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not later than

Monday 4 April 2011

STRICT ADHERENCE TO THIS ARRANGEMENT WILL GREATLY FACILITATE THE PROMPT PUBLICATION OF THE BOUND VOLUMES OF PROCEEDINGS IN GENERAL COMMITTEES
The Committee consisted of the following Members:

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

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

Chris Stanton, Mark Etherton, Committee Clerks

† attended the Committee
Public Bill Committee

Thursday 31 March 2011

(Afternoon)

[Mr Mike Hancock in the Chair]

Health and Social Care Bill

1 pm

The Chair: Before we proceed, I will explain one other thing that I meant to explain this morning. There will be Divisions in the House this afternoon, but, unlike in other circumstances, there will be no extra time as a result. If hon. Members want to make points and there are two Divisions, that will be half an hour out of the debating time. I repeat what I said this morning. The debate finishes at 4 o’clock, so please bear that in mind. If you have important points to make and want to get to them, we will have to work together.

Clause 242

Powers to require and request provision of information

Emily Thornberry (Islington South and Finsbury) (Lab): I beg to move amendment 652, in clause 242, page 200, line 41, leave out ‘such period’ and insert ‘a reasonable amount of time’.

I entirely take on board what you have said, Mr Hancock. I shall do my best to go as fast as I can, because I know that hon. Members want to raise a large number of points.

Amendment 652 relates to subsection (2), which requires that health and social care bodies comply with requests for information from the Information Centre in a manner and time period specified by it. The primary role of health and social care bodies must clearly be the provision of care to patients, and the amendment seeks reassurance that health care professionals will be protected from unreasonable demands for information that take them away from their clinical duties and expect them to provide information within an unreasonable amount of time. This short, sharp amendment is straight to the point.

The Minister of State, Department of Health (Paul Burstow): I think I can offer the reassurance that the hon. Lady will be able to withdraw the amendment.

Emily Thornberry: I beg to ask leave to withdraw the amendment.

Amendment, by leave, withdrawn.
danger that in this new world, because so many commercial actors are involved, we might have less well sourced and fewer uniform, mineable data available to Ministers?

Paul Burstow: I return to what I said to the hon. Member for Islington South and Finsbury. The first point is that where a provider—whether private, a charity or a public body—provides publicly funded services, it will be covered by this clause and the other clauses in this part of the Bill. The scenario that the hon. Gentleman described is important to test, but I can reassure him. As far as we were concerned when drafting the Bill, the clauses, and the powers they give to the Information Centre and other bodies, will enable us to ensure that there is consistency and the ability to compare information in the way that the hon. Gentleman fears we might not.

In addition to that, there is the contracting route, which would be available to reinforce that further, but we are confident that, as drafted, the clauses allow for those requirements to be placed on any provider funded by the taxpayer to provide free NHS care. We drafted the Bill to have that policy effect.

Also, to ensure that we can fulfil those information questions, Government amendments 683, 684 and 685, which I have just moved formally, clarify that the Information Centre will have powers to collect information from publicly funded private organisations providing health services or adult social care under arrangements with public bodies. For example, Monitor, as one of the bodies involved, could request information through the Information Centre in that way. Part of the issue is about having one organisation that is seen as the honest broker and the place where data are held, within a framework that guarantees patient confidentiality. That is the key guiding principle that we have followed in framing the provisions.

If, on reflection and having read Hansard, I feel that I have not covered every point that the hon. Gentleman has raised, I will be sure to write to him.

Owen Smith: I am grateful for that answer. However, it still seems to me that, as it relates to this discussion, clause 242 conflicts slightly with clause 243(1)(a), which essentially says that the information might not be provided if the Information Centre deemed it detrimental to the interests of the provider.

I still think that my question stands. If a commercial company, albeit one normally bound by the same rules in respect of providing services to the NHS, does not want to provide the information because it is damaging to its commercial interests—competition law will obviously apply here, so there will be a slightly different set of parameters—could it withhold that information?

Paul Burstow: No.

Question put and agreed to.

Clause 242, as amended, accordingly ordered to stand part of the Bill.

Clause 243

Publication of information

Paul Burstow: I beg to move amendment 686, in clause 243, page 201, line 15, leave out ‘—’ and insert ‘the information falls within subsection (1A); and, subject to the following provisions of this section, if the information falls within that subsection, the Centre must not publish it. (1A) Information falls within this subsection if—’.

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

Government amendments 687 to 691.

Amendment 653, in clause 243, page 201, line 24, leave out paragraph (c).

Government amendments 692 to 698.

Paul Burstow: Replying to a speech before one has heard it makes for an interesting debate. I will first deal with our amendment and then I will discuss amendment 653. We have already discussed the importance of confidentiality and privacy safeguards in respect of information collected by the Information Centre. In particular, we need to ensure that information published by the Information Centre does not lead to individual patients being identified. I would like to reiterate how important an issue that is; we do not take it in any way lightly.

Amendment 686 clarifies that when the information collected by the Information Centre is in a form described in the next subsection, the centre must not publish the information. For example, the amendment makes it clear that the Information Centre is prohibited from publishing information that identifies patients or service users. Amendment 698 corrects an inaccuracy in the definition of “provider” originally proposed in this clause. The original definition did not capture all those whose identities it may be in the public interest for the Information Centre to publish. Amendment 698 provides a more comprehensive definition of whose identity might be published.

Amendment 692 removes the old definition and amendments 687 to 690 replace the previous term with the new one. Amendment 691 ensures that when the information collected by the Information Centre does not meet published standards, the Information Centre must use its discretion as to whether the public interest is sufficient to warrant publication. The reliability of information is an important consideration for professional statisticians, for the public purse and for those who need to trust the information made available.

I want to make it clear, however, that the Information Centre may not disclose information that identifies any individual patient or service user without specific further statutory authority to do so. In addition, the powers to direct or request the Information Centre to collect information provided by clauses 238 and 239 do not themselves provide such statutory authority.

Amendment 694 sets out the circumstances in which the Information Centre may pass information to one or more bodies whether or not it was obliged to publish that information. It replaces the existing provision, which is removed by amendment 697. The Information Centre may disclose information if it considers that it is in the public interest to do so, when the reason why the information was not published was to protect the identity of a body that provided care or because the information did not meet relevant published standards.

However, we do not feel that the role of the Information Centre is to collect information that cannot be published: that should be the exception rather than the rule. There
may be circumstances, however, in which the Secretary of State or the NHS commissioning board would want information that identifies bodies to be published but in which the Information Centre, if it were using its discretion, would choose not to do so.

Amendment 693 makes it clear that the Information Centre does not have discretion where it has been directed to publish such information. We recognise that the Information Centre’s views may be important and should be taken into account. Indeed, clause 245(4) requires the Secretary of State or the NHS commissioning board to have regard to advice that the Information Centre may give. However, we feel that ultimately the Information Centre should not be authorised to disregard a lawful direction.

Amendments 695 and 696 provide the Information Centre with discretion as to how and when, and in what additional forms, it will publish information that it has collected. That discretion is subject to the duty of the Information Centre to have regard to making information easily accessible and to the likely needs of those who may benefit from the information.

Opposition amendment 652 seeks to prevent the Secretary of State or the NHS commissioning board from directing the Information Centre not to publish information that it collects.

The Chair: Order. We are discussing amendment 653, but you can come back if you choose.

Paul Burstow: I misread my brief. I shall do that.

1.15 pm

Emily Thornberry: I am grateful to the Minister for the opportunity to explain what amendment 653 is about before he decides that he does not want it. However, you never know; after seven weeks, this might be the one—[Interruption.] Perhaps we will just have to wait until the Prime Minister steps in.

Clause 243 is about the publication of information. It states that the Information Centre must publish all information that it collects, but there are some exceptions. Those are, first, when

“the information is in a form which identifies any provider”,

which makes sense, and secondly, when

“the information is in a form which identifies any individual”.

The third exception, however, is when

“the information is of a description specified in a direction given to the Centre by the Secretary of State or the Board.”

All information will be published, therefore, apart from the information that the Secretary of State would rather is not, and we wondered what that was. Will the Minister give us an example of what that information would be, particularly in light of the debate that we had on the previous clause?

Bupa, for example, might say to the Minister, “We are happy to provide services to the NHS, but we see no reason why we should be providing all this information to the Information Centre. As far as we are concerned, it should be confidential, because it will embarrass us commercially otherwise.” The Secretary of State might say, “Yes, we understand.” Would the Information Centre not publish information in such circumstances?

The Minister’s response was interesting. I wonder whether he has thought it through and whether there has been real consultation with private providers about the attitude of the Department on publishing all the information on any services provided by the private sector to the national health service. I am interested to know whether I am right, and whether clause 243(1)(c) covers those points.

Paul Burstow: I do not resile from what I said earlier. I stand by it, and it is on the record.

The Opposition amendment seeks to prevent the Secretary of State or commissioning board from directing the Information Centre not to publish information that it collects when that information would otherwise have been published. I fully sympathise with the desire to ensure that information is not withheld simply because the commissioner of that information does not like what it says. It is for that reason that a number of safeguards have been built into the Bill to ensure that this further amendment is unnecessary.

For example, the Information Centre may provide advice about the publication of information under clause 245, and the Secretary of State and the commissioning board are obliged to have regard to that. The Information Centre is also under an obligation provided by clause 244 to maintain a register that contains a description of the information that it has collected, and I referred to that register in this morning’s sitting. It would therefore be very obvious if an attempt were made to suppress the publication of data collection.

There will, however, be rare occasions when it is entirely appropriate for the Secretary of State to direct that information should be collected, but not published. For example, there might be information about a serious epidemic or a threat to public health. The release of such information will occur, but that needs to be done carefully to prevent unnecessary alarm.

I hope that hon. Members are reassured that the powers are needed and would not be abused, and that they feel able not to press their amendment to a Division.

Amendment 686 agreed to.


‘(ba) the Centre considers that—
(i) the information fails to meet the information standards published under section234 (so far as they are applicable), and
(ii) it would not be in the public interest to publish the information, or’.

Amendment 692, in clause 243, page 201, line 26, leave out subsection (2).

Amendment 693, in clause 243, page 201, line 27, at end insert—

‘(2A) A direction under section 238 may provide that the obligation to publish imposed by subsection (1) applies to information falling within subsection (1A)(a).’.
Amendment 694, in clause 243, page 201, line 27, at end insert—

‘(2B) The Information Centre may disseminate to any such persons and in such manner as it considers appropriate any information which it collects pursuant to a direction under section 238 or a request under section 239 and which falls within subsection (2C).

(2C) Information falls within this subsection if—

(a) the information is required to be published under this section,

(b) the information is in a form which identifies any relevant person to whom the information relates or enables the identity of such a relevant person to be ascertained and the Centre, after taking into account the public interest as well as the interests of the relevant person, considers that it is appropriate for the information to be disseminated, or

(c) the Centre is prohibited from publishing the information only by virtue of it falling within subsection (1A)(ba) and the Centre considers it would be in the public interest for the information to be disseminated.

(2D) In the case of a direction under section 238 or a mandatory request under section 239 the power in subsection (2B) is subject to the requirements of the direction or mandatory request.

(2E) Nothing in this section prevents the Information Centre from disseminating information (otherwise than by publishing it) pursuant to the exercise of any function conferred by or under any other provision of this or any other Act.’.

Amendment 695, in clause 243, page 201, line 28, leave out subsection (3) and insert—

‘(3) Where the Information Centre publishes information which it collects pursuant to a direction under section 238 or a mandatory request under section 239 in accordance with the requirements of the direction or the mandatory request, it may also publish the information to the person under this section.’—(Paul Burstow.)

Amendment 696, in clause 243, page 201, line 36, leave out ‘must’ and insert ‘may’.

Amendment 697, in clause 243, page 201, line 38, leave out paragraph (b).

Amendment 698, in clause 243, page 201, line 45, at end insert—

‘(3A) In this section “relevant person” means—

(a) any person who provides health care or adult social care, or

(b) any body corporate not falling within paragraph (a).’—(Paul Burstow.)

Clause 243, as amended, ordered to stand part of the Bill.

Clause 244 ordered to stand part of the Bill.

Clause 245

ADVICE OR GUIDANCE

Paul Burstow: I beg to move amendment 699, in clause 245, page 202, line 24, leave out from beginning to ‘about’ in line 26 and insert

‘The Secretary of State must, at least once in any review period, exercise the power under subsection (1)(b) by requesting the Information Centre to give the Secretary of State advice.’.

The Chair: With this it will be convenient to discuss Government amendment 700.

Paul Burstow: The amendments arise from evidence that the Government have heard. We have listened carefully to comments made outside the Committee and will continue to do so.

The NHS Confederation supports the amendments, and its members told us that the overlap and duplication of requirements to provide information can be a problem for NHS organisations. Its report on the burdens of bureaucracy, published in 2007, reflects that view. It told us:

“We are pleased that Ministers have listened to this concern and will create a new requirement for this to be reviewed every three years.”

It continued:

“We would also urge the Government to ensure that the Information Centre or the Department of Health has adequate powers to ensure its findings are put into practice when information is being collected.”

I am pleased to be able to reassure the confederation. Under subsection (4), all health and social care bodies given advice under the section must have regard to that advice. The amendments add a useful provision to ensure that every three years the Information Centre conducts a review of the burdens that data collections might have placed on the system, and they are welcomed outside the Committee.

Amendment 699 agreed to.

Amendments made: 700, in clause 245, page 202, line 28, at end insert—

‘(4) For the purposes of subsection (3) a review period is—

(a) the period of 3 years beginning with the day on which this section comes into force, and

(b) each subsequent period of 3 years.’.

Amendment 701, in clause 245, page 202, line 32, at end insert—

‘(4A) A person (other than a public body) who provides health services, or adult social care in England, pursuant to arrangements made with a public body exercising functions in connection with the provision of such services or care must, in providing those services or that care, have regard to any advice or guidance given to the person under this section.’—(Paul Burstow.)

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

Emily Thornberry: I have just been passed a note, but I have not had a chance to read it—[Interruption.] It is not from the Prime Minister, so Government Members can stand down. May I have the chance to read it, Mr Hancock because it is relevant to the clause—you might have seen it passed to me about 20 seconds ago? [HON. MEMBERS: “Who is it from?”] It is from the NHS Confederation, and since we have just heard that an amendment has been made as a result of the confederation, I want to make sure that I know what it says before I speak to the clause.

The Chair: Order. Rather than take a moment, I think it would be better if the hon. Lady read it out to everyone.

Emily Thornberry: I would rather read it first.

The Chair: Order. Then I am in the hand of the Committee. Is it the wish of the Committee that we adjourn for a minute or so to give the hon. Lady time to read the note? I hope that I have given her time to do so by asking that question. The answer is no, so I will not suspend the sitting.
Emily Thornberry: I was at the Bar for 20 years and during that time I learned a very important lesson: one should never get to one’s feet to speak on something that one does not know about. I have lived by that rule, and when I get to my feet to argue a case, I try to ensure that I understand it. Since I have not had a chance to read my note, I am not in a position to tell the Committee whether the NHS Confederation has any comments on the Government’s amendments.

The Chair: I am sure the hon. Lady has been here long enough to find a chance in the next two and a half hours to introduce whatever the confederation said.

Question put and agreed to.

Clause 245, as amended, accordingly ordered to stand part of the Bill.

Clauses 246 ordered to stand part of the Bill.

Clause 247

POWER TO ESTABLISH ACCREDITATION SCHEME

Emily Thornberry: The clause deals with the power to establish an accreditation scheme. Why does the establishment of an accreditation provider exclude public bodies? Why should a public body—perhaps a shared service function within a major foundation trust—not provide such a service? Why is it limited to private providers?

Paul Burstow: I shall speak briefly to the clause and answer that question as I do so.

The clause will allow regulations to make provision for a scheme to accredit organisations that act as information intermediaries. Information intermediaries are expected to play a key part in making better use of information to support service improvement and patient choice. An accreditation scheme may be run by the Information Centre or by any other body that is specified in regulations. The regulations would enable the operating body to set the accreditation criteria, to keep the scheme under review and to charge reasonable fees. The scheme will essentially act as a kitemark, indicating that the products of an accredited organisation are of a high quality and enabling those seeking the services of an information intermediary to select one that has demonstrated that it meets quality standards.

I return to the hon. Lady’s question, which suggested that it would not be possible for a public body to deal with that. The matter would be dealt with by regulations, so I do not believe that that is the case—I believe that the regulations could cover a public body discharging this role. If I am incorrect I will certainly write to her to correct that information, but that is my understanding. We do not prescribe that in the Bill; we deal with it through regulations—[Interruption.]

I now know that I have given the correct answer.

Question put and agreed to.

Clause 247 accordingly ordered to stand part of the Bill.

Clause 248 ordered to stand part of the Bill.

Clause 249

POWER TO CONFER FUNCTIONS IN RELATION TO IDENTIFICATION OF GPs

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

Jeremy Lefroy (Stafford) (Con): I am sorry to delay the Committee, but I have read this clause and the relevant explanatory note and I just wondered what its purpose was.

Paul Burstow: This perfectly crafted clause gives support to many of the others in the Bill. It enables the Information Centre to be provided, under regulations, with functions in connection with verification of the identity of GPs who are able to issue prescriptions. The clause is necessary to ensure that the Information Centre can collect such information. The process would involve the Information Centre checking the identity of GPs and issuing numbers that are unique to individual GPs and used in prescribing services. That is needed to ensure that only authorised GPs are able to issue prescriptions, which is a necessary safeguard of the sort that we discussed earlier in the week.

Question put and agreed to.

Clause 249 accordingly ordered to stand part of the Bill.

Clause 250 ordered to stand part of the Bill.

Clause 251

ARRANGEMENTS WITH OTHER BODIES

Emily Thornberry: Clause 251 allows the Information Centre to make arrangements with others to provide services. Would the restrictions that apply to the Information Centre, such as making reasonable charges, also apply to such an arrangement?

Paul Burstow: To illuminate the Committee, the clause enables the Information Centre to make arrangements with other bodies to carry out services. That is needed to allow the centre to make decisions on the best way of meeting its obligations. It can act only in the context for which the Bill provides, so the answer to the hon. Lady’s question is no.

Question put and agreed to.

Clause 251 accordingly ordered to stand part of the Bill.

Clause 252

FAILURE BY INFORMATION CENTRE TO DISCHARGE ANY OF ITS FUNCTIONS

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

**Emily Thornberry:** Our consideration of this clause seems an appropriate stage to address the NHS Confederation’s point:

“The Committee should consider placing a responsibility on the Secretary of State to periodically review the level of bureaucracy on NHS commissioners and providers”.

Its members say that there is overlap and duplication of requirements to provide information, which can be a real problem for NHS organisations, as the NHS Confederation highlighted in its report “The bureaucratic burden in the NHS”. It is pleased that Ministers have listened to its concerns and will create a new requirement for this to be reviewed every three years. It also urges the Government to ensure that the Information Centre or the Department of Health has adequate powers to ensure its findings are put into practice when information is being collected.

**Paul Burstow:** It is good to have that on the record twice, because I have just rehearsed those points. I am also pleased to be able to reassure the NHS Confederation and the hon. Lady. Clause 245(4) states:

“A health or social care body to whom advice or guidance is given under this section must have regard to the advice”.

As we have discussed at various points in our proceedings, “have regard” is not a term to be taken lightly. It means that such bodies will have to take the information carefully into consideration. Those issues were raised by the NHS Confederation back in 2007, and the Government have acted on them at the earliest opportunity.

**Question put and agreed to**

Clause 252 accordingly ordered to stand part of the Bill.

Clause 253 ordered to stand part of the Bill.

