develop the point a little. I am giving an example, which I thought would have helped.

In answer to the hon. Gentleman’s question on how the public are to be involved, I was about to say that the parties to that process have already spoken to the local overview and scrutiny committee. They are being very open about the process. In answer to his question about the role of the NHS trust development authority, which is the body that we are discussing, we have already touched on the subject. Indeed, it is well documented in our proceedings.

Liz Kendall: It has not been well documented. The Minister said that when we reached the relevant clause, which I believe this is, he would give us more information about the special health authorities, which I assume will take over between April 2012 and April 2014, after which all trusts should have gone through the pipeline. We have been given no information about what it is or who runs it, and for what it is responsible. Am I allowed to make a second point?

The Chair: Please.

Liz Kendall: Thank you, Mr Hancock. The Minister named Epsom and St Helier hospital. I was glad to hear that. Will he name the other 19?

Paul Burstow: It is one of 120, not one of 20. I ask the hon. Lady not to write that press release, although she may wish to write another. It is not one of the 20. I do not have a list. There is no list. There is an estimate—

Liz Kendall rose—

The Chair: No, the Minister has replied.

Paul Burstow: May I develop the argument? I can probably give the hon. Lady more answers that way than by constantly taking interventions.

What the hon. Lady said was wrong, and I hope that she will not leave the Committee and give a different impression. I was explaining the general process of supporting NHS trusts in moving to foundation trust status. I described my experience as a constituency MP of how it is being done. It is not one of those basket cases about which the chief executive of the NHS spoke.

I shall now say two other things in response to the hon. Lady’s intervention. She suggested that I had said that this was the clause in which we would deal with special health authorities. In our earlier exchange, I thought that we were talking about the banking function, which was dealt with in clause 148, but the Opposition did not raise questions on it. I am happy to write to her on that point.

The hon. Lady also asked about the NHS trust development authority. It will play a crucial role in ensuring that NHS trusts become, or are part of, foundation trusts following the abolition of SHAs on 31 March.
next year. We will ensure continuity, consistency and focus on the support for NHS trusts in developing foundation trust applications. It will provide business continuity to the functions provided by strategic health authorities, including supporting NHS trusts to achieve FT status by April 2014, managing clinical quality, governance and risk for the remaining NHS trusts and performance managing NHS trusts against quality performance and financial requirements and standards.

In relation to supporting delivery of the FT pipeline, concerns about the authorisation process—for example those following the events in Mid Staffordshire, which have rightly prompted intervention at various points in Committee—have been taken into account in the design of those processes to ensure that quality is a key component. That, as the hon. Lady rightly identified, is intended to be a short-life special health authority running from late 2011 to the close of 2014, working to the same timetable as that of achieving a full foundation trust sector—something that I hope we share because it was a commitment in the Opposition's manifesto as well as part of the coalition agreement.

Emily Thornberry: I do not know whether the Minister will grant us this information. Are any of the 20 hospitals that may go into special measures before becoming foundation trusts in London? Will he give us their names? Furthermore, for those of us who are constituency MPs who have hospitals that are not currently foundation trusts, and who will be concerned that their hospitals may be one of those that will go into special measures—

The Chair: Order. That has no relevance at all to the business before us. It will cause speculation and unnecessary problems, and that is not the domain of the Committee. We are here to discuss the Bill, not to take questions on those matters. I am sorry to say that I will rule it out, and if you reply, Mr Burstow, I will rule you out too.

Paul Burstow: I take your ruling, Mr Hancock. The Committee should not be harming patient interests in that way, so we will not do so. We will be absolutely clear in the process, which will be transparent in the way that I have described. The objective here is to move all organisations to foundation trust status, and we have the necessary means to do so and support them; if not, we have the necessary means to deal with that as well. That is what we have been discussing in the clauses over the past hour. There will be arrangements that will deal with that transition. With that, I urge colleagues to support the clause.

The Chair: Before I call anyone else, I would like to remind the Committee that we are discussing amendment 635 as laid out in the notice paper. I hope that anyone else who speaks from now on will reserve their comments to that alone.

