Public Bill Committee

HEALTH AND SOCIAL CARE
(RE-COMMITTED) BILL

Eleventh Sitting
Thursday 14 July 2011
(Morning)

CONTENTS
Written evidence reported to the House.
Clauses 149 and 156 agreed to, both with an amendment.
Clause 165 under consideration when the Committee adjourned will this
day at One 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

Monday 18 July 2011

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

© Parliamentary Copyright House of Commons 2011

This publication may be reproduced under the terms of the Parliamentary Click-Use Licence, available online through The National Archives website at www.nationalarchives.gov.uk/information-management/our-services/parliamentary-licence-information.htm

Enquiries to The National Archives, Kew, Richmond, Surrey TW9 4DU;
e-mail: psi@nationalarchives.gsi.gov.uk
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

Thursday 14 July 2011

(Morning)

[Mr Jim Hood in the Chair]

Health and Social Care
(Re-committed) Bill

Written evidence to be reported to the House

HSR 39 Action against Medical Accidents
HSR 40 Monitor
HSR 41 Diabetes UK
HSR 42 Institute of Commissioning Professionals
HSR 43 Association of Directors of Public Health
HSR 44 Unite
HSR 45 Centre for Mental Health
HSR 46 Lightfoot Solutions
HSR 47 Macmillan Cancer Support

Clause 149

DIRECTORS

9 am

The Minister of State, Department of Health (Paul Burstow): I beg to move amendment 192, in clause 149, page 138, line 3, at end insert—

'( ) After paragraph 18D of that Schedule insert—

18E (1) The constitution must provide for meetings of the board of directors to be open to members of the public.

(2) But the constitution may provide for members of the public to be excluded from a meeting for special reasons.'.

Mr Hood, it is absolutely lovely to serve under your chairmanship, especially on our last day of deliberations.

Amendment 192 is intended to strengthen transparency in NHS foundation trusts by requiring boards of directors to hold their meetings in public. The Bill already proposes legislative changes that will establish a stronger, more transparent and more accountable governance regime for foundation trusts. In particular, the roles of governors and directors are clarified; governors can already remove the chair and non-executive directors, but we are giving them more explicit practical powers to help them to hold the board to account, for example, by questioning directors at special general meetings.

We have always encouraged the holding of public board meetings in foundation trusts. Our concern was about forcing change through legislation, as it is argued that that can be counter-productive. As we discussed in March, holding open board meetings is really about cultural change within an organisation. Genuine accountability for decision making in foundation trusts is best achieved by governors and directors agreeing locally the arrangements that work best for them, the foundation trust and the public it serves.

NHS Future Forum recommended that there must be transparency about how public money is spent, how and why decisions are made and the outcomes being achieved at every level of the system, including a requirement on foundation trusts to hold their corporate board meetings in public. All other NHS organisations are required to hold public board meetings, although that requirement has never applied to foundation trusts and is a matter for each to decide. Although many foundation trusts do hold their board of directors meetings in public, others do not. The Foundation Trust Governors’ Association says that open board meetings help governors to hold the board of directors to account more effectively and would like that to be made compulsory.

The amendment would ensure that all foundation trusts hold open board meetings, so that the membership and wider public can understand the internal arguments, tensions and restrictions that lead to a decision, and better scrutinise and contribute to decisions on the delivery of local health care provision. As I said, NHS trusts must hold public board meetings, and because our clear expectation is that the majority of NHS trusts will become foundation trusts by 2014, the amendment would address the risk of some trust boards choosing to become less open at the point of foundation trust authorisation.

Like all other public bodies that are required to hold open board meetings and as NHS trust boards do now, foundation trusts would be able to have a closed part of their meetings to discuss confidential and sensitive matters. Requiring public board meetings in foundation trusts is a response to our listening exercise and mirrors the existing requirement on other public bodies and boards of governors of foundation trusts. It demonstrates our commitment to make the NHS more accountable and transparent.