**Clause 254**

**POWERS OF SECRETARY OF STATE AND BOARD TO GIVE DIRECTIONS**

**Amendments made:** 702, in clause 254, page 205, line 18, leave out ‘functions’ and insert ‘of the information functions of any health or social care body’.

Amendment 703, in clause 254, page 205, leave out lines 19 and 20.—(Paul Burstow.)

Clause 254, as amended, ordered to stand part of the Bill.

Clases 255 to 257 ordered to stand part of the Bill.

**Schedule 18**

**PART 9: CONSEQUENTIAL AMENDMENTS**

**Amendment made:** 704, in schedule 18, page 337, line 34, at end insert—

‘National Assembly for Wales (Disqualification) Order 2010 (S.I. 2010/2969)’

In Part 1 of the Schedule to the National Assembly for Wales (Disqualification) Order 2010 (bodies of which the members are disqualified), at the appropriate place insert—“Health and Social Care Information Centre;”.—(Paul Burstow.)

Schedule 18, as amended, agreed to.

**Clause 258**

**THE ALCOHOL EDUCATION AND RESEARCH COUNCIL**

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

**Mr Kevin Barron** (Rother Valley) (Lab): The clause will abolish the Alcohol Education and Research Council, and I want to ask the Minister a few questions about that. The council’s role is to generate and disseminate research-based evidence to inform and influence policy and practice, and to develop the capacity of people and organisations to address alcohol issues.

My understanding is that the council works. It gives good advice to different organisations in the UK about alcohol which, as I am sure all hon. Members realise, is a public health issue that has grown rapidly in the last decade or two in this country. I am concerned about the abolition of this council, even though the explanatory notes say that it will be made into a separate charitable body. I would like to ask the Minister exactly how it will operate and what its new status means.

Hon. Members will know that in recent months the Government have been putting together the responsibility deal. There are numerous areas in which people are trying to influence what we eat and drink and everything else, but the Government’s responsibility deal alcohol network has not been able to agree the way forward, as I am sure the Minister is well aware. Six organisations in the network have refused to sign up to what the Government are proposing: Alcohol Concern, the British Association for the Study of the Liver, the British Liver Trust, the British Medical Association, the Institute of Alcohol Studies and the Royal College of Physicians, in which I have registered an interest during our Committee proceedings.

Those organisations have refused to sign up because they are not convinced that the Government’s responsibility deal on alcohol will work. Their collective statement says:

“The overall RDA policy objective to ‘foster a culture of responsible drinking’ does not adequately address the need to reduce alcohol-related mortality and morbidity.”

It continues:

“The RDA drinks industry pledges are not specific or measurable and do not state what would be the evidence of success.”

The statement goes on and on, but it also says:

“There has been no commitment made on what alternative actions the Government will take if the RDA pledges do not significantly reduce levels of alcohol-related harm.”

These major charities have been involved for decades in examining alcohol misuse and treating people for alcohol abuse and binge drinking in this country. If they will not sign up to the responsibility deal, it must raise some question marks about the journey that the Government are making. The British Retail Consortium, the members of which have played a major part in the responsibility deal, has also questioned the whole issue.

**Nick de Bois** (Enfield North) (Con): I am sure the right hon. Gentleman is aware that the Alcohol Education and Research Council has said of its future status that it believes:
“The creation of a new, independent charity will bring considerable benefits and open up significant new opportunities for the stakeholders in it.”

The council itself therefore welcomes this opportunity.

Mr Barron: As I have said, I want the Minister to allay my concern about these changes and how they will affect alcohol policy. Alcohol policy is in a bit of a mess at the moment.

The British Retail Consortium put out a press release saying:

“it has emerged that a number of NGOs have opted to not support the responsibility deal, believing that the pledges do not go far enough, or that Government is too close to industry.”

The Health Committee echoed that in the last Parliament, when I was a member, when one of its reports found that the previous Government were far too close to the industry. The British Retail Consortium also says:

“While this is disappointing, we think this reaction, as well as the process itself, should form part of a review into the Deal, to capture the lessons, before the Government rolls this approach out in other areas of policy.”

There are major issues around alcohol and public health. I am disappointed that we have ended up in such a situation with the responsibility deal, but I would not want Members to think for one minute that I am not in favour of its aims. If we look at what has happened with processed food in the past eight years or more, there has been a massive reduction in salt, for example, and that has happened due to co-operation among the food industry itself, the Food Standards Agency and other organisations.

Let us hear the Minister say that the abolition of the council, or its change to a charitable body, will not affect the work it has been doing and our uphill struggle against alcohol abuse in this country and its ill effects. Will he confirm that that change to charitable status will not stop the work that the council has been doing in recent years?

Owen Smith: My right hon. Friend has set out many of the points that I was going to make. I am particularly interested in the clause because I know that the Alcohol Education and Research Council has had a particular impact in Wales. It has conducted research into the impact of alcohol misuse on young people and families, which led to the formation of the strengthening families programme—SFP10-14—which operated extremely successfully in south Wales, particularly in the Cardiff area with the drug and alcohol misuse board. Although the clause does not abolish the fund that the council has hitherto administered, can the Minister offer any reassurance that the funding will in no way be jeopardised by the council’s change in status because, as my right hon. Friend said, alcohol misuse is such an enormously important issue?

Debbie Abrahams (Oldham East and Saddleworth) (Lab): Most of my points have been made, but I reiterate that the organisation has contributed significantly to the evidence base around alcohol-related harm. It is a real concern that this will not be able to continue in the way that we would like. There are also concerns about the trend towards the alcohol industry having more sway than such important organisations.

Paul Burstow: I am happy to respond to the debate and give some of the reassurances that right hon. and hon. Members have sought.

The comments that the right hon. Member for Rother Valley made about the responsibility deal, and particularly about the way in which such engagement with industry can result in greater and more rapid progress, were welcome. That is the responsible way to approach the responsibility deal, too. One of the misconceptions that has been spread around is the belief that the deals are the only game in town when it comes to public health policy. Some of the non-governmental organisations with which we have engaged on the responsibility deal in respect of alcohol have certainly had that misapprehension. They thought that the responsibility deal was the only way in which issues around alcohol harm could be pursued, but that is not true.

In the meetings that we have had with a variety of NGOs, including those to which the right hon. Gentleman referred, the Under-Secretary of State for Health, my hon. Friend the Member for Guildford (Anne Milton), and I have made it very clear that the Government also intend to produce a strategy for reduction in alcohol harm. The Government are already moving on a number of fronts, particularly around price and the use of tax policy to make more progress than has perhaps been made up until now. However, the NGOs seemed to want to have a debate with industry, with all the companies in the room, about setting prices and tax policy. It is not possible to have industry in the room collectively agreeing on price issues because that breaches competition law, so we were not prepared—or able—to have conversations in that context.

That does not mean that the Government do not want to make progress on those issues. Indeed, the key thing is who sets policy. I am clear that it is the Government who set policy, not industry and not NGOs. As long as we are clear about that, we will listen to both sides and make judgments appropriately. We have seen some marked movements already with the responsibility deal on alcohol, not least from one supermarket that has decided to withdraw all front-of-shop alcohol promotions. Another alcohol purveyor has committed itself to reducing the alcohol content of one of its leading brands. Those are useful nudges—to use a much maligned phrase—to others to act in such a way.

1.45 pm

To answer Opposition Members’ questions, the Alcohol Education and Research Council does have a future. It does not have a future as an arm’s length body within statute, but it has a future as a charity. Dave Roberts, the chief executive of the AERC, has said:

“We are very excited by these developments. We believe that the creation of a new, independent charity will bring considerable benefits and open up significant new opportunities for both the organisation and our stakeholders.”

The body is embracing the change and sees an opportunity to be an independent organisation offering the expertise that it has developed over several years.

The fund is secure, and we are not changing the funding arrangements in that regard. We are simply ensuring that the organisation can act independently of the Government as a charity and continue to provide its valuable services. On Wales, which we should not leave out of our considerations, the fund will still be there,
and it will still work in Wales in the future. I can also assure the Committee that the Welsh Assembly Government have agreed to the change.

Question put and agreed to.

Clause 258 accordingly ordered to stand part of the Bill.

Clause 259

THE APPOINTMENTS COMMISSION

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

Liz Kendall (Leicester West) (Lab): As hon. Members know, the Appointments Commission, which the clause will abolish, oversees, among others, all primary care trust chair and non-executive director appointments. We learnt from page 3 of The Times today that the Prime Minister is seeking to put a brake on the reforms that the Ministers are so valiantly attempting to defend. The article states:

“Instead of a swift revolution, in which GPs take control of all local healthcare services within two years, Downing Street is considering a slower pace of change”.

Nick de Bois rose—

The Chair: Order. I have to say that, interesting though it is, that article bears little relationship to the business before us today. I have to rule that we discuss what is before us, rather than what is potentially before us. If you are talking about the Appointments Commission, can we stick to that and not to something that might be purely hypothetical?

Liz Kendall: My point is absolutely relevant. If the Government are about to make changes to the Bill and say that primary care trusts will not, as we read in The Times—

The Chair: Order. I have to rule that speculation on changes could effectively be made on every clause that we are about to discuss, because the article does not explicitly explain where the Prime Minister might make changes, so we can only speculate. We are not here to speculate; we are here to decide whether clause 259 will abolish, oversees, among others, all primary care trust chair and non-executive director appointments. We learnt from page 3 of The Times today that the Prime Minister is seeking to put a brake on the reforms that the Ministers are so valiantly attempting to defend. The article states:

“Instead of a swift revolution, in which GPs take control of all local healthcare services within two years, Downing Street is considering a slower pace of change”.

Order. I have to rule that speculation on changes could effectively be made on every clause that we are about to discuss, because the article does not explicitly explain where the Prime Minister might make changes, so we can only speculate. We are not here to speculate; we are here to decide whether clause 259 should remain in the Bill. We cannot make speculative judgments. We must recognise what we are discussing here.

Liz Kendall: I bow to your ruling, Mr Hancock.

It is wrong to abolish the Appointments Commission. Opposition Members would argue that if we need to keep primary care trusts to ensure that there is greater stability and financial control in the system, they will have to have chairs and non-executive directors appointed, just as GP commissioning consortia or clinical consortia, or whatever they end up being called, would, I hope, also have such positions appointed in future to give them some kind of governance or accountability. We argue that the commission should be kept, so that appointments can be made, especially if primary care trusts, as nobody is speculating, will be kept in future.

Mr Barron: I do not want to carry on from where my hon. Friend left off, except to say that, if there are any changes to the Bill coming down the road—particularly anything about the slowing-down of the process—it might be the case that people in situ, who were appointed by the Appointments Commission, may have to be kept on for a length of time.

I have one other question. I have been through the NHS Appointments Commission process—the second time I was appointed a lay member of the General Medical Council. It was very much at a distance from Government, although I was a politician at the time. I see that the power will remain with the Secretary of State if and when the commission is abolished, and I would like some reassurance that, if in any future shape or size it sits in Richmond house, it will be as even handed, no matter who is in government, and professional as when I went through it.

Owen Smith: My point is nothing to do with the story in The Times this morning, however fascinating that was—

Liz Kendall: Will my hon. Friend give way?

The Chair: Order. I can understand hon. Members being demob happy this afternoon, but their enthusiasm encourages me to believe they have something to say.

Owen Smith: My question relates more broadly to the decision to abolish the Appointments Commission. The history of the Appointments Commission is quite interesting. It was established in 2001 as a body to appoint people within the NHS—

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

The Chair: If you wish to intervene, Mr Burns. I suggest you rise to do so. I think that Ministers are here to answer the questions, rather than Opposition Members.

Owen Smith: Thank you Mr Hancock. As I was saying, I will briefly relate the fascinating history of the Appointments Commission. It was established in 2001, within the NHS, to appoint people to trusts and other NHS bodies, but its role has expanded significantly over the last couple of years. In 2003 it was expanded to include appointments to all bodies in the health and social care sector. Then—this is my real point—in 2006, its role was expanded further and its name changed to the Appointments Commission, from its original title, the NHS Appointments Commission. It became a body responsible for providing recruitment and selection services to all Government Departments. It is therefore no longer concerned solely with the NHS, or just health and social care bodies; it is responsible for absolutely everything—all Government Departments. To safeguard its original role in the NHS, a special committee—the health and social care appointments committee—was established internally to carry on the NHS part of the role.

I have three questions. First, if the Government wanted to change the procedures in the NHS and, as the clause suggests, pass all the responsibility for recruiting and selecting for all NHS bodies to the Secretary of...
State, why not simply abolish that committee within the Appointments Commission?

Secondly, what will be the procedure in future for selecting, recruiting and sourcing people for public bodies within the NHS? The responsibility will pass to the Secretary of State. His responsibilities will be dramatically reduced by the Bill, because he will no longer be directly responsible for promoting universal health care—that will be the responsibility of the NHS commissioning board quango—but I would not have thought he will have enough time to recruit and select people for all the various GP consortia and other public health bodies. Is it not likely that we will see Odgers or one of the other headhunting firms, as opposed to a public body, selecting people with the relevant expertise and experience? Is it not more likely that we will see more private recruiting companies employed by the Secretary of State to source, select and appoint these individuals?

Thirdly, what process will apply in other Departments? The decision implemented in the Bill will affect all other Departments. Every year, the Appointments Commission selects more than 1,000 people to leading roles in public bodies in this country. That is a lot of work for other Ministers to undertake. Can the Minister point to where in other Bills those other Ministers will be given the responsibility for taking on the role that previously has been conducted by the Appointments Commission?

The Chair: I do not think it is the Minister's job to explain what is going to happen in different Departments. His responsibility to this Committee is to explain what is going to happen in the Department of Health. I was a bit nervous for a minute there, Mr Smith. You got very comfortable leaning on the back of your chair. I thought that we were in for a very long speech.

Paul Burstow: Let me start by being very clear about where responsibility sits once the Appointments Commission is abolished. Yes, it rests with Ministers, but it rests within the context of a framework of existing safeguards that apply to ministerial appointments in other Government Departments. These appointments will be undertaken in accordance with the code of practice issued by the Commissioner for Public Appointments, who is not being abolished and will continue to be subject to that office's scrutiny. That will help to ensure that the process remains open, transparent and that appointments are made, as they always should be, on the basis of the merits of the candidates.

There was a number of questions about how long the Appointments Commission will continue to work. The Department and the commission are working towards a planned abolition date of 31 March 2012, which leads on to a question about what happens in the interim period between its abolition and the abolition of primary care trusts in 2013. Where necessary re-appointments, or in a more limited number of cases, extensions of appointments, should be made for strategic health authority and PCT chairs and non-executive directors up to the latest abolition date for the body. Otherwise, either a vacancy will be carried, as long as the board can function effectively and is quorate, or a temporary appointment will be made in the context of the code that I just described, which is overseen by the commissioner.

The Department has also amended legislation to allow the flexibility for primary care trust non-executive directors to serve on more than one PCT board, in part to reflect the current clustering. The hon. Member for Pontypridd asked me about the Appointments Commission's responsibility for other Government Departments. It can make appointments elsewhere, but the vast majority of the appointments it makes are to the NHS. One of the other changes that we have already debated are the changes to the governance arrangements for NHS trusts, with all of them moving to foundation trust status, where they will be responsible for their own appointments. The commission is not sustainable as a non-departmental public body once those NHS appointments are removed from its remit, so other Departments will appoint in the same way as I have described: Ministers will appoint on the basis of merit and subject to the code of practice.

Owen Smith: Does the Minister not accept that it is a retrograde step to reverse the arrangement wherein an arm's length body administers appointments in the NHS and return to the status quo ante where the Secretary of State does it? Is that not also at odds with the Government's stated aim to remove the Secretary of State and reduce political interference in the NHS?

Paul Burstow: No, no and no. To expand ever so slightly, the number of appointments that would be made in future would be in the tens, not the thousands and because of that and because they are appointments to positions such as the chair of the Care Quality Commission, or to Monitor, or to a limited number of other posts such as on the NHS commissioning board, it will be appropriate for those matters to be discharged by ministerial appointment in the context of the code and the necessary supervision that is provided both to the Department of Health and other Government Departments.

2 pm

John Pugh (Southport) (LD): I stand to be corrected, and I am obviously a disappointed and bitter person because I have never been on a quango in my life or been a non-executive anything, but presumably appointments will be made to acute trusts which are managed through the appointments process. Is that not the case? Acute trusts will continue to exist and there will presumably be plenty of them. I received an advertisement today about my local acute trust that appeared to come from the Appointments Commission. In the past, a disproportionate number of the candidates who got such posts seemed to be of a favoured political party, depending on who was the Secretary of State at the time. Will the Minister assure me that there will be rigid monitoring, so that when the Secretary of State has this power, appointments will be made in a transparent way and no political bias can be detected?

Paul Burstow: Yes is the first and straightforward answer to that question. Secondly, in future all acute trusts will be foundation trusts and therefore responsible for their own governance arrangements. There will be accountability and safeguards for that, which we debated last week. Such decisions will not be made by the Secretary of State; they will be made by the members and the governors of the foundation trusts.
In its report, “Smaller Government: Shrinking the Quango State”, the Public Administration Committee concluded that the Government’s current approach to arm’s length bodies “is not going to deliver significant cost savings or result in greater accountability.”

That is an important consideration, although patient safety is paramount in our present discussion. It goes back to the Government’s whole approach to quangos and arm’s length bodies and whether there are real savings to be made, or whether it is the product of an ideological drive to make changes. I do not want to muddy the waters, but concerns have been raised about that generally. The Royal College of Nursing is concerned that patient safety could be compromised by a much reduced service resulting from the NPSA’s abolition. As I have said, the Public Administration Committee has stated that the Government’s approach to abolishing quangos does not necessarily deliver all that they said it would. I would like to hear the Government’s views on that.

The patient safety division function will become part of the remit of the NHS commissioning board. There was some debate earlier about this, but this is our first chance to discuss it in some detail. The impact assessment states that “Only the functions relating to the PSD will require primary legislation”.

I am not trying to make a political point, but I would like the Minister to say a bit more about that. The impact assessment goes on to state that “The work of the PSD relating to reporting and learning from serious patient safety incidents will move to the NHS Commissioning Board as a Patient Safety sub-committee of the Board.”

I understand from the impact assessment that that is supposed to happen by September this year. The Minister may want to say more about that, because the timing and the scale of the change are clearly important. Given that the new body would be a sub-committee of the board, what assurances can the Minister give us on the priority and focus that the NHS commissioning board will give it?

Again, the impact assessment states that “The work of the PSD relating to reporting and learning from serious patient safety incidents will move to the NHS Commissioning Board...This is intended to happen by September 2011.” I have just mentioned that, but it is useful to repeat it. The impact assessment continues:

“The functions for which the sub-committee would be responsible (for overseeing or arranging) would include: Coordinating system-wide patient safety activity in the health service; Improving the safety of NHS care by promoting a culture of reporting and learning from patient safety incidences including adverse events or near misses; Devising, implementing and managing patient safety systems, or arranging for these, including providing for the existing national reporting and learning system (NRLS) and central alerting system (CAS), with a view to informing and disseminating learning; Appraising and analysing information on reported adverse events and near misses, identifying patterns of practice or service provision that appear causally related to unexpected or serious adverse outcomes.”

Those are exceptionally important areas of responsibility. Is the Minister confident that that can all be simply transferred and taken on by the board? As I have stated, according to the impact assessment it is intended that the sub-committee should be up and running by September this year.
The priority that the sub-committee will be given by the NHS commissioning board is important, as is the make-up of the sub-committee. I suspect the Minister will probably say that that is up to the national commissioning board to decide, but I wonder whether in drawing up this legislation the Minister has had discussions with the other Departments or with the health service as a whole about the possible make-up of the sub-committee. Although he could say that that is up to the NHS commissioning board—he might not say that; I might be pre-empting him—it is important that we know the level, calibre and responsibilities of people who could be considered for that sub-committee, in order to give us confidence.

