Public Bill Committee

HEALTH AND SOCIAL CARE
(RE-COMMITTED) BILL

Tenth Sitting
Tuesday 12 July 2011
(Afternoon)

CONTENTS
Clauses 67 to 69 agreed to, one with an amendment.
Schedule 9 agreed to.
Clauses 70 to 75 agreed to.
Clauses 100 and 101 agreed to, with amendments.
Clauses 112 to 117 agreed to, some with amendments.
Clause 147 agreed to, with amendments.
Adjourned till Thursday 14 July at Nine o’clock.
Members who wish to have copies of the Official Report of Proceedings in General Committees sent to them are requested to give notice to that effect at the Vote Office.

No proofs can be supplied. Corrigenda slips may be published with Bound Volume editions. Corrigenda that Members suggest should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor’s Room, House of Commons,

not later than

Saturday 16 July 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 ROGER GALE, †MR MIKE HANCOCK, MR JIM HOOD, 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)
† O’Donnell, Fiona (*East Lothian*) (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)
† Wilson, Phil (*Sedgefield*) (Lab)

Sarah Davies, Mark Etherton, *Committee Clerks*

† attended the Committee
Public Bill Committee

Tuesday 12 July 2011

(Afternoon)

[Mr Mike Hancock in the Chair]

Health and Social Care (Re-committed) Bill

Clause 67

Requirements as to procurement, patient choice and competition

4 pm

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

The Chair: We reconvene where we left off, except Mr Simon Burns has taken the place of Mr Burstow.

The Minister of State, Department of Health (Mr Simon Burns): Thank you, Mr Hancock. I apologise to the Committee that, sadly, they have the monkey rather than the organ grinder. That is simply due to pressure of work, both in this Committee and on the Floor of the House, where there is an urgent question on Southern Cross. I apologise that the Committee is not being addressed by my fellow Minister, my hon. Friend the Member for Sutton and Cheam, but I will seek to do my best to fill his shoes for the rest of the debate.

As you will remember, Mr Hancock, when the Committee broke for lunch my hon. Friend was responding to a number of questions raised by Opposition Members. Before I discuss the main theme of the clause, I will continue to answer those questions. My hon. Friend had just answered points raised by the hon. Member for Oldham East and Saddleworth, regarding funding and conspiracy theories. I will respond to three further assertions she made, before going on to answer points raised by the hon. Member for Oldham East and Saddleworth. However, it is only fair that he does not miss out on the opportunity to have his say. As I said at the beginning, I am coming to his comments as amended, stand part of the Bill.

The role of the private sector in the areas that you are suggesting is expanding, will continue to expand and will be a lot bigger in the next few years than it is now.

I vividly remember the hon. Lady’s comments on the subject, not least because I was, rather hurtfully, reprimanded during them by my hon. Friend the Whip. To be frank, it saddens me that Opposition Members seek to misrepresent these issues and scaremonger among members of the public.

Mr Kevin Barron (Rother Valley) (Lab): I do not disagree with what the Minister said about what happened in the past, but the question the Opposition have consistently posed is why we need all this competition law laid down in statute when, as the Minister says, we have been able to use the independent sector on many occasions for many years? Why do we need all this competition law?

I am particularly pleased that the hon. Lady asked me that. I have read the report, because I had the privilege of going to Washington in November last year in the place of my right hon. Friend the Secretary of State to give a speech to the Commonwealth Fund when it launched that report. I am very familiar with the report, because the following day we had a conference that I chaired on the subject.

I do not know if that was a diversionary tactic, but it will not take me away from the main point that I was making in response to the hon. Member for Oldham East and Saddleworth, which was that, on the basis of figures from the ONS and not from Conservative campaign headquarters, since 1997 productivity in the NHS has fallen each year by 0.2%. We are working hard to support the NHS to reverse that worrying trend.

The hon. Lady tried to assert that patient choice and any qualified provider would inevitably lead to financial meltdown. Again, I have to remind the Committee that it was the previous Labour Government who introduced choice of any hospital for elective treatment. Patients have been able to choose to be treated in any private hospital since 2007 and 200,000 patients a year do so; so far, that has resulted in neither financial meltdown nor service closure. Let me tell her, in the nicest possible way, that if that procedure and methodology for treating NHS patients free at the point of use was acceptable under a Labour Government, it is equally acceptable under a Conservative coalition Government.

If my memory serves me correctly, the hon. Lady repeated her Front-Bench colleagues’ claims that the Bill ushers in privatisation of the NHS. My fellow Minister of State, my hon. Friend the Member for Sutton and Cheam, made a series of excellent points about that this morning. All that I can add is a quote from another supporter of private sector involvement in the NHS, the right hon. Member for Kirkcaldy and Cowdenbeath (Mr Brown), who told the Liaison Committee in 2007:

“The role of the private sector in the areas that you are suggesting is expanding, will continue to expand and will be a lot bigger in the next few years than it is now.”

Mr Burns: I am particularly pleased that the hon. Lady asked me that. I have read the report, because I had the privilege of going to Washington in November last year in the place of my right hon. Friend the Secretary of State to give a speech to the Commonwealth Fund when it launched that report. I am very familiar with the report, because the following day we had a conference that I chaired on the subject.

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The right hon. Gentleman must be patient.

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Mr Burns: The right hon. Gentleman must be patient. As I said at the beginning, I am coming to his comments and those of the hon. Member for Oldham East and Saddleworth. However, it is only fair that he does not queue-jump and that she has the opportunity to have the benefit of my views on her remarks.
I must tell the hon. Lady that it saddens me that people seek, for party political gain, to misrepresent the issues and scaremonger about Conservatives’ intentions towards the health service. There is no difference between the two of us in terms of our commitment to a national health service that is based on the principle of its being free at the point of use for those eligible to use it. I will bow to no one in my support of Nye Bevan’s founding principles of the NHS.

If we look at the years between 1945 and 1997, Conservative Governments were in office for a longer time than Labour Governments, but at no time did we seek, in any shape or form, to privatise the NHS. I do not want to be controversial or to rev up the Opposition, but those who remember their history will know that it was not a Conservative Government who introduced dental charges or prescription charges in 1950. The Opposition and the Government differ on how the NHS should be made more responsive to patients and more effective in delivering patient care and improving outcomes, but it is disingenuous to question the sincerity of our belief in the core principles of the NHS.

Debbie Abrahams (Oldham East and Saddleworth) (Lab) rose—

The Chair: Order. After you have responded to this intervention, Mr Burns, can we slightly drift back to where we ought to be?

Debbie Abrahams: I am grateful to the Minister for his statement about how committed he is to the NHS, which reflects what those on both sides of the Committee want to achieve. If that is the case, I am sure that he will be able to withdraw the proposals in the Bill that deal with competition. That was the argument that I put forward: why have them? He is setting up the NHS to fail through these measures, so he should just withdraw them.

Mr Burns: The hon. Lady, in the nicest possible way, has spoilt it. We were getting along so well until she tried to tempt me down a path along which I am not prepared to go. The short answer to her question is: because although we are totally committed to the same core principles, there is a chasm of difference between us on how to improve and enhance patient care and outcomes and put patients at the centre of the patient experience. The Government are doing it as laid out in the Bill, because we passionately believe that within the core principles it will improve and enhance the delivery of health care. The hon. Lady, from a perfectly respectable position, strongly disagrees. To put it crudely, however, we got the votes.

The hon. Member for Middlesbrough South and East Cleveland asked about quality and why it was not previously seen in a piece of health legislation. I hope that my hon. Friends and the Opposition can agree with me on that point.

Finally, but not least, the hon. Member for Leicester West and the right hon. Member for Rother Valley asked specific questions about competitive tendering, and I am pleased to be able to provide further details on that point. The intention is that regulations under clause 67 could impose requirements governing the process of tendering for NHS services. To avoid that, it is not the Government’s intention under clause 67 for regulations to impose compulsory competitive tendering requirements on commissioners, or for Monitor to have powers to impose such requirements.

Jeremy Lefroy (Stafford) (Con): One concern that has been raised with me over the question of tendering is the frequency with which people will be required to tender. Will the Minister comment on whether services will be required to be tendered annually, biannually, or every three or four years? Some people believe that frequent tendering might lead to inefficiency and excessive work.

Mr Burns: I am grateful to my hon. Friend for giving me the opportunity to clarify the situation and, I hope, to reassure him. This will also be relevant to the hon. Lady, given that she and her right hon. Friend have raised the matter. I can tell my hon. Friend that no, we do not intend to use the power comprehensively in that way. The purpose of the regulations will be to ensure that the commissioning board and the CCGs respect good practice and protect patient choice, and that they do not restrict competition to the detriment of patients. In some cases that would mean competitive tendering, but in others it might be in the interests of patients for commissioners to restrict competition, for example in specialised surgery or critical care networks. Ultimately, it will be for commissioners to decide which services to tender. We do not anticipate that time scales will be laid down stating that it has to be done every six months or every 12 months, for example. The system will respond to the needs of local commissioners in the areas. I hope that helps my hon. Friend.

Mr Barron: Will the Minister give way on that point?

Mr Burns: May I finish? This may satisfy the right hon. Gentleman, so that we can make some progress. There are already rules now, such as the PCT procurement guide, first published by the previous Government. Procurement law already applies to the NHS funding clinical services, and the Bill does not change that. The intention is that the regulations made under clause 67 will reflect the current rules.

I hope I have answered the points raised by hon. Members. I would now like to make a number of general points regarding the clause, before urging the Committee to support clause 67 stand part of the Bill.
Clause 68 enables various powers to be given Monitor through regulations, as we have seen in previous clauses, including the power to “declare that an arrangement for the provision of health care services for the purposes of the NHS is ineffective”. On 17 March, the Minister said that the reason for the clause was “to establish clear requirements on commissioners that would be binding and enforceable…Monitor needs credible sanctions to deter the types of behaviour that would be bad for patients…Without enforcement powers, Monitor would be in the same toothless position as the Co-operation and Competition Panel”,—[Official Report, Health and Social Care Public Bill Committee, 17 March 2011; c. 882.]

the same Co-operation and Competition Panel that the Government are now saying is a crucial part of Monitor. I will ask the right hon. Gentleman the question that I asked him last time, and to which I did not get an answer.

Mr Burns: I am sure you did.

Liz Kendall: Well, it was not a satisfactory answer.

Mr Burns: It would not be to you.

Liz Kendall: If the Minister gives me a direct answer, I am usually satisfied, although I might not agree with it, but he does not tend to do so.

The measure prompts the question: what is ineffective? If Monitor decides to declare health services provided for the purposes of the NHS ineffective, what does that mean? Why is it up to Monitor—not commissioners, the doctors and clinicians whom the Minister is so keen to involve, the NHS board, clinical senates or networks—to decide whether a service is ineffective? Amendment 236 would delete that part of the clause, which is why we will be pressing it to a vote.

Mr Burns: This is a tremendous pleasure. I assumed that some other Opposition Members would want to contribute to this debate.

The Chair: Don’t provoke them.

Mr Burns: I will not, Mr Hancock. Funnily enough, on this occasion, for the first time today, I was rather keen to provoke them, but we are where we are.

Subsection (3) provides that regulations made under clause 67 on procurement, choice and competition that apply to commissioners could include a power for Monitor to declare a contract or other arrangement for the provision of services invalid. The power would be a back-stop provision and there would be restrictions on its use. The regulations would ensure that commissioners procured services effectively, in line with best practice and in patients’ best interests. For example, they might provide that commissioners should not restrict tenders for services to existing providers unless they could demonstrate that doing so would benefit patients. Limiting potential providers could deny patients access to treatment at home or innovative treatments, for example.

If a provider breaches regulations on procurement, it is unlikely that Monitor would declare the arrangements for a particular service invalid as a first step. As subsection (4) makes clear, regulations would have to set out the circumstances in which Monitor could do so, as well as restrictions on its use of the power. Subsection (4)
also makes it clear that Monitor could use the power only where it was satisfied that a commissioner had failed to comply with requirements in the regulations and that the failure was significant.

For example, if a commissioner tendered a service failure to consider one of the tenders would be significant. However, if a commissioner made an error in procedure, Monitor might conclude that in that particular case the failure had not had a significant effect on the outcome of the exercise. In such circumstances, it would not set aside the arrangement, but take other action, such as reminding the commissioner of the relevant provision in the regulations or directing it to take steps to prevent the failure in future.

There would be further constraints on Monitor’s exercise of any power conferred on it by regulations under subsection (3). The Committee has discussed Monitor’s main duties at some length. Monitor can set aside any arrangement that commissioners have made only in furtherance of its main duty to protect and promote the interests of patients by promoting the economic, efficient and effective provision of health care services. If it were relevant to a specific case of a breach of the clause 67 regulations, Monitor would also have to take account of its duties to enable integration of services and any relevant matters in clause 58.

Jeremy Lefroy: Since we have amended the Bill such that the general duties of Monitor in clause 56 are indeed to promote provision that is economic, efficient and effective, I fully understand why Monitor should have the ability to say whether a service is ineffective. The second part of Monitor’s duty is to promote provision which

“maintains or improves the quality of the services.”

I wondered whether there was room for Monitor to talk about quality of services, as well as ineffectiveness, as that is one of its main amended duties.

Mr Burns: Again, I am grateful to my hon. Friend for that question, because it enables me to give greater clarity to the context of our discussions. Yes, Monitor will be able to do that.

Amendment 236 would remove Monitor’s power to declare that an arrangement is ineffective. I understand the Opposition Members may need reassurance about that power and, as I have set out, there would be safeguards and restrictions on Monitor’s use of it. It is an important provision. If a commissioner fails to comply with the regulations and if that failure is sufficiently serious and has a significant impact on patients, Monitor should be able to declare the arrangements for a particular service ineffective. The commissioner would then have to make alternative arrangements, in line with the requirements in the regulations. I remind the committee that the Secretary of State already has that power. In the event of a severe failure to comply with the principles and rules of co-operation, the Secretary of State could direct a commissioner to set aside a contract. Following my assurances and explanation, I ask the hon. Lady to consider withdrawing the amendment.

Grahame M. Morris (Easington) (Lab): I seek clarification on the Minister’s concluding remarks about the reserve powers and that the Secretary of State may choose to direct Monitor not to use its powers of referral. Can he give a situation where that might arise?

John Pugh (Southport) (LD): I think I am reassured by what the Minister said. If I have got it wrong, he can correct me as I try to replay what I think he said. As I understand it, Monitor works with a constrained set of rules as an adjudicator or referee, which is the expression I used the other day, and if clear breaches of those rules occur that can be identified within the tight remit of Monitor, Monitor has the power to declare a service to be ineffective. I imagine that the Co-operation and Competition Panel previously had a power to throw things back at the commissioners in a similar sort of way, but it lacked any statutory effect. What I am—or think I am—assured about is that Monitor will not be taking a strategic view about which services within a local authority are effective and which are not, but rather it is working within its tight remit.

Liz Kendall: Does the hon. Gentleman agree that that is not what the legislation actually says?

John Pugh: The Minister is on record explaining what it says and that has some force in terms of how it will be interpreted. There are certainly ways in which that can be made clear through the legislation, but the clear intent of the legislation seems to be the clear intent of the Minister’s remarks.

4.30 pm

Mr Burns: I can, I hope, deal with this very quickly. I can give the hon. Member for Southport the assurance in respect of what he thought I said. The answer is yes.

I hope that the Committee will bear with me while I explain something to the hon. Member for Easington; I would like to repeat what I said so that there is no misunderstanding of the tail end of my speech. I think that it is quite clear, and I assume that my hon. Friends do. I hope that the hon. Gentleman will also think so once I have repeated myself.