Owen Smith (Pontypridd) (Lab): Mr Hood, it is absolutely lovely to serve under your directions, and terrific that it is the last day of the Committee. On that we absolutely agree. Another matter on which we completely agree with Ministers is that this is an excellent amendment—a first-rate amendment. In truth, it bears remarkable similarity to Opposition amendment 641, tabled in the previous iteration of this fine Committee, which suggested requiring public board meetings in foundation trusts and why decisions are made and the outcomes being understood. We absolutely agree. We completely agree with Ministers is that this is an excellent amendment...
And he went on to say
"we do not think the amendment is necessary. We believe the changes"—

Mr Steve Brine (Winchester) (Con): Will the hon. Gentleman give way?

Owen Smith: I will when I have finished this lovely quotation:

“We believe the changes we are making to the governance arrangements of foundation trusts are a significant step in the direction that all Members want to see. We should not be attempting to fetter the organisations that we want to be more autonomous, as we would by making the amendment.”—[Official Report, Health and Social Care Public Bill Committee, 24 March 2011; c. 1058-60.]
The Government have clearly decided that they are going to fetter the discretion of those bodies and make them less autonomous. In my view they will not be less autonomous, but simply more transparent—something of which the Government are ostensibly very much in favour.

Mr Brine: I suspect that the hon. Gentleman knows what I am going to say, but I have two points to put to him. First, when his party’s Government set up foundation trusts, they did not mandate that the boards met in private. Secondly, when the knife falls at 7 o’clock this evening, I dare say Opposition Members will complain that we have not had enough time. As they agree wholeheartedly with the amendment, shall we just agree it and move on?

Owen Smith: I think that the public expect us to scrutinise all aspects of the Bill, so I have some other questions for the Minister. Given that we suggested that this was a good idea last time and he did not agree—[Interuption.]
The Chair: Order. This is the last day, I know.

Owen Smith: I am grateful, Mr Hood. I shall move on to a few further questions for the Minister, because I do not think that he has explained clearly why he changed his mind. He did not explain what happened in the intervening period to persuade him that he was fundamentally wrong last time and is absolutely right this time. I would be grateful if he did so.

The substantive point is that, under the amendment, new paragraph 18E(2) of schedule 7 to the National Health Service Act 2006 still states that the “constitution may provide for members of the public to be excluded from a meeting for special reasons.”
The crucial question is: what sort of special reasons? Non-FTs may or may not meet in public, just like FTs, and when we tabled amendment 641 I think we conceded that FTs in particular ought to be obligated to meet in public. That was clearly an omission from earlier legislation, because it is a good idea that they do so. Will the Minister spell out the special reasons for which a board of directors might decide to meet in camera? Can he provide some examples of when it might want to meet in camera? I do not think that is too much to ask.

Dan Byles (North Warwickshire) (Con): Obviously, I am not speaking for the Ministers, so if I give a hypothetical example, the hon. Gentleman must not pin it on those guys. This is such a waste of time. Can the hon. Gentleman not think of reasons? Suppose a board has to meet to discuss dismissing the clinical director for gross incompetence; something like that might well be discussed in private, not in public, if the board if had to talk about specific clinical cases. There are many possible reasons.

Owen Smith: I concede that there might be a reason why the board wanted to meet in private to discuss, for example, dismissing a medical director. However, in that example, should the public not know if the board decided to dismiss a medical director? [Interuption.]

The Chair: Order. The hon. Member for North Warwickshire cannot ask the hon. Gentleman a question and then heckle him while he is answering.

The Minister of State, Department of Health (Mr Simon Burns): Why not?

The Chair: Why not? Because it is against order, and it is not going to happen. The Minister should know better.

Owen Smith rose—

Mr Kevin Barron (Rother Valley) (Lab): Will my hon. Friend give way?

Owen Smith: Certainly.

Mr Barron: We have made a very interesting start this morning. It is a great pity that, for the last few weeks, Government Back Benchers have not been asking Ministers about this atrocious Bill and the way that they are trying to ram it through Parliament without proper debate.