I note with interest paragraph E98 of the impact assessment, the second sentence of which states:

“If the NHS Commissioning Board is set up with outposts, the strategic thinking and leadership on safety could sit at Board level, while support for operational delivery could sit with the outposts.”

That is interesting for a couple of reasons. When we asked whether the national commissioning board would have regional or local offices, we were told that that was completely up to the board to decide, yet the impact assessment suggests that there could be outposts. What is the likely outcome? [Interruption.] The Minister can intervene if he wants.

Paul Burstow: It says “if”.

Derek Twigg: In earlier sittings, Ministers refused to discuss whether the national commissioning board would have regional offices—I think you were here for that, Mr Hancock. Whether or not the word used is “if”, the matter is discussed in the impact assessment. It is interesting to see that a regional office is known as an outpost—that might be some indication of how important the regions will be. I am not sure where the terminology comes from. Has the Minister had any more thoughts on whether having regional offices would be a logical extension? I want to repeat the quote for him, because this is important:

“the strategic thinking and leadership on safety could sit at Board level, while support for operational delivery could sit with the outposts.”

Is the Minister able to confirm the costs? Paragraph E103 says that “the Department anticipates that there will be”—could be—

“indirect costs, such as a loss in output caused by the underperformance of a disenchanted workforce during the transition period.”

I accept that it is in the impact assessment as a possibility, but it will be useful to hear whether the Government are thinking along those lines. Is there more information on the staff and how they are reacting? What safeguards have been put in place? The paragraph also mentions “a loss of NPSA stakeholder assurance”, which is important. Interestingly, the following paragraph says:

“There is a possible risk that bringing the PSD into the NHS Commissioning Board will lead to reduced importance for patient safety”.

I accept what the Minister says about the mitigating measures in that regard.

These are important matters. We are not trying to score political points, but asking crucial questions about patient safety and the changes that the Government are making. Part of our argument, which is very real, is about fragmentation. The whole reorganisation process will take a long time and many people will be involved, and they could take their eyes off the ball—that is in the impact assessment. It is important to get answers to our questions and assurances about the crucial area of patient safety.

Jeremy Lefroy: I have three very brief points, and with them three very brief questions.

My first point follows what the hon. Member for Halton said about the importance of patient safety. Clearly, after the Mid Staffordshire experience, patient safety is now taken extremely seriously throughout the NHS—I am sure that it always was in most cases, but it is now at the forefront of NHS services. There are two ways to regard the abolition of the NPSA. Either it indicates that there is less emphasis on patient safety; or—the alternative that I subscribe to and the explanatory notes endorse—it embeds patient safety in the heart of the NHS. In fact:

“The intention is to ensure that patient safety is embedded into the health service through commissioning consortia and the contracts they agree with providers.”

I welcome that.

Derek Twigg: The hon. Gentleman makes an important point. Does he accept that our concern is reasonable? I hear what he says about a lot of emphasis being put on patient safety, and of course there is, but the health service is about to go through the biggest reorganisation in its history. There is a massive amount of work to do, ranging from work on clinical care and commissioning to pricing, accommodation and other reorganisation issues, so there could be a danger that people will take their eye off the ball, because the reorganisation will pull them so much in one direction. That is the point I was trying to make.

Jeremy Lefroy: I thank the hon. Gentleman and I would underline his point. I was about to say that it is vital that the ball is not dropped in the transition between the NPSA and the embedding of patient safety in the heart of the NHS and the national commissioning board. Patient safety is of the utmost importance. I would like to hear the Minister’s reaction to that and to get that on the record.

2.15 pm

Secondly, I ask the Minister to comment on the likely outcome of the Francis inquiry. I am sure that there will be a lot on patient safety, and I ask him what his reaction will be to any suggestions that might be made. Patient safety has been an important part of that inquiry.

My third point concerns the national research ethics service. It may be a minor part of the NPSA’s remit, but I see the risk of something falling between the gaps when I read the explanatory notes. Research ethics are key if we want to be at the forefront of medical research internationally—indeed, we are at the fore at the moment, and we must not fall behind. How will the Government ensure that there is no hiatus between the present provision under the NPSA and that envisaged in the Bill?
Liz Kendall: At the end of his speech the hon. Gentleman the Member for Stafford asked a question I was going to ask. It is clear that the clause abolishes the National Patient Safety Agency and moves responsibility for the national reporting and learning service to the NHS commissioning board, but it does not say what will happen to the national research ethics service, which guarantees or attempts to guarantee the safety and rights of patients involved in research and to promote ethical research; nor is it clear what will happen to the national clinical assessment service, a part of the NPSA which helps practitioners and managers to prevent patient safety incidents from happening.

I have an example of what the National Patient Safety Agency does from my own experience of running the ambulance service network. The NPSA’s work is very important, and I am concerned about its responsibilities moving to the national board. We did a large piece of work with the NPSA where it provided from the ambulance services all the reports of patient incidents where there were real safety concerns. Those incidents often happened during the handover period, when ambulances turn up at hospital or people are leaving hospital. The NPSA gave its initial findings to the network and we met with all our members from the various ambulance services and talked about how to increase reporting rates where appropriate—there were big variations between different ambulance services which did not make sense. We explored the data, saw what was happening, what the impact on patients was and what was going wrong. We held a big event where people could, in a safe environment, say what had really happened and why they thought things had gone wrong. We learned from best practice and from what other people were doing to try to reduce those safety concerns.

That is one small area of patient safety, yet a very important one that had not been looked at before. My worry is that the national commissioning board has so much else on its plate that it will not be able to do that kind of work in detail across a range of different areas.

With the big reorganisation that the Government want, it is right that safety is integral to the work of commissioners. However, we know staff have been worried in the past about reporting patient safety incidents, basically in case they got into trouble. Now they are being asked to report incidents not to an independent service but to the board itself in future?

Owen Smith: In that case, I will not repeat concerns that my hon. Friend has just raised, but I will add one further, important illustration. The National Patient Safety Agency is responsible for both funding and monitoring the national confidential inquiries. Three are undertaken every year; they examine patient outcome and death, maternal and child health care, and suicide and homicide. NCEPOD—the national confidential enquiry into patient outcome and death—is particularly important to the NHS. It is one of the key investigative tools that the NHS has to provide it with meaningful scrutiny of outcomes—the most important outcome, which is whether patients die as a result of NHS treatment.

By way of further illustration, the most recent NCEPOD report, which was about deaths of patients within 30 days of cancer treatment, has been hugely influential in shaping the latest iteration of the national cancer strategy. I cannot imagine that NCEPOD is being abolished, so will its funding and monitoring pass to the national commissioning board? Is the Minister confident that among the commissioning board’s many other priorities, many of which will be administrative, it will have the requisite time and expertise to conduct that work? Is there not a danger that some of the expertise of the NPSA will be lost?

My second point, as ever, relates to Wales. The NPSA is a prime example of a body that touches Wales and England. Its remit covers both countries, and in passing its responsibility wholly to the national commissioning board, there is, as far as I can see, no provision in the Bill for what will happen in Wales henceforth. Which body will be responsible for the activities undertaken hitherto by NPSA? If I am wrong, and the Minister can point me to the place in the Bill where it says what will happen in Wales, I shall be grateful.

My third and final point relates to the national clinical assessment service. The explanatory notes state that it will move to being self-funding, which raises a question in my mind, related to the one I asked on Tuesday about the abolition of the Office of the Health Professions Adjudicator. My concern is that that will lead to less independent scrutiny of clinicians’ fitness to practice. What reassurance can the Minister give that, in becoming somehow self-funding, the important work that the NPSA undertakes in that respect will not become less rigorous? In other words, will people not want to use the service if they have to pay for it in future, which seems an obvious risk? In other words, will people not want to use the service if they have to pay for it in future, which seems an obvious risk? In other words, will people not want to use the service if they have to pay for it in future, which seems an obvious risk? In other words, will people not want to use the service if they have to pay for it in future, which seems an obvious risk? In other words, will people not want to use the service if they have to pay for it in future, which seems an obvious risk?

Paul Burstow: I shall try to work my way through the various questions that I have been asked.

With the opening remarks of the hon. Member for Halton, we returned to a debate on which we spent some happy hours at the beginning of the Committee: whether the NHS commissioning board would have a local or regional presence. As I tried to intimate to the hon. Gentleman, the impact assessment is drafted to indicate that that is an if and remains so. All I would say is that we have indicated that we expect, not least because the NHS commissioning board will have membership of the local health and well-being boards, that it will have some form of local presence. We expect the NHS commissioning board to have the responsibility for defining precisely how that is delivered.
The hon. Member for Halton made a point about the RCN and its view about the important role that is currently discharged by the National Patient Safety Agency. There is no difference between either side of the Committee on the importance that the Government attach to patient safety. We see that as a key priority for all those working in the health service. We cannot allow patient safety to be an add-on, or an afterthought. For that reason, the Bill puts safety at the heart of the NHS and not at arm’s length, which is how it is currently arranged.

Currently, the NPSA’s core function is to improve the safety of the NHS by promoting a culture of reporting and learning from adverse events. It does that primarily through the patient safety division, which runs the national reporting and learning systems. Functions of the organisation, while necessary in the system to support wider quality and safety improvement, do not of themselves need to be reformed at arm’s length from the Department. Safety is a key domain of quality and will therefore be a central priority for the commissioning board. Patients rightly expect that any service provider within the NHS, and funded by the NHS, should be safe.

The hon. Gentleman’s suggestion that somehow this is an example of fragmentation, is really nonsense. Clause 19 inserts new section 13M in the National Health Service Act 2006 to make provision to give the NHS commissioning board responsibility for the functions currently carried out by the NPSA: the collection of information about patient safety incidents, the analysis of that information, and the sharing of the resulting learning with all providers of NHS services—those who contract with commissioning consortia, or directly with the NHS commissioning board. There is a notion that having those functions in a nominally arm’s length body somehow makes them more effective than bringing them right into the core of commissioning activity and leadership within the system, which we think is a far more powerful way of driving a safety agenda through the NHS.

Let me address the question from the hon. Member for Halton about what will happen to the NPSA. We now know of the power the national reporting and learning system has for driving improvements in the safety of services; the NPSA’s national reporting and learning system is the most comprehensive system of its kind in the world, and we will preserve and improve on it. There is no intention for that system to be jettisoned as part of the transition.

The hon. Gentleman also asked about staff at the NPSA. The NPSA is working with its board and the Department of Health to ensure that a robust transition plan is in place to help protect staff. The NPSA has offered various forms of support to its staff, and, in December, embarked on a consultation with staff on the detail of proposals for staff. Indeed, the hon. Gentleman referred to paragraph E104 of the impact assessment. If we read on, it notes:

“Furthermore the transfer of staff to the NHS Commissioning Board will ensure that expertise in patient safety is retained and the commitments outlined above”—

in that clause of the document—

“will ensure that the role of patient safety - and the importance that patients place on safety under the NHS care - are maintained.”

That is an important part of the impact assessment, which it is right to refer to in this part of our proceedings as well.

I was asked when the functions will be transferred. The NHS commissioning board is unlikely to take on NPSA functions until early 2012. Abolition of the NPSA is expected to take place on 31 March 2012. Therefore, the suggestion that it will take place in September 2011 is no longer the case. Following discussions with the shadow chief executive of the NHS commissioning board, it has been decided to make clear, to ensure—

Derek Twigg: Just to be clear, paragraph E97 states that the transition will happen by September. I accept that these things change. The Minister has just said that it will now happen in 2012. What led those who wrote the document, and the Ministers who approved it, to think that the transition could be made by September 2011?

Paul Burstow: The thinking was that it was a task that would need to be dealt with at an early stage in the preparations of the NHS commissioning board. We have now taken the view that to maintain continuity in service and to work through the issues of staff transfer, it makes more sense to work on the basis of 31 March 2012 as the point at which the National Patient Safety Agency is abolished.

I was asked some questions about the National Clinical Assessment Service, the patient safety division, the National Research Ethics Service and the national clinical audit and patient outcomes programme. The patient safety division, which both reports on and learns from serious patient instances, should move to the NHS commissioning board as a patient safety sub-committee of that board, covering the whole function from getting evidence to working up evidence-based services. That will provide an opportunity to preserve the synergy between the learning and operational practice that already exist in the system. We are engaging with the National Patient Safety Agency to discuss the transitional arrangements for the patient safety division.

In respect of the questions about the National Clinical Assessment Service that were asked by the hon. Member for Leicester West and my hon. Friend the Member for Stafford, I have to say that the service is widely valued by doctors, dentists and pharmacists. However, there is an expectation that revalidation of the medical profession and other incentives in the system will reduce the need for such a service in the future. The National Clinical Assessment Service will become self-funded, and the Department intends to agree a date with the service for achieving that self-sufficiency.
Reference was made to the National Research Ethics Service, which helps to protect the interests of patients and research participants in clinical trials and facilitates and promotes ethical research. It also recognises and authorises research ethics committees that approve individual research applications. We propose that the future of the National Research Ethics Service is considered as part of the wider Academy of Medical Sciences review of research regulation with a view to moving the function into a single research regulatory body in due course.

The hon. Member for Pontypridd asked about the National Patient Safety Agency’s work in respect of clinical audits and so on. Currently, there are three confidential inquiries to provide learning about what went wrong in adverse health care incidents. In future, the inquiries would sit with the national clinical audit and patient outcomes programme, which consists of 30 individual national clinical audits managed on behalf of the Department by the Healthcare Quality Improvement Partnership.

Finally, let me come back to the over-arching point about patient safety. We are developing outcome measures for patient safety so that everyone can see how the NHS is performing and organisations can be held to account by the people they serve. My hon. Friend the Member for Stafford asked about the inquiry and the Francis report. I reiterate the point that I made to him previously. We are listening to that inquiry.

Owen Smith: Wales?

John Pugh: The Minister said at one point that if someone is a whistleblower, it is at least probable that they will want to refer to a commissioning body rather than to an arm’s-length organisation. There is no either/or in this. I was slightly concerned by what he said. I am well aware of a specialist commission in which there are serious accusations of incompetence on the part of surgeons. I am also aware of allegations that these whistleblowers have been treated extraordinarily badly within the organisation.

It is obviously very important that a whistleblower with an honest concern should find it easy to blow the whistle when appropriate. The whistleblower can do one of two things. First, they can blow the whistle and get in trouble with their own provider, which is a tough choice to make, especially if they are not guaranteed anonymity or protection. I can cite a number of whistleblowers who have been offered anonymity but that anonymity has been betrayed by the provider.

Secondly, given the scenario laid out in the Bill, the whistleblower can report to an organisation that directly commissions the particular service. I am not certain whether that will make a whistleblower more or less confident to do the important job of whistleblowing. The Government have made appreciable progress and their rhetoric gives the impression that they genuinely wish to make it easier for whistleblowers to report errors.

I may be asking for too much, but I wonder whether there is sufficient evidence to suggest that people are more comfortable going to a body that provides the wherewithal—the funding or the cash—for their organisation, even if it is one of its sub-committees, or going to a completely independent body. The hon. Member for Leicester West made that point, but it was not quite answered by the Minister, who seemed to suggest that that might be an alternative. However, it need not be an either/or if the net effect is that fewer whistleblowers feel secure in what they endeavour to do.

Owen Smith: I want to come back in, because the Minister did not answer my question about Wales. Other members of the Committee with Welsh interests may not be concerned about having an answer, but I absolutely am. I am very keen to hear who will be responsible for paying for services in Wales that were previously carried out by the National Patient Safety Agency.

Derek Twigg: I welcome some of the things that the Minister said, but we still have serious concerns. The fact that the Government got the date wrong—the change was intended to happen by September 2011—is a serious concern, as we are talking about national patient safety. It is worth repeating, so that we can understand this, that the Government stated:

“The work of the PSD relating to reporting and learning from serious patient safety incidents will move to the NHS Commissioning Board as a Patient Safety sub-committee of the Board. This is intended to happen by September 2011.”

We have now heard that that will not happen until September 2012, and I would not put money on even that being the date. If they can get that wrong in their impact assessment, that is a serious issue that raises more concerns about their going apace with the whole process.

We are told that that is what the Bill is all about, but we have to examine the fragmentation caused by the Bill, the pressure brought about by both the reorganisation and the monetary constraints on people, and the speed at which the Government are trying to take the changes forward. That is why we have had this debate. We have found out only one nugget of information on one or two other interesting issues. I am interested to hear what the Minister has to say on the points that have been made, as we have serious concerns. Unless he can convince us otherwise, we will vote against the clause.

The Chair: For the third and last time, I hope, I call the Minister.

Paul Burstow: I will be brief, not least because we are expecting one or two Divisions at 3 pm, and there are still 20 clauses and two groups of new clauses to be dealt with. As a result, we may not manage to get to them all.

Patient safety is an important issue, and hon. Members are right to want answers to their questions. The hon. Member for Pontypridd asked about Wales, and I confirm that we have agreed the provisions in the Bill with the Welsh Assembly Government and that we are working closely with colleagues in Wales to ensure that both the transition and future arrangements are adequately managed.

On reporting, health care professionals working in the NHS have not only the right to protection in law, but a fundamental professional duty to raise any concerns they may have about the quality of patient care. They should feel free to raise legitimate concerns within their organisation and be supported.
when they do so. The Government have made it clear to NHS organisations that they should have policies and procedures in place to support and encourage staff to raise legitimate concerns, which should be acted on. We want to see a culture in the NHS in which whistleblowers can come forward and raise legitimate concerns without fear of repercussions or reprisals.

Of course, we are not changing the system that people can use to report such concerns; we are merely moving the function back into the heart of the NHS, where it properly belongs. How people access that function and make their reports is not changing. In that sense, people should have no doubt about how they discharge their responsibilities to patients. If my hon. Friend the Member for Southport writes to me about the details of their responsibilities to patients, if my hon. Friend the Member for Halton about the change of date. We are in matters up with him subsequent to our deliberations.

Member for Southport writes to me about the details of their responsibilities to patients. If my hon. Friend the people should have no doubt about how they discharge and make their reports is not changing. In that sense, where it properly belongs. How people access that function moving the function back into the heart of the NHS, people can use to report such concerns; we are merely fear of repercussions or reprisals.

can come forward and raise legitimate concerns without raising legitimate concerns, which should be acted on. We procedures in place to support and encourage staff to NHS organisations that they should have policies and when they do so. The Government have made it clear to

The Chair: We have a decision on whether clause 261 should stand part of the Bill.

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

The Committee divided: Ayes 11, Noes 10.

Division No. 96

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
Soubry, Anna
Sturdy, Julian

NOES

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

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

Question accordingly agreed to.

Clause 261 ordered to stand part of the Bill.

Clause 262

THE NHS INSTITUTE FOR INNOVATION AND IMPROVEMENT

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

2.45 pm

Derek Twigg: This clause is important. The explanatory notes state that the organisation mentioned in the clause title supports the NHS in analysing its current practices against best practice and implementing changes to achieve better results. What we have been talking about in terms of improving quality is paramount to improving patient safety, about which we have had a long discussion. Obviously, a body that plays an important role in analysing current NHS practices against best practice and bringing about changes to achieve better results is very important. It will be interesting to hear what the Minister has to say about the rationale for the measure.