I said that if a commissioner fails to comply with the regulations, and that failure is sufficiently serious and has a significant impact on patients, Monitor should be able to declare the arrangements for a particular service ineffective. The commissioner would then have to make alternative arrangements, in line with the requirements in the regulations, and under these proposals—under this legislation, if and when it receives Royal Assent—it will be up to Monitor, not the Secretary of State, to take the decisions in the circumstances.

Just to cheer up the hon. Member for Leicester West—I think that this is going to be the end of my debut today—may I say that when we last discussed this, in March, she seemed to think that I did not answer her question about the meaning of “ineffective”? I think she will now agree, having listened to me for the past 10 minutes or so, that I dealt with it during the course of my comments this afternoon. In the vernacular, it would mean that the contract was invalid. I urge Opposition Committee members to withdraw the amendment.

Jeremy Lefroy: I thank the Minister for his clarification that Monitor will have an important role in ensuring that service quality is maintained, because that is one of its main functions. May I ask about the duty of the Care Quality Commission and Monitor to co-operate with each other, which is clearly set out in clauses 281 and 282? It does relate to clause 68, which we are discussing at the moment.
How does the Minister envisage the two bodies working very closely with each other, particularly in matters of quality, in which they both have an interest? I am concerned by the lack of communication that has come out in the Francis inquiry into Mid Staffordshire. I am talking about the lack of communication between Monitor as it exists now—I appreciate that its role is changing, but it will still be a body called “Monitor” with many of the same functions—and the then Healthcare Commission, which will now be the Care Quality Commission.

Will the Minister reassure me that there will not be a great separation of the two bodies’ roles, which might mean that they do not talk to each other—something that would be against the spirit and letter of the Bill? Will they co-operate in a way that is efficient and effective?

Liz Kendall: As always—for the record, I say this with irony—the Minister’s great clarity in describing what the Bill seeks to do has inspired me to stand up and make a couple of closing points. First, as the hon. Member for Stafford and my right hon. Friend the Member for Rother Valley have said, the Bill does not guarantee that Monitor will consider quality alongside issues of efficiency when looking at the competitive tendering of services.

Secondly, having listened to the Minister’s response, I should say that if I was a commissioner I would have no idea about the process, whether my services would come under scrutiny or whether Monitor would swoop in to say that I had somehow broken the rules and that my services were now ineffective. What the Minister has described is completely unclear and so, for clarity of purpose, we should delete this part of the clause. That is why I wish to push my amendment to a vote.

The Chair: Mr Burns, would you like to respond to your hon. Friend?

Mr Burns: My hon. Friend raised a number of issues with regard to the CQC and Monitor working jointly. Let me give him some examples that hopefully go some way to addressing his issues, which include the sharing of information and a close working relationship. There is already a memorandum of understanding that will need to be updated, and the CQC will remain primarily responsible for quality regulation. I hope that those examples answer his points.

Question accordingly negatived.

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

The Committee divided: Ayes 12, Noes 9.

Division No. 22]

AYES
Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
James, Margot
Poulter, Dr Daniel
Pugh, John
Soubry, Anna
Sturdy, Julian

NOES
Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O’Donnell, Fiona
Smith, Owen
Thornberry, Emily
Wilson, Phil

Question accordingly agreed to.

Clause 68 ordered to stand part of the Bill.

Clause 69

Requirements under section 67: undertakings

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

The Committee divided: Ayes 12, Noes 9.

Division No. 23]

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

NOES
Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O’Donnell, Fiona
Smith, Owen
Thornberry, Emily
Wilson, Phil

Question accordingly agreed to.

Clause 69 ordered to stand part of the Bill.

Schedule 9

Requirements under section 67: undertakings

Question put. That the schedule be the Ninth schedule to the Bill.

The Committee divided: Ayes 12, Noes 9.

Division No. 24]

AYES
Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Lefroy, Jeremy
Morgan, Nicky
Poulter, Dr Daniel
Pugh, John
Soubry, Anna
Sturdy, Julian

NOES
Crabb, Stephen
James, Margot
Lefroy, Jeremy
Morgan, Nicky

Question accordingly negatived.

Question put. That the schedule be the Ninth schedule to the Bill.

The Committee divided: Ayes 12, Noes 9.
would be best done by a dedicated regulator with a greater

Although it may be the last time; that depends on how

What are the other organisations in this context? It also

Involving all foundation trusts, whether or not they

It is a major step on the NHS to put legislation around

It does not fit. It does not work.

It does not work.

All that has been required. It has dealt with them
to certain foundation trusts. It provides that

That is exactly what was said to me at the first sitting of

That is a very good question.”—[Official Report, Health and
Social Care Re-committed Public Bill Committee, 28 June 2011; c. 12, Q18.]
I will continue to vote against the clauses, which the Government themselves have admitted are unnecessary—they can do what they want, as we have been doing for the last 10 years.

Tom Blenkinsop: Further to the point I made earlier, is it not also the case that if foundation trusts have the wrong constitutions, by changing the wording to enterprise and business there is potential for litigation, which can externally change the constitution of a trust, making it easier to acquire under acquisition law? What is more thought-provoking and scary in this process is the civil service, in this instance, gold-plating the copy and paste scenario of competition regulation from Europe. We have asked questions about that, but Ministers obviously have no clue about it. This is yet more gold-plating of European regulation without any interpretation by anybody.

Mr Barron: That is true, and I shall let my hon. Friend look at the studies that I have been reading on competition law and health care throughout the EU. From what I have read in recent months, the Bill is alien to health care throughout the EU—for the life of me, I cannot understand why we are putting all these clauses into the Bill, unless we are enticing and encouraging lawyers to start crawling over it.

Let me go back to clause 71. It has not changed; the OFT and the Competition Commission will decide whether NHS trusts could or should merge with other businesses. Hopefully, the Minister will tell us what those other businesses are.

I do not want to delay the Committee; I do not think that we had enough time to debate the Bill the first time around, and we certainly do not the second time around. My hon. Friend the Member for Pontypridd brought up the Co-operation and Competition Panel, which was a big issue in the health service and in the Future Forum. As I said, the proposals for introducing competition as laid out in the Bill still, in my view—although some people may be happy with them now—potentially destabilise the NHS.

The Government allegedly accepted that the Co-operation and Competition Panel should remain within Monitor; that was confirmed in an earlier sitting of this re-committed Bill Committee. If the Co-operation and Competition Panel’s position inside Monitor has the statutory underpinning contained in the Government document that was published on the same day as the Future Forum report, what is the clause telling us or telling the panel? In my reading of the situation, it is telling the panel that that is a sop to the Future Forum, and that nothing will stop the OFT or the Competition Commission from looking at mergers between NHS trusts or with other businesses. I firmly believe that that is why question marks hang over the future of our NHS. That is particularly true because this has not moved in any way, shape or form, but Monitor will allegedly be taking these decisions in future.

Liz Kendall: Does my right hon. Friend agree that the reason why this issue is so pressing is that the chief executive of the NHS has told the Public Accounts Committee that there are about 20 trusts that are not financially viable? The decisions about whether they should merge are pressing and urgent, and they will need to be made in the next couple of years.

Mr Barron: If we are to believe what has been said to the Committee since the re-committal of the Bill about integration and a more integrated service, I do not see how the OFT and the Competition Commission will make that easier—I suspect that they will make it much harder. My hon. Friend has every right to talk about trusts that are not viable at the moment. They would need to seek, as the NHS has done in the past, to work out an integrated service for them to join with other local trusts, so that they—and, in particular, the services that they provide for patients—could be protected and looked after. These are not matters for lawyers. I want the Minister to stand up and tell us why this clause—it has a different number on it; it is now clause 71, not clause 65—remains unamended, when so many so-called concessions were made to the NHS about the introduction of competition.

John Pugh: I have a small point to make. I take on board what the right hon. Gentleman has said about the mechanism through which we should treat mergers, and I will not say anything about that. While he was speaking, however, I was alerted to the use of the term “businesses”. When I first read subsection (3), it seemed to imply that an NHS foundation trust and a business are one and the same thing. I do not think that the legislation intends to make that easy equation, however. I assume that two such bodies are intended by the Government to be distinct things, and I would like that to be confirmed. Presumably, using the word “business” as a synonym for the NHS foundation trust would have different consequences from not doing so. Equally, the terms “enterprise” and “activities” are used. Now, two different NHS foundation trusts are two different “activities”; I understand that. Are they in strict legal terms, however, two “enterprises”? I do not know the answer to that, but I assume that it is yes. And are they two “businesses”? I suspect that the answer to that is no, and that the merger regime is a merger system that applies to both NHS foundation trusts and businesses.

Mr Barron: The hon. Gentleman is right in that respect. This quote is from the explanatory notes that were first issued when this Bill started in Committee, and it sums up what the clause means:

“This means that the OFT and the Competition Commission would be responsible for reviewing mergers involving all foundation trusts whether or not they are enterprises.”

It is quite clear that they will become enterprises for the implementation of the 2002 Act.

John Pugh: Clarity is dawning on me. I now understand that NHS foundation trusts and businesses within the national health service are both collectively “enterprises” and are subject to the same merger arrangements, which makes the clause clearer.

Owen Smith: I beg your indulgence, Mr Hancock, to point to another clause which I think pertains to this debate, and which I was going to discuss later. It throws further confusion on whether NHS providers will be
Competition Panel is currently looking at, a primary mean a consortium or, as the Co-operation and private providers or non-NHS providers. It might well make it clear that “businesses” does not mean only Clauses 71 and 101, in particular when read in conjunction, distinct. That is, if there is a merger of some sort.

Enterprise Act to describe the bodies that will be subject to review, were their activities to merge and cease to be enterprise. It merely co-opts the language of part 3 of NHS trust or some other NHS provider—and a business distinguishes between what constitutes an NHS body—an NHS trust and businesses. Clearly, we are not talking about NHS trusts around, and there will continue to be, mergers involving NHS trusts. There are still many

John Pugh: I am sympathetic to the idea that we differentiate hospitals from businesses in legal as well as conceptual terms, although some hospitals—for example in the United States—are clearly just businesses, as are some private hospitals in the UK. We are all sympathetic to that. As I understand it, the intent of the legislation in front of us now is to maintain that distinction and to use them as parallel but different terms, but to treat them as a parallel regime when it comes to mergers, whether mergers of businesses or mergers of foundation trusts. We can argue about that, but I think, for the moment, I am clear.

Jeremy Lefroy: There is one point on which I would appreciate clarification. We are talking about mergers involving NHS foundation trusts, or NHS foundation trusts and businesses. Clearly, we are not talking about mergers involving NHS trusts. There are still many NHS trusts around, and there will continue to be, particularly as, I understand, the time limit in legislation for converting NHS trusts into foundation trusts is being extended. I can envisage circumstances—in fact, I can think of examples within my region—in which there was a merger of an NHS trust with a foundation trust. That would not be covered, as I see it, by this clause. What does the Minister have to say about that? Clearly, the effect of the merger of an NHS trust with an NHS foundation trust would be almost exactly the same as that of two NHS foundation trusts.

Owen Smith: I think my right hon. Friend the Member for Rother Valley has raised an important point here. It was one that I would have raised later, but now is the time for the Minister to clarify this issue. My interpretation differs from that of the hon. Member for Southport. I do not think that this element of the Bill adequately distinguishes between what constitutes an NHS body—an NHS trust or some other NHS provider—and a business or enterprise. It merely co-opt the language of part 3 of the Enterprise Act, takes the powers there and applies them to the NHS.

5 pm

“Enterprise” and “business” are the terms used in the Enterprise Act to describe the bodies that will be subject to review, were their activities to merge and cease to be distinct. That is, if there is a merger of some sort. Clauses 71 and 101, in particular when read in conjunction, make it clear that “businesses” does not mean only private providers or non-NHS providers. It might well mean a consortium or, as the Co-operation and Competition Panel is currently looking at, a primary care service integrating fully with a foundation trust. That is the sort of merger the Co-operation and Competition Panel has investigated hitherto. In future, that will be the precisely the sort of area where the Competition Commission, the OFT or Monitor might equally apply the law.

Here is another example where language inappropriate to the NHS throws confusion as to whether NHS providers might be deemed to be enterprises, undertakings, businesses or engaged in economic activities. The Minister said earlier that the courts will decide the extent to which competition law will apply in future. The courts will read this debate, see the legislation and know that henceforth these things are effectively far more commercial operations, and therefore ought to be bound by competition law in a market place.

Tom Blenkinsop: I am looking at Hansard for 17 March, when we originally talked about the clause in Committee. My right hon. Friend the Member for Rother Valley raised this point:

“Does that mean that, on that basis, the OFT and the Competition Commission could not have the power to override what has been agreed locally? Or does it mean that they do have the power to override what has been agreed locally?”

That again referred to a foundation trust’s constitution and whether it can be externally played around with by the Competition Commission. The Minister, the right hon. Member for Chelmsford, replied:

“Yes, if there is a substantial lessening of competition.”—[Official Report, Health and Social Care Public Bill Committee, 17 March 2011; c. 885.] The clause is unamended. Irrespective of changes to the surrounding clauses, this one has a fundamental aspect to how foundation trusts will go in future, how they will be merged or how they could be acquired, as I raised earlier. That is what is scary about the clause, which remains unamended.

The Minister of State, Department of Health (Paul Burstow): Given the point made by the hon. Member for Pontypridd about the importance of the way in which the courts construct what we say, I hope hon. Members will forgive me if I am less willing to take interventions, so that I have the opportunity to set out clearly the answers to the questions that I have been asked. I hope then to avoid any confusion when it comes to reading what we were trying to achieve through the legislation.

I would like to start by addressing a question posed by the right hon. Member for Rother Valley: why do we have 12 competition clauses if there is no change? That seems to be a key theme of the Committee’s deliberations on all these clauses. I say to Opposition Members that the changes are necessary to get the right institutional framework and independent scrutiny of competition. There are three clauses that establish concurrency, enabling a dedicated health regulator to apply the powers that the OFT currently has. There are four clauses that ensure commissioning will be done well by replacing the procurement guide and allowing the principles and rules of co-operation to be applied in a new environment, where the Secretary of State would not have powers to direct commissioners, as he can now. Consistent scrutiny of mergers, which we will discuss in detail, is provided for in clause 71, and I will set out the Government’s response to Opposition Members’ concerns. There are
three clauses that provide for independent, informed review of how competition is developing and of how Monitor is performing. All those are in the public interest, and there are provisions to ensure co-operation between the OFT and Monitor.

It useful to rehearse such points for those who follow the back and forth of the Committee, and the clauses are in the Bill for those reasons. I will go one stage further, however, because the right hon. Gentleman also returned to his concern that surely, by the simple act of repeating powers that are concurrently operated by Monitor and that are already exercised by other bodies, there is an invitation, in some way, for that to be interpreted as competition being extended. Let me be absolutely clear: the existence of a sectoral regulator does not mean that the courts are more likely to decide that competition law applies. Competition authorities and courts consider the facts on the ground when applying the law, regardless of the institutional arrangements for its enforcement.

This is simply about putting in place institutional arrangements, which, I should add, have wide support outside the Committee. The NHS Confederation, in its written evidence, said:

“The NHS Confederation believes the creation of a sector regulator is an essential part of the new system”.

The King’s Fund stated:

“We agree that a sector-specific regulator with expertise in healthcare is the most effective safeguard against inappropriate application of competition law”.