Owen Smith: What has got into the Conservative Back Benchers this morning? They have been pretty somnolent throughout most of our proceedings. To be honest I thought they had been slipped a mickey for most of it, so little did they have to say, but this morning, for some reason—with an audience, perhaps—they have all decided they need to show off. Let me make it clear: he is my boss, not yours. Do not worry about it.

Although there may be certain circumstances in which it is entirely proper for a board of directors to meet in camera, will the Minister let us know whether such circumstances include, for example, the board of directors, under the new dispensation the Bill provides, deciding whether to treat more private patients and fewer public patients in a hospital? Is that one of the clear areas where the board of directors might, for commercially sensitive reasons, meet in camera?

Grahame M. Morris (Easington) (Lab): I wish to place on the record my thanks to you, Mr Hood, and to say what a pleasure it is to serve under your chairmanship.

I have a couple of brief points and a question I would like to pose to the Minister. As my hon. Friend the Member for Pontypridd has outlined, we support the amendment and the strengthening of the Bill by placing
[Grahame M. Morris]
a general duty on FT boards to be more open about their meetings. Clause 165 sets out that the directors of an FT must avoid conflicts of interest—not just declare conflicts of interest, but avoid them—and not accept benefits from third parties which relate in any way to their role in the foundation trust. That is very significant, and I would like some clarification from the Minister, such as an example—

The Chair: Order. I am finding it difficult to tell whether the hon. Gentleman is speaking to the amendment. I suspect he is speaking to clause stand part and not the amendment.

Grahame M. Morris: I will come back on clause stand part, Mr Hood.

Paul Burstow: I anticipate the clause stand part debate even more keenly.

The hon. Member for Pontypridd asked why the Government tabled the amendment, which he powerfully welcomed as a sensible measure. The answer is simple: we as a Government decided to pause, listen and reflect; and having done all those things and respected the representations we received from outside the Committee, we have changed our mind. Given that he claimed ownership of the amendment, I hoped that he would already be assured that foundation trusts exercising their responsibility as public bodies that choose in certain circumstances to meet in private would do so properly in accordance with the provisions set out in the Public Bodies (Admission to Meetings) Act 1960. In the amendment, we are attempting to give effect in this Bill to those provisions, which give a clear guide to what is and is not a matter that can be dealt with in camera.

9.15 am

Let me give a couple of examples. A discussion in the board might involve a breach of data protection legislation if it were held in public, so it would be necessary for that discussion to take place in private. If there was a concern that the common law duty of confidentiality might be breached by discussing a matter in public, the board would have to consider discussing it in private. Similarly, if a commercially sensitive matter was being discussed, such as the sale of intellectual property rights and so on, the board might well decide that it needed to meet in private. The hon. Gentleman asked about discussions on whether a trust would take on a larger case load of private paying patients. We can see absolutely no circumstances that would allow a board to decide to meet in private to discuss and make decisions on a matter that is fundamental to the purpose of foundation trusts, which is to provide services to the NHS.

With all those reassurances, and anticipating further questions on clause stand part, I hope that the hon. Gentleman has been reassured and that the Committee will accept the amendment.

Owen Smith: Will the Minister clarify his final remarks? I think he said that the board to consider shifting the proportions of patients being treated privately and publicly, they could do that in private.

Paul Burstow: No.

Owen Smith: That is not what he said?

Paul Burstow: If the hon. Gentleman reads Hansard, it will be clear that I have made clear that they could not do that in private.

Amendment 192 agreed to.

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

Owen Smith: My hon. Friend the Member for Easington has already touched on new paragraph 18B(1), which inserts a duty on directors “to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the corporation.”

The Future Forum made recommendations to the Government on other provisions. Notably, recommendation 16 suggested that health and well-being boards ought to have a role in identifying and addressing conflicts of interest in commissioning consortia, but the Government have rejected that. The clause talks about conflicts of interest only in relation to trusts, which gives rise to a couple of questions.

All FT trusts have on their board a medical director, who is normally also a consultant or senior clinician in the trust. My simple question is: would that individual be obliged to declare an interest or to absent himself from a meeting of the board of directors if the board was considering increasing the proportion of private patients to be treated in the FT, because of the clear risk that that consultant, certainly if he practised in a mainstream area of medicine, would be among those who treated those patients privately in that hospital and would thereby benefit financially from it.