I refer again to the gold mine of information that is the impact assessment. It states:

“An alternative possibility is that the functions remain provided by, and staff employed by, the social enterprise under a contract to provide the leadership for commissioning improvement services directly to the Commissioning Board. It is possible there might be indirect costs from staff due to underperformance from changes. However, it is believed the changes will be small and negligible in cost terms.”
It would be useful to know the Government’s position, because I cannot underestimate the concern of the Opposition about the impact of the changes in the Bill—obviously on patient safety, but also on quality improvements and commissioning. Those are essential elements throughout the health services in terms of clinical care and patient pathways.

We have some concerns about the provision. We have raised concerns about patient safety under the previous clause, so I will not try your patience, Mr Hancock, by going through all that again. It would be useful, however, to hear from the Minister about the rationale and to have my questions answered.

Paul Burstow: I agree with the hon. Gentleman that the impact assessment is a gold mine of information, and I urge anyone who is closely following our proceedings to ensure that they do not rely solely on the extracts. When it comes to it, they should source everything directly from the document. If they do, they will sometimes get a fuller picture.

As the Committee has already seen, the Bill provides for the NHS commissioning board to have the functions of the NHS Institute for Innovation and Improvement that will support the board in promoting innovation and leading quality improvement. Clause 19 places a duty on the NHS commissioning board to promote innovation when exercising its functions. We also had a recent debate on the role of NICE in promoting innovation. Innovation could be achieved, for example, through the NHS commissioning board’s developing guidance for commissioning consortia, hosting some clinical commissioning networks, where appropriate, and working to encourage a culture of innovation within commissioning organisations.

Clause 19 also provides for the NHS commissioning board to make payments as prizes in order to promote innovation in this way will support the delivery of innovation in the provision of health services. Promoting innovation will help transform health care for patients and the public. With the board’s responsibilities around innovation, the arm’s-length body is no longer necessary and that is why clause 262 provides for its abolition. The issue is about ensuring that patient safety and innovation are not subcontracted or at arm’s length, but rather that about ensuring that patient safety and innovation are public. With the board’s responsibilities around innovation, to help transform health care for patients and the public. With the board’s responsibilities around innovation, to help transform health care for patients and the public.

Once again, it is a matter of looking at the Bill, seeing that it seems very permissive and being rightly concerned about whether the necessary controls are in place. We all know that confidentiality plays an essential role in the relationship between health professionals and their patients. The requirement for confidentiality allows patients to divulge sensitive information to their doctor without worrying that it will be disclosed to others without their consent. If there was any doubt about that, patients might think twice about divulging such information. So could the Minister provide some reassurance that patient confidentiality will be preserved when all these bodies are under a duty to co-operate with one another?

Mr Burns: I know that the Committee wants to make progress so I will be as quick as I can and, hopefully, provide the hon. Lady with the reassurances that she seeks.

The primary purpose of the information provisions of clauses 264 and 265 is to ensure that the Care Quality Commission and Monitor work together to operate an effective joint licensing and registration regime in a streamlined way. This regime would present a single, integrated process and interface for providers.

The provisions ensure that both bodies assist each other in the exercise of their functions, by sharing information. For example, given that a provider has to...
be registered with the CQC to fulfil the requirements for holding a licence issued by Monitor, there would be a need for the commission to share information relating to a provider’s registration status with Monitor. That is important in preventing the two regulators from requesting the same information separately, which will reduce demands placed on health care providers themselves.

These duties are absolutely not designed to enable either body to override current checks on the sharing of confidential information. In particular, patient confidentiality is an important principle and is something that everyone entrusted with sensitive information about patients and service users should recognise. Under the Health and Social Care Act 2008, the CQC is prevented from disclosing confidential personal information except in particular circumstances set out in legislation. For example, disclosure is permitted when the information is necessary to protect the welfare of any individual or for the purpose of criminal proceedings. The Bill does not alter that.

In addition, the 2008 Act places the CQC under a statutory duty to publish a code of practice in relation to how it will obtain, use, handle and disclose confidential personal information. The Commission is required to consult with interested parties, such as user and advisory groups, before publishing the code. That remains unchanged.

As the economic regulator, Monitor will not need to collect or make use of attributable personal information. Consequently, Monitor should not require any such information from the CQC in order to carry out its functions, nor should it have any such information to share. Monitor might collect information only in relation to individual cases, such as the costs of particular care, if it is necessary, for example, to carry out economic analysis or to investigate anti-competitive behaviour. In such cases, the information collected will again be non-attributable.

In carrying out its competition functions, Monitor will also be bound by the restrictions on disclosure of information in part 9 of the Enterprise Act 2002. These restrictions would prohibit the disclosure of information—relating to the affairs of an individual or any business of an undertaking—that was obtained by Monitor when exercising functions under the Competition Act 1998, or in relation to market investigation references, except as expressly permitted.

All the bodies bound by the new duties of co-operation in clauses 264, 265 and 266 will continue to be subject to existing rules protecting confidential information. In particular, they will all be subject to the Data Protection Act 1998. The new duties in these clauses do not allow them to share information outside those legal constraints.

The hon. Lady also wanted specific reassurance on whether Monitor might need to see patient records. There is no reason for Monitor to need to see patient records. I hope that that helps her. Monitor may require only information necessary for the exercise of its functions, and patient records would not be necessary for that purpose. For those reasons I hope that the hon. Lady will withdraw the amendment.

Emily Thornberry: I beg to ask leave to withdraw the amendment.
Mr Burns: What cold wind?

Emily Thornberry: The cold wind that will result in at least a £4 billion shortfall in the funding of social care over the period—

Mr Burns: Oh, please.

3 pm

Emily Thornberry: The Minister asked. He can groan as much as he likes, but according to the Association of Directors of Adult Social Services, that is exactly what will happen to social care. [Interruption.] I understand from the heckle, made from a sedentary position—from someone who ought to know better—that that is time wasting. If anyone seriously believes that pointing out that there will be a £4 billion shortfall in the money paid to look after the elderly and most vulnerable is time wasting, what is the purpose of our being here?

The Chair: Let us not go down that route, or we will be here beyond four o’clock.

Mr Burns: I shall not go down that route, Mr Hancock, but in passing I would say that the hon. Lady’s fantasy figures totally ignore the extra money made available for social care in the Budget.

Paul Burstow: It would appear on this occasion that the King’s Fund is not being prayed in aid; it published a report a few weeks ago saying that before taking account of efficiency savings the gap would be only £1 billion by 2014, and that once efficiency savings were taken into account there will be no gap. [Interruption.]

Mr Burns: The hon. Member for Islington South and Finsbury must know that she cannot intervene on an intervention. My hon. Friend the Minister for social care makes a telling point. Whenever the King’s Fund can be prayed in aid, we are jumped on with glee by Opposition Members, but in this case the silence is deafening.

The Chair: Order. Can we just slide round to the debate?

Mr Burns: Indeed I will, Mr Hancock.

We have had a brief but important debate on clause 264. I shall be brief because we got to the nub of the issue when we discussed the amendments. I thank my hon. Friend the Member for Stafford for his brief contribution and his support for the clause. He was right in his analysis. Given his experience as a constituency MP in Stafford, what he said was relevant. The right hon. Member for Rother Valley asked for an example. I am more than happy to give one. The information could, for example, disclose suspicion of poor quality.

The hon. Member for Islington South and Finsbury mentioned social care. In debates on an earlier clause it was made clear that Monitor’s role will not apply to social care until regulations are made. There will be full consultation before that. If Monitor is given functions in relation to adult social care—before anyone gets hold of the wrong end of the stick, that sentence began with “if”—we would expect it to co-operate fully with the CQC on concerns that might arise in relation to the provision of such care. For those reasons, I ask that the clause stand part of the Bill.

Mr Barron: The Minister did not answer my question. He was trying to tell the Committee that the Office of Fair Trading will have responsibility for the quality of care in the health service. He will correct me if I am wrong. Am I misreading what he said? I did refer to the Office of Fair Trading.

The Chair: The Minister does not have to answer. Does he want to?

Mr Burns: The right hon. Gentleman asked for an example. I gave an example, which I thought he would be happy about, but if he would like me to repeat it—

Mr Barron indicated dissent.

Mr Burns: The right hon. Gentleman is clearly unhappy. I am saddened, so I will try again to enlighten his afternoon. For example, providing services below cost in abuse of dominant position could provide evidence of a reduction in quality. That has broadened my original answer, and I hope it satisfies the right hon. Gentleman. Does it?

The Chair: Do not invite him.

Question put and agreed to.

Clause 264 accordingly ordered to stand part of the Bill.

Clauses 265 to 268 ordered to stand part of the Bill.

Clause 269

ARRANGEMENTS BETWEEN THE BOARD AND NORTHERN IRELAND MINISTERS

Amendment made: 705, in clause 269, page 212, line 29, at end insert—

‘ “Northern Ireland health service” means any of the health services under any enactment which extends to Northern Ireland and which corresponds to section 1(1) of the National Health Service Act 2006 (and, for that purpose, “enactment” includes subordinate legislation (within the meaning of the Interpretation Act 1978) and Northern Ireland legislation), and’.—(Mr Simon Burns.)

Clause 269, as amended, ordered to stand part of the Bill.

Clauses 270 and 271 ordered to stand part of the Bill.

Schedule 20

AMENDMENTS RELATING TO RELATIONSHIPS BETWEEN THE HEALTH SERVICES

Amendments made: 734, in schedule 20, page 341, line 5, at end insert—

‘(a) after paragraph (f) insert—

“(fa) a Special Health Board constituted under that section,”; and

(b) ‘. ’.
Amendment 736, in schedule 20, page 343, line 4, after ‘(f),’ insert ‘(fa).’

Amendment 737, in schedule 20, page 343, line 21, at beginning insert—

‘(1) Section 67 (effect of intervention orders) is amended as follows.’

Amendment 738, in schedule 20, page 343, line 27, at end insert—

‘(3) In subsection (7)(a) omit “(or in the case of an NHS trust to the membership of its board of directors)”.’

Amendment 739, in schedule 20, page 343, line 36, leave out paragraph (a) and insert—

( ) in paragraph (c) after “NHS trusts” insert “established under section 25”, and.

Amendment 740, in schedule 20, page 344, line 3, at end insert—

( ) after paragraph (f) insert—

“(fa) a Special Health Board constituted under that section,”.

Amendment 741, in schedule 20, page 344, line 11, after ‘(f),’ insert ‘(fa),’.

Amendment 742, in schedule 20, page 344, line 34, leave out paragraph (iv) and insert—

(iv) for “section 24 of the National Health Service Act 2006 (c. 41)” substitute “the preparation of joint health and wellbeing strategies under section 116A of the Local Government and Public Involvement in Health Act 2007”, and.

Amendment 743, in schedule 20, page 344, line 41, leave out paragraph (iv) and insert—

(iv) for “section 24 of the National Health Service Act 2006 (c. 41)” substitute “joint health and wellbeing strategies under section 116A of the Local Government and Public Involvement in Health Act 2007”.

Amendment 744, in schedule 20, page 347, line 10, at end insert—

( ) after “exercisable by” insert “the National Health Service Commissioning Board,”.

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

Amendment 745, in schedule 20, page 348, line 42, at end insert—

( ) in sub-paragraph (h) after paragraph (i) insert—

(i) Special Health Boards;”.

Amendment 746, in schedule 20, page 349, leave out lines 18 to 20.

Amendment 747, in schedule 20, page 349, line 25, leave out ‘(gg)’ and insert ‘(gf).’—(Mr Simon Burns.)

Schedule 20, as amended, agreed to.

Clause 272 ordered to stand part of the Bill.

Clause 273

Certificate of consent of community patients to treatment

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

Liz Kendall: I want briefly to say something about the clause and ask the Minister some questions. The clause relates to an important and controversial issue, which is the use of supervised community treatment orders for people with mental health problems.

Members may be aware that supervised community treatment orders were introduced in an attempt to stop the revolving door, whereby patients with mental health problems who are released from hospital and back into the community but do not take their medication may end up being a risk to themselves and, on some rare but significant occasions, becoming a danger to others as well. One of the features of such orders is that within 28 days, a patient has to automatically have an interview with a doctor, who gives a second opinion—the second opinion appointed doctors. In England, they are appointed by the Care Quality Commission and in Wales, they are appointed by the Healthcare Inspectorate on behalf of Welsh Ministers.

A large number of community treatment orders have been used. In answer to a recent parliamentary question, the Minister said that there are now more than 7,000 supervised community treatment orders. That is a lot more than the previous Government initially predicted.

There is huge concern among patient groups, psychiatrists, mental health campaigners and others about the shortage of second opinion doctors. That shortage may mean delays in treatment, because patients are not supposed to receive such treatment unless they have had a second opinion. As I have said, this is a controversial area. Many mental health charities are concerned that patients will be forced to receive treatment. Others are concerned that although the provision is meant to help patients—requiring them to take their medicine—there will be the whole revolving door issue. Under the clause, if a patient consents to having treatment in the community, a second opinion is not needed. I think the clause also clarifies that if at any stage the patient changes their mind and decides to withdraw their consent, they cannot be forced to receive the treatment.

It is a complicated clause. I think it seeks to strike the difficult balance between ensuring that patients take the medicine they need without infringing their rights and clarifying that patients can receive that treatment without having a second opinion, while at the same time allowing them to change their mind. As Members can tell from my speech, it is a difficult issue.

The Royal College of Psychiatrists has welcomed the clause, which is a good thing. It believes that the clause strengthens safeguards and frees up the time of second opinion doctors, which should enable the Care Quality Commission to provide second opinion doctors with enough time for the patients who lack capacity to give consent.

Has the Minister made an assessment of the shortage of second opinion appointed doctors? Does he think that amending the Bill would reduce the number of supervised community treatment orders? My concern is that the initial clinician may still determine that a patient requires a supervised community treatment order if they think there will be a serious consequence. That is where the difficulty lies, so could the Minister tell the Committee whether that definition has been established? Is he in discussion with the profession about it?

Paul Burstow: I am grateful to the hon. Lady for raising this important issue, because I know that many patient groups representing people with mental health concerns are concerned about it. The issue was aired during the passage of the provisions that gave rise to
community treatment orders in the first place. She is
correct; the figures published so far are higher than the
original estimates made by the Department at the time
of the impact assessment produced for the Bill that
introduced them.

The advice that Ministers have received until now has
been very clear, and we have come to the view that we
are still in the very early days of the introduction of
CTOs. For that reason it would be premature to think
that we should change them. We believe that the clause,
which is born of our discussions with people in the
sector, is welcomed by others, as the hon. Lady said.

The clause amends the rules in the Mental Health
Act 1983 on the treatment of patients receiving supervised
community treatment. Members will recall that they
were introduced by the previous Government. The main
effect of the change will be that approval by a second
opinion appointed doctor will not generally be necessary
if a patient consents to the treatment in question.
Instead, the approved clinician in charge of the treatment
would be able to issue a certificate, prescribed in regulations,
stating that the patient has capacity and is consenting.
The change would not apply to, for example, electro-
convulsive therapy patients under 18, for whom a second
opinion appointed doctor certificate would still be required.

Clause 273 brings the rules on approval of treatment
for patients on supervised community treatment more
into line with those for detained patients. That will
reduce the pressure on the CQC in respect of second
opinion doctors, to which the hon. Lady referred. None
of this will change the rule that patients on supervised
community treatment with capacity to consent cannot
be treated against their will unless they are recalled to
hospital.

3.15 pm

Why has the use of supervised community treatment
orders been greater than predicted? Our conclusion at
this stage is that we need more data before we can take a
final view on whether a real and significant change in
practice is going on.

The second opinion appointed doctor system obviously
provides an important safeguard for patients. The hon.
Lady asked about assessment. These issues are kept
under close review because of the clear public interest in
ensuring that anything that has an impact on a patient’s
freedom is closely monitored. The clause allows a
resource—second opinion doctors—to be used in a
more targeted way. Appropriate safeguards are provided
for the patient interest.

For those reasons, I hope that the clause will stand
part of the Bill.

Liz Kendall: I am grateful to the Minister for his
response. It is good to hear him make it clear that it is
too early to consider making changes or to say whether
the measures are working. As I said, this is a controversial
issue, and although it is right that second opinion
doctors focus on patients who really need them, I was
concerned that that would remove safeguards from
other patients. At this stage, the provision probably
strikes the right balance, but will the Department or
anyone else do research on the issue? Is there a timetable
for assessing how the measures are working? We want
to protect patients and the public, but also to retain
people’s freedom. Is there a timetable?

Paul Burstow: I will write to the hon. Lady with the
details.

Question put and agreed to.
Clause 273 accordingly ordered to stand part of the
Bill.

Clause 274

Transfer schemes

Amendments made: 706, in clause 274, page 215, line 11, after ‘body’ insert ‘or other person’.
Amendment 707, in clause 274, page 215, line 12, after ‘body’ insert ‘or other person’.
Amendment 708, in clause 274, page 215, line 15, after ‘body’ insert ‘or other person’.
Amendment 709, in clause 274, page 215, line 17, after ‘body’ insert ‘or other person’.
Amendment 710, in clause 274, page 215, line 19, after ‘body’ insert ‘or other person’.
Amendment 711, in clause 274, page 216, line 1, at end insert—
“public authority” means any body or other person
which has functions conferred by or under an Act
or by royal charter.’.—[Mr Burns.]

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

Derek Twigg: We have not had much discussion of
NHS property, which is a significant area to which we
should give some time. The top-down reorganisation
will probably have the single biggest impact on property
owned by the NHS, which of course can range from the
Department to strategic health authorities and primary
care trusts. Perhaps the Minister will correct me, but I
think that it is potentially the largest single change in
NHS history. The clause relates to transfer schemes.
Here is an example: the scale of change, the awful lot of transferring
will be going on. That is the implication of the Bill.

I have a number of questions and comments. Will the
Minister set out who in the Department of Health will
be responsible for ensuring that the transfer scheme
happens, works and is managed? We are talking about
billions of pounds’ worth of property owned by the
taxpayer. I will come to that issue during debate on
amendments to the next clause. Will the chief executive
of the NHS be responsible? How much influence and
impact will he have on what happens in terms of the
transfer of NHS property?

We have made this point continuously, although I
know that the Minister has a different point of view. We
believe that massive costs will be incurred as a result of the
reorganisation, although there are differences of
opinion about how much. Part of that cost must be due
to transfer of properties. I will come to some of the
specifics.

It would be useful to know whether the Department
has worked out how much staffing resource it expects to
be taken up in the Department, strategic health authorities
and primary care trusts. It is an extensive exercise; as I
know it is, that is the largest single change in
property in NHS history. Will the Minister also tell us
what the size of the estate is? How many buildings and
premises are we talking about? Is there a timetable
or other person.

“...”

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premises are we talking about? Is there a timetable

It is also important to know what value is currently placed on the NHS estate, and how much of it will change hands. I assume that some business assessment or analysis must have been done. I have heard, for instance, that the primary care trust estate is estimated at about £36 billion. That is a massive amount of money to be affected by the Bill. It would be useful to have some idea.

We believe strongly that this is just another element of the upheaval that the Government are inflicting on the national health service, as well as all the clinical procedures affected by the Bill: commissioning consortia, GP surgeries, hospitals and other NHS services. It is a massive upheaval, and many staff must be affected. It is important that we understand that. We have made the point that people are taking their eye off the ball of the real purpose of the NHS by spending so much time on this.

The much-maligned managers whom the Government like to attack have an exceptionally important role in property management and maintenance, and will be involved. A lot of them are leaving because of the changes, and the forthcoming PCT clusters will have an impact on staffing. The measures will be an important part of that. They will also have an impact on patients. It matters where and how commissioning and service provision are delivered, how they are delivered and whether they are disrupted during the various stages of proposed changes to the health service that the Government want to make.