Liz Kendall: I want to be clear what I asked the Minister about, which we have been discussing until now. There were two issues. The first was about the independent banking facility and the second was about the special health authority. I am perfectly aware that they are two separate issues; I have not confused them. He may remember that, in a previous debate, I asked for information about the special health authority, and I hope that he will write to me on both points.

The Minister said that there is no list, and I am interested that that is now on the record. If the Department did not have a clear list of which hospitals are struggling to become foundation trusts, I think it would be remiss in its role. My understanding is that there will be such a list. The chief executive of the NHS said so, so I respectfully ask the Minister to be careful about what he says to the Committee because I am not sure that that is the case.

Paul Burstow rose—

The Chair: Are you taking Mr Burstow's intervention?

Liz Kendall: Yes, I am.

The Chair: I think we have exhausted most of the issues relating to clause stand part; we have allowed the debate on the amendments to go much wider so that it relates to clause stand part. I would like Members to bear that in mind. Mr Burstow, your intervention.

Paul Burstow: My intervention was simply to say that there is no list. The answer that was given in the PAC stands. I do not resile from the answer given by the chief executive of the NHS, which the hon. Lady should read again. We have—and, in Committee, I have described—the process that will lead to a series of foundation trusts being established, and a process that will clarify which ones need additional support and which will be capable of moving without support to foundation trust status. That is an ongoing process which has not reached a conclusion, so there cannot be a list, only speculation at this stage.

Amendment 635 agreed to.

Amendments made: 636, in clause 164, page 137, line 2, leave out ‘functions on behalf of an NHS trust’ and insert—

‘the main functions of an NHS trust on behalf of the trust’. Amendment 637, in clause 164, page 137, line 3, leave out from ‘section’ to end of line 8 and insert—

‘, the trust is to continue after that commencement to be constituted as an NHS trust until—

(a) it is dissolved or becomes, merges with or is acquired by an NHS foundation trust,

(b) where none of those events occurs before the end of the period of three years beginning with the day on which the franchise arrangements come to an end, the end of that period, or

(c) where other franchise arrangements come into force before the end of that period, the end of the period of three years beginning with the day on which those other franchise arrangements or any subsequent franchise arrangements come to an end.’.

Amendment 638, in clause 164, page 137, line 8, at end insert—

‘(5A) In subsection (5)(c), the reference to subsequent franchise arrangements is a reference to franchise arrangements which come into force before the end of the period of three years beginning with the day on which the preceding franchise arrangements come to an end.'
(5B) For the purposes of subsection (5)—
(a) Chapter 3 of Part 2 of the National Health Service Act 2006 is, despite subsection (2), to continue to have effect,
(b) Chapter 5A of that Part is, despite section 162(1), to continue to have effect,
(c) the repeals made by section 162(2) are not to have effect,
(d) the amendments made by Schedule 11 are not to have effect (and subsection (6) is to be read accordingly), and
(e) the amendments made by paragraph 9 of Schedule 19 are not to have effect (and section 271 is to be read accordingly).—(Paul Burstow.)

Question put forthwith (Standing Orders Nos. 68 and 89). That the clause, as amended, stand part of the Bill. Question agreed to.

Clause 164, as amended, accordingly ordered to stand part of the Bill.

Schedule 12

PUBLIC INVOLVEMENT AND SCRUTINY

Amendments made: 577, in schedule 12, page 301, line 17, at end insert—
In section 9 (NHS contracts), omit subsection (3).''.

Amendment 534, in schedule 12, page 301, line 18, omit paragraph 4.

Amendment 535, in schedule 12, page 302, line 8, after 'trusts' insert—
(a) in subsection (3)(a), omit "an NHS trust",
(b) in subsection (4), omit "or an NHS trust", and
(c) '.

Amendment 540, in schedule 12, page 302, line 25, at end insert—
Omit section 78 (directed partnership arrangements).''.

Amendment 578, in schedule 12, page 302, line 26, leave out paragraph 18.