The reason why we are particularly worried about abolishing the private patient cap is that, in our view, it is another area where the Government did not listen adequately during the pause. They did not listen what to the Future Forum was telling them. I am not talking about its report—the Future Forum has conceded that it did not raise the private patient cap vigorously enough in its report—however, it has raised it subsequently.

I will finish with a quote. In his evidence to the Committee, Steve Field said of the private patient cap: “If you wanted a gut feeling for what was happening in the listening, the feeling was that the private cap should actually stay, because people felt that that would provide a protection.”

He also said that “we did not put much in our report as perhaps we could have done. In fact, it was one area, having re-read the paper at the end, that we might have been stronger on.”

He went on to say that—and this is something I hope to raise later—“if you opened the cap, it made you more likely to be under...EU law, competition and Monitor.”—[Official Report, Health and Social Care (Re-committed) Public Bill Committee, 28 June 2011; c. 14, Q 24.] I think Professor Field means that this is one of the key areas in which changing the nature of what have hitherto been social providers, by shifting them in the eyes of the law to a more commercial setting, risks destructively subjecting them to EU competition law in the courts. That is what we have been saying all along. I would be grateful if the Minister cleared up whether medical directors should absent themselves from decisions on shifting the proportion of patients. What does he have to say on the decision to raise the private patient cap?
Grahame M. Morris: I rise to reinforce my hon. Friend’s point. Proposed new paragraph 18B(1)(a) of schedule 7 to the National Health Service Act 2006 sets out a duty that foundation trust directors must avoid conflicts of interest, rather than simply declaring them; and proposed new paragraph 18B(1)(b) specifies that directors must not accept benefits from third parties that are related in any way to their role within the foundation trust.

Will the Minister elaborate on that duty to avoid conflicts of interest? I am particularly thinking of foundation trust directors who come from private sector health care companies and who might seek some advantage. The board as a whole might see some advantage in having outside expertise, but my concern is that it may be used as a Trojan horse to bring a private sector interest into a foundation trust. I would welcome the Minister’s views on that and any reassurances that he can give.

Paul Burstow: I will start by elaborating a little further on conflicts of interest, but perhaps I will come back with a bit more detail in a minute.

When it comes to directors avoiding conflicts of interest with third-party benefits and so on, foundation trusts have always been able to participate in joint ventures. Principles of public law mean that foundation trust directors are already subject to the same duties as directors of other organisations. The clause specifically clarifies the duty on all conflicts of interest.

The hon. Member for Pontypridd has raised some broader points on the cap and what has and has not been said by Steve Field and the NHS Future Forum. When Professor Field spoke to the Committee on 28 June, he said that the Future Forum had talked “a little bit” about the private patient cap, but that

“we did not put as much in our report as perhaps we could have done. In fact, it was one area, having re-read the paper at the end, that we might have been stronger on, but, because the feedback was so mixed, I did not feel that we could actually make a strong recommendation.”—[Official Report, Health and Social Care (Re-committed) Public Bill Committee, 28 June 2011; c. 14, Q24.]

It is important to have the whole quote because there were many different and conflicting opinions. Opposition Members have a strong and clear opinion that is not reflected by all of the many opinions that were gathered during the listening exercise.

The Government’s response to the NHS Future Forum report said:

“We have heard concerns about our proposal to lift the cap on the amount of income foundation trusts can earn from treating private patients. Some fear that this could lead to NHS resources being used to cross-subsidise private care. Any cross-subsidy of this kind would breach the fundamental principles of the NHS, as set out in the NHS Constitution, which makes clear that ‘public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.’ To provide assurance and transparency, we will require foundation trusts to produce separate accounts for NHS and private-funded services.”

That sets out the Government’s approach clearly. We want transparency and separate accounting for any resources generated through private activity, and, because these are public benefit organisations that have a legal, statutory duty to provide services to the NHS, we are clear that the safeguards are sufficient. I will say more about those in a moment, because it is important to have the issue on the record.