Clause 274(2) refers to liabilities. Does the Minister have any idea what those liabilities might be or add up to? I assume that that will be an important consideration in how the process is managed and what costs it might leave the taxpayer if there is a transfer to a private provider in future. Liability is important to discuss.

Who will deal with the legal work? Will it be subcontracted outside the Department, the strategic health authorities or the primary care trusts? Those of us who have bought or moved houses know that the legal process is an important part of that. Selling property for commercial or public use must involve a significant amount of legal work. I know from my PCT that it has sometimes had to seek legal advice on issues that I have raised with it, so I am not sure whether the expertise exists in those organisations in the quantity needed to manage the process. We need to know whether a lot of money will be spent buying in legal advice from outside, because it is important.

The clause states:

"The Secretary of State may direct the Board or a qualifying company to exercise the functions of the Secretary of State in relation to the making of a property transfer scheme or a staff transfer scheme in connection with the abolition of—"

(a) one or more Primary Care Trusts specified in the direction,
or
(b) one or more Strategic Health Authorities so specified.”

It would be useful if the Minister could give us more information about what qualifying companies are because we want to ensure that our understanding is correct.

Subsection (7) states:

"references to the transfer of property include references to the grant of a lease.”

I will say more about the staff in discussing the next clause. Property is an important part of the Bill, and I have already mentioned the scale and the cost of the measure. We have not had much discussion on the matter, so this is the opportunity to explore some of the issues to a greater extent. As the Minister will realise, we feel that much of this property is owned by the taxpayer and we are concerned about how it will be managed in the future.

Finally, another issue is the fact that some of the buildings are purpose-built for NHS use, and there would be difficulties in transferring them to anyone else. If the Minister will answer those questions, I will be grateful.

Leases are another important part of any transaction relating to the future of property, so it would be useful to know whether there have been any discussions in the Department about the length of time for which leases should be given and whether there is a particular impact on how the property is transferred over as a result of lease and legal complications.

I might have missed the reason for this—I apologise in advance if that is the case—but I want to double check what subsection (9) means by the term “local authority.” I am not sure whether that includes unitary and metropolitan councils as well. Unless I have misread it, the list does not seem to include those. It would be useful if the Minister could say if that is the case.

As the Government have said, significant changes are included in the Bill. However, they have already started making changes in terms of the clustering of PCTs, which I have mentioned. They are also doing various other things before the Bill has been agreed. Has any work begun on the clustering of the PCTs, as I understand they are to be in place by June? Another important issue is that of private finance initiative and LIFTCo property, including a number of NHS buildings—for example, my PCT and one of my local hospitals. Will the Minister say how the transfer of properties will work in the case of PFI buildings—hospitals and whatever—and LIFTCo? My PCT is part of such a scheme. That is very important because it will have implications for the health service.

It would be useful if the Minister could say what the Government intend to do with the part of LIFTCo that the NHS owns during the transfer process. Do they intend to sell it off? Will the Minister also mention private sector joint ventures? I have read around on the internet and some people are talking about private sector joint ventures being set up for future property dealings as a result of the Bill’s changes. Will the Minister tell us what discussions he, his colleagues, the Secretary of State or his departmental officials have had with private companies about the NHS estate? What discussions has he had about how NHS property or the NHS estate will be managed as a result of the changes in the Bill and the transfer procedures set out in the clause? There is a definition of who has responsibility to see the process through in terms of the NHS, but have the Government got plans to set up some sort of private sector joint ventures? What private sector involvement will there be in managing the future NHS estate?

I will say more about the staff in discussing the next clause. Property is an important part of the Bill, and I have already mentioned the scale and the cost of the measure. We have not had much discussion on the matter, so this is the opportunity to explore some of the issues to a greater extent. As the Minister will realise, we feel that much of this property is owned by the taxpayer and we are concerned about how it will be managed in the future.

Finally, another issue is the fact that some of the buildings are purpose-built for NHS use, and there would be difficulties in transferring them to anyone else. If the Minister will answer those questions, I will be grateful.
3.30 pm

John Pugh: This is a big issue, which the Minister does not have time to deal with thoroughly and we do not have time to debate thoroughly. My concern, which is at a slightly different angle from the hon. Member for Halton, is that of orphan buildings. Many buildings were built rather quickly under PFI and local improvement finance trusts. I have calculated that the legacy cost to the NHS is some £4.5 billion. I have a building in my constituency that no one can find much to do with. When the PCTs go, there will be a problem of disposing of these buildings. What do we do with buildings that other people do not want to inherit, because they are costly to run and the overheads are high? I assume that the Government intend to set up a residual body of some sort.

There is a difference between the LIFT arrangement, where the PCT will be a vanishing trustee in the arrangement, and the PFI schemes. I have had conversations with some of the companies behind the LIFTCo initiative, who ask the exact same question as we are asking here. They cannot lose, because they are in contract for the next twenty years, or however long it may be. The only person that can lose appreciably is the taxpayer. If people will not use these buildings, even though they will be there—unnecessarily endowed in some cases with Darzi clinics—what will befall these unwanted properties?

Mr Burns: It will be helpful to start by giving the Committee a relatively brief outline of what the clause does, before answering the number of specific questions that the hon. Member for Halton has asked, echoed partly by the hon. Member for Southport.

Clause 274 allows the Secretary of State to establish transfer schemes for the transfer of property, staff, rights and liabilities in connection with the creation, modification or abolition of bodies as a result of the Bill. That includes, for example, the transfer of staff currently employed by PCTs, SHAs and certain special health authorities, such as the Health and Social Care Information Centre, as well as the transfer of property held by bodies such as the Health Protection Agency. The schemes allow for transfers to a range of bodies, some newly established by the Bill. For example, PCT property may be transferred to commissioning consortia, ensuring that that property remains available for delivering health care.

The lists of the bodies that transfers can be made from and to are set out, as some hon. Members will already be aware. The clause allows the Secretary of State to direct whether property and property to be transferred to a qualifying company. A qualifying company is one established under section 1277 of the NHS Act 2006, which is partly or wholly owned by the Secretary of State and which is formed for the purposes of providing services or facilities to persons or bodies exercising functions under the 2006 Act.

Section 223 companies are a long-established means for providing services to the NHS, with examples in the past including the successful NHS Professionals and Dr Foster Intelligence. It is not a prelude to privatisation; it is a means of allowing private investment and private sector expertise to be brought in as required. At this stage we are still considering the role such a company could play, as work in this area is still being developed. The clause also allows the Secretary of State to direct either the NHS commissioning board or a qualifying company to make transfer schemes on his behalf. He may also direct them as to how they exercise those functions.

The powers in these clauses are broad, but purposefully so. We are still at an early stage in deciding how staff and property will be distributed, and many decisions will have to be made on a case-by-case basis. We think this power strikes a sensible balance between flexibility and ensuring that the property and staff of the NHS are properly transferred to the structures in the new scheme.

The hon. Member for Halton asked a number of specific questions, which I would like to go through. First, he asked who was going to be responsible in the Department of Health. The answer to that is that the Secretary of State will be, but he can delegate to the commissioning board or to a section 223 company owned by the Secretary of State. The hon. Gentleman also asked about Department of Health staffing.

Derek Twigg: The Minister said that it could be delegated to the commissioning board by the Secretary of State. Does the chief executive of the National Health Service have no say whatsoever on decisions relating to the transfer of property—in other words, to the proposals in this clause? Is it solely the Secretary of State who can delegate to the national commissioning board? Can the Minister be clear on that point?

Mr Burns: As the hon. Gentleman will be aware, the chief executive of the NHS and the national commissioning board chief executive designate are one and the same person.

Derek Twigg: Let me be clear. The issue was extensively debated at one of the Select Committee hearings in terms of a specific allegiance to one or the other. There is an accounting officer issue as well. Will it, therefore, be delegated to him not as chief executive of the NHS, but as chief executive of the commissioning board? Is that correct?

Mr Burns: The fact is that the NHS chief executive has no statutory role. He advises the Secretary of State. On the question of Department of Health staff raised by the hon. Gentleman, currently the process is to be determined. The issue is taken very seriously. There is already a well-established team within the Department of Health to manage transitional issues, as the hon. Gentleman would expect. He also raised the issue of legal processes. There are legal advisers to the Secretary of State and the commissioning board who will be dealing with legal issues. Again, I assume that the hon. Gentleman would expect that.

Derek Twigg: The question was—unless I misheard what the Minister said—whether there is currently the resource in the Department to deal with all the legal issues, not just in terms of departments and the commissioning board, but also SHAs and PCTs. Will this involve buying in legal advice?

Mr Burns: Certainly, as of now, the answer to his first question is yes. We have the facilities and the manpower to deal with the situation. We will have to see whether that remains the case. We will obviously make the
necessary arrangements to ensure that there are proper legal processes and proper legal advisers to do the work that is needed to accomplish the transition. It will be kept under review to ensure that it is done with due process. The hon. Gentleman also asked about costs. I think he raised, for example, a figure of £36 billion.

Derek Twigg: For primary care.

Mr Burns: Yes, for primary care. As the hon. Gentleman will appreciate, this is a horribly complex issue. To be frank, I cannot give an accurate figure off the top of my head, but I can guarantee the hon. Gentleman that I will write to him with the accurate figures as soon as I can after this Committee so that he is fully aware of the sort of numbers involved. I hope that he finds that helpful. The hon. Gentleman also asked what will happen to unwanted properties. Everything will have to be transferred somewhere, and no property will be abandoned. He also asked about private sector joint ventures to be set up and discussions held. I can tell him that discussions are under way within the Department and with the Cabinet Office. We have not had discussions with the private sector.

The hon. Gentleman asked about unitary and metropolitan councils. Clause 274(9)(b) relates to unitary authorities, so property can be transferred to them provided that it is for public health service, which I hope reassures him. The hon. Gentleman and my hon. Friend the Member for Southport have mentioned PFI and LIFTCo. PFI deals could be transferred, as could NHS shares in LIFTCo, but discussions are still ongoing and the most appropriate solution in both cases will depend on individual circumstances. The hon. Member for Halton has also asked about our discussions on leases. Leases could be transferred but, again, decisions need to be made on a case-by-case basis. I think that that has answered all his questions.

John Pugh: I am glad that no building would be abandoned. My concern—it is a very particular concern in my constituency, but it is probably replicated in lots of others—is that GP consortia will prefer to conduct many of the clinics that are currently set up in-house in their own clinics. The buildings will not actually be abandoned, therefore, but they may not be used either and the costs will be incurred.

Mr Burns: I appreciate the point that my hon. Friend raises, and I understand and share his desire to avoid waste in the NHS. In such circumstances—I think it will be a relatively small number of cases—decisions will have to be taken on a case-by-case basis, rather than giving a blanket, overarching direction that this or that have to be taken on a case-by-case basis, rather than decisions will have to be made on a case-by-case basis. I think that that has answered all his questions.

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

The Committee divided: Ayes 12, Noes 10.

Division No. 97]

AYES

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Crabb, Stephen
Poulter, Dr Daniel
Pugh, John

Soubry, Anna
Sturdy, Julian

NOES

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

Shannon, Jim
Smith, Owen
Thornberry, Emily
Twigg, Derek
Wilson, Phil

The Chair: We will now discuss amendment 275 [HON. MEMBERS: “725!”] I am sorry. It is late in the day.

Mr Burns: Punch-drunk.

The Chair: Yes, I am.

Schedule 21

PROPERTY TRANSFER SCHEME

Derek Twigg: I beg to move amendment 725, in schedule 21, page 350, leave out lines 5 to 7.

Clauses 274 and 275 deal with the transfers of property, liabilities and staff that will take place as a result of changes made in the Bill. Schedule 21 details the types of property transfers that the Secretary of State can make, or can direct the board or qualifying company—which can be partly or wholly owned by the Government for NHS purposes—to make. Such transfers will generally be from existing bodies that will be abolished, such as PCTs and SHAs, as we have discussed, to new bodies or existing bodies that will continue to function after the Bill becomes law. The amendment would remove the provision that allows the transfer of property that is currently held by a PCT to any other person who provides services as part of the health service in England and consents to the transfer. In practice, that means that a public property built with public money could be transferred to private providers that are providing services for the NHS. As PCTs currently own properties worth billions of pounds, which we have already discussed, it is clearly of concern that they can vanish from public hands and be put into private hands. Further clarification is needed on the circumstances in which Ministers would hand over NHS assets to private providers and why they would need this power to do so. Specifically, when we talk about transfer are we talking about it being free or at a cost?

3.45 pm

Mr Burns: I will be very quick. This amendment would prevent any property currently held by a PCT from being transferred to any provider of services, apart from the health service in England, that is not a public authority. That would stop the Secretary of State or the NHS commissioning board from transferring property from PCTs to social enterprises, voluntary and community groups or to any other person providing services as part of the health service who is not a public authority.

I am aware of the concerns expressed by Unite during the evidence sessions earlier in the month that the Secretary of State could simply hand over the assets of
PCTs to private providers for free or below market rate. I can categorically assure the Committee that we will not do that. Furthermore, there are long-established safeguards to ensure that the Secretary of State could not simply hand over the assets of PCTs and strategic health authorities to private providers without proper scrutiny. As with all public assets, where a property is transferred to a third party and the potential gift—the reduction in market value—is worth more than £250,000 the transaction must be approved by Her Majesty’s Treasury and the case laid before Parliament.

Any such transfer would also need a proper business case to show a commensurate social or other benefit to justify transfer at below market rate before it could proceed. Where the potential gift is worth less than £250,000 the board of the NHS body entering into the transaction must similarly develop a business case and satisfy themselves and their auditors that they are receiving commensurate benefit in kind. In this case, the board minutes would be publicly available.

The transfer scheme provisions in the Bill also contain powers to ensure that transferred property is used to provide health care. Clause 275(3) allows transfer schemes to create rights and liabilities in relation to property transferred. For example, a transfer scheme could place a covenant on the property to ensure that it continues to be used for purposes connected to providing NHS-funded services.

In the transfers from PCTs to community foundation trusts, which are already taking place under the transforming community service programme, we are already proposing to incorporate a buy-back provision. That will ensure that if the property is vacant, if a provider is no longer providing services or if the provider ceases to exist, the property can be returned to the Secretary of State or a body nominated by him, such as another foundation trust. The power is a means to ensure that property would continue to be used to provide services. For transfers under these clauses in the Bill, we are actively considering a similar arrangement, though the precise details are still being worked out.

I hope that the hon. Gentleman will be reassured that we do not have the faintest intention of handing over NHS property to private companies, and there are existing safeguards in place to ensure that it does not happen. For those reasons and my assurances, I urge the hon. Gentleman to withdraw his amendment.

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

Amendment, by leave, withdrawn.

Amendment made: 748, in schedule 21, page 351, line 6, column 2 at end insert—

“A Special Health Authority”.—(Mr Simon Burns.)

Schedule 21, as amended, agreed to.

Schedule 22

STAFF TRANSFER SCHEMES

Amendment made: 749, in schedule 22, page 352, line 35, column 2 at end insert—

“A Special Health Authority”.—(Mr Simon Burns.)

Schedule 22, as amended, agreed to.

Clause 275

TRANSFER SCHEMES: SUPPLEMENTAL

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

Derek Twigg: I will be brief, given we have discussed what some of the impact on staff will be as a result of these changes. Clause 275(5) states:

“A staff transfer scheme may make provision which is the same or similar to the TUPE regulations.”

Will the Minister put on the record what that means? We are concerned to ensure that the impact on staff, as a result of the Government’s proposals, is taken seriously. That would be useful. Subsection (6) states:

“A property transfer scheme or a staff transfer scheme may provide—(a) for the scheme to be modified by agreement”.

Will he say what it means for staff transfer for the scheme to be “modified by agreement”? In view of the time, I will not push further on this clause.

Mr Burns: Clause 275 makes supplemental provision for the transfer schemes we discussed in the previous clause. It sets out, specifically, the things that may be transferred by a staff or property transfer scheme, which includes, for example, the transfer of property, rights and liabilities that could not otherwise be transferred, and the transfer of criminal liabilities in a limited range of bodies. The clause also allows supplementary, incidental, transitional and consequential provision to be made by a transfer scheme. For example, a transfer scheme may create rights or impose liabilities, such as requiring that a property transferred to a local authority from a PCT should continue to be used for health care purposes. The clause requires the Secretary of State to ensure that the liabilities of all PCTs, SHAs and certain special health authorities are dealt with by the time those bodies are abolished by the Bill.

The hon. Gentleman also asked two specific questions. He asked whether a transfer would be conducted under TUPE, or any similar provision?

Derek Twigg: What is the similar provision?

Mr Burns: I am just about to explain to the hon. Gentleman, if that is a help. If it is not TUPE, it would be COSOP—the Cabinet Office statement of practice for staff transfers in the public sector. I hope that satisfies the hon. Gentleman. For the sake of time, I will not go into the details of what COSOP is, because I assume that the hon. Gentleman is more familiar with it than I am.

Question put and agreed to.

Clause 275 accordingly ordered to stand part of the Bill.

Clause 276

POWER TO MAKE A CONSEQUENTIAL PROVISION

Amendments made: 712, in clause 276, page 217, line 8, leave out from ‘amend’ to end of line 9 and insert ‘, repeal, revoke or otherwise modify any enactment’.
Amendment 713, in clause 276, page 217, line 12, leave out subsection (3).

Amendment 714, in clause 276, page 217, line 24, leave out paragraphs (c) to (e) and insert—

'(c) any other enactment.'.

Amendment 715, in clause 276, page 217, line 27, at end insert—

'( ) Before making an order under this section that contains provision which would, if included in an Act of the Scottish Parliament, fall within the legislative competence of that Parliament, the Secretary of State must consult the Scottish Ministers.'.

Amendment 716, in clause 276, page 217, line 30, leave out subsection (6) and add—

'(6) In this section, “enactment” includes—

(a) an enactment contained in subordinate legislation (within the meaning of the Interpretation Act 1978),

and

(b) an enactment contained in, or in an instrument made under, an Act of the Scottish Parliament, an Act or Measure of the National Assembly for Wales or Northern Ireland legislation, and references to an enactment include a reference to an enactment passed or made after the passing of this Act.”.—[Mr Simon Burns.]

Emily Thornberry: On a point of order, Mr Hancock. I hope that this is the appropriate time to mention it, but the Minister gave an undertaking that he would write to me on a point and I am yet to receive that correspondence. I have left it until the last minute, hoping that I would get the letter before the Committee rose. I believe that you were in the Chair at the time, and that matter related to amendment 359, which is about the role of the overview of scrutiny.

The Chair: That is not relevant to the clause, but if the Minister has given an undertaking I would hope that a letter would be forthcoming.

Paul Burstow: Further to that point of order, Mr Hancock, I did indeed give such an undertaking and there are a number of letters that are still wending their way as quickly as possible to hon. Members, and they will arrive.

Emily Thornberry: I am grateful, Mr Hancock. Thank you.

Clause 276, as amended, ordered to stand part of the Bill.

Clause 277

REGULATION, ORDERS AND DIRECTIONS

Paul Burstow: I beg to move amendment 729, in clause 277, page 217, line 35, after ‘State’, insert ‘, the Welsh Ministers’.

The Chair: With this it will be convenient to discuss Government amendments 730 and 731 to 733.

Government new clause 19—Fluoridation of water supplies.

Government new clause 20—Procedural requirements in connection with fluoridation of water supplies.

Government new clause 21—Fluoridation of water supplies: transitional provision.

Paul Burstow: In view of the time, I undertake that if I do not sit down before 4 o’clock, I shall write to the Committee giving all the details that I wish to share, and there are quite a few.