Amendment 579, in schedule 12, page 302, line 38, at end insert—
( ) in subsection (1)(b), for "relevant Welsh bodies" substitute "NHS trusts".

Amendment 580, in schedule 12, page 302, line 41, leave out paragraphs (b) and (c) and insert—
(b) in that subsection, omit the definition of "relevant Welsh body", and
(c) in subsection (2), for "relevant Welsh body" substitute "NHS trust".

'( ) In consequence of the repeal made by sub-paragraph (1)(c), omit section 233(3) of the Local Government and Public Involvement in Health Act 2007.'.

Amendment 541, in schedule 12, page 303, line 2, at end insert—
Omit section 272(5).''.

Amendment 581, in schedule 12, page 303, line 7, leave out paragraph 27 and insert—
(1) Schedule 15 (accounts and audit) is amended as follows.
(2) In paragraph 1—
(a) in sub-paragraph (1) omit paragraphs (d) and (e), and
(b) omit sub-paragraph (3).
(3) In paragraph 4(1), omit paragraph (b) and the "or" which precedes it.

(4) In paragraph 5— In paragraph 6—
(a) in sub-paragraph (1) for "neither a Special Health Authority nor NHS Direct" substitute "not a Special Health Authority", and
(b) in sub-paragraph (3) for "NHS body that is a Special Health Authority or NHS Direct" substitute "Special Health Authority".
(c) in sub-paragraph (1) for "an NHS body that is a Special Health Authority or NHS Direct" substitute "a Special Health Authority", and
(d) in sub-paragraph (3) for "body" substitute "Special Health Authority".

Amendment 582, in schedule 12, page 303, line 18, leave out paragraph 30.

Amendment 542, in schedule 12, page 304, line 35, leave out paragraph 44.

Amendment 583, in schedule 12, page 305, line 27, at end insert—
The Charities Act 1993 is amended as follows.'.

Amendment 584, in schedule 12, page 305, line 33, at end insert—
In section 43B (annual audit etc. of Welsh NHS charity accounts), in subsection (4)—
(a) in paragraph (b) omit the words from "all or most" to the end,
(b) in paragraph (c) omit "falling within paragraph (b)", and
(c) in paragraph (d) omit "such".

Amendment 585, in schedule 12, page 306, line 22, at end insert—
The Audit Commission Act 1998 is amended as follows.'.

Amendment 586, in schedule 12, page 306, line 24, at end insert—
In section 53(1) (interpretation), in the definition of "health service body" omit "or NHS Direct National Health Service Trust".

Amendment 587, in schedule 12, page 306, line 28, at end insert—
"Health Act 1999"

In section 16 of the Health Act 1999 (conversion of initial loans to NHS trusts to public dividend capital), in subsection (5) after the definition of "initial loan" insert—
""NHS trust" includes an NHS trust which was established by virtue of the National Health Service (Consequential Provisions) Act 2006 under section 25 of the National Health Service Act 2006, prior to the repeal of that section by section 164 of the Health and Social Care Act 2011."

Amendment 588, in schedule 12, page 307, line 7, leave out paragraph 70.

Amendment 589, in schedule 12, page 309, line 2, at end insert—
In section 28(1) (arrangements to safeguard and promote welfare: Wales), in paragraph (c) omit the words from "all or most" to the end.'.

Amendment 590, in schedule 12, page 309, line 17, leave out paragraph 93.

Amendment 591, in schedule 12, page 309, line 31, leave out paragraphs 99 and 100.

Amendment 592, in schedule 12, page 310, line 7, leave out paragraphs 104 to 106.—(Paul Burstow.)

Schedule 12, as amended, agreed to.
Clause 165

Repeal of provisions on authorisation for NHS Foundation Trusts

Amendment made: 543, in clause 165, page 137, line 20, after 'Act' insert 'and the preceding cross-heading'.—
(Paul Burstow.)

Clause 165, as amended, ordered to stand part of the Bill.

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

6.3 pm

Adjourned till Tuesday 29 March at half-past Ten o’clock.