The other intriguing aspect of the debate about the cap is that, even towards the end of the previous Administration, there was recognition that the current arrangement was inconsistent and unfair. It was unfair because it resulted in a situation where NHS trusts have no restriction whatever on the level of private activity that they can engage in.

It may interest the Committee to hear about the top 10 NHS organisations—FTs and non-FTs—when it comes to their income from private activities. Those activities are not just about treating patients; they can be joint ventures, the realisation of value from intellectual property through research and so on. We find that Great Ormond Street hospital, which is an NHS trust, earns 7.8% of its total income from private patients. The figure for Imperial College Healthcare NHS Trust is 4.6%. The Robert Jones and Agnes Hunt orthopaedic and district hospital earns 4%. Royal Free Hampstead NHS Trust, which is number 11 on the list, has a figure of 4%.

The reality is that those organisations are not in any way eroding the fundamental principles of the NHS as a service—to provide support, care and treatment for people that is free at the point of use and based on people’s needs. If they had been, the Labour Government would surely have taken the opportunity over the past 13 years to impose a cap on them as well. They chose not to.

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): The Minister just made an important point. Does he agree that, under the current system, a medical director may well be involved in performing some operations that are run by the private sector elsewhere in the hospital, as he has just outlined? Does he also agree that there would be no concerns that I am aware of—I wonder whether he is aware of any—about medical directors having conflicts of interest between the NHS and a private provider that also provides services to the hospital?

Paul Burstow: The hon. Gentleman again draws on his own expertise and experience, but the issue returns to the specific question of the hon. Member for Pontypridd as well. The clause specifically says that directors of any sort must avoid situations in which they would have a conflict of interest. If there is such a conflict, they must take the necessary steps that would apply in any corporate body.

Debbie Abrahams (Oldham East and Saddleworth) (Lab): We need to consider the collection of clauses and measures in the Bill—not just the private bed cap—and what the Government’s intentions are. Those are the arguments that we have made. It is not just the private patient cap; it is also the ability of NHS trusts to dispose of their assets and raise loans. Those abilities shift the agenda considerably.

Paul Burstow: And they were part of the agenda set out by Alan Milburn when he first announced the policy of foundation trusts and part of the direction of
travel under the previous Government. It is extraordinary that the hon. Lady would suggest some sort of new agenda was being promoted by the current Administration. The idea of autonomous organisations accountable to their local populations and to NHS staff was—

9.30 am

Liz Kendall (Leicester West) (Lab): Will the Minister give way?

Paul Burstow: No, I will not at the moment, because I want to talk about the safeguards.

Liz Kendall: He is making a point about—

The Chair: Order.

Paul Burstow: I am not giving way, Mr Hood. I want to make some progress.

There are the following safeguards: first, the NHS commissioning board and clinical commissioning groups would be responsible for ensuring that NHS patients are offered prompt and high quality care. Secondly, the principal lead and purpose of FTs is, and would continue to be, the provision of goods and services to the NHS in England, as I have said. Thirdly, FTs cannot distribute surpluses externally. Fourthly, the Bill would strengthen FT governance arrangements in a way that currently does not exist. Fifthly, there would be greater transparency, not least in regard to the accounting for separate incomes.

That is the Government’s approach, and those safeguards are measured and reflective of the direction of travel under the previous Administration.

Margot James (Stourbridge) (Con): It is important that we are not defensive about the removal of the private patient cap. In the early sittings of the re-committed Bill, we heard evidence from Sue Slipman, the director of the Foundation Trust Network, who talked about the benefits of bringing more private money in to the NHS, and that it would benefit NHS patients. She also made the point that it would not only be about bringing new money in, which I am sure we would all applaud, because it would be about intellectual property and the development of new services from which NHS patients could benefit, too.

Paul Burstow: My hon. Friend is absolutely right. That bit tends to get lost, which is why it is important to rehearse the fact that we are talking about opportunities that arise from joint ventures, and from exploiting the intellectual property rights of organisations, in a way that would benefit NHS patients, because capacity would be increased.