Even the British Medical Association, in its written evidence, stated that

“we believe it is more appropriate for those powers to be exercised by an exclusive health regulator”.

There seems to be consensus outside the Committee about the benefits of these provisions, even if we cannot reach it here.

The right hon. Gentleman and my hon. Friend the Member for Southport asked about “other organisations”. I would like to address that and go on to say something about the terms “business”, “enterprise” and “activities”.

“Other organisations” simply refers to businesses for the purposes of the Enterprise Act 2002, so it would only apply where a foundation trust is acquiring the business or part of the business of another body. To avoid doubt, I make it absolutely clear that the legislation would not permit a foundation trust to merge with a private entity or be acquired by one.

In terms of “business”, “enterprise” or “activities”, what do FTs count as? Foundation trusts are principally public benefit corporations providing NHS services. That is important, not least in terms of the misrepresentation of the impact of lifting the cap. Of course, any resources that are secured by a foundation trust must be delivered and used in a way that furthers that principal purpose as organisations. That gives us pause for thought on some misrepresentations that have been made about the intentions behind that. Whether a foundation trust could be considered as an enterprise in whole, in part or not at all, would depend on its activities. As that would depend on the facts of each case, there is uncertainty about whether the Enterprise Act would apply. Clause 71 means that the uncertainty would be avoided by bringing mergers involving foundation trusts under one regime. This is about removing uncertainty, which I understand that the Opposition may wish to maintain for their purposes.

Questions have been asked about the role of the Co-operation and Competition Panel, and there was an exchange on 7 July between the right hon. Gentleman and the Minister of State, my right hon. Friend the Member for Chelmsford, which was reported in that day’s Hansard, column 336. That exchange dealt with this very point. I will not read it out, but I commend it to the Committee. Let me try to paraphrase it. It states that the Co-operation and Competition Panel and the Principles and Rules of Co-operation and Competition remain. The CCP will no longer look at foundation trust mergers. Instead, we propose that that should be dealt with under the single regime set out in this clause.

That no longer disadvantages the NHS foundation trusts vis-à-vis the private sector, as my right hon. Friend said in his response to the right hon. Gentleman last week.

Having responded to all the questions, let me now set this clause in context. The clause applies merger control regimes for enterprises in the UK to mergers involving foundation trusts. That means that the OFT could make a reference to the Competition Commission to review the merging of activities involving foundation trusts to test whether they give rise to a substantial lessening of competition. However, the OFT has a discretion not to refer where patient benefits outweigh the adverse effects on competition. Patient benefits would include consideration of availability of patient choice and greater innovation and provision of high quality services. A merger can include the merging of some or all activities in an organisation—for example in partnerships and joint ventures—and not just mergers of whole organisations.

The clause means that we would have a single regime for merger control, which would avoid duplication of resources between Monitor and the OFT, and it would also address the current situation whereby the Co-operation and Competition Panel formally assesses all mergers involving acute or foundation trusts where the turnover of the combined entity is more than £70 million. The OFT would only consider mergers—I have already made this clear in response to the issue about private acquisitions—where the body being acquired had a turnover of more than £70 million or where the resulting share of supply exceeded 25% of the market.

Liz Kendall: We have never heard this before.

Paul Burstow: That is why I am making it clear now, and why I was so keen to have the opportunity to do so.

In practice, this would mean that the OFT would consider fewer mergers between foundation trusts than the panel currently does. A single regulator would present a significant improvement on the current arrangement, whereby both the Co-operation and Competition Panel and the OFT could end up considering the same merger as has happened for a merger of foundation trusts that also have significant private incomes.

It might be suggested that Monitor should therefore consider all mergers—NHS and private. However, there are several complications with this approach. First, mergers are a specialist area. The OFT is the expert. It is
the regulator of mergers in all types of services including those which have a separate sectoral regulator. With the lower number of mergers that would be caught under the higher threshold, Monitor would struggle to build up the expertise to consider these appropriately.

Monitor would only be the regulator of health care services in England. Complicated arrangements involving the OFT would therefore be required to address mergers between providers of health care services, social care services or health care products. Private and voluntary providers could undertake such mergers, whereas foundation trusts would not. There would also need to be special arrangements for mergers involving organisations in Scotland, Wales, Northern Ireland or overseas.

Finally, the OFT has an established reputation for effective, light-touch regulation where mergers are concerned. This gives confidence to providers that might be considering a merger and ensures that mergers that are in the patients’ best interests go ahead. None of this would enable a foundation trust to emerge with a private company or to be acquired by a private company. A foundation trust would still be able to enter into a joint venture with a private provider or acquire a private company or part of one.

Therefore, it seems a far better use of resources to maintain the responsibility and expertise within the OFT. As part of its investigation, it would engage with Monitor as the sectoral regulator in order better to understand the services involved. It would obtain Monitor’s view on how a merger would affect competition and whether it would bring benefits for patients. These views are then considered in its analysis, along with other evidence. That is what this clause does. It does not do the things that some Opposition Members have suggested, and I am grateful for the opportunity to clarify the matter. I recommend that this clause should stand part of the Bill.

5.15 pm

Owen Smith: We are genuinely grateful to the Minister for providing us with a wealth of new information in that answer, in which five or six new, distinct and extremely interesting bits of information emerged. It also prompts a series of obvious questions.

First, the Minister confirmed in respect of the use of terms such as “business”, “enterprise” and so on that the OFT might consider an enterprise—in this case, a foundation trust—acquiring the business of another body. However, he did not explain what he means by “business” in that context. Does it mean, for example, part of the activity of another NHS provider? Is that what is meant by “another body”, or does that phrase relate solely to private companies? I assume that it cannot, but I would be grateful if the Minister clarified that point.

Secondly, he said that foundation trusts may be considered to be enterprises. That is another new piece of information to us, and it bears out what we said in the earlier debate. The Bill is starting to describe and interpret the NHS for the courts in a manner that it has not done in the past. That is deeply worrying in terms of future challenge by courts and lawyers.

Tom Blenkinsop: My hon. Friend is giving an excellent account. On 17 March, when we originally discussed the clause, which is still unamended, the Minister of State, the right hon. Member for Chelmsford, who is not in his place, told the Committee:

“Under the clause, the OFT could make a reference to the Competition Commission to review foundation trust mergers to test whether they gave rise to a substantial lessening of competition.”

He mentioned “mergers of foundation trusts and mergers between foundation trusts and others”,

and said:

“The clause enables the merger control regime for enterprises in the UK to be applied to mergers of foundation trusts and mergers between foundation trusts and other businesses.”—[Official Report, Health and Social Care Public Bill Committee, 17 March 2011; c. 885.]

Surely a lawyer looking at the term “other businesses” will interpret it as every single business in the country.

Owen Smith: Potentially, yes. That is absolutely the point. It is deeply unclear. Will “businesses” apply to other NHS providers? It must, judging from the comments made earlier by Ministers. It must refer on occasion to the sort of merger that the Co-operation and Competition Panel considers: for example, between primary care providers in Birmingham and foundation trusts in Birmingham. That is precisely the sort of thing that the panel has considered.

We also learned that in future, the Co-operation and Competition Panel will not consider mergers at all. They will now be the responsibility solely of the OFT, or, I presume, partly of Monitor and partly of the Competition Commission, if there is a problem. That prompts the question: what on earth will the Co-operation and Competition Panel do in future? We have been told that it will be maintained in what it does and put on a statutory footing, and that Monitor will “work through it”, in the words of the Secretary of State. However, if the Minister reads what the panel has done in the year or so since it was set up, he will see that it has only about six cases, all of which involved mergers. If the panel will not do what it has done in the past, what on earth will it do?

Mr Barron: Does my hon. Friend agree that the sop given to the Future Forum, that the Co-operation and Competition Panel will have statutory underpinnings, is exposed as nothing but words? It is clear that the intention is that mergers between NHS trusts and other organisations will not be a matter for Monitor. They are being written on to the face of the Bill as a matter for the Office of Fair Trading and the Competition Commission, which is not what the Government promised the Future Forum when it published its deliberations a few weeks ago.

Owen Smith: I completely agree. It is worse than a sop; it is, as I said the other day, smoke and mirrors. The Government are trying to throw people off the scent by giving the impression that the core of the Bill has been altered, but, as we have exposed in the case of mergers and all the competition provisions, the Bill remains red in tooth and claw.

The Minister’s previous point was genuinely astonishing, to use a word of which my hon. Friend the Member for Leicester West is fond. I apologise if I slightly misquote the Minister, but he spoke quickly and I may not have taken his words down entirely accurately. Broadly speaking, he said, “The OFT will only look at mergers where the
body involved in the merger had a turnover of more than £70 million or took up more than 25% of activity.” A financial threshold to determine the OFT’s involvement is totally new.

Paul Burstow: The hon. Gentleman has been diligent in his research in preparation for the Committee. The clause applies the OFT’s function to look at mergers, so I am surprised he is not aware that that is the threshold set by the OFT when it looks at mergers.

Owen Smith: In fact, I doubt it is in the primary legislation. If the Minister reads the Competition Act or the Enterprise Act, he will fail to find a specific reference to a financial threshold of £70 million. I would be surprised if old legislation, or any legislation, had a specific number. I suspect that the figure might be in regulations, which get updated, or in some other form of OFT guidance. I am convinced that the threshold has previously been applied only to mergers of public or private bodies that have absolutely nothing to do with the NHS. That is the key point.

Paul Burstow indicated dissent.

Owen Smith: The Minister disagrees, but the OFT, as far as I am aware, has not investigated or ruled on any merger between NHS foundation trusts or other NHS bodies, so it cannot be true that the threshold has ever been applied in the NHS. I am prepared to believe that the OFT might do so in future, but frankly, when the civil servants helpfully handed a note to the Minister to give him the numbers, I suspected the numbers were a straightforward read-across from regulations or some other statute on the operation of the OFT in the commercial world in which it normally operates. It is not something that has ever been applied in the NHS.

Crucially, in that case, what is meant by “25% of activity”? I presume that in other businesses it is meant to be used as a guideline to determine whether a potentially monopolistic cartel or potential monopoly is being created. I presume that such a threshold might be used in the case of BSkyB, but I cannot imagine that 25% of activity in the NHS has ever been defined in statute. If it has, I will be grateful if the Minister explains it to us.

John Pugh: We can take two views on this matter: there is the conspiracy view, which is popular with Opposition Members, and there is the view that such complex legislation always has some rough edges that need to be refined and perhaps explained. We have argued for the overall benefit of a sectoral regulator that will keep the OFT at bay, so I find it problematic that we seem to have indirectly unearthed an area in which the OFT and the sectoral regulator will work side-by-side on big mergers—or they might start working side-by-side, but the sectoral regulator could be edged out—and we would be left with judgment by the Competition Commission. I need to be persuaded that there is a good reason for doing that.

I will reread everything that the Minister said in the cold light of day tomorrow, and no doubt he could try to convince me again, but there are three reasons why that might be a problem. The Competition Commission has absolutely no history of doing that sort of work—mergers between NHS trusts. I phoned the OFT and said, “Can you put me through to the section that deals with health matters?” They said, “We haven’t got a health section.” I said, “Could you do health at all?” I did not get much further than the switchboard because they could not think who to put me through to, or of when the OFT had previously done anything to do with health. I need to be persuaded that the OFT has any relevant experience. Even if it did, I think the Minister said that it would need to balance a range of factors—patient access, competition, and so on. That is a different sort of expertise from knowing competition law and raises the question whether the OFT has the required expertise.

That matters because I am thinking of real examples of mergers of trusts in, for example, parts of London, where financial constraints have bitten and, for better or for worse, trusts have already merged in a variety of ways to sustain existing hospitals. Some of the trusts that have merged have done so ill-advisedly and are still in financial trouble, but I can think of other, smaller foundation trusts that might want to merge with bigger trusts to become more financially viable. Clearly there will be a process of consultation and that will have to be hardened to, but what if it produces a result that the OFT does not like? Is that a possible scenario? Those are legitimate concerns that I would like the Minister to answer.

Owen Smith: Has the hon. Gentleman looked at the board of the Co-operation and Competition Panel? It has about 15 or 20 people who are genuine experts in health care from different disciplines who bring to the table a rounded view of the needs of patients and an understanding of how hospitals and primary care work. Is he concerned that those people will be frozen out of looking at mergers? Apparently they will be kept doing something else—we do not know what—but the OFT has no expertise to fill the gap.

John Pugh: There may genuinely be a reason why the Co-operation and Competition Panel cannot deal with mergers involving NHS foundation trusts. That is in the heading of the clause, which is about not businesses or private firms, but NHS foundation trusts. There may be some reason why the panel cannot do that, although I do not understand what it could be. Perhaps it is because NHS foundation trusts will want to run alongside, do business with, or in some way take other over bodies that are not NHS foundation trusts. That is not, however, the heading of the clause. There may be some reason unknown to me why another body can do that work a lot better. It seems to me that the case has not been very well expressed or teased out, although perhaps I have not understood it. It does give sustenance to the, hopefully deluded, conspiracy theory across the way that the provision is based on the premise that NHS foundation trusts will ultimately become just businesses.

Mr Barron: The hon. Gentleman may recall that in the evidence session on Tuesday 28 June, I specifically asked why what was clause 65 and is now clause 71 was not to be amended. I asked Sir Neil Douglas, the chairman of the Academy of Medical Royal Colleges, how he felt about the clause, and he said that he remained “deeply concerned”. Dr Meldrum, the chairman of the British Medical Association Council, which the Minister seemed to suggest supported the changes, said:
“Yes, I also have concerns remaining. Mergers should take place for good clinical reasons.”—[Official Report. Health and Social Care (Re-committed) Public Bill Committee, 28 June 2011; c. 52.]

How can the Minister stand in front of us now and say that these organisations are in favour of the unamended clause?

5.30 pm  

John Pugh: I am hoping that there is a very clear and obvious answer that I have not hit upon. I am well aware that people way above my pay grade who understand these things far better than me can see that concern. The Minister has endeavoured to relieve us of that concern, but in doing so has presented new information that we may well need to go away and ingest.

Fiona O’Donnell (East Lothian) (Lab): I want to appeal to the hon. Gentleman—[Interruption.] I hope that I am not delaying an urgent comfort break. I am sure that Mr Hancock will afford us all a moment of comfort very shortly. I appeal to the hon. Gentleman to think about the accusations that he makes about the Opposition when he talks about conspiracy theories. I know that he has inside knowledge of how difficult mergers can be and how carefully one has to choose one’s words. What for him may be rough edges are for us very real concerns.

I am new to this process. As I watch the pieces of paper arrive on the Minister’s desk, I feel that the Bill is taking shape and flowering. He is discovering what it means and we are only now discovering what it means. It is the role of Opposition Members to scrutinise the Bill; it is not about conspiracy. The Minister is very happy to talk about context. In justifying Monitor, he spoke about the need to have a regulator that had inside knowledge of the NHS and would put patients first, but what we are hearing now flies in the face of that. To apply the callous and clumsy rules of the free market to what we are hearing now is completely inconsistent. It is the role of Opposition Members to scrutinise the Bill; it is not about conspiracy. The Minister is very happy to talk about context.

Paul Burstow: This is important, so I will take the opportunity to address the substantive questions that have been asked by hon. Members on both sides of the Committee. I look forward to a rerun of the Third Reading speech on Report and Third Reading in the autumn.