Fluoridation is a controversial subject, and I want to make it clear that, in the new clauses and the associated amendments, we do not seek to come down on one side or the other. However, to ensure that we consider the policy fully and carefully it was thought important to introduce further amendments. With the abolition of strategic health authorities, responsibility for proposing fluoridation schemes and for conducting consultation on such schemes should be transferred to local authorities, and responsibility for contracting fluoridation schemes should be transferred to the Secretary of State. In practice, the Secretary of State’s function will be carried out by Public Health England.

Making local authorities responsible for consultation on fluoridation schemes would fit well with their responsibilities for public health. Proposals for fluoridation schemes would derive from the joint strategic needs assessments that local authorities make of their populations. On the other hand, negotiating and managing contracts—or “arrangements” in the new clauses—is a complex legal and technical process. It is unlikely that any single local authority would have the necessary expertise, and it would be wasteful to try to replicate it across 50 or so local authorities, so we intend that Public Health England should take on the task.

Mr Barron: I declare an interest. I am a patron of the British Fluoridation Society. These Government new clauses were tabled only this week; they are bigger than the original Bill on the subject that went through the House in the 1980s. It seems ridiculous that we have only two minutes to talk about a major issue, which the Minister rightly pointed out caused debate on the Floor of the House. It is a disgrace that we have all this work here trying to get some oversight of a most important Bill.—[Interruption.]

Mr Barron:—the biggest Bill on the national health service since the original one in the 1940s. It is outrageous. [Interruption.]

The Chair: Order.

Paul Burstow: As I indicated, it is not our intention to make new fluoridation schemes more or less likely. We are merely putting in place a fair and practical way to discharge the function once the strategic health authorities are abolished. In that respect, putting local authorities in charge of consultations would make decisions on fluoridation more democratically accountable. Government new clauses 19, 20 and 21 amend the Water Industry Act 1991, which is where the primary legislation of fluoridation is located. I shall now discuss what is proposed in each of the clauses.

Under Government new clause 19, we intend that Public Health England should be part.—[Interruption.] Mr Hancock, I shall write in detail on all three clauses, but I suspect that a number of hon. Members are
chuntering so much that they are not listening to the details that I am trying to share with the Committee.

We intend that Public Health England should be part of the Department of Health, so it will be accountable to the Secretary of State. Hence subsections (2) to (8) of Government new clause 19 amend the Water Industry Act 1991 to provide for the Secretary of State to make arrangements with a water undertaker to fluoridate a water supply. However, he may do so only if a local authority has proposed fluoridation, if it has consulted on that proposal and if a final decision has been taken.

Derek Twigg: On a point of order, Mr Hancock. We had no idea that the Minister wanted to spend so long on this, or we would have accommodated it. [Interruption.] It would have been good to have reached clause 279 on commencement, and to talk about the proposed delays and changes to the Bill that were mentioned in the press this morning.

The Chair: Order. That far exceeded a point of order. I surprised that it took us until the last few minutes of the sitting to discover that an “outrageous” would be written in _Hansard_—or was it diabolical?

Paul Burstow: Further to that point of order, Mr Hancock.

The Chair: That was not a point of order.

Paul Burstow: In that case I shall make the point rather than making it a point of order. The point is this: the Opposition and the Government Whips have been discussing—

4 pm  
Debate interrupted (Programme Order, 8 February and 8 March).

The Chair: We still have quite a bit of work to do, but before we commence the formalities to wind up the Committee, on behalf of all those who have chaired this Committee, I would like to thank both Front-Bench teams for their co-operation and all right hon. and hon. Members for their attendance, which has been remarkable. I pay special tribute to Mr Lefroy for the expertise and experience that he brought to bear on our proceedings. It has been useful for all of us to hear about some of his experiences during the events in the Mid Staffordshire 

It has been useful for all of us to hear about some of his experiences during the events in the Mid Staffordshire 

Thank you.

The Chairman put forthwith the Question already proposed from the Chair (Standing Order No. 83D), That the amendment be made.

Question agreed to.

Amendment 729 accordingly agreed to.

The Chairman then put forthwith the Questions necessary for the disposal of the business to be concluded at that time (Standing Order No. 83D).

Amendments made: 717, in clause 277, page 218, line 28, leave out from ‘276’ to end of line 29 and insert ‘(consequential provision) which includes provision that amends or repeals a provision of an Act of Parliament’.

Amendment 730, in clause 277, page 218, line 38, at end insert ‘, the Welsh Ministers’.

Amendment 607, in clause 277, page 219, line 15, leave out ‘or by virtue of’.—(Mr Simon Burns.)
Amendment 722, in clause 280, page 220, line 21, leave out ‘214(2) to (4) and (6)’ and insert ‘214(1) to (4) and (6) and paragraphs 48 and 55 of Schedule 14’.

Amendment 609, in clause 280, page 220, line 23, at end insert—

‘( ) section 259(1) and (3) and Part 2 of Schedule 19 (abolition of the Appointments Commission),’.

Amendment 610, in clause 280, page 220, line 23, at end insert—

‘( ) sections 274 and 275 (transfer schemes) insofar as they confer powers in connection with the abolition of the Health Protection Agency.’.

Amendment 723, in clause 280, page 220, line 27, at beginning insert ‘The following provisions extend to England and Wales and Scotland—

(a) sections 114 to 119 (health special administration);
(b) .

Amendment 724, in clause 280, page 220, line 27, leave out from ‘Ministers’ to the end of line 28.—(Mr Simon Burns.)

Clause 280, as amended, ordered to stand part of the Bill.

Clause 281 ordered to stand part of the Bill.

New Clause 2

CERTIFICATION OF DEATH

‘(1) Chapter 2 of Part 1 of the Coroners and Justice Act 2009 (notification, certification and registration of deaths) is amended as follows.

(2) In section 19 (medical examiners)—

(a) in subsection (1) for “Primary Care Trusts” substitute “Local authorities”,
(b) in subsection (2) for “Trust” (in each place where it occurs) substitute “local authority”, and
(c) in subsection (5) for “a Primary Care Trust” substitute “a local authority”.

(3) In section 20 (medical certificate of cause of death), in subsection (3) for “a Primary Care Trust” substitute “a local authority”.

(4) In section 57 (reviews of data, studies and research), in subsection (5) for “a Primary Care Trust” substitute “a local authority”.’.—(Mr Simon Burns.)

Brought up, and added to the Bill.

New Clause 3

CONDUCT OF REVIEWS ETC. BY CARE QUALITY COMMISSION

‘(1) Part 1 of the Health and Social Care Act 2008 (the Care Quality Commission) is amended as follows.

(2) In section 48 (special reviews and investigations)—

(a) in subsection (1) after “may” insert “, with the approval of the Secretary of State,”, and
(b) after subsection (1) insert—

“(1A) The Commission may conduct an investigation under this section without the approval of the Secretary of State where the Commission considers there to be a risk to the health, safety or welfare of persons receiving health or social care.”.

(3) In section 54 (studies as to economy, efficiency etc.), in each of subsections (1) and (3) after “may” insert “, with the approval of the Secretary of State,”.

(4) In section 57 (reviews of data, studies and research), in subsection (1) after “may” insert “, with the approval of the Secretary of State.”.—(Mr Simon Burns.)

Brought up, and added to the Bill.

New Clause 4

AMENDMENTS CONSEQUENTIAL ON SECTION 175

‘(1) Section 245 of the National Health Service Act 2006 (joint overview and scrutiny committees) is amended in accordance with subsections (2) to (4).

(2) In subsection (1) for the words from “relevant functions” to the end of the subsection substitute “relevant functions means functions under regulations under section 244(2) to (2ZC).”.

(3) After subsection (4) insert—

“(4A) The regulations may provide that, where a relevant function in relation to a local authority is exercisable by a joint overview and scrutiny committee by virtue of arrangements under regulations under subsection (2)(a), the local authority may not discharge the function.”.

(4) Omit subsections (5) and (9).

(5) Section 246 of that Act (exempt information) is amended in accordance with subsections (6) to (8).

(6) In subsection (1) for the words from “a meeting of” to the end of the subsection substitute “a meeting of a local authority or a committee of a local authority which is an item relating to functions of the authority under regulations under section 244(2) to (2ZC).”.

(7) In subsection (5) for “overview and scrutiny committees” substitute “local authorities”.

(8) In the heading to section 246 for “Overview and scrutiny committees” substitute “Business relating to functions of local authorities by virtue of section 244”.

(9) Section 247 of that Act (application to the City of London) is amended in accordance with subsections (10) to (12).

(10) For subsection (1) substitute—

“(1) This section applies to a committee of the Common Council appointed to exercise functions that the Council has under regulations under section 244(2) to (2ZC).”.

(11) In subsection (2), for the words from the beginning to “apply” substitute “Section 245(2)(b) and (c) applies”.

(12) In subsection (4)—

(a) for “sections (2) to (3A)” substitute “sections (3) and (3A)”, and
(b) for the words from “in the case of the committee” to the end of the subsection substitute “in the case of a committee to which this section applies, references to functions under regulations under section 244(2) to (2ZC) which are exercisable by the committee.”.

(13) In consequence of the amendments made by subsections (2) and (6), paragraphs 64(2) and 85 of Schedule 3 to the Localism Act 2011 are omitted.—(Mr Simon Burns.)

Brought up, and added to the Bill.

New Clause 7

REQUIREMENTS UNDER SECTION 63: UNDERTAKINGS

‘(1) Regulations under section 63 may confer on Monitor a power to accept an undertaking (referred to in this Chapter as a “section (Requirements under section 63: undertakings) undertaking”) from the National Health Service Commissioning Board or a commissioning consortium to take such action of a kind mentioned in subsection (2) as is specified in the undertaking within such period as is so specified.

(2) The specified action must be—

(a) action of a description given in paragraphs (a) to (e) of section 64(6), or
(b) action of such a description as may be prescribed.

(3) Where Monitor accepts a section (Requirements under section 63: undertakings) undertaking then, unless the Board, or (as the case may be) the consortium from whom the undertaking is accepted, has failed to comply with the undertaking or any part of it, Monitor may not—

(a) continue to carry out the investigation in question,
(b) make a declaration by virtue of subsection (3) of section 64 in relation to the arrangement in question, or
(c) give a direction by virtue of subsection (6) of that section in relation to the failure in question.

(4) Where the Board, or (as the case may be) the consortium from whom Monitor has accepted a section (Requirements under section 63: undertakings) undertaking, has failed to comply fully with the undertaking but has complied with part of it, Monitor must take the partial compliance into account in deciding whether to do something mentioned in paragraphs (a) to (c) of subsection (3).

(5) Schedule (Requirements under section 63: undertakings) (which makes further provision about section (Requirements under section 63: undertakings) has effect.1289 1290

Brought up, and added to the Bill.

New Clause 8

GUIDANCE

'(1) Monitor must publish guidance about—
(a) compliance with requirements imposed by regulations under section 63;
(b) how it intends to exercise powers conferred on it by regulations under that section.

(2) Before publishing guidance under subsection (1)(a), Monitor must consult—
(a) the National Health Service Commissioning Board, and
(b) such other persons as Monitor considers appropriate.

(3) Before publishing guidance under subsection (1)(a) or (b), Monitor must obtain the approval of the Secretary of State.

(4) Monitor may revise guidance under this section and, if it does so, must publish the guidance as revised.'—(Mr Simon Burns.)

Brought up, and added to the Bill.

New Clause 9

REVIEWS UNDER SECTION 66: POWERS OF INVESTIGATION

'(1) The following provisions of Part 3 of the Enterprise Act 2002 apply, with the modifications in subsections (2) to (8), for the purposes of the exercise by the Competition Commission of its function under section 66(3) as they apply for the purposes of investigations on references under that Part—
(a) section 109 (attendance of witnesses and production of documents),
(b) section 110 (enforcement of powers under section 109: general),
(c) section 111 (penalties),
(d) section 112 (penalties: main procedural requirements),
(e) section 113 (payments and interest by instalments),
(f) section 114 (appeals in relation to penalties),
(g) section 115 (recovery of penalties),
(h) section 116 (statement of policy),
(i) section 117 (offence of supplying false or misleading information), and
(j) section 125 (offences by bodies corporate) so far as relating to section 117.

(2) Section 110 has effect as if—
(a) subsection (2) were omitted,
(b) in subsection (4), for “the report of the Commission on the reference concerned” there were substituted “the report of the Commission on the review concerned”;
(c) for subsections (5) to (8) there were substituted—

“(5) Where the Commission considers that a person has intentionally altered, suppressed or destroyed a document which he has been required to produce under section 109, it may impose a penalty in accordance with section 111.,” and
(d) in subsection (9), for the words from “or (3)” to “section 65(3)” there were substituted “, (3) or (5)”.  

(3) Section 111 has effect as if—
(a) in subsection (1), for “or (3)” there were substituted “, (3) or (5)”, and
(b) in subsections (3) and (6), after “110(3)” there were inserted “or (5)”.  

(4) Section 111(5)(b)(ii) has effect as if—
(a) for “the reference concerned” there were substituted “the review concerned”,
(b) the words “(or, in the case of a report under section 50 or 65, given)” were omitted,
(c) the words “(or given)”, in each place they appear, were omitted, and
(d) the words “by this Part” were omitted.

(5) Section 112 has effect as if, in subsection (1), for “or (3)” there were substituted “, (3) or (5)”.  

(6) Section 114 has effect as if, in subsection (1), for “or (3)” there were substituted “, (3) or (5)”.  

(7) Section 115 has effect as if for “or (3)” there were substituted “, (3) or (5)”.  

(8) Section 116 has effect as if, in subsection (2), for “or (3)” there were substituted “, (3) or (5)”.  

(9) Provisions of Part 3 of the Enterprise Act 2002 which have effect for the purposes of sections 109 to 116 of that Act (including, in particular, provisions relating to the making of orders) have effect for the purposes of the application of those sections by virtue of subsection (1) in relation to those sections as applied by virtue of that subsection.

(10) Accordingly, corresponding provisions of this Act do not have effect in relation to those sections as applied by virtue of this section.'—(Mr Simon Burns.)

Brought up, and added to the Bill.

New Clause 10

COMPLAINT ABOUT GRANT OF APPLICATION FOR DESIGNATION

'(1) Where an application for the designation of a service under section 69 is granted, Monitor must, on a complaint by a provider mentioned in subsection (2), reconsider its decision to grant the application.

(2) The providers are—
(a) the provider of the designated service,
(b) any other provider of health care services who has sufficient interest in the application.

(3) For the purposes of the reconsideration, Monitor must—
(a) where the provider mentioned in subsection (2)(a) made the complaint, consult the commissioner who applied for the designation;
(b) where a provider mentioned in subsection (2)(b) made the complaint, consult the commissioner and the provider mentioned in subsection (2)(a).

(4) Monitor may remove the designation if, having regard to the matters in subsection (4) of section 69, it is satisfied that the criterion in subsection (3) of that section is not met.

(5) If Monitor removes the designation—
(a) an appeal by the commissioner against the decision to remove it lies to the First-tier Tribunal, and
(b) where a provider mentioned in subsection (2)(b) made the complaint, an appeal by the provider mentioned in subsection (2)(a) against the decision also lies to the First-tier Tribunal.
(6) If Monitor does not remove the designation—

(a) an appeal by the provider mentioned in subsection (2)(a) against the decision not to remove the designation lies to the First-tier Tribunal, and

(b) where a provider mentioned in subsection (2)(b) made the complaint, an appeal by that provider against the decision also lies to the First-tier Tribunal.’.—

(Mr Simon Burns.)

Brought up, and added to the Bill.

New Clause 11

Complaint about refusal of application for designation

'(1) Where an application for the designation of a service under section 69 is refused, Monitor must, on a complaint by the commissioner who applied for the designation or by the provider of the service, reconsider the application.

(2) For the purposes of the reconsideration, Monitor must—

(a) where the commissioner made the complaint, consult the provider;

(b) where the provider made the complaint, consult the commissioner.

(3) Monitor may grant the application if, having regard to the matters in subsection (4) of section 69, it is satisfied that the criterion in subsection (3) of that section is met.

(4) If Monitor grants the application—

(a) the service is designated and this Part applies in relation to it accordingly, and

(b) an appeal by the provider against the decision to grant the application lies to the First-tier Tribunal.

(5) If Monitor refuses the application, an appeal by the commissioner or the provider against the decision to refuse the application lies to the First-tier Tribunal.’.—

(Mr Simon Burns.)

Brought up, and added to the Bill.

New Clause 12

Complaint about grant of application for removal of designation

'(1) Where an application for the removal of a designation under section 71(3) is granted, Monitor must, on a complaint by the provider of the service, reconsider its decision to grant the application.

(2) For the purposes of the reconsideration, Monitor must consult the commissioner who applied for the removal of the designation.

(3) Monitor may revoke the removal of the designation if, having regard to the matters in subsection (4) of section 69, it is satisfied that the criterion in subsection (3) of that section is met.

(4) If Monitor revokes the removal of the designation—

(a) the service is no longer designated, and

(b) an appeal by the commissioner against the decision to revoke the removal of the designation lies to the First-tier Tribunal.

(5) If Monitor refuses the application, an appeal by the commissioner or the provider against the decision to refuse the application lies to the First-tier Tribunal.’.—

(Mr Simon Burns.)

Brought up, and added to the Bill.

New Clause 13

Complaint about refusal of application for removal of designation

'(1) Where an application for the removal of a designation under section 71(3) is refused, Monitor must, on a complaint by the commissioner who applied for the removal of the designation or by a provider mentioned in subsection (2), reconsider its decision to refuse the application.

(2) The providers are—

(a) the provider of the designated service,

(b) any other provider of health care services who has sufficient interest in the application.

(3) For the purposes of the reconsideration, Monitor must—

(a) where the commissioner made the complaint, consult the provider of the designated service;

(b) where the provider mentioned in subsection (2)(a) made the complaint, consult the commissioner;

(c) where a provider mentioned in subsection (2)(b) made the complaint, consult the commissioner and the provider of the designated service.

(4) Monitor may grant the application if, having regard to the matters in subsection (4) of section 69, it is satisfied that the criterion in subsection (3) of that section is no longer met.

(5) If Monitor grants the application—

(a) the service ceases to be designated, and

(b) an appeal by the provider mentioned in subsection (2)(a) against the decision to grant the application lies to the First-tier Tribunal.

(6) If Monitor does not grant the application—

(a) an appeal by the commissioner or the provider mentioned in subsection (2)(a) against the decision not to grant the application lies to the First-tier Tribunal, and

(b) where the provider mentioned in subsection (2)(b) made the complaint, an appeal by that provider against the decision also lies to the First-tier Tribunal.’.—

(Mr Simon Burns.)

Brought up, and added to the Bill.

New Clause 14

Complaints: general provisions

'(1) This section applies in relation to a complaint under section (Complaint about grant of application for designation), (Complaint about refusal of application for designation), (Complaint about grant of application for removal of designation) or (Complaint about refusal of application for removal of designation).

(2) The complaint must be made before the end of the period of 28 days beginning with the day on which notice of the decision to which the complaint relates was received.

(3) No individual involved in the decision to which the complaint relates may be involved in the reconsideration of the decision.

(4) Monitor must give notice of its decision on the reconsideration to—

(a) the commissioner who applied for the designation of the service or (as the case may be) for the removal of the designation,

(b) the provider of the designated service, and

(c) where, in a case within section (Complaint about grant of application for designation) or (Complaint about refusal of application for removal of designation), the person who makes the complaint is the provider mentioned in subsection (2)(b) of that section, that provider.

(5) The grounds for an appeal against Monitor’s decision on the reconsideration are that the decision was—

(a) based on an error of fact,

(b) wrong in law, or

(c) unreasonable.