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

Paul Burstow: No, I am developing a point. I will consider giving way as I progress, but I am equally keen for us to make progress in the seven and a quarter hours that we have to consider the Bill today—/[Interruption.]
Owen Smith: Fine. The Minister listed the percentages, which prompts me to ask whether he thinks there is an upper limit to which trusts or foundation trusts should adhere. Or is it the Minister’s view that there is absolutely no limit, and that FTs can raise as much income as they want from private operations such as research, treating private patients or any of the other things that he listed? If he thinks that there is absolutely no limit, it is hard to see how the stipulation in the Bill that the principal role of FTs is to provide public NHS goods and services—to provide health care on the NHS—can be met. A particularly entrepreneurial trust might seek to ratchet up such activities over the years to levels that impinged on its ability to deliver its prime duty. Does the Minister think that that is wholly unforeseeable and that the Government will not have to legislate in future to redress that balance?

The Chair: Do you want to respond, Mr Burstow?

Paul Burstow: No.

Question put and agreed to.

Clause 149, as amended, accordingly ordered to stand part of the Bill.

Clause 156

AUTHORISATION

Paul Burstow: I beg to move amendment 193, in clause 156, page 141, line 34, at end insert—

‘(3A) The regulator must not give an authorisation unless it is notified by the Care Quality Commission that it is satisfied that the applicant is complying with (so far as applicable) the requirements mentioned in section 12(2) of the Health and Social Care Act 2008 in relation to the regulated activity or activities the applicant carries on.

(3B) In subsection (3A), “regulated activity” has the same meaning as in section 8 of the Health and Social Care Act 2008.’.

We remain committed to patients being able to expect high-quality health care from the best providers available. Our aim in updating the national health service is that we should go further. Alongside our commitment to provide public NHS goods and services—to provide health care on the NHS—can be met. A particularly entrepreneurial trust might seek to ratchet up such activities over the years to levels that impinged on its ability to deliver its prime duty. Does the Minister think that that is wholly unforeseeable and that the Government will not have to legislate in future to redress that balance?

Liz Kendall: The Minister referred just now and earlier to the fact that the previous Labour Government established foundation trusts. I would like him to confirm to the Committee that on 7 March 2003—

The Chair: Order. A conversation is taking place in the middle of the Committee, which is not allowed. Please keep to order.

Liz Kendall: Thank you, Mr Hood. I would like the Minister to confirm that on 7 March 2003 both he and his right hon. Friend the Member for Chelmsford—who appears to be popping out—voted against the establishment of foundation trusts.

Paul Burstow: A stunning revelation, which adds nothing to our debate today.

Liz Kendall: Yes, it does.

Paul Burstow: Over the last six years—

Liz Kendall: You changed your mind.

Paul Burstow: The Opposition seem to have changed their mind dramatically in the last 12 months on so many issues that they cherished and stood on in their manifesto last year. For example, progressive—

The Chair: Order. The hon. Lady must stop heckling. I insist that hon. Members do not ask questions and then heckle when they are getting an answer.

Paul Burstow: I am getting used to it now, Mr Hood. When Opposition Members do not like what they are hearing, they shout from a sedentary position.

Mr Burns: I remind my hon. Friend that the reason that I, as a shadow Health Minister, and my colleagues voted against foundation trusts in the original legislation had nothing to do with the fact that we opposed the principle. We did not. We voted against them because the wishes of Alan Milburn and Tony Blair had been so watered down by the Neanderthal tendency of the Labour party that we felt that they would fail to achieve the potential that was designed for them.

Paul Burstow: I will leave that on the record as it was clearly set out to be.