Let me start with the right hon. Member for Rother Valley and his question about the BMA, what it has said and what I have said about its position. At that point, I was talking about concurrence. I was responding to his question about why there are 12 clauses in the Bill that deal with competition matters. I specifically referred to the fact that the BMA, the King’s Fund and the NHS Confederation, as well as the NHS Future Forum, have made it clear that they see the virtue and value of concurrence. I am not claiming more than that for the BMA’s position, and the right hon. Gentleman has rehearsed some of the other points.

Let me go through some of the issues. There is about an hour and half to go, and I want to ensure we make progress as well. The Bill does not change the status of foundation trusts and enterprises. That is not true now and will not be once the Bill is enacted. Clause 71 removes uncertainty by having one regime for mergers. The hon. Member for Pontypridd asked about the meaning of businesses and other NHS bodies. Let me restate that clause 71 covers mergers between two foundation trusts. When other organisations are involved, I put on the record again that it simply refers to businesses for the purposes of the Enterprise Act 2002, so it would apply only where a foundation trust was acquiring the business or part of the business of another body. To avoid doubt, legislation would not permit a foundation trust to merge with or be acquired by a private entity.

My hon. Friend the Member for Stafford asked about mergers involving NHS trusts. We would not expect trusts to be subject to the Enterprise Act. NHS trusts remain under the Secretary of State’s powers of direction, and such an arrangement is unlikely, so we have no plans for mergers involving NHS trusts to be referred to the OFT.

Mr Barron: Will the Minister give way?

Paul Burstow: Is it on that point?

Mr Barron: It is exactly on that point. I have read this out at least twice today. The explanatory notes to the clause say,

“This means that the OFT and the Competition Commission would be responsible for reviewing mergers involving all foundation trusts whether or not they are enterprises.”

That completely contradicts what the Minister has just said. Will he explain?

Paul Burstow: I am providing the Committee with an explanation of how, in the Government’s view, the clauses should be construed. That is why what I have said is what I will stick to.

I will move on to the OFT thresholds in response to questions from the hon. Member for Pontypridd. The £70 million turnover test is laid down in section 23(1)(b)
of the Enterprise Act 2002. Section 23(3) covers the question about 25% of supply asked by the hon. Gentleman. This the standard practice for merger control, and the OFT already operates the threshold across sectors.

Liz Kendall: Whatever the Minister likes to say, he has announced new policy today, which people have not heard before. That is that the OFT will decide on mergers over £70 million. He likes to give out the figure from the Enterprise Act, but that legislation is nothing to do with hospitals; it covers other sectors. Does he not understand that?

Paul Burstow: We are exploring how clause 71 applies to mergers between foundation trusts, and we are explaining how we move from the current arrangements to the arrangements that require concurrence. That is what we are debating at the moment. I am clear that that provides the basis on which we have a single regime for dealing with mergers. We use the expertise accumulated by the OFT for that purpose. That goes back to the question asked by my hon. Friend the Member for Southport. The point here is that, because the threshold is higher, fewer mergers are likely to be referred in this process in the future than are currently considered by the Co-operation and Competition Panel.

The hon. Member for Pontypridd asked about what the CCP will do in the future. That is an important question, because it allows us to demonstrate that the role of that body goes well beyond considering mergers. It does much more than that—indeed, it is undertaking a major review of PCT procurement and contracting practices in respect of patient choice of independent sector hospitals for elective care. That report will be published later this month. It deals with a number of other matters that cover the 10 principles and rules set out and established by the previous Government.

Liz Kendall: The Minister is in government. He says we are exploring the impact of clause 71, but we are not. He is asking the Committee to vote on the clause and to get it through. It is quite clear from what has happened today that he does not know or understand the impact of the clause. He has given a new figure, which has never been given before; he has just picked it out of two other Acts that have nothing to do with the NHS. He is giving to a body that has no expertise, which has never been given before; he has just picked it out and established by the previous Government.

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Paul Burstow: There was a little anger there. The Committee may be exploring, but the Government are clear, and I have set out very clearly the Government’s position on why the clause is necessary, why it establishes certainty where there would otherwise be uncertainty, and why, if the Opposition had been doing their job at an earlier stage, they might have noticed that these figures were there. We have spelt out clearly today how the OFT regime would apply. Having set it out, responded and not satisfied the Opposition, I urge that the clause stand part of the Bill.

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Paul Burstow: There was a little anger there. The Committee may be exploring, but the Government are clear, and I have set out very clearly the Government’s position on why the clause is necessary, why it establishes certainty where there would otherwise be uncertainty, and why, if the Opposition had been doing their job at an earlier stage, they might have noticed that these figures were there. We have spelt out clearly today how the OFT regime would apply. Having set it out, responded and not satisfied the Opposition, I urge that the clause stand part of the Bill.

Paul Burstow: We are exploring how clause 71 applies to mergers between foundation trusts, and we are explaining how we move from the current arrangements to the arrangements that require concurrence. That is what we are debating at the moment. I am clear that that provides the basis on which we have a single regime for dealing with mergers. We use the expertise accumulated by the OFT for that purpose. That goes back to the question asked by my hon. Friend the Member for Southport. The point here is that, because the threshold is higher, fewer mergers are likely to be referred in this process in the future than are currently considered by the Co-operation and Competition Panel.

The hon. Member for Pontypridd asked about what the CCP will do in the future. That is an important question, because it allows us to demonstrate that the role of that body goes well beyond considering mergers. It does much more than that—indeed, it is undertaking a major review of PCT procurement and contracting practices in respect of patient choice of independent sector hospitals for elective care. That report will be published later this month. It deals with a number of other matters that cover the 10 principles and rules set out and established by the previous Government.

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5.45 pm

On 17 March, the Minister of State, the right hon. Member for Chelmsford, said:

“Other sectors do not have such a review requirement, but we think it is particularly important for health care services.”

Will his colleague explain to me precisely why he thinks it particularly important that the Competition Commission reviews the development of competition in the NHS?

The right hon. Gentleman also said:

“The Competition Commission will be able to make informed, independent judgments, including making recommendations on any matters it had considered”.—[Official Report, Health and Social Care Public Bill Committee, 17 March 2011; c. 886.]

Like the right hon. Gentleman the last time around, his ministerial colleague has not answered this question: what knowledge, experience or expertise does the Competition Commission have, and what kind of major recommendations could it make following its review of how competition is developing in the NHS?

More fundamentally, just as we asked about why the OFT has a role at all, why should the Competition Commission have any role in assessing how competition is developing in the NHS? The Minister claims that the Government have changed the Bill to make it clear that they do not want to promote competition as an end in itself, but the clause shows that that is simply not the case. The Government have tabled no amendments to this crucial clause. If they really wanted to say that competition was not an end in itself, they would not give the Competition Commission a role.

Owen Smith: Does my hon. Friend agree that it would be useful to hear from the Minister whether a financial threshold will also be applied in respect of the Competition Commission? I do not know how many millions that might be, but given that we now know that the size of a hospital’s turnover—I was not aware that millions that might be, but given that we now know that the size of a hospital's turnover—was the determining factor as to whether the OFT intervenes, will the same apply to intervention by the Competition Commission?

Liz Kendall: I look forward to the Minister’s response and to whether he will give us any new policies, as he did on the previous clause.

Paul Burstow indicated dissent.

Liz Kendall: The Minister shakes his head, but he knows that to be the case, as we will see. We want more details about what the reviews will cover. Will there be any thresholds? What expertise is there in the Competition Commission to do that work?

Amendment 235 would delete the requirement that the Competition Commission reviews the development of competition in the NHS. It is simple. If the Government say that that is not their primary goal, they should accept the amendment. Amendment 237 refers to clause 73, and I will remind hon. Members what that clause does.

During the previous Committee stage, the Minister, the right hon. Member for Chelmsford, explicitly introduced a new clause 9 giving the Competition Commission “powers to collect information to inform its reviews of the development of competition”—[Official Report, Health and Social Care Public Bill Committee, 17 March 2011; c. 886.]

in the NHS. The clause also gave the Competition Commission powers to impose penalties on any NHS organisation that does not comply with its request for information.

Amendment 237 would delete the Competition Commission’s ability to issue penalties to NHS commissioners or providers if they do not comply with information requests, because that part of the Bill is unnecessary. Why is the Competition Commission taking on that role? If the Government are really doing what they say, which is to give all responsibility to a sector-specific regulator, why should the Competition Commission have a role in the reviews? If the Government are honest about the real role of the Bill and the clauses, they will acknowledge that they seek to promote competition. The organisations leading these changes are not sector specific. The Government should accept these amendments and delete these powers if they really want to make true their word to Future Forum.

Paul Burstow: This feels like the proverbial question, “Have you stopped kicking your dog yet?” No matter how I answer the question, I end up accepting that I have kicked my dog. I am certainly not prepared to accept the proposition that the hon. Lady is putting forward.

Owen Smith: They have shot the dog.

The Chair: Can we leave the dog out of it?

Paul Burstow: We have a clear position on the applicability of competition. We have debated that in Committee. We have been clear about the amendments that we have already debated on changing the role of Monitor and about not seeing it as a promoter of competition. It is worth just noting that the Competition Commission does not have a duty to promote competition either. The hon. Lady has posited a whole set of amendments on the idea that that is the mission of the Competition Commission. It is not. It is indeed why it is not the case either for the sector-specific regulator Monitor.

The amendments narrow the focus of these reviews and reduce the Competition Commission’s ability to gather information required to undertake an effective evaluation. Given the importance of these reviews to the future of the NHS health care system, we believe the amendments would weaken the effect and I urge hon. Members to vote against them if they are pressed to a vote.

The hon. Member for Pontypridd asked whether there was a financial threshold. [Interruption.] I apologise if I have mispronounced his constituency. I will have to work on it—on that occasion I was trying to get it right. There is no threshold. The Bill sets out a basis upon which these reviews will take place every seven years. The first one has to be started before 2019.

Amendment 235 would remove the Competition Commission’s duty to analyse the development of competition in its seven-yearly reviews, only allowing it to evaluate how Monitor has delivered its functions. Independent evaluation of the system is important to ensure that the health care system is improving under these provisions and to identify where changes could be made to deliver further benefits for patients and taxpayers. Indeed, the very notion of these things was put forward by the right hon. Member for Exeter (Mr Bradshaw) in a debate back in 2009 when he advanced the very same proposition in terms of the benefits of competition.

Liz Kendall: The Minister is generous in giving way. Why does he think the Competition Commission needs to review how competition is developing in the NHS?
Paul Burstow: The hon. Lady will forgive me but I am going to develop my arguments rather than allow myself to be battered around by interventions that are not relevant to the point I am making. I will not take any further interventions for a little while.

The independence of the review will allow a neutral look at the system without political bias and influence from Monitor and the NHS commissioning board. The Competition Commission would not undertake this review to see how much competition had increased or to push blindly for further increases. The key focus of the evaluation of the NHS would be public interest. The Competition Commission is required by the legislation to consider whether any matters would have an adverse effect on the public interest. That is the test. Competition is not an end in itself. It is not seen in that way in the competition legislation. It is not seen that way in this Bill as amended. It should only be used in the patient’s best interest.

Emily Thornberry: Will the Minister give way?

Paul Burstow: No, not yet.

The Competition Commission will make any recommendations that it sees fit to address any matters adverse to that public interest. It would surely also be useful for the Competition Commission to highlight areas in which competition has produced higher quality and more efficient services, and to disseminate that information for the benefit of commissioners across the country.

Amendment 237 would remove the Competition Commission’s ability to impose financial penalties where there is a failure to comply with the commission’s investigative powers, for example where there is a failure to provide information that the commission requires to undertake its review effectively or where it receives false or misleading information. I have already set out the importance of effective independent evaluation, and the amendment would hinder that process.

Liz Kendall: You do not believe that.

Paul Burstow: Mr Hancock, it is difficult to make progress when there is a constant, running editorialising of my remarks.

The Chair: Order. It is very difficult to follow what the Minister is saying. I am sure that he does believe it, because he is saying it. It is very disconcerting to hear the Minister being challenged about whether he believes what he is saying. Let us hope for the duration of the sitting that we can assume that he believes what he is saying.

Paul Burstow: Thank you, Mr Hancock. It is entirely right that we should scrutinise the amendments and debate the Government’s clauses.

Emily Thornberry (Islington South and Finsbury) (Lab): Will the Minister give way?

Paul Burstow: No.

Emily Thornberry: Why not?

Paul Burstow: It is not acceptable to use interventions solely to obscure the setting out of the Government’s position, so I will not accept any interventions until I have made some progress.

Emily Thornberry: Will the Minister give way later? Can I book an intervention?

The Chair: Order. When the Minister says that he will not take any interventions until he has progressed a little further with his speech, I think we can assume that he will take interventions later. We will let the Minister at least proceed with this part of his speech.

Paul Burstow: Thank you, Mr Hancock. We have two hours left of consideration today, and we are trying to make progress. I have been more than generous when it comes to taking interventions, as the record will show.

I have already set out the importance of effective independent evaluation, and amendment 237 would hinder that process. The power to impose financial penalties on organisations is a backstop that can be used to ensure that they have delivered what is required from them. Without that provision, the Competition Commission could not guarantee that it had access to the information that it required to produce an accurate and effective review. The Competition Commission has never used those powers in any of the market investigations that it has undertaken, but the powers need to be provided as an incentive.

We expect that the Competition Commission will be able to gather much of the information that it requires from Monitor, so we have made provision in clause 72 for Monitor to provide information and assistance that the commission requests and other information that Monitor considers would be useful in carrying out the review. In other words, sector-specific knowledge and insight will be integral to this process.

The public have the right to expect an independent evaluation to ensure that good practice is shared and that there is an understanding of how the reforms are changing and improving the quality of NHS services. The amendments that have been tabled by the Opposition stand against the public interest in openness and disclosure, and they would preclude effective evaluation of changes to the NHS. I urge the hon. Member for Leicester West to withdraw her amendment. If she does not, I urge my colleagues to vote against it.

The Chair: Order. Minister, I think you indicated to the hon. Member for Islington South and Finsbury that you would take an intervention.

Paul Burstow: Time has moved on.

Liz Kendall: I apologise if I was asking questions from a sedentary position.

Paul Burstow: Chuntering.

Liz Kendall: I was not chuntering; I was asking questions. I realise that questions can be asked only through interventions, although sometimes it is difficult to do so when interventions are not taken. I accept that both Ministers have mostly been generous with their time. The Minister has not answered any of my basic questions, however. They were not designed to catch
him out; they were simple questions, to which I would expect any Minister to be able to give a simple answer. Why should the Competition Commission have any role in reviewing how competition is developing in the NHS? What expertise, experience and knowledge does the Competition Commission have? Throughout the course of this Bill, both Ministers have failed to answer that simple question.

6 pm

The Minister said that we needed some kind of independent review of competition, but he cannot have it both ways. He either means what he says and there will be a sector-specific regulator who will do it all or there will be something else. The Minister has not answered the question that my right hon. Friend the Member for Rother Valley has put to him on many occasions. Why do the Competition Commission and the OFT still have roles when the Government have promised the Future Forum that there would be only a sector-specific regulator?

Tom Blenkinsop: Does my hon. Friend not wonder why the Competition Commission is involved at all given Monitor is already there? One would think that Monitor would be collating this information already. If it is, why is the Competition Commission involved?

Liz Kendall: My hon. Friend raises a simple practical point. These poor clinical commissioning groups and foundation trusts have been collecting information, giving it to the Competition Commission, the clinical senates, the national board, the clinical networks and the health and well-being boards. We have layer upon layer of organisations involved here. The Government are not clear about what all these different bodies do.