(6) On the appeal, the First-tier Tribunal may confirm Monitor’s decision or direct that it is not to have effect.’.—

(Mr Simon Burns.)

Brought up, and added to the Bill.
New Clause 16

THE NATIONAL TARIFF: FURTHER PROVISION

(1) The ways in which a health care service may be specified in the national tariff under section 104(1)(a) include in particular—

(a) specifying it by reference to its components,

(b) specifying it as a service (a “bundle”) that comprises two or more health care services which together constitute a form of treatment,

(c) specifying it as a service in a group of standardised services.

(2) Where a service is specified in accordance with subsection (1)(a), the national tariff must specify a national price for each component of the service.

(3) Where a service is specified in accordance with subsection (1)(b), the national tariff must specify a national price for the bundle.

(4) Where a service is specified in accordance with subsection (1)(c), the national tariff must specify a single price as the national price for each service in the group.

(5) Neither a component specified in accordance with subsection (1)(a) nor a service comprised in a bundle specified in accordance with subsection (1)(b) is to be treated for the purposes of this Part as a service capable of being provided separately for the purposes of the NHS except—

(a) where the component, or the service comprised in the bundle, is specified separately under subsection (1)(a) of section 104, or

(b) in accordance with rules under subsection (2) of that section.

(6) After subsection (7B) of that section (as inserted by subsection (5) above) insert—

(7C) If the Secretary of State and the Welsh Ministers request a particular water undertaker to enter into arrangements in respect of adjoining areas—

(a) they must co-operate with each other so as to secure that the arrangements (taken together) are operable and efficient; and

(b) if suitable terms are not agreed for all the arrangements, a combined reference may be made by them under section 87B below to enable the terms of each set of arrangements to be determined so that they are consistent.

(7D) If the Secretary of State requests a water undertaker to vary arrangements for an area which adjoins an area in respect of which the Welsh Ministers have made arrangements with the same water undertaker, the Secretary of State must co-operate with the Welsh Ministers so as to secure that following the variation the arrangements (taken together) will be operable and efficient.

(7E) If the Welsh Ministers request a water undertaker to vary arrangements for an area which adjoins an area in respect of which the Secretary of State has made arrangements with the same water undertaker, the Welsh Ministers must co-operate with the Secretary of State so as to secure that following the variation the arrangements (taken together) will be operable and efficient.

(7F) If suitable terms are not agreed for a variation to which subsection (7D) or (7E) applies, a combined reference may be made by the Secretary of State and the Welsh Ministers under section 87B below so that (following the variation) both sets of arrangements are consistent.

(7) Omit subsections (8) to (10) of that section.

(8) In subsection (11) of that section for “a relevant authority” substitute “the Welsh Ministers”.

(9) In section 87A (target concentration of fluoridation), after subsection (3) insert—

“(3A) If the Secretary of State proposes to—

(a) make arrangements which provide for the concentration in the specified area (or any part of it) to be lower than the general target concentration, or

(b) vary existing arrangements so that they so provide,

the Secretary of State shall consult any local authority whose area includes, coincides with or is wholly or partly within the specified area.”

(10) In section 87B (fluoridation arrangements: determination of terms), in subsection (2)—

(a) for paragraph (a) substitute—

“(a) the Secretary of State may—

(i) determine the terms of the arrangements as the Secretary of State sees fit; or

(ii) refer the matter for determination by such other person as the Secretary of State considers appropriate; and”, and

(b) omit paragraph (b).

(11) In that section, in subsection (4) for the words from the beginning to “section 88G(2)” substitute “Where a combined reference is made under section 87C(b) or 87C(7F)”,

(12) In section 87C (fluoridation arrangements: compliance), omit subsection (8).

(13) In section 89—

(a) in the heading, after “Consultation” insert “:Wales”,

(b) in subsections (1) and (4) for “a relevant authority” substitute “the Welsh Ministers”,

(c) in subsection (1) for “the appropriate authority” (in each place where it occurs) substitute “the Welsh Ministers”,

(d) in subsection (3), in paragraph (a) for “relevant authorities” substitute “the Welsh Ministers”,

Brought up, and added to the Bill.

New Clause 19

FLUORIDATION OF WATER SUPPLIES

(1) Chapter 4 of Part 3 of the Water Industry Act 1991 (fluoridation), as amended by the Water Act 2003, is amended as follows.

(2) In section 87 (fluoridation of water supplies at request of relevant authorities), in subsection (3)(a) for sub-paragraph (i) substitute—

“(i) in relation to areas in England, are to the Secretary of State;”.

(3) After subsection (3) of that section insert—

“(3A) The Secretary of State may make a request under subsection (1) only if the Secretary of State is required to do so by section 88G(2) (following the making of a fluoridation proposal in accordance with section 88B).”

(4) In subsection (4) of that section, for paragraph (a) substitute—

“(a) in relation to England, such area as the Secretary of State considers appropriate for the purpose of complying with section 88G(2);”.

(5) After subsection (7) of that section insert—

“(7A) The Secretary of State must, in relation to the terms to be included in any arrangements under this section, consult any local authority whose area includes, coincides with or is wholly or partly within the specified area.

(7B) In this section and the following provisions of this Chapter “local authority” means—

(a) a county council in England;

(b) a district council in England, other than a council for a district in a county for which there is a county council;

(c) a London borough council;

(d) the Common Council of the City of London.”

(6) After subsection (7B) of that section (as inserted by subsection (5) above) insert—

(7C) If the Secretary of State and the Welsh Ministers request a particular water undertaker to enter into arrangements in respect of adjoining areas—

(a) they must co-operate with each other so as to secure that the arrangements (taken together) are operable and efficient; and

(b) if suitable terms are not agreed for all the arrangements, a combined reference may be made by them under section 87B below to enable the terms of each set of arrangements to be determined so that they are consistent.

(7D) If the Secretary of State requests a water undertaker to vary arrangements for an area which adjoins an area in respect of which the Welsh Ministers have made arrangements with the same water undertaker, the Secretary of State must co-operate with the Welsh Ministers so as to secure that following the variation the arrangements (taken together) will be operable and efficient.

(7E) If the Welsh Ministers request a water undertaker to vary arrangements for an area which adjoins an area in respect of which the Secretary of State has made arrangements with the same water undertaker, the Welsh Ministers must co-operate with the Secretary of State so as to secure that following the variation the arrangements (taken together) will be operable and efficient.

(7F) If suitable terms are not agreed for a variation to which subsection (7D) or (7E) applies, a combined reference may be made by the Secretary of State and the Welsh Ministers under section 87B below so that (following the variation) both sets of arrangements are consistent.”

(7) Omit subsections (8) to (10) of that section.

(8) In subsection (11) of that section for “a relevant authority” substitute “the Welsh Ministers”.

(9) In section 87A (target concentration of fluoridation), after subsection (3) insert—

“(3A) If the Secretary of State proposes to—

(a) make arrangements which provide for the concentration in the specified area (or any part of it) to be lower than the general target concentration, or

(b) vary existing arrangements so that they so provide,

the Secretary of State shall consult any local authority whose area includes, coincides with or is wholly or partly within the specified area.”

(10) In section 87B (fluoridation arrangements: determination of terms), in subsection (2)—

(a) for paragraph (a) substitute—

“(a) the Secretary of State may—

(i) determine the terms of the arrangements as the Secretary of State sees fit; or

(ii) refer the matter for determination by such other person as the Secretary of State considers appropriate; and”, and

(b) omit paragraph (b).

(11) In that section, in subsection (4) for the words from the beginning to “section 88G(2)” substitute “Where a combined reference is made under section 87C(b) or 87C(7F)”,

(12) In section 87C (fluoridation arrangements: compliance), omit subsection (8).

(13) In section 89—

(a) in the heading, after “Consultation” insert “:Wales”,

(b) in subsections (1) and (4) for “a relevant authority” substitute “the Welsh Ministers”,

(c) in subsection (1) for “the appropriate authority” (in each place where it occurs) substitute “the Welsh Ministers”,

(d) in subsection (3), in paragraph (a) for “relevant authorities” substitute “the Welsh Ministers”,

Brought up, and added to the Bill.
(e) in subsection (4) for "the appropriate authority so directs" substitute "the Welsh Ministers so direct", and
(f) omit subsection (5).

(14) In section 90A (review of fluoridation) after subsection (5) insert—
"(5A) The relevant authority must, in exercising its functions under subsection (1)—
(a) consult any local authority affected by the arrangements at such times as the relevant authority considers appropriate, and
(b) in particular, consult any such local authority before it publishes a report under paragraph (b) of that subsection."—(Mr Simon Burns.)

Brought up, and added to the Bill.

New Clause 20

PROCEDURAL REQUIREMENTS IN CONNECTION WITH FLUORIDATION OF WATER SUPPLIES

'After section 88A of the Water Industry Act 1991 insert—
"88B Requirement for fluoridation proposal: England
(1) The Secretary of State may not request a water undertaker to enter into arrangements under section 87(1) unless a fluoridation proposal is made to the Secretary of State.

(2) A fluoridation proposal is a proposal that the Secretary of State enter into arrangements with one or more water undertakers to increase the fluoride content of the water supplied by the undertaker or undertakers to premises within such area or areas in England as may be specified in the proposal.

(3) A fluoridation proposal may be made by one or more local authorities in England.

(4) A local authority may not make a fluoridation proposal unless its area includes, coincides with or is wholly or partly within the area, or at least one of the areas, specified in the proposal.

(5) In the following provisions of this Chapter, "proposer", in relation to a fluoridation proposal, means the local authority or authorities which made the proposal.

(6) Any reference in the following provisions of this Chapter to a local authority affected by a fluoridation proposal is a reference to a local authority whose area includes, coincides with or is wholly or partly within the area, or at least one of the areas, specified in the proposal.

88C Initial consultation etc. on fluoridation proposal
(1) This section applies if a fluoridation proposal is made.

(2) The proposer must consult the Secretary of State as to whether the arrangements which would result from implementing the proposal would be operable and efficient.

(3) The proposer must consult each water undertaker who supplies water to premises within the area or areas specified in the proposal.

(4) Each person consulted under subsection (2) or (3) must give the proposer its opinion on the matter mentioned in that subsection.

(5) The proposer must notify the Secretary of State of the opinion of each water undertaker consulted under subsection (3).

(6) If the Secretary of State informs the proposer that the Secretary of State is of the opinion that the arrangements would not be operable and efficient, no further steps may be taken in relation to the proposal.

88D Additional requirements where other local authorities affected
(1) This section applies where—
(a) a fluoridation proposal is made,
(b) the Secretary of State is of the opinion that the arrangements which would result from implementing the proposal would be operable and efficient,
(c) one or more local authorities other than the proposer are affected by the proposal, and
(d) the proposer wishes to take further steps in relation to the proposal.

(2) The proposer must notify any other local authority which is affected by the proposal.

(3) The proposer must make arrangements for enabling the authorities affected by the proposal to decide whether further steps should be taken in relation to the proposal.

(4) The Secretary of State must by regulations—
(a) make provision as to the arrangements which must be made for the purposes of subsection (3), and
(b) prescribe conditions, with respect to the outcome of the arrangements, which must be satisfied before any further steps may be taken in relation to the proposal.

88E Decisions on fluoridation proposal
'(1) This section applies where—
(a) a fluoridation proposal is made,
(b) the Secretary of State is of the opinion that the arrangements which would result from implementing the proposal would be operable and efficient,
(c) in a case where section 88D applies, the conditions prescribed under subsection (4)(b) of that section are satisfied, and
(d) the proposer wishes to take further steps in relation to the proposal.

(2) The proposer must comply with such requirements as may be prescribed in regulations made by the Secretary of State as to the steps to be taken for the purposes of consulting and ascertaining opinion in relation to the proposal.

(3) The proposer may (after any requirements imposed by regulations under subsection (2) have been complied with) modify the proposal.

(4) But the proposal may not be modified so as to extend the boundary of any area to which it relates, or to add another area, except in circumstances prescribed in regulations by the Secretary of State.

(5) The proposer must (after any requirements imposed by regulations under subsection (2) have been complied with) decide whether to request the Secretary of State to make such requests under section 87(1) as are necessary to implement the proposal.

(6) The Secretary of State may by regulations make provision—
(a) as to factors which the proposer must or may take into account in making the decision mentioned in subsection (5);
(b) as to the procedure to be followed by the proposer in exercising functions under or by virtue of subsection (2) or (5).

88F Decision-making procedure: exercise of functions by committee
'(1) This section applies in relation to the exercise of functions under or by virtue of section 88E(2) to (5) ("the fluoridation functions") except where the proposer is a single local authority and either—
(a) no other local authorities are affected by the proposal,
or
(b) no other local authority which is affected by the proposal informs the proposer that it wishes to participate in the exercise of the fluoridation functions.

(2) The local authorities affected by the proposal must—
(a) arrange for an existing joint committee of the authorities to exercise the fluoridation functions,
(b) establish a joint committee of the authorities for that
purpose, or
(c) arrange for the Health and Wellbeing Boards established
by them under section 178 of the Health and Social Care Act 2011 to exercise the fluoridation functions.

(3) Where arrangements are made under subsection (2)(c) the
Health and Wellbeing Boards in question must exercise the
power conferred by section 182(b) of the Health and Social Care
Act 2011 to establish a joint sub-committee of the Boards to
exercise the fluoridation functions.

(4) The Secretary of State may by regulations make provision—
(a) for subsection (2)(a) to apply only in relation to a joint
committee which meets prescribed conditions as to its membership;
(b) as to the membership of a joint committee established
under subsection (2)(b) (including provision as to qualification and disqualification for membership
and the holding and vacating of office as a member);
(c) as to the membership of a joint sub-committee of
Health and Wellbeing Boards established in accordance
with subsection (3);
(d) as to the procedure to be followed by any joint
committee, or any joint sub-committee of Health and
Wellbeing Boards, in exercising the fluoridation
functions.

88G Secretary of State’s duty in relation to fluoridation
function

‘(1) This section applies if the Secretary of State is requested
to make such requests under section 87(1) as are necessary to
implement a fluoridation proposal.

(2) The Secretary of State must comply with the request if the
Secretary of State is satisfied that the requirements imposed by
sections 88B to 88F have been met in relation to the proposal.

(3) Subsection (2) does not require the Secretary of State to
to consider the adequacy of any steps taken for the purposes
of complying with any requirement to consult or to ascertain
opinion which is imposed under or by virtue of section 88C(2) or
(3), 88D(3) or 88E(2).

88H Payments by local authorities towards fluoridation
costs

‘(1) This section applies where a water undertaker enters into
arrangements with the Secretary of State under section 87(1).

(2) The Secretary of State may require all local authorities
affected by the arrangements to make payments to the Secretary
of State to meet any costs incurred by the Secretary of State
under the terms of the arrangements.

(3) The amount to be paid by each of the affected local
authorities is to be determined—
(a) where a joint committee, or a joint sub-committee of
Health and Wellbeing Boards, has exercised the
fluoridation functions of the authorities in relation
to the proposal which resulted in the arrangements
being made and the committee or sub-committee continues to exist at the time when the Secretary
of State exercises the power conferred by subsection (2),
by that committee or sub-committee;
(b) in any other case, by agreement between the local
authorities.

(4) If the amount to be paid by the affected local authorities is
not determined as mentioned in subsection (3), the Secretary of
State may—
(a) determine whether to vary the amount (and, if so,
how), or
(b) refer the matter for determination by such other
person as the Secretary of State considers
appropriate.

(5) The amount determined in accordance with subsection (3)
may, at the request of one or more of the affected local
authorities, be varied with the agreement of all of them.

(6) If the affected local authorities fail to reach agreement for
the purposes of subsection (5), the Secretary of State may—
(a) determine whether to vary the amount (and, if so,
how), or
(b) refer the matter for determination by such other
person as the Secretary of State considers
appropriate.

(7) Any reference in this section to a local authority affected by
arrangements under section 87(1) is a reference to a local
authority whose area includes, coincides with or is wholly or
partly within the area specified in the arrangements.

88I Variation or termination of arrangements under
section 87(1)

‘(1) The Secretary of State may not request a water undertaker
to vary arrangements entered into by the water undertaker under
section 87(1) unless a proposal (“a variation proposal”) is made
to the Secretary of State for a variation in the arrangements.

(2) The Secretary of State may not give notice to a water
undertaker under section 87C(7) to terminate arrangements
entered into by the water undertaker under section 87(1) unless a
proposal (“a termination proposal”) is made to the Secretary of
State for the termination of the arrangements.

(3) Subsection (1) does not apply in relation to a variation to
provide for the concentration of fluoride in the area specified
in the arrangements (or any part of it) to be lower than the general
target concentration.

(4) The Secretary of State may by regulations provide that
subsection (1) or (2) does not apply in prescribed circumstances.

(5) A variation or termination proposal may be made by one
or more of the local authorities affected by the arrangements.

(6) The Secretary of State may by regulations provide that,
where a termination proposal is made in relation to arrangements
under section 87(1), no further termination proposal may be made in relation to the arrangements until
the end of such period as may be specified in the regulations.

(7) In the following provisions of this Chapter, “proposer”, in
relation to a variation or termination proposal, means the local
authority or authorities which made the proposal.

(8) Any reference in this section and in the following
provisions of this Chapter to a local authority affected by a
variation or termination proposal is a reference to a local
authority whose area includes, coincides with or is wholly or
partly within the area specified in the arrangements.

(9) In relation to a proposal for the variation of the area
specified in arrangements under section 87(1), any reference in
this section and in the following provisions of this Chapter to a
local authority affected by the proposal also includes a reference
to a local authority whose area would include, coincide with or be
wholly or partly within the area specified in the arrangements
if the variation were made.

“88J Initial consultation etc. on variation or termination
proposal

(1) This section applies if a variation or termination proposal
is made.

(2) In the case of a variation proposal, the proposer must
consult the Secretary of State and the water undertaker who
entered into the arrangements as to whether the arrangements as
varied in accordance with the proposal would be operable and
efficient.

(3) In the case of a termination proposal, the proposer must
consult the Secretary of State and the water undertaker who
entered into the arrangements as to whether it would be
reasonably practicable to terminate the arrangements.

(4) Each person consulted under subsection (2) or (3) must
give the proposer its opinion on the matter mentioned in that
subsection.

(5) The proposer must notify the Secretary of State of the
opinion of each water undertaker consulted under subsection (2)
or (3).
(6) If the Secretary of State informs the proposer that the Secretary of State is of the opinion that the arrangements as varied would not be operable and efficient or (as the case may be) that it would not be reasonably practicable to terminate the arrangements, no further steps may be taken in relation to the proposal.

88K Additional requirements where other local authorities affected

'(1) This section applies where—

(a) a variation or termination proposal is made,
(b) the Secretary of State is of the opinion that the arrangements as varied would be operable and efficient or (as the case may be) that it would be reasonably practicable to terminate the arrangements,
(c) one or more local authorities other than the proposer are affected by the proposal, and
(d) the proposer wishes to take further steps in relation to the proposal.

(2) The proposer must notify any other local authority which is affected by the proposal.

(3) The proposer must make arrangements for enabling the authorities affected by the proposal to decide whether further steps should be taken in relation to the proposal.

(4) The Secretary of State may by regulations provide that the duty in subsection (3) does not apply in prescribed circumstances.

(5) The duty in subsection (3) does not apply in relation to a termination proposal if the Secretary of State so directs by an instrument in writing (and such a direction may apply generally or in relation to a particular proposal).

(6) The Secretary of State must by regulations—

(a) make provision as to the arrangements which must be made for the purposes of subsection (3), and
(b) prescribe conditions, with respect to the outcome of the arrangements, which must be satisfied before any further steps may be taken in relation to the proposal.