Tom Blenkinsop: On 17 March 2011, the Minister, the right hon. Member for Chelmsford, said: “It will be for the convenience of the Committee if I speak first. Clause 66”—now clause 72—“requires the Competition Commission to review how competition in the provision of quality health care services is developing and how Monitor is fulfilling its duties in relation to competition.” [Official Report, Health and Social Care Public Bill Committee, 17 March 2011; c. 886.]

Essentially, this clause is almost exactly the same as it was.

Liz Kendall: My hon. Friend hits the nail on the head. This clause and the one we have just discussed will be the most damaging for the NHS. I will certainly not be withdrawing my amendment—[Interruption.] Sorry, our amendment. In a collegiate way, I would like to press it to a Division.

Question put, That the amendment be made:—

The Committee divided: Ayes 10, Noes 12.

Division No. 26]

AYES
Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O'Donnell, Fiona
Smith, Owen
Thornberry, Emily
Wilson, Phil

NOES
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

Question accordingly negatived.

Question put, That the clause stand part of the Bill:—

The Committee divided: Ayes 12, Noes 10.

Division No. 27]

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)
O'Donnell, Fiona
Smith, Owen
Thornberry, Emily
Wilson, Phil

Question accordingly agreed to.

Clause 72 ordered to stand part of the Bill.

6.6 pm

Sitting suspended.

6.21 pm

On resuming—

Clause 73

REVIEWS UNDER SECTION 72: POWERS OF INVESTIGATION

Amendment proposed: 237, in clause 73, page 86, leave out lines 8 to 12.—[Liz Kendall.]

Question put, That the amendment be made.

The Committee divided: Ayes 10, Noes 11.

Division No. 28]

AYES
Abrahams, Debbie
Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O'Donnell, Fiona
Smith, Owen
Thornberry, Emily
Wilson, Phil

NOES
Mr Barron: This is the clause that puts into statute the issue of Monitor’s duties to co-operate with the Office of Fair Trading. Subsection (2) lays out the three areas in which it must co-operate. Will the Minister explain why that is the case, given the debates that we have just had on issues involving NHS mergers and so on? Does the need to co-operate go wider than mergers? If he explained briefly, it might help the Committee to scrutinise the Bill further.

Paul Burstow: I am grateful for the question. The clause requires the Office of Fair Trading and Monitor to co-operate with each other in the exercise of their concurrent functions under the Competition Act 1998 and the Enterprise Act 2002. Specifically, each must give the other any information that it holds that the other might require or that it considers might assist the other in the exercise of its functions. That could include information about particular patients if relevant to deciding a case. Both parties, however, would be bound by requirements on confidentiality in their use of that information. One organisation would also be required to provide the other with the assistance that it may need to exercise its functions.

The clause will help ensure that the OFT and Monitor work effectively together in exercising their concurrent functions, and, with regard to our recent debates, it will ensure that there would not be an overly burdensome approach from these organisations. Much of the information needed to do the relevant work could be acquired, and in terms of Monitor, there would be insights to gain from a specific sector regulator, too.

Liz Kendall: How does our debate today about the roles of the Competition Commission and the OFT fit with the Public Bodies Bill—currently being debated in the Chamber—which proposes to merge the OFT and the Competition Commission? There would be a new body responsible for mergers of trusts, which would undertake reviews on competition. We do not know what is happening with that; nor do we know what that new body would look like. Will the Minister tell us what the impact will be on this Bill?

Paul Burstow: I will write to the hon. Lady with that information. Although her question warrants a more substantive response, because there are two Bills going through Parliament that deal with different aspects, we expect no change in the functions of the regulator in relation to these mergers. In that regard, there is no direct consequence for this legislation whatever, but I will respond in further detail in writing.

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

The Committee divided: Ayes 12, Noes 10.

Division No. 31

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)

O’Donnell, Fiona
Smith, Owen
Thornberry, Emily
Turner, Karl
Wilson, Phil

Question accordingly agreed to.
Clause 75 ordered to stand part of the Bill.

Clause 75

CO-OPERATION WITH THE OFFICE OF FAIR TRADING

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

471

6.30 pm
NOES
Abrahams, Debbie O’Donnell, Fiona
Barron, rh Mr Kevin Smith, Owen
Blenkinsop, Tom Thornberry, Emily
Kendall, Liz Turner, Karl
Morris, Grahame M. (Easington) Wilson, Phil

Question accordingly agreed to.
Clause 75 ordered to stand part of the Bill.

Clause 100

LIMITS ON MONITOR’S FUNCTIONS TO SET OR MODIFY LICENCE CONDITIONS

Amendments made: 159, in clause 100, page 100, line 41, leave out from first ‘of’ to end of line 42 and insert

‘preventing anti-competitive behaviour in the provision of health care services for those purposes which is against the interests of people who use such services.’

Amendment 160, in clause 100, page 101, line 19, leave out

‘public or (as the case may be) private ownership’

and insert

‘the public or (as the case may be) private sector’.—(Paul Burstow.)

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

Owen Smith: It is a pleasure to serve under your chairmanship, Mr Hancock.

Clause 100 and clause 101, which we will come to next, are the only two clauses that we will look at in the re-committed Bill that deal with licensing directly. However, in total, there are 28 clauses in part 3, chapter 4 of the Bill, that address this issue—the licensing of any body or institution that provides services to the NHS. It is an important part of the Bill, which has become more important as we have listened to today’s debate. Confusion is emerging on the part of the Government about how mergers might be scrutinised between NHS licence-holders and about whether they will be scrutinised by the sector-specific regulator, Monitor, or by someone else. I am not in any way shape or form confused. The confusion perhaps prompts the question of how wrong it was of the Government to recommit the Bill so partially. We are allowed to debate only two clauses here today. We are not allowed to look at the clauses that establish what is meant by licensed conditions, and we are not allowed to talk about the parts where it refers to exemptions—where service providers to the NHS might not be required to be licensed.

We received from the Minister, the right hon. Member for Chelmsford, a bit of an indication of the Government’s attitude to scrutiny and the extent to which the Government need to worry about it when he said, “‘We’ve got the votes.’” I thought that that was telling about the attitude of the Government.

We will not be able to look at lots of the important clauses, but we can look at clause 100. Clauses 100 and 101 are back in Committee because they are part of the Government’s attempt to spin the fact that they have put competition back in its box and it no longer applies. We heard last week and again today that Monitor is no longer about promoting competition but about preventing anti-competition. Last week, I expressed real scepticism as to whether there was a real difference between those two things, especially when this underpinning power of Monitor has not changed. The debate we have heard today has increased my certainty that there is no fundamental difference and that the core of the Bill remains entirely unchanged.

However, the clauses on licensing give the Minister a chance to get to the bottom of this and to tell us in hard detail exactly what the change in emphasis and in wording around Monitor’s duty will mean in practice. It is in licensing where the practical impact of Monitor’s decision either to promote competition or prevent anti-competition will come to be seen. It is also in licensing an NHS provider that we will start to see what is really meant when the Secretary of State talks about Monitor acting “ex post” as opposed to “ex ante” as it was originally conceived. The nature of the conditions and the contractual obligations that are placed on providers are one of the key means by which Monitor might impose those conditions and seek to level the playing field.

Clause 100 as amended would give Monitor the power to include a special condition in a licence for a provider. It says that Monitor may only exercise a function to which this section applies

“for the purpose of preventing anti-competitive behaviour in the provision of health care services for those purposes which is against the interests of people who use such services.”

Having read that, one has to ask what has changed. Monitor, in the pre-pause Bill, was still able to set conditions for the purposes of promoting competition in the provision of health services. What is the practical impact of that change in emphasis? Is that the key piece of evidence that the Government present to demonstrate that they have listened and thought and made substantive changes? If it is the key change in emphasis on the part of Monitor, the Minister has conceded—as David Bennett has conceded—that the powers of Monitor have not changed one jot. The emphasis may have changed. The Minister can help us to understand how in licensing we will see that shift in emphasis carried out. What are the special conditions that Monitor might have set previously when it was going to promote competition that it will not now set?

Emily Thornberry: Would it not help the Committee if the Minister provided us with some examples?

Owen Smith: That is precisely what I was asking for: not necessarily the specifics—down to what hospital the Minister might be talking about—but what sort of special condition Monitor would have been able to set, to promote competition, that it will not now be able to set. What special conditions will it now set to prevent anti-competitive behaviour?

How does the setting of such special conditions, up front in the licence to a provider, square with what the Secretary of State said, which was that Monitor would now only operate ex post—after the fact—to tackle evident problems where integration or collusion, depending on one’s point of view, was not in patients’ interests? Surely the fact that such conditions are going to be written up front into the contracts that the licensees have to sign to provide services to the NHS is definitely ex ante—I am sure that that is how the Secretary of State, with his penchant for Latin, might describe it.
How on earth is that reconcilable with the notion that Monitor is only now, with its new riding orders, going to come in after the fact where there is a higher burden of proof, as David Bennett put it? I intend to come back to those questions when we come to the specificities of clause 101. For the moment, maybe the Minister could set the scene by clearing up that particular fog.

Paul Burstow: The hon. Gentleman did a very thorough job of trying to knit fog or smoke in his earlier presentations to try to persuade those who read our proceedings that the Bill is one thing, when in fact it is another. He is progressing along that particular approach again today.

I find it extraordinary that, in his exposition of what clause 100 is all about, the hon. Gentleman completely glosses over—completely ignores, it seems—the changes that we have already made to earlier clauses of the Bill that fundamentally change the purpose of Monitor. That goes to the very heart of the point that he grudgingly acknowledged in his closing remarks, which relate to the exchanges that took place in the evidence sessions when we heard, very clearly, from Dr Bennett. He said: "Secondly, it significantly raises the burden of proof on us. If we feel—normally working alongside the commissioning board—that the use of competition is a way of furthering the interests of patients, the burden of proof that that, rather than other ways of furthering such interests, is the right way to go is significantly higher. That is the other key thing that has changed."—[Official Report, Health and Social Care (Re-Committee) Public Bill Committee, 28 June 2011: c. 32, Q68.]

That is the key thing that allows the Committee, and how the clause works, to be properly understood. The hon. Gentleman has ignored that; that is why I think he has been confused in how he has posed his questions.

Owen Smith: I will happily give way to the hon. Gentleman in a moment. The clause has to be understood as a power, but a power that can be exercised by Monitor only in the context of a higher burden of proof and the changed purpose of the organisation. It is no longer an organisation with the mission of promoting competition; first and foremost, its purpose is to protect and promote the interests of patients, and to enable integration. It is a significantly different organisation in terms of how it exercises its licensing responsibility. Does the hon. Gentleman want to clarify his position?

Owen Smith: No, I would like the Minister to clarify his. I would like the Minister to explain how Monitor can apply this famous higher burden of proof up front, when it is setting the conditions in a licence for an NHS provider. How does it do that?

Paul Burstow: It is an interesting point and I hope that we spend an appropriate amount of time on these clauses. It worth noting that licensing is an important part of the Bill. While we agree with that, it is slightly at odds with the fact that Opposition Members spent only 75 minutes scrutinising 28 clauses on licensing when we considered them at the previous Committee stage. Given that Opposition Front Benchers, at the conclusion of the previous Committee stage, said that every inch of the Bill had been scrutinised, they clearly thought that 75 minutes was sufficient to cover 28 clauses.

6.45 pm

The clause sets out the purposes for which Monitor can set or modify licensing conditions. It gives Monitor powers to do the job of regulating NHS services effectively and appropriately limits the areas in which Monitor can act via the licence.

That means that the licence can only make requirements relating to certain functions—regulating price by, for example, requiring providers to adhere to the national tariff or to comply with NHS standard contracts, which was an example that may have been missed; preventing anti-competitive behaviour that acts against patient interests; protecting and promoting patient choice; ensuring continuity of essential services; overseeing governance by, for example, ensuring that all providers have broadly the same level of regulation regarding their organisational form and structure; maintaining the register of foundation trusts; operating the licensing regime by, for example, compelling providers to pay licence fees to Monitor; and for the purposes of discharging Monitor’s general duties of protecting and promoting the interests of patients for the purposes stipulated in regulation.

The clause also prevents Monitor from setting and modifying licence conditions that place particular groups of providers at an unfair advantage or disadvantage compared with other groups. For example, it must not, in exercising its functions under the clause, place private providers at an unfair advantage over public providers in relation to providing NHS services. We have already discussed some of the powers in detail and we will discuss others as we consider later parts of the Bill.

Overall, in broad terms, the clause balances the desire to ensure that regulatory action is appropriate, targeted and does not exceed the boundaries of the role prescribed by the regulator with the need for efficient regulatory action in relation to Monitor’s core duties, which I have just described and which the hon. Member for Pontypridd did not seem to think were at all relevant to interpreting this part of the Bill.

The Chair: I caution Members about speeches; if the Minister chooses not to reply again, they will lose their opportunity to speak. It is far better to intervene, if you can, when he is still willing to respond.

Owen Smith: I am grateful to you, Mr Hancock, for that advice. I intervened once, obviously, but I did not sense that the Minister would give me another opportunity.

I need to put a few points of clarification on the record. First, the Opposition may have scrutinised the clauses for only 75 minutes in the previous iteration of the Committee, but we now appreciate how much more significant they are in the light of the confusion that we have heard today and previously. Secondly, the Minister again drums out the line about the higher burden of proof for making a determination.

Mr Barron: On my hon. Friend’s first point, a 300-clause Bill was put in front of us with new clauses and hundreds of amendments. It was timetabled, so we did not get the opportunity to scrutinise it as a Committee should, and
the Minister has the audacity to stand up and say that we did not spend any time on previous clauses. It would have been impossible to do so in view of the timetable that we had to scrutinise the Bill.

The Chair: I sense that the right hon. Gentleman’s point does not need to be addressed on this clause. That is a point for debate rather than for a back and forward discussion.

Mr Barron: He started it. [Laughter.]

The Chair: For the benefit of the record, we can assume that you had the last word on this occasion.

Owen Smith: I am grateful to you, Mr Hancock, but I entirely agree with the point made by my right hon. Friend.

A moment ago, the Minister took umbrage at my suggestion that he was using the phrase, “burden of proof” a lot, but we have heard that phrase a lot. I come back to it because we had never heard the phrase before David Bennett used it when he gave evidence to us the week before last. Subsequently, the Ministers’ mantra seems to have become that captured somewhere in the Bill is a higher burden of proof that Monitor has to adhere to in order to demonstrate whether it can intervene.

All it says in the Bill is that Monitor needs to be mindful of whether acting in order to promote competition, or rather to prevent anti-competitive practices, will be in the interests of patients. There is no further explanation of what is meant by “burden of proof”.

More importantly, we return to the question of competence. Exactly what expertise and competence does Monitor, which consists essentially of economists, have to judge whether the decision that it is making to promote competition or prevent anti-competition will impinge negatively on the patient experience, the quality of the clinical service being offered or outcomes? That is what the Minister suggests Monitor will do.

Paul Burstow: It is important that the hon. Gentleman should not inadvertently mislead the Committee. He will know that we have made it clear that Monitor, where appropriate, will have to seek clinical advice in doing its work. To suggest that it is just economists making all the decisions is clearly nonsense.

Owen Smith: It is principally—[Interruption.] It is Monitor’s job to decide; that is written clearly into the Bill. Irrespective of whether it has taken clinical advice, it is Monitor’s job to decide whether its intervention—

Paul Burstow: Will the hon. Gentleman give way?

Owen Smith: I will, but I will ask the Minister a question before I do. Is the OFT under any obligation to seek clinical advice before it intervenes? It has no expertise, and I cannot see anywhere in the Bill that it must refer to senates or anybody else.

Paul Burstow: In the time-honoured fashion of interventions, I will make my point to the hon. Gentleman, and he can respond if he sees fit. He knows, because he was in the Committee last week, that we moved amendments requiring Monitor not just to take patients’ views into account but to involve clinicians. Those are significant improvements to the Bill that address that very concern, which he does not seem to realise has been addressed.

Owen Smith: I remember that, because I recall that I asked the Minister whether he could tell us how much extra money it would cost Monitor to build in all those extra levels of bureaucracy and clinical consultation. Notably, he did not respond to my question whether the OFT, which we learned this afternoon will have a crucial role in deciding whether mergers will affect the clinical services offered to patients in a given area, will have to take clinical advice. I would be grateful if he answered it at some point today.

The other critical question is this. The Government have given us the impression—the Secretary of State said it explicitly—that Monitor is moving from an ex ante position of reviewing competition and its impact to an ex post position. The Minister did not answer my earlier question, so will he tell us how that can be squared with the setting of conditions in the licence for a provider of NHS services up front—or definitely ex ante?

Paul Burstow: I am happy to deal with a couple of the points made by the hon. Gentleman. I reiterate that the Bill’s initial Committee met for 28 sittings; it was the longest Committee since the Criminal Justice Bill of 2002-03, which met for 32 sittings. It is not the case that, as the right hon. Member for Rother Valley suggested, ample time was not given to scrutinise the Bill; ample time was used by Opposition Members to scrutinise the Bill, as acknowledged.

The hon. Gentleman had an exchange with the Minister, my right hon. Friend the Member for Chelmsford, about the question whether Monitor will be involved before or after. My right hon. Friend said that the ex ante regulations would help prevent restrictions on competition from arising. Monitor will be able to set licence conditions to enable integration in a way that benefits patients and does not improperly restrict competition. As a result, the need for a competition regulator to intervene and apply competition law is less likely, reducing the risk that competition law will be applied in a way that fragments services, is not integrated or restricts competition to the detriment of patients.

The hon. Gentleman also asked what no duty to promote competition will mean for licensing. As a result of our proposed amendments, Monitor would not have a duty to promote competition. In other words, it would not be Monitor’s role to maximise opportunities for competition or to increase competition in the NHS. For example, in licensing providers Monitor would have no power to require an incumbent provider to make its facilities open to a third party for the purpose of increasing competition.

Monitor would retain a role in addressing anti-competitive conduct that acted against patients’ interests, however. It would still be able, for example, to set licence conditions preventing providers from restricting patient choice, and to facilitate patient switching. Those are the answers to the hon. Gentleman’s questions.

To underscore that, the OFT has to take clinical advice; in considering matters it must consider all the relevant issues. It will seek views from others where it is appropriate to do so and where it needs those views to
reach informed opinions. In this context, as we have already discussed, it would have access to Monitor’s expertise when it comes to such matters.

Question put and agreed to.

Clause 100, as amended, agreed to.

Clause 101

CONDITIONS: SUPPLEMENTARY

Amendment made: 161, in clause 101, page 101, line 33, leave out from ‘to’ to end of line 34 and insert ‘prevent anti-competitive behaviour in the provision of health care services for the purposes of the NHS which is against the interests of people who use such services.’—(Paul Burstow.)

Paul Burstow: I beg to move amendment 162, in clause 101, page 102, line 14, at end insert—

‘(c) Monitor must not include a condition under subsection (1)(c) that requires the licence holder with access to facilities of A. to provide another licence holder with access to facilities of A.’.

The Chair: With this it will be convenient to discuss Government amendment 163.

Amendment 46, in clause 101, page 102, line 15, leave out subsection (3).

Government amendment 190.

Government new clause 6—Standard condition as to transparency in setting and application of certain criteria.

I call Mr Simon Burns—no, Mr Paul Burstow; I am sorry.

Paul Burstow: I think that that gave my right hon. Friend a slight start. It would have been a very good speech and worth listening to, I am sure.

Amendment 46, which I would like to address now, was proposed as part of a package of amendments aimed at altering the scope and duties of Monitor, to address concerns about its competition functions and accusations that the Bill would pave the way for privatisation. That concern was reflected in the previous Committee, in the listening exercise and duly in the NHS Future Forum report. It was not the intention of the Bill, as previously drafted, to pave the way for privatisation. Not only do the Government amendments propose to remove Monitor’s power to require that one provider open up access to its facilities to another, but they do so in a way that is more comprehensive than that set out in amendment 46. As a consequence of our amendments, Monitor will not now have power to regulate access to facilities as a mechanism for increasing competition, even where that would help to increase patient choice.

With our amendments, we aim to achieve greater clarity by going one step further. I will deal with each one in turn. Government amendment 162 specifies that “Monitor must not include a condition under subsection (1)(c)” to require that an existing provider give access to its facilities to another provider. Government amendment 163 removes the detail about how that power would have been exercised, and in deleting both subsections (3) and (4) it does so more comprehensively than amendment 46, which would delete only subsection (3). These amendments will help to ensure that NHS facilities are utilised for the maximum benefit of NHS patients and that facilities that are funded through charitable donations are used as intended.

7 pm

We also propose to amend clause 147. Amendment 190 will confirm that the definition of “facilities” is the same as that set out in the 2006 Act, so that amendments 162 and 163 do not contradict existing principles and rules for co-operation and competition, principle 7 of which prohibits unreasonable refusal to supply services where such a refusal would restrict choice or competition against the patient interest.

New clause 6 will give further reassurance on cherry-picking. It forms part of a package of amendments that introduce new provisions to better enable Monitor to prevent cherry-picking. The NHS Future Forum set out significant concerns about the risk associated with not having sufficient safeguards to prevent cherry-picking.

The Government’s position is unequivocal: competition should be on quality, not price. Providers should be paid a rate for their service that accurately reflects the cost of treating the case mix of patients using that service. That is an area in which we have listened to concerns and looked to strengthen the Bill, and our response is supported by Professor Steve Field’s evidence to the Committee. He said:

“I am extremely pleased at the way Government have responded. Particularly in areas such as cherry-picking”—[Official Report, Health and Social Care (Re-committed) Public Bill Committee, 28 June 2011; c. 8, Q2].

As I said, new clause 6 forms part of a package of anti-cherry-picking amendments, the majority of which amend chapter 5, which we are yet to debate, in addition to a number of non-legislative interventions. I will, therefore, set out the context by briefly describing the anti-cherry-picking amendments that we have tabled to chapter 5. I will outline our additional non-legislative interventions, too.

First, the prevention of cherry-picking is supported by wider changes to Monitor’s duties. For example, the amendments will, if accepted, place a specific duty on
Monitor to ensure, when setting the national tariff, that providers receive fair reimbursement for their work, taking into account the clinical complexity of the cases that they treat and the range of services that they offer. That will be complemented by the duty our amendments will place on the NHS commissioning board to standardise service specifications across the country with the aim of increasing the number of services subject to national tariffs.

To prevent cherry-picking, we also propose to strengthen contractual terms to require providers to accept patients referred to them unless there is a genuine overriding clinical concern. Additionally, we will also ask the royal colleges and other professional clinical bodies to undertake work to identify the procedures most at risk of cherry-picking and to prioritise work on payment by results to ensure that fair prices are set for such procedures from 2013-14.

Taken together, the proposals will give Monitor the power to act to prevent and combat cherry-picking by adjusting tariffs. To prevent cherry-picking, however, Monitor first needs to identify it—that is, Monitor needs access to the relevant information from providers. That is where new clause 6 comes in. This new clause in chapter 4, which sets out Monitor’s licensing regime, will require Monitor to include an anti-cherry-picking condition in all licences. The condition will work by requiring licence holders to act transparently when using criteria to determine patient eligibility for particular services, for accepting or rejecting referrals and for determining the manner in which a patient is to be treated. That transparency requirement will apply wherever services are subject to patient choice of provider.

The provision will work on a number of levels. First, it will be a breach of their licence for a provider not to set out any referral or patient eligibility criteria in advance. Secondly, the requirement for providers to disclose their eligibility and selection criteria to Monitor, and to apply them in a transparent manner, should help to ensure that patients are not rejected by the provider of their choice.

Thirdly, as I have noted, such transparency will provide Monitor with the information it needs to work with the NHS commissioning board to assess the impact of patient selection on the variation between providers in the cost of delivering services. It will, therefore, enable such bodies to work together to adjust the tariff according to the case mix any one provider chooses to treat, which will ensure fair reimbursement for efficient services. The net result will be to minimise the scope for private providers to profit from cherry-picking the simplest, cheapest cases at the expense of NHS hospitals and patient choice.

Together with the amendments on pricing, the provision will help to ensure that taxpayers get what they pay for and patients get fair access to the services that they wish to use. I ask Opposition Members not to press amendment 46, which is deficient where our amendments are sufficient. I urge hon. Members to support our amendments.

Owen Smith: I propose to address all of these amendments together, in a similar fashion to the Minister. If I may, I will also set them within the context of the clause. I will of course leave it for you, Mr Hancock, to judge whether I stray into the stand part debate.

The context is important in terms of the distinction between promoting competition and preventing anti-competition. When pressed last week to give a practical example of what such change in the law would mean, the Minister turned to the area of licensing, specifically the changes to clause 101. In Hansard, at column 381, the Minister said that Monitor could not "disapply a particular set of licence conditions to a certain group of providers in order to make it easier for them to enter the market."—[Official Report, Health and Social Care (Re-committed) Public Bill Committee, 7 July 2011; c. 381.] When I asked him where to look for that in the Bill, he said that it was in clause 101(1)(c), which reads:

"The standard or special conditions of a licence under this Chapter may in particular include conditions—

(c) requiring the licence holder to do, or not to do, specified things or things of a specified description (or to do, or not to do, any such things in a specified manner) within such a period as may be specified in order to promote competition in the provision of health care services for the purposes of the NHS".

I was very grateful to the Minister for pointing me to that paragraph. I confess that I had not previously interpreted what I thought was a fairly innocuous part of the Bill as being the part that, unless amended, would allow Monitor to rig the market in favour of a particular sort of private provider—a new entrant, I presume. I was not aware that that was what that paragraph meant, but clearly it did. The Minister went on to say that even if Monitor had previously been able to do that, as he suggested, it would not be able to do so any more, by virtue of his amendment 161, which changes "promote competition" to "prevent anti-competitive behaviour". How exactly will that take effect? How does it change Monitor’s powers simply to remove the words "promote competition" and replace them with "prevent anti-competitive behaviour"? How does that stop Monitor, as the Minister said, disapplying a particular set of licence conditions to a certain group of providers?

Other parts of the Bill imply that Monitor cannot vary conditions in order to facilitate the entry to a market of a specific set of providers, as designated by whether they are in the public or private sector. I concede that, but this clause does not do that. It seems that in reality, whatever the change in the words and their implied emphasis, Monitor will still enjoy the power to intervene in the market where it perceives there is collusive behaviour between providers and act through licensing to try to level the playing field. As far as I can see that is entirely unchanged.

Monitor cannot now allow competitors access to facilities solely in the ownership of existing NHS public providers. The Minister is right to say that that has been ruled out by Government amendments 162 and 163. In light of that we will not press amendment 46 because what we sought to achieve with it is accomplished by the two Government amendments. That is not to say that Monitor cannot still modify the licence of an NHS provider—a commissioner, for example—to compel them to contract with more than one provider. That seems to be absolutely allowed.

Where Monitor might perceive that there is a traditional contractual relationship, or commissioning relationship, between one NHS provider—a hospital offering a diabetes service—and another, such as a GP practice, there is nothing to say that Monitor cannot consider that collusive
behaviour, or anti-competitive or not in the interests of patients. That would especially be the case if Monitor perceived that as disadvantaging other potential providers in the marketplace; the marketplace being that particular corner of England, whether Sutton and Cheam or Chelmsford.

Point 5.15 of the Government’s response to the Future Forum report says that Monitor will be charged with “tackling specific abuses and restrictions…to ensure a level playing field between providers. For example, Monitor could take action against a provider seeking to frustrate patient choice, or colluding with another provider not to offer patients home-based treatments.”

I did not insert the word “colluding”; that is the Government’s word.

That takes me again to the example we offered. I know the Minister is wary of taking specific examples about particular clinical services. He is certainly loth to take up our example of diabetes. We have already offered the example of renal services. I know from my experience in industry that there has been a traditional, fairly long-running dispute between NHS providers of haemodialysis in hospitals and other private home-care providers of haemodialysis, and a suggestion that private providers ought to be allowed to operate because it would save money and be better for patients. It may well be that it is in the interests of patients to have home haemodialysis provided for them. I think most patients would rather have the dialysis machine come to them in the comfort of their own home. It is perfectly imaginable that Monitor might think that sort of behaviour—that is, the hospital refusing to put out its renal dialysis to a home-care service—might be objected to by patients. It would be perfectly understandable under the Bill that the OFT or Monitor or somebody else might consider that to be collusive behaviour, because it is colluding with another provider not to offer patients home-based treatments.

It cannot be right that the decision that it may be collusive behaviour can be taken in the interests of patients without thinking about the impact on the hospital’s haemodialysis provision, nor the impact on other patients who need to go to hospital to have that provision. That is a concrete example of where we can see the Bill running the NHS into all sorts of problems.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): I am struggling to follow this argument. The hon. Gentleman is going round in circles. We have already offered an example of renal services. I know from my experience in industry that there has been a traditional, fairly long-running dispute between NHS providers of haemodialysis in hospitals and other private home-care providers of haemodialysis, and a suggestion that private providers ought to be allowed to operate because it would save money and be better for patients. It may well be that it is in the interests of patients to have home haemodialysis provided for them. I think most patients would rather have the dialysis machine come to them in the comfort of their own home. It is perfectly imaginable that Monitor might think that sort of behaviour—that is, the hospital refusing to put out its renal dialysis to a home-care service—might be objected to by patients. It would be perfectly understandable under the Bill that the OFT or Monitor or somebody else might consider that to be collusive behaviour, because it is colluding with another provider not to offer patients home-based treatments.

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Dr Poulter: This goes to the heart of the problem. The reality on the front line of the NHS is completely different from this hypothetical scenario that keeps being painted by the Opposition. It is quite frustrating to sit here and hear hon. Members going round and round in circles about hypothetical debates that bear no relation to the front line. Decisions have always been made in the NHS for the benefit of patients. Those decisions under this legislation will not be able to be challenged in the courts.

Owen Smith: My experience does not come from hypothetical cases.

Grahame M. Morris: Will my hon. Friend give way?

Owen Smith: I will in a moment. My experience does not come from a hypothetical reading of the situation. It comes from having worked in the health care industry. Working as a director of strategy for the world’s biggest bio-tech company and working with companies providing renal health care in this country. There is an active lobbying attempt going on by renal dialysis companies to provide precisely these services. The terms under which they take that argument—

7.15 pm

The Chair: Order. We are moving further and further away from what this clause is about. [Interruption.] Order. I urge hon. Members to confine their comments away from what this clause is about.

Owen Smith: I give way to my hon. Friend the Member for Easington.