88L Decisions on variation or termination proposal

'(1) This section applies where—

(a) a variation or termination proposal is made,
(b) the Secretary of State is of the opinion that the arrangements which would result from implementing the proposal would be operable and efficient or (as the case may be) that it would be reasonably practicable to terminate the arrangements,
(c) in a case where the duty in section 88K(3) applies, the conditions prescribed under subsection (6)(b) of that section are satisfied, and
(d) the proposer wishes to take further steps in relation to the proposal.

(2) The proposer must comply with such requirements as may be prescribed in regulations made by the Secretary of State as to the steps to be taken for the purposes of consulting and ascertaining opinion in relation to the proposal.

(3) The Secretary of State may by regulations provide that the duty in subsection (2) does not apply in prescribed circumstances.

(4) The duty in subsection (2) does not apply in relation to a termination proposal if the Secretary of State so directs by an instrument in writing (and such a direction may apply generally or in relation to a particular termination proposal).

(5) Where arrangements are made under subsection (2)(c) the Health and Wellbeing Boards in question must exercise the power conferred by section 182(b) of the Health and Social Care Act 2011 to establish a joint sub-committee of the Boards to exercise the relevant functions.

(6) The Secretary of State may by regulations make provision—

(a) for subsection (2)(a) to apply only in relation to a joint committee which meets prescribed conditions as to its membership;
(b) as to the membership of a joint committee established under subsection (2)(b) (including provision as to qualification and disqualification for membership and the holding and vacating of office as a member);
(c) as to the membership of a joint sub-committee of Health and Wellbeing Boards established in accordance with subsection (5);
(d) as to the procedure to be followed by any joint committee, or any joint sub-committee of Health and Wellbeing Boards, in exercising the relevant functions.

88N Secretary of State's duty in relation to requests for variation or termination

'(1) This section applies if (following the making of a variation or termination proposal) the Secretary of State is requested—

(a) to request a variation of arrangements entered into under section 87(1), or
(b) (as the case may be) to give notice under section 87C(7) to a water undertaker to terminate such arrangements.
(2) The Secretary of State must comply with the request if satisfied that the requirements imposed by sections 88I to 88M have been met in relation to the proposal.

(3) Subsection (2) does not require the Secretary of State to consider the adequacy of any steps taken for the purposes of complying with any requirement to consult or to ascertain opinion which is imposed under or by virtue of section 88J(2) or (3), 88K(3) or 88L(2).

88O Power to make regulations as to maintenance of section 87 arrangements

(1) The Secretary of State may by regulations prescribe circumstances in which arrangements must be made in accordance with the regulations—

(a) for consulting and ascertaining opinion on whether arrangements under section 87(1) (“section 87(1) arrangements”) should be maintained, and

(b) for enabling authorities affected by section 87(1) arrangements to decide whether to propose to the Secretary of State that they be maintained.

(2) The regulations must make provision requiring the Secretary of State to give notice under section 87C(7) to a water undertaker to terminate section 87(1) arrangements entered into by the undertaker if—

(a) the outcome of arrangements made by virtue of subsection (1)(b) is that the affected authorities decide not to propose that the section 87(1) arrangements be maintained, and

(b) the Secretary of State is satisfied that any requirements imposed by regulations under subsection (1), as to the arrangements to be made for the purposes mentioned in that subsection, have been met.

(3) Subsection (2)(b) does not require the Secretary of State to consider the adequacy of any steps taken for the purposes of complying with any requirement to consult or to ascertain opinion which is imposed by regulations made under subsection (1).

(4) The provision that may be made by regulations under subsection (1) (as to the arrangements to be made for the purposes mentioned in that subsection) includes provision corresponding, or similar, to any requirements imposed by or under sections 88K to 88M.

Brought up, and added to the Bill.

New Clause 22

SPECIAL NOTICES OF BIRTHS AND DEATHS

(1) Section 269 of the National Health Service Act 2006 (special notices of births and deaths) is amended as follows.

(2) For subsection (2) substitute—

“(2) Each registrar of births and deaths must furnish to such relevant body or bodies as may be determined in accordance with regulations the particulars of such births or deaths kept in a register of births or deaths kept for the registrar's sub-distRICT as may be prescribed.”

(3) In subsection (4) for “the Primary Care Trust for the area in which the birth takes place” substitute “such relevant body or bodies as may be determined in accordance with regulations”.

(4) In subsection (6)—

(a) after “under subsection (4)” insert “to a relevant body”, and

(b) for “the Primary Care Trust” (in each place where it occurs) substitute “the body”.

(5) In subsection (7)—

(a) for “A Primary Care Trust” substitute “A relevant body to whom notice is required to be given under subsection (4)”, and

(b) for “any medical practitioner or midwife residing or practising within its area” substitute “such descriptions of medical practitioners or midwives as may be prescribed”.

(6) In subsection (9) for “the Primary Care Trust concerned” substitute “the relevant body or bodies to whom the failure relates”.

(7) In subsection (10), in paragraph (a) for “A Primary Care Trust” substitute “a relevant body”.

(8) After subsection (10) insert—

“(11) For the purposes of this section, the following are relevant bodies—

(a) the National Health Service Commissioning Board,

(b) commissioning consortia,

(c) local authorities.

(12) Information received by a local authority by virtue of this section may be used by it only for the purposes of functions exercisable by it in relation to the health service.

(13) In this section, “local authority” has the same meaning as in section 2B.”

(9) Until the commencement of section 29, section 269(11) of the National Health Service Act 2006 has effect as if Primary Care Trusts were included in the list of bodies that are relevant bodies for the purposes of that section.”

Brought up, and added to the Bill.

New Clause 23

PROVISION OF INFORMATION BY REGISTRAR GENERAL FOR HEALTH SERVICE PURPOSES

(1) Section 270 of the National Health Service Act 2006 (provision of information by Registrar General) is amended as follows.

(2) In subsection (1)—
(a) for “the Secretary of State” substitute “any of the following persons”, and
(b) at the end insert “—
(a) the Secretary of State,
(b) the Board,
(c) a commissioning consortium,
(d) a local authority,
(e) the National Institute for Health and Care Excellence,
(f) the Health and Social Care Information Centre,
(g) a Special Health Authority which has functions that are exercisable in relation to England,
(h) the Care Quality Commission, and
(i) such other persons as the Secretary of State may specify in a direction.”
(3) In subsection (2) —
(a) for “the Secretary of State” substitute “the person to whom the information is provided”, and
(b) for “his functions” substitute “functions exercisable by the person”.
(4) After subsection (4) insert—
“(5) In this section, “local authority” has the same meaning as in section 2B.”.—(Mr Simon Burns.)
Brought up, and added to the Bill.

New Clause 24

Provision of Information by Registrar General for Health Service Purposes: Wales

’(1) Section 201 of the National Health Service (Wales) Act 2006 (provision of information by Registrar General) is amended as follows.
(2) In subsection (1) —
(a) for “the Welsh Ministers” substitute “any of the following persons”, and
(b) at the end insert “—
(a) the Welsh Ministers,
(b) a Special Health Authority which has functions that are exercisable in relation to Wales,
(c) a Local Health Board,
(d) an NHS trust established under section 18, and
(e) such other persons as the Welsh Ministers may specify in a direction.”
(3) In subsection (2) —
(a) for “the Welsh Ministers” substitute “the person to whom the information is provided”, and
(b) for “their functions” substitute “functions exercisable by the person”.
—(Mr Simon Burns.)
Brought up, and added to the Bill.

New Clause 25

Provision of Statistical Information by Statistics Board for Health Service Purposes

’(1) Section 42 of the Statistics and Registration Service Act 2007 (information relating to births and deaths etc) is amended as follows.
(2) For subsection (4) substitute—
“(4) The Board may disclose to a person mentioned in subsection (4A) any information referred to in subsection (2)(a) to (c) which is received by the Board under this section, or any information which is produced by the Board by analysing any such information, if—
(a) the information consists of statistics and is disclosed for the purpose of assisting the person in the performance of functions exercisable by it in relation to the health service, or
(b) the information is disclosed for the purpose of assisting the person to produce or to analyse statistics for the purpose of assisting the person, or any other person mentioned in subsection (4A), in the performance of functions exercisable by it in relation to the health service.
(4A) Those persons are—
(a) the Secretary of State,
(b) the Welsh Ministers,
(c) the National Health Service Commissioning Board,
(d) a commissioning consortium,
(e) a local authority,
(f) a Local Health Board,
(g) an NHS trust established under section 18 of the National Health Service (Wales) Act 2006,
(h) the National Institute for Health and Care Excellence,
(i) the Health and Social Care Information Centre,
(j) a Special Health Authority,
(k) the Care Quality Commission, and
(l) such other persons as the appropriate authority may specify in a direction given for the purposes of this section.
(4B) For the purposes of subsection (4A)(l), the appropriate authority is—
(a) in relation to a direction to be given for purposes relating only to Wales, the Welsh Ministers, and
(b) in any other case, the Secretary of State.”
(3) After subsection (5) insert—
“(5A) A direction under subsection (4A)(l) must be given by an instrument in writing.
(5B) Sections 272(7) and 273(1) of the National Health Service Act 2006 apply in relation to the power of the Secretary of State to give a direction under subsection (4A)(l) as they apply in relation to powers to give a direction under that Act.
(5C) Sections 203(9) and 204(1) of the National Health Service (Wales) Act 2006 apply in relation to the power of the Welsh Ministers to give a direction under subsection (4A)(l) as they apply in relation to powers to give a direction under that Act.”
(4) After subsection (6) insert—
“(7) In subsection (4A)—
“commissioning consortium” and “Special Health Authority” have the same meaning as in the National Health Service Act 2006;
“local authority” has the same meaning as in section 2B of that Act of 2006.”.—(Mr Simon Burns.)
Brought up, and added to the Bill.

New Clause 5

Chief Social Worker

‘There will be a Chief Social Worker—
(a) to report to and advise Ministers,
(b) to make an annual report to Parliament on the state of social work in England,
(c) to work in close co-operation with the College of Social Work, the Social Work and Health Professions Council, the Professional Standards Authority for Health and Social Care, the National Institute for Health and Care Excellence, inspectors and employers.’.—(Emily Thornberry.)
Brought up.
Question put, That the clause be added to the Bill.
New Clause 17

NORTHERN IRELAND ASSEMBLY AND LEGISLATIVE CONSENT

‘In section 62 of the Health Act 1999 (regulation of health care professions etc.), after subsection (10), insert—
(10A) But if any provision made by an Order in Council under that section would, if it were included in an Act of the Assembly, no recommendation is to be made to Her Majesty to make the Order unless a draft—
(a) has been laid before, and approved by resolution of, each House of Parliament, and
(b) has been laid before, and approved by resolution of, the Northern Ireland Assembly.”.—(Jim Shannon.)

Brought up.

Question put, That the clause be added to the Bill.

The Committee divided: Ayes 10, Noes 12.

New Schedule 1

ABOLITION OF THE HEALTH PROTECTION AGENCY: CONSEQUENTIAL AMENDMENTS

Parliamentary Commissioner Act 1967 (c. 13)
1 In Schedule 2 to the Parliamentary Commissioner Act 1967 (departments etc. subject to investigation)—
14 In section 7 (matters which may be investigated: restrictions), omit subsection (6A).
15 In Part 2 of Schedule 2 (persons liable to investigation), omit paragraph 90.
National Health Service Act 2006 (c. 41)
16 The National Health Service Act 2006 is amended as follows.
17 In section 9 (NHS contracts), in subsection (4) omit paragraph (j).
18 In section 71 (schemes for meeting losses and liabilities of certain health bodies)—
   (a) in subsection (2) omit paragraph (g), and
   (b) in subsection (5) for “(f) and (g)” substitute “(f)”.
National Health Service (Wales) Act 2006 (c. 42)
19 The National Health Service (Wales) Act 2006 is amended as follows.
20 In section 7 (NHS contracts), in subsection (4) omit paragraph (j).
21 In section 30 (schemes for meeting losses and liabilities of certain health bodies)—
   (a) after paragraph (b) insert “and”, and
   (b) omit paragraph (e) and the preceding “and”.
National Health Service (Consequential Provisions) Act 2006 (c. 43)
22 In Schedule 1 to the National Health Service (Consequential Provisions) Act 2006 (consequential amendments), omit paragraphs 257 to 259 (and the cross-heading preceding them).
Health and Social Care Act 2008 (c. 14)
23 In section 159 (functions of Health Protection Agency in relation to biological substances), omit subsections (2) to (6).
Health and Personal Social Services (Northern Ireland) Order 1991
24 In article 8 of the Health and Personal Social Services (Northern Ireland) Order 1991 (health and social services contracts), in paragraph (2)(g) omit paragraph (vi).—(Mr Simon Burns.)
Brought up, and added to the Bill.

New Schedule 2

Requirements under section 63: undertakings

Procedure

1 (1) Monitor must publish a procedure for entering into section (Requirements under section 63: undertakings) undertakings.

(2) Monitor may revise the procedure and, if it does so, Monitor must publish the procedure as revised.

(3) Monitor must consult such persons as it considers appropriate before publishing or revising the procedure.

2 (1) Where Monitor accepts a section (Requirements under section 63: undertakings) undertaking, Monitor must publish the undertaking.

(2) But Monitor must not under sub-paragraph (1) publish any part of a section (Requirements under section 63: undertakings) undertaking which contains commercial information the disclosure of which Monitor considers would or might significantly harm the legitimate business interests of any person to whom it relates.

Variation of terms

3 The terms of a section (Requirements under section 63: undertakings) undertaking (including in particular the action specified under it and the period so specified within which the action must be taken) may be varied if both the person giving the undertaking and Monitor agree.

Compliance certificates

4 (1) Where Monitor is satisfied that a section (Requirements under section 63: undertakings) undertaking has been complied with, Monitor must issue a certificate to that effect (referred to in this Schedule as a “compliance certificate”).

(2) A person who has given a section (Requirements under section 63: undertakings) undertaking may at any time make an application to Monitor for a compliance certificate.

(3) The application must be made in such form, and accompanied by such information, as Monitor requires.

(4) Monitor must decide whether or not to issue a compliance certificate, and give notice to the applicant of its decision, before the end of the period of 14 days beginning with the day after that on which the application is received.

5 (1) An appeal lies to the First-tier Tribunal against a decision of Monitor to refuse an application for a compliance certificate.

(2) The grounds for an appeal under this paragraph are that the decision was—
   (a) based on an error of fact,
   (b) wrong in law, or
   (c) unfair or unreasonable.

(3) On an appeal under this paragraph, the Tribunal may confirm Monitor’s decision or direct that it is not to have effect.

Inaccurate, incomplete or misleading information

6 Where Monitor is satisfied that a person who has given a section (Requirements under section 63: undertakings) undertaking has supplied Monitor with inaccurate, misleading or incorrect information in relation to the undertaking—

(a) Monitor may treat the person as having failed to comply with the undertaking, and

(b) if Monitor decides so to treat the person, Monitor must by notice revoke any certificate of compliance given to that person:—(Mr Simon Burns.)
Brought up, and added to the Bill.

Ordered,

That certain written evidence already reported to the House be appended to the proceedings of the Committee.—(Mr Simon Burns.)

Mr Burns: On a point of order, Mr Hancock. On behalf of the Committee, may I thank you and your colleagues, Mr Hood, Mr Gale and Dr McCrea, very much for how you have chaired our proceedings over our 28 sittings? It has been a particular pleasure to serve under your chairmanship—[HON. MEMBERS: “Hear, hear!”] We have come to respect and enjoy the firm but light touch with which you have ruled us. Your anecdotal comments and guidance have been appreciated by Members on both sides of the Committee.

I also give our thanks to your Clerks and the Doorkeepers and others, who have kept us stocked with documents and made sure that the Committee has run smoothly. I pay tribute to the Hansard staff—

Derek Twigg: In bold. [Laughter.]

Mr Burns:—for their fantastic work. I also pay tribute to the dedicated civil servants from the Department of Health, who have worked beyond the call of duty for many months to ensure that we have got to this position today. I pay tribute, too, to those in my private office for their tremendous work behind the scenes.

I thank all my hon. Friends not only for attending very regularly but for their contributions. There have been clear divisions between the two sides of the Committee, but my hon. Friends have ensured that our debates have been carried out in a friendly and reasonable way. I pay tribute to my hon. Friend the Member for Preseli Pembrokeshire and the hon. Member for Sedgefield, because I have always found that it is very foolish to fall foul of a Whip and because of how they have controlled us and organised our proceedings.
It has been a particular pleasure to work with Opposition Committee members. The hon. Member for Halton has been the perfect gent; the hon. Members for Islington South and Finsbury and for Leicester West—the latter better known as “Leicester Liz”. They have all been stalwarts in pushing their case. I have now come to understand more fully the meaning of the words “misconception” and “misinterpretation”. I have learned a lot that I will not forget in a hurry. I do thank Opposition Committee members, because although we may have serious differences of opinion on our vision for improving and modernising the health service, at least our debates have been conducted in a friendly and constructive way. That is particularly due to how they have responded to the debating from the Government side of the Committee.

I thank you once again, Mr Hancock, for chairing the Committee.

The Chair: As an aside, I should point out that the Clerk has just told me that our last vote was the 100th in the Committee. There cannot be many Committees that have had 100 Divisions. That is some record.

Derek Twigg: Further to that point of order, Mr Hancock. I should like to follow the Minister by putting on the record our thanks to you and your fellow Chairs, Mr Hood, Mr Gale and Dr McCrea, for your excellent chairmanship of the Committee, which has sometimes been a little difficult, although that is par for the course. I thank you for your fairness and how you have handled the proceedings.

I also thank the Clerks and their staff; when we have tabled our many amendments, they have been extremely helpful. I thank them for all their hard work in keeping track of everything. Of course, I also thank Hansard for the excellent job that they have done, as always; it is no doubt very difficult sometimes to keep up with proceedings. I put our thanks on the record.

I also thank the Doorkeepers and the police for their work in making sure that we could conduct our proceedings. As a former Minister, I thank the civil servants; I know the work they will have done to ensure that Ministers are kept on the right track as much as possible. That might have been difficult, but they will have done outstanding work in trying to support Ministers.

There are also the many groups outside—I will not name them because there are so many—that have an interest or are part of the national health service. They took such an interest in providing briefings to Members on both sides of the Committee and suggestions for amendments, and those have been very helpful.

Of course, I also thank my colleagues—specifically, my shadow ministerial colleagues, my hon. Friends the Members for Islington South and Finsbury and for Leicester West. In particular, I pay tribute to my party’s Back Benchers, who have done a sterling job in holding the Government to account and have put in a tremendous amount of hard work. I also thank the Government Back Benchers; we would have liked to have heard more from them, although I am sure that their Whip thought differently.

I thank our staff, who have been tremendous. One of the things that I have found is that I do not have quite the same support as I did when I was a Minister.

Mr Burns: Funny, that.

Derek Twigg: Indeed. The staff who have been working for us—all of us here—have been outstanding. They have ensured that we have been able to table amendments, helped us with the debates and scrutinised every inch of the Bill. I really thank them.

I thank the Ministers, who have been helpful. Sometimes we have had disagreements about what they can and cannot say, but we had best not go into that. I thank you again, Mr Hancock, for your and your colleagues’ chairmanship of the Committee.

The Chair: Thanks very much. This is the only time a Chairman will get passed a brief from a civil servant. Not only did we have 100 Divisions, which must be a bit of a record, but this is believed to have been the longest-sitting Committee in the House since 2002. That is quite an achievement. Thank you all.

Bill, as amended, reported (Standing Order No. 83D(6)).

4.15 pm

Committee rose.