Grahame M. Morris: Government Members are criticising us for theorising about this and for not giving any practical examples. If they gave us some practical examples to demonstrate that these changes are not purely cosmetic, they might have a bit more credibility. As someone who worked for a dozen years or more in a pathology department in a district general hospital, let me give an example. If we are looking for a service where a challenge to Monitor could be mounted on the basis that a private provider, or private laboratories offering analytical tests, were accessing the NHS, this would be a route for it. It could mount an argument based on value and price. It could match or better the in-house service without going into all the complications of the convenience of having blood gas analysis in situ and so on. I suggest that this is a solid example—

The Chair: Order. Interventions are one thing. Your colleague was in the middle of his speech. Interventions are supposed to be to the point. [Interruption.] I know you did, but you went far beyond what was reasonable in an intervention.
Owen Smith: But I thoroughly enjoyed it. I will move on now. The Minister can dispute it, but the point has been made that there is a flaw in the Bill in respect of this particular provision.

One of the other changes that the Government have made to this clause is to amend the language from stating that Monitor “must” include provisions in setting licensing in respect of (a), (b), (c), (d), (e), (f) and (g) to stating that it “may” include provisions. In particular, I would like to highlight the problem that I see that that poses in respect of paragraph (j), which talks about “the use or disposal...of assets used in the provision of designated services.”

Under this chapter, Monitor may include an obligation on licence holders, trusts or other consortia to tell it when they are going to dispose of assets used in the provision of designated or important services. It is extraordinary that that obligation is merely to be that they “may” have to tell Monitor when they have decided to flog off a particular asset that is crucial to a designated service. Surely, they should be obligated to do so. That takes us to the example that we used earlier; St George’s healthcare trust has decided to sell off £509,000 worth of its beds to a Dutch agri-business and then rent them back. Under the clause Monitor would not necessarily have to be told about that—it just might have to set an obligation on the trust to do so. Does the Minister think that is sufficiently robust?

Emily Thornberry: My hon. Friend has just given a concrete example. Is it right that the story can be found in the Health Service Journal dated 7 July 2011?

Owen Smith: I am grateful to my hon. Friend for that intervention.

My contention is very simple. When there is the possibility of licence holders selling off assets, be they buildings or beds—[Interruption.] From a sedentary position the Government Whip says, “Under Labour’s provisions.” I agree. These things were permissible under Labour, but I do not think we saw any hospitals flogging off half their beds under Labour. That probably speaks to the change of culture. More importantly, it is only really the Southern Cross debacle that has alerted those on both sides of the Committee to the real risks posed by modern forms of financing, such as releasing equity through assets or securitising debt against buildings. It is a serious point. We have said very straightforwardly that Monitor has nothing to prevent that. Therefore should not the Government think about putting clauses into the Bill to prevent the things that have happened with Southern Cross from happening in the NHS? That is not a party political point. It is just an observation that those on both sides of the Committee should think about.

New clause 6 is an interesting addition to the Bill. It places a duty on the licence holders to set transparent eligibility and selection criteria to be applied to licence holders when determining “whether a person is eligible, or is to be selected, to receive health care services” and if so, “the manner in which the services are provided”.

When I first looked at this I thought that it was positive change to the Bill. The Minister described it as an attempt to prevent cherry-picking, which is what I think the Government genuinely intend it to do. But the nature of the clause raises several questions and may also, inadvertently perhaps, give licence to what I would consider to be undesirable and localised rationing of health services by the NHS and other providers. What might be the rationale for denying a patient access to cost-effective treatments other than NICE having determined through its guidance that such patients would not benefit from the treatments and therefore should not have them provided to them? Otherwise surely the NHS assumes that all patients are equal and ought to have cost-effective care extended to them free at the point of need?

If the new clause is not about adhering to mandatory NICE guidance, which is already enabled in legislation, what is it about? What is it there to do? Perhaps there is some thought to allow providers in this respect, as in other aspects of the Bill, a greater degree of autonomy in terms of who they afford care to and which patients they treat. Is there a reason for shifting from what we have always understood to be the arrangement: if it is cost-effective and NICE says that patients X,Y and Z should get it, why should other patients not get it?

Secondly, it does not state anywhere in the Bill that the licence providers will have to publish such criteria. It says they must have them and it says they must be transparent, but it does not say that they need to publish them. Can the Minister clear that up and let us know that they will have to publish the criteria so that we can see precisely why a treatment is afforded to patients or not? If it is transparent and uniform across the country, it would be a welcome change because the current procedure whereby local decisions are taken at the margins of NICE guidance around exceptional cases, for example, is unhelpful. Effectively a postcode lottery applies at the margins of NICE guidance. If this is an attempt to clear that up, it would be good.

Lastly, will the specific transparent eligibility criteria be uniform? Will all NHS providers and all licence holders have the same criteria? That is unclear in the Bill and prompts the question whether one licence holder might set a different set of eligibility criteria from another. That would be worse than the current situation, because there would effectively be a licensed postcode lottery as opposed to the unlicensed one operates through exceptional case reviews.

Paul Burstow: Mr Hancock, I am not certain whether we have strayed wide enough to turn the debate into a clause stand part.

The Chair: Yes, we have.

Paul Burstow: Good. I thought you had said that, but I wanted to be absolutely clear.

Let me go through the various questions of the hon. Member for Pontypridd. He asked whether there was a difference between promoting competition and acting to deal with anti-competitive behaviours, and there most certainly is. The changes that we have proposed to Monitor’s overarching duty will impact on the exercise of all its functions and will particularly impact on how Monitor prioritises the use of its limited resources. It will also profoundly impact on Monitor’s tariff-setting functions, because Monitor would not be able, for example, to set tariffs for the purpose of stimulating new entry...
from private providers. In licensing, the change will impact on the nature of the licence conditions that Monitor could impose. As I have already said, Monitor could not impose licence conditions for the purpose of increasing competition, and it is worth repeating the example that Monitor could not force an incumbent provider to divest itself of a particular service or require a provider to grant third-party access to its facilities.

The hon. Gentleman asked whether Monitor could arbitrarily intervene in markets, and he wanted to see that tested. Monitor can only intervene where it can demonstrate that patient interests are being harmed. Its decisions could be challenged by patients, commissioners or others with sufficient interest. Things are very different in the way the Bill is now drafted, because Monitor no longer has a duty to promote competition actively, but rather it has a simple duty to deal with anti-competitive behaviours and to enable integration, all of which is seen through the lens of promoting and protecting the interests of patients.

The hon. Gentleman asked about St George’s healthcare trust, and the first thing to say is that the matter is one for the trust, not for the Department. It takes place under current arrangements. The trust took the decision under its own authority. It did not require approval from the Department of Health or the strategic health authority. Leasing arrangements are common in the NHS, but any contracts must meet the twin criteria of delivering value for money and transferring a significant amount of risk to the private sector supplier. Sale and leaseback arrangements are acceptable under the current arrangements if they meet those criteria. It is not some imposition or new invention; it currently exists within the system.

The hon. Gentleman asked whether new clause 6 promotes rationing. That is, to be honest, absolute nonsense, but I understand that the hon. Gentleman wants to ensure that there are no unintended consequences. Let me reassure him that the new clause 6 is concerned with transparency only and would confer no power whatsoever on Monitor to determine a patient’s eligibility for particular treatments. NICE guidelines will of course be a fundamental part of providers’ decisions. However, they do not cover all specialities or circumstances.

Finally, the hon. Gentleman asked whether eligibility criteria will be published. Given that they are not intended to be such criteria in the way that he has described, they will not, but we would expect Monitor to require providers to publish selection information of the sort that I described earlier.

I hope that that has answered the hon. Gentleman’s various questions.

Dr Poulter: It is important to set the record straight on a couple of things. An earlier intervention raised a spurious example about blood gas and how that may be affected. Blood gas machines are actually fully automated in all hospitals, and they have nothing to do with mainline pathology services. It is worth setting the record straight about what actually happens on the front line by using front-line experience, because if there were more of that feeding into what happens in the Committee, we would make better progress and get through the Bill. We would also be talking more about the Bill’s benefits for patients, rather than going round in circles.

7.30 pm  
Paul Burstow: I am very grateful to my hon. Friend for those very useful points. He has underlined again why the Government are right to ensure that the Bill provides that all the relevant organisations get clinical advice as part of their decision making.

I did not get around to answering the question about whether all providers have the same criteria. It would not be appropriate for Monitor to require that all providers operate the same criteria for determining patient eligibility. On the contrary, different providers would have different skills, capabilities and referral criteria needed to reflect that reality. I suspect that if the policy were not applied in this manner, organisations such as independent treatment centres that select in such ways would not be able to operate.

Amendment agreed to.  
Amendment made: 163, in clause 101, page 102, line 15, leave out subsections (3) and (4).—[Paul Burstow.]  
Clause 101, as amended, ordered to stand part of the Bill.

Clause 112 ordered to stand part of the Bill.

Clause 113  

IMPOSITION OF LICENCE CONDITIONS ON DESIGNATED NHS FOUNDATION TRUSTS

Owen Smith: I beg to move amendment 47, in clause 113, page 111, line 42, leave out subsection (12).

Mr Burns: Oh no.

Owen Smith: The Minister saddens me by groaning, but I shall try to cheer him up by being quick.

Amendment 47, very straightforwardly, seeks to omit subsection (12) of clause 113. That in turn omits section 52 of the National Health Service Act 2006, which makes provision for failure of NHS foundation trusts. We suggest that reverting to the situation that pertained under the 2006 Act is a good idea, because the Government have failed to bring forward any proposals in respect of the failure regime. We do not know what the Government propose to do in the event of failure and, as we have heard from my hon. Friend the Member for Islington South and Finsbury, there are at least 20 trusts teetering on the brink, as we speak. This provision allows for directors to be removed and for interim directors to be appointed. The lack of a failure regime is a big hole in the middle of the Bill, which is why we suggest, as belt and braces, that the Government return to 2006 and the Act that we put on the statute book.

Grahame M. Morris: As my hon. Friend has indicated, clause 113 would remove some of the existing safeguards in respect of the failure regime, as set out in sections 53 to 55 of the 2006 Act. It requires the Secretary of State to implement secondary legislation as soon as possible to apply existing corporate insolvency procedures to foundation trusts. The explanatory notes issued with the Bill say that clause 113 should ensure
a level playing field between foundation trusts and other providers, and the procedures could facilitate the rescue of a failed foundation trust (for example, through administration or a voluntary arrangement with creditors”).

It could also allow a speedy wind-up when a foundation trust has failed.

However—this is an interesting point, on which I would appreciate a response from the Minister—we learned yesterday through a Guardian article arising from confidential Government documents revealed through a freedom of information request that Ministers, although I am not certain from which Department, had been privately advised to allow schools and hospitals to fail if the Government’s public service reforms were to succeed. That is directly relevant to what we are discussing in the clause. The documents obtained by The Guardian revealed that civil servants have warned Ministers that “markets are susceptible to ‘failure’ and costs could in fact rise unless a true market is created by allowing public services to collapse if they are unsuccessful.”

That seems, on the face of it, to contradict directly the assurances that we have received in this Committee from Members and Ministers.

The Minister of State, the right hon. Member for Chelmsford, explained the purpose of the clause when we debated it previously:

“The clause provides for the Secretary of State to make regulations to apply relevant parts of insolvency and company legislation to foundation trusts for the purposes of rescuing an insolvent foundation trust as a going concern or ensuring an orderly winding-up of its affairs in the best interests of creditors as a whole.”

The Opposition oppose the measures set out in the insolvency arrangements, but I would be interested to hear from the Minister an explanation of how the insolvency regime that he has described fits in with the Prime Minister’s public service reform agenda as set out in a statement to the House of Commons yesterday.

We must wait for regulations concerning much of the Bill. We have heard that not all the Future Forum recommendations are reflected in the Bill; some will be introduced in another place, and some will be implemented through secondary legislation. However, it is important, if we are effectively to scrutinise the Bill, that we have information about the failure regime. We need to know how it will apply to the NHS and whether it will conflict with the statement given to the House of Commons yesterday.

All Committee members, not just Opposition Members, must consider the proposals in the Bill, many of which are unclear. We are being asked to make a judgment without all the information. It seems bizarre to me that failure is a sign of success if we follow Tory principles. I have heard of the concept in fashion—not that I am much of a fashion victim—that brown is the new black, but when failure is a sign of success, it is difficult. It is said that failure is a sign that the free market is working. That might be all right if we are dealing with white goods or lesser issues, but an issue of such critical importance to everybody in this country cannot be left to free market disciplines. Labour Members reading the Prime Minister’s comments yesterday and the clauses on insolvency today can only assume that the introduction of insolvency provisions is intended to make it easier, not harder, to close hospitals. Is that the new Tory ethos for our public services?

In a previous sitting, the Minister, the right hon. Member for Chelmsford, said that “the whole purpose of the Bill and the clause is to protect, not close, essential services”—[Official Report, Health and Social Care Public Bill Committee, 24 March 2011; c. 1012,1034.] but we know that that is not the direction of travel of this Government’s policies on public service reform. We heard yesterday that for nurseries and schools and so on a failure regime was essential in order to encourage new entrants into the market. Well, if it applies in those sectors, is it not reasonable to assume or suspect that there is an interest that it should apply in the NHS?

Has the Minister discussed with No. 10 the fact that a reformed health market will look to prevent service closures, if what he is telling us it true, and will therefore not represent the free market with real competition all? The insolvency clauses are about putting competition above the interests of patients, directly against what all the evidence suggests. It is an attack on in-house NHS provision of service, which has been described by Government as monolithic, and it is about opening up the structure of the NHS to private providers, creating a fluid market. The clause is about making the NHS work for profit and commercial interests and has nothing to do with improving the quality of care.

In conclusion, it is about how the market functions and how the NHS will be broken down and sold off. That is in complete opposition to what the 2006 Act did, which was to put in place a strong early intervention regime to pinpoint those areas where trusts were failing and to put the problem right.

Paul Burstow: It was a delight to have that peroration just now and to hear the powerful points that were made. It is perhaps worth sharing some thoughts with the Committee about some of the other powerful points that have been made by the hon. Gentleman’s hon. Friends—and former hon. Friends. The former Secretary of State for Health, Patricia Hewitt, said:

“new providers help us to all the things we want to do: improve the quality of care; increase capacity; support patient choice; drive value for money and promote greater equality...We are working with Ed Miliband, minister for the third sector to help ensure a truly level playing field.”

The then Prime Minister, the right hon. Member for Kirkcaldy and Cowdenbeath (Mr Brown), also told us:

“The role of the private sector in the areas that you are suggesting”—such as treatment centres—

“is expanding, will continue to expand and will be a lot bigger in the next few years”.

The Labour manifesto of just last year stated:

“Patients requiring elective care will have the right, in law, to choose from any provider who meets NHS standards of quality at NHS costs.”

The hon. Member for Easington stood on that manifesto and has spent the past many months running away from the position he had at the election.

Tom Blenkinsop: That’s a bit rich coming from you.

Paul Burstow: On the contrary, we stood on a manifesto where any willing provider was an essential part of reforms that we would make to the NHS. I will just share with the hon. Member for Easington one more
quote. It might interest him to know that his right hon. Friend the Member for Exeter (Mr Bradshaw), and the then Minister of State, said:

“PCTs need to see it as their role not to commission services in order to prop up a local underperforming or failing provider, but to get the best services and best value possible for their public.”—[Official Report, 24 February 2009; Vol. 488, c. 66WH.] I wonder whether the hon. Gentleman would rather prop up organisations and waste taxpayers’ money. It does seem to me that that is the proposition that the hon. Gentleman has been advancing.

Amendment 47, which is at the heart of the debate that we are having now, seeks to maintain Monitor’s statutory power to intervene formally in an NHS foundation trust by retaining section 52 of the 2006 Act. We agree that it is essential that, in the event of a provider failing, Monitor can intervene. In such circumstances, the overriding priority will be to protect patient interest by ensuring continued access to essential services for patients. It needs to be able to intervene in this way whenever a commissioner asks for its help to protect continuity of services. Under the provisions currently in the Bill, Monitor would operate a distress regime and will be able to require specific actions to address the situation before an organisation actually fails.

Our goal remains clear. It is to avoid failure. Failure is the last resort, not as the hon. Member for Easington suggested, some sort of desired outcome. When Opposition Members lecture this side of the Committee about failure regimes, it is worth remembering that the idea of a failure regime was first floated in 2003 by the then Labour Government when they introduced foundation trusts in the first place. It took six years for the Labour Government to come up with any details of what that failure regime looked like.

We have listened to issues that people have raised about the detail of our original proposals, and we have heard worries about the practicality of our current proposal for an up-front system of designating services for additional regulation. We propose to table amendments to the Bill, taking those concerns into account and are therefore developing a regime in which providers who experience difficulties receive early intervention to help them to improve.

Our progress. I hope that I can answer the question that the hon. Member for Stafford asked, and that the hon. Lady might ask.

Order.

Paul Burstow: The Minister of State, my right hon. Friend the Member for Chelmsford, in answer to a question today at Health questions identified the fact that the Government are concerned about the issue. They are examining it.

Liz Kendall: Will the Minister give way?

Paul Burstow: No, not at this moment. I am trying to respond to a previous intervention. Let me just deal with that. I want the opportunity to do so without quite so much noise, as a result of which we can make some progress. I hope that I can answer the question that the hon. Member for Stafford asked, and that the hon. Lady might ask. [Interruption.]

The Chair: Order.

Paul Burstow: I was about to say that we have to deal with the legacy of a desire by the previous Government to move off the balance sheet the financing of capital investment in the NHS. The reality is that those chickens are coming home to roost. They are costing the NHS a fortune, and we must deal with that to make sure that we have a sustainable national health service going forward, and that is what the Government are committed to doing.

Liz Kendall: David Nicholson, the chief executive of the NHS—not us—has said that about 20 trusts will not be able to make it to foundation trust status because of their financial viability in the future, so the Minister is wrong to say that that is not the case.

Paul Burstow: They are organisations that will need additional support and help to succeed. I wanted to make it clear that they are not organisations that are on a list of those subject to the failure regime or that would fall into the failure regime. The hon. Lady might not want to accept that point, but we have a process, and, as I have said, failure is not what this is about. It is about supporting organisations to improve so that they can continue to deliver good-quality results for their patients.
Jeremy Lefroy: Does the Minister agree that one of the real pressures is to move people, quite rightly, out of acute beds into the community when possible? We agree that across the board that is good for patients, but it exerts financial pressures on acute hospitals.

Paul Burstow: The hon. Gentleman makes an important point about how we have to ensure as we implement the Bill that we avoid such unintended consequences. We are committed to making sure that the failure regime that we introduce is robust. It is about improving services and improving organisations’ chances of succeeding in the future. With that, I urge hon. Members to reject the amendment and support the clause.

Question put, That the amendment be made.

The Committee divided: Ayes 10, Noes 13.

Division No. 32]

AYES

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

O’Donnell, Fiona
Smith, Owen
Thornberry, Emily
Turner, Karl
Wilson, Phil

NOES

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

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

Question accordingly negatived.

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

Question agreed to.

Clause 113 accordingly ordered to stand part of the Bill.

Clause 114

Price payable by commissioners for NHS services

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

Owen Smith: Unfortunately, as a result of how little time we have left, we are not going to have much time to discuss the crucial issue of pricing—[Interruption.]

The Chair: Order. Mr Smith is pushed for time, and he is trying to make his point.

Owen Smith: Pricing is vital to the Bill, which is why it is a shame that we do not have more time to discuss it. It is vital in terms of basic economics, because of the relationship between price and competition, and vital because David Bennett, the man in charge of Monitor, has repeatedly said that he thinks price and price competition are very important. He has previously said: “I think over time an amount of price competition will be appropriate”.

He has also said that “price competition is a way” to drive “productivity improvement.”

His saying those things started our grave concern that the Government are seeking to use price as a means of increasing competition in the NHS. The Government have subsequently sought to address that concern by amending the Bill, and the spin on that has evolved over the past couple of months.

Crucially, the word “maximum” has been struck out of the Bill, so there will now not be maximum prices. We have also heard rhetoric that suggests that price competition has been ruled out—that is the phrase that Ministers are keen to use. I contend, although I will not do so at any great length because we do not have time, that that is unfortunately not an entirely accurate picture of the Bill’s contents, even in its amended form. Although it is true that the reference to a maximum price has been cut from the Bill, different providers and commissioners in the NHS retain the ability to vary prices, both on-tariff and particularly off-tariff. The only change is that providers, commissioners and Monitor are at different junctures in the pricing pathway and are forced to publish where they vary price. Monitor and commissioners who accept that they will pay a different price are forced under the Bill to say expressly why they decided on a varied price and what changes allowed them to shift away from the tariff price. That is not outlawing or ruling out price variation. It is simply making it transparent and open that there are variations in pricing.

That prompts very real questions, the most important of which is whether the Government have got their economics wrong. As a result of transparency, there will be more information about differing prices pertaining to the same service or variations in that service in different parts of the NHS, but will not that new transparency lead to a greater degree of price competition? There will potentially be a race to the bottom, as procurers and commissioners choose to pick and demand the lowest price in health care, just as happens in every other walk of economics and life.

Mr Barron: We should not let this pass without saying that we are getting to the section on pricing when we have just seven minutes left. That is ludicrous in my view. The national tariff has been an issue in the health care system for years, and it would be true to say that the previous Government did not get it perfect when it was first introduced in children’s services. It has been very difficult. That we have, with just a few minutes to go, moved on into the whole area of pricing is ludicrous. I hope that people in another place who have an interest in the matter will take the subject on and give it the proper scrutiny it deserves.

Owen Smith: Another area that I hope those in another place will have a chance to look at is the complexity of setting the tariff and the nonsense that Monitor, as well as regulating foundation trusts and dealing with competition, will be able to do what the NHS has failed to do for six years and set a comprehensive tariff.

Mr Barron: I agree entirely with my hon. Friend. It is a great pity that we have about two minutes left to hear...
anything from the Government about this crucial issue of the new NHS promised in the Bill. We still have two minutes, so I will let the Minister reply.

Paul Burstow: We have had six and a half hours of delight and deliberation on the Bill today. In that time, we had 22 clauses and a schedule to consider. It surprises me that Opposition Members did not have the opportunity adequately to scrutinise all the clauses. It is down to them to decide how they use their time, and they have chosen to use it in a way that has meant that some important parts of the Bill are not being scrutinised. However, Mr Hancock, I will ensure that I write to hon. Members on the provisions we have not reached, so that they have that information.

The hon. Member for Pontypridd asked whether the Bill prevents price competition. It most certainly does, ensuring that services covered by national tariffs have a fixed price attached to them that cannot be altered for the same service delivery. That is an important element, and I look forward to further discussion on the matter on Report. In six and a half hours, we have had ample time to cover 22 clauses and a schedule, and it is a great shame that some hon. Members have chosen not to use it.

Question put and agreed to.

Clause 114 accordingly ordered to stand part of the Bill.

8 pm

Proceedings interrupted (Programme Order, 28 June).

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

Clause 115

THE NATIONAL TARIFF

Amendments made: 164, in clause 115, page 112, line 11, insert '—

Amendment 165 in clause 115, page 112, line 29, leave out 'must also' and insert 'may'.

Amendment 166, in clause 115, page 112, line 33, at end insert—

'(2A) Where a variation is agreed in accordance with rules provided for under subsection (2), the commissioner of the service in question must maintain and publish a written statement of—

(a) the variation, and

(b) such other variations as have already been agreed in accordance with rules provided for under that subsection in the case of that service.'.

Amendment 167, in clause 115, page 112, line 34, after 'also', insert '—

(a) specify variations to the national price for a service by reference to circumstances in which the service is provided or other factors relevant to the provision of the service,

(b) provide for rules for determining the price payable for the provision for the purposes of the NHS of health care services which are not specified under subsection (1)(a), and

(c)'.

Amendment 168, in clause 115, page 112, line 36, at end insert—

'(3A) Rules provided for under subsection (3)(b) may specify health care services which are not specified under subsection (1)(a).

(3B) The national tariff may also provide for rules for determining, where a health care service is specified in more than one way under subsection (1)(a) or in more than one way in rules provided for under subsection (3)(b), which specification of the service is to apply in any particular case or cases of any particular description.'.

Amendment 169, in clause 115, page 112, line 37, leave out subsection (4) and insert—

'(4) The national tariff may include guidance as to—

(a) the application of rules provided for under subsection (2), (3)(b) or (3B),

(b) the application of variations specified under subsection (3)(a), or

(c) the discharge of the duty imposed by subsection (2A), and a commissioner of a health care service for the purposes of the NHS must have regard to guidance under this subsection.'.

Amendment 170, in clause 115, page 112, line 43, leave out 'provide for different rules under subsection (1)(d)' and insert 'different variations under subsection (3)(a)'.

Amendment 171, in clause 115, page 113, line 5, leave out 'public or private ownership' and insert 'the public or (as the case may be) private sector'.—(Paul Burstow.)

Clause 115, as amended, ordered to stand part of the Bill.

Clause 116

THE NATIONAL TARIFF: FURTHER PROVISION

Amendments made: 172, in clause 116, page 113, line 19, after '115(1)(a)', insert 's', or in rules provided for in the national tariff under section 115(3)(b)'.

Amendment 173, in clause 116, page 113, line 24, leave out subsections (2) to (4) and insert—

'( ) In the case of a service specified in the national tariff under section 115(1)(a), the national tariff must—

(a) if the service is specified in accordance with subsection (1)(a), specify a national price for each component of the service;

(b) if it is specified in accordance with subsection (1)(b), specify a national price for the bundle;

(c) if it is specified in accordance with subsection (1)(c), specify a single price as the national price for each service in the group.

( ) In the case of a service specified in rules provided for in the national tariff under section 115(3)(b), the rules may—

(a) if the service is specified in accordance with subsection (1)(a), make provision for determining the price payable for each component of the service;

(b) if it is specified in accordance with subsection (1)(b), make provision for determining the price payable for the bundle;

(c) if it is specified in accordance with subsection (1)(c), make provision for determining the price payable for each service in the group.'.

Amendment 174, in clause 116, page 113, line 36, after '115', insert 'or (as the case may be) in rules provided for under subsection (3)(b) of that section'.
Amendment 175, in clause 116, page 113, line 37, at end insert—

‘(a) Where the commissioner of a health care service for the purposes of the NHS agrees to pay a price for the provision of the service other than the price that is payable by virtue of this Chapter, Monitor may direct the commissioner to take such steps within such period as Monitor may specify to secure that the position is, so far as practicable, restored to what it would have been if the commissioner had agreed to pay the price payable by virtue of this Chapter.

(b) Where the commissioner of a health care service fails to comply with rules provided for under section 115(2), (3) or (3B), Monitor may direct the commissioner to take such steps within such period as Monitor may specify—

(a) to secure that the failure does not continue or recur;

(b) to secure that the position is, so far as practicable, restored to what it would have been if the failure was not occurring or had not occurred.’.—(Paul Burstow.)

Clause 116, as amended, ordered to stand part of the Bill.

Clause 117

CONSULTATION ON PROPOSALS FOR THE NATIONAL TARIFF

Amendments made: 176, in clause 117, page 114, line 6, leave out paragraph (c) and insert—

“(c) the prices, determined in each case by using the applicable method specified under paragraph (b), that Monitor proposes as the national prices of those services,’.

Amendment 177, in clause 117, page 114, line 8, leave out paragraph (d).

Amendment 178, in clause 117, page 114, line 11, leave out ‘must also specify the rules for which Monitor proposes to provide’ and insert ‘may specify such rules as Monitor proposes to provide for’.

Amendment 179, in clause 117, page 114, line 15, at end insert—

‘(4A) The notice may also specify—

(a) such variations (by reference to circumstances in which a service is provided or other factors relevant to its provision) as Monitor proposes to specify to the effect that it proposes as the national prices;

(b) such rules as Monitor proposes to provide for in the national tariff for determining the price payable for the provision of the purposes of the NHS of health care services not specified for the purposes of subsection (3)(a), and

(c) such rules as Monitor proposes to provide for in the national tariff for determining, where a health care service is provided, the price payable for the purposes of subsection (3)(a) or in more than one way for the purposes of subsection (3)(a) or in more than one way in rules specified for the purposes of paragraph (b), which specification of the service is to apply in any particular case or cases of any particular description.’.

Amendment 180, in clause 117, page 114, line 15, at end insert—

‘(4B) The notice may include guidance as to the application of rules specified for the purposes of subsection (4) or (4A)(b) or (c) or the application of variations specified for the purposes of subsection (4A)(a).’.

Amendment 181, in clause 117, page 114, line 22, leave out subsection (6).

Amendment 182, in clause 117, page 114, line 35, at end insert—

‘( ) Such variations as are specified for the purposes of subsection (4A)(a), and such guidance on the application of those variations as is included for the purposes of subsection (4B), are only such variations and such guidance as Monitor considers should be so specified and included and—

(a) as Monitor and the Board agree will be so specified and included, or

(b) in default of agreement, as are determined by arbitration as being the variations that will be so specified and the guidance that will be so included.’.

Amendment 183, in clause 117, page 114, line 36, leave out subsection (9).

Amendment 184, in clause 117, page 114, line 41, leave out ‘The rules specified for the purposes of subsection (4) are only such rules’ and insert

‘Such rules as are specified for the purposes of subsection (4) or (4A)(c), and such guidance on those rules as is included for the purposes of subsection (4B), are only such rules and such guidance’.

Amendment 185, in clause 117, page 114, line 43, after ‘specified’, insert ‘and included’.

Amendment 186, in clause 117, page 114, line 44, after ‘specified’, insert ‘and included’.

Amendment 187, in clause 117, page 114, line 46, after ‘specified’, insert ‘and the guidance that will be so included’.

Amendment 188, in clause 117, page 114, line 46, at end insert—

‘(10A) Such rules as are specified for the purposes of subsection (4A)(b), and such guidance on those rules as is included for the purposes of subsection (4B), are only such rules and such guidance as Monitor considers should be so specified and included and—

(a) as Monitor and the Board agree will be so specified and included, or

(b) in default of agreement, as are determined by arbitration as being the rules that will be so specified and the guidance that will be so included.’.—(Paul Burstow.)

Clause 117, as amended, ordered to stand part of the Bill.

Clause 147

INTERPRETATION AND CONSEQUENTIAL AMENDMENTS

Amendments made: 189, in clause 147, page 135, line 7, at end insert—

“anti-competitive behaviour’ has the meaning given in section [General duties: supplementary] and references to preventing anti-competitive behaviour are to be read in accordance with subsection (2) of that section;’.

Amendment 190, in clause 147, page 135, line 13, at end insert—

“facilities” has the same meaning as in the National Health Service Act 2006 (see section 275 of that Act);’.

Amendment 191, in clause 147, page 135, line 16, leave out ‘56’ and insert ‘[General duties: supplementary]’.—(Paul Burstow.)

Clause 147, as amended, ordered to stand part of the Bill.

Ordered, That further consideration be now adjourned.

—(Stephen Crabb.)

8.1 pm

Adjourned till Thursday 14 July at Nine o’clock.