We are making a number of the changes to the Bill in the amendments because during the listening exercise particular concerns were expressed about quality and patient care. People felt that that might be compromised if NHS trusts were pushed to apply for foundation trust status before they were ready. Although the NHS Future Forum did not specifically suggest this, we have decided that we should go further. Alongside our commitment for all NHS trusts to achieve foundation trust status, we have already given assurances that there will be no lowering of the bar in Monitor’s stringent tests, including in the way in which the quality of services is considered during the application process. We maintain that undertaking.
Applicants will need to have strong boards, be clinically and financially robust in order to succeed, and quality will be at the heart of the assessment process. We now need to go further, building on the work that has been done in response to the first Mid Staffordshire inquiry findings Monitor, as foundation trust regulator, and the Care Quality Commission, as quality regulator, have improved the authorisation process for new foundation trusts. They have already signed, and work to, a memorandum of understanding governing their co-operation and collaboration to assure the quality of services provided by NHS trusts in advance of their authorisation by Monitor as foundation trusts. However—and it is an important loophole at the moment—this is only a voluntary agreement and it is not legally enforceable.

The amendment therefore creates a statutory basis for these improvements, made after the tragic failings at Mid Staffordshire, ensuring that the new arrangements remain an essential part of the authorisation process. It does that by placing a statutory requirement on Monitor to gain assurance from the CQC that the quality of services provided by a trust meets the requirements necessary to remain registered. The amendment is needed to ensure that quality is not compromised in any way and remains paramount in a successful foundation trust application. The amendment underscores the Government's commitment to quality as a vital organising principle of the NHS.

Owen Smith: This is a technical and slightly curious amendment. I take the Minister’s word that it places on a statutory footing the need for Monitor to consult the CQC before authorising foundation trusts. I also heard what he said about there being no lowering of the bar in respect of the authorisation of trusts as FT trusts. I am not sure that that is correct or exactly what will be achieved, so I want to explore precisely what the clause does and how it builds on previous legislation, because it is very complicated.

As the Minister said, the clause effectively places a duty on Monitor to consult the CQC to determine that it is happy that the trust is up to scratch in quality terms before granting it FT status. According to the clause, the sorts of thing that the CQC must consider are established in statute under sections 12(2) and 20 of the Health and Social Care Act 2008. Those provisions broadly provide a list of the sorts of activity in which the trust is engaged. It is not a detailed list of precisely what a trust does. That additional safeguard, as the Minister put it, is required because clause 156 changes the nature of authorisation from an ongoing process to a one-off process. Hitherto, when FTs have been authorised, the authorisation was an ongoing set of riding orders for the trust, with the implication that if the trust resiled from carrying out some of the things it agreed to do when authorised, thus shifting the nature of what it offered, that authorisation could be called into question.

As this is pretty complicated I shall quote the explanatory notes, because they make the position clear:

"Under current legislation, Monitor sets terms of authorisation when authorising an NHS Trust to become a foundation trust, and these terms form the basis of Monitor’s foundation trust-specific regulatory regime...Monitor would in future issue licences to providers with conditions attached, and all providers would be regulated on the basis of such conditions."

We discussed licensing conditions last week and exposed a flaw, as the conditions are not mandatory. Monitor does not have to insist that specific conditions will be set or placed on a trust; it may insist on them, and the constitution of the trust may stipulate the conditions. A licensing process will take place, rather than the trust “receiving ongoing terms of authorisation”. Instead there will be “a one-off test to gain authorisation.”

Crucially, the clause goes further and repeals the duty placed on FTs by section 33(2)(a) of the National Health Service Act 2006 to “describe the goods and services” to be provided. That is important, because the duty imposes a transparent benchmark for the services that the trust will offer. It stipulates what the trust offers at the point of seeking and gaining authorisation. I will cite an example of such an application in a moment.

The explanatory notes explain that the clause “repeals the requirement in section 33(2)(a) of the NHS Act to describe the goods and services...This information is currently required to set the terms of authorisation. In future, Monitor as the economic regulator—...Strangely, they do not say that it is sector specific—“would be able to use its licensing regime to require a provider to provide a particular service.”

As I said, the licensing regime does not specifically mandate or force the trust to provide, every time, all the services that it offers at the point at which it is authorised. The explanatory notes state:

“The existing powers under which Monitor can use terms of authorisation to ensure the provision of a particular service would therefore no longer be required.”

Previously, that authorisation was ongoing and contingent on the trust providing a specific set of services. The latest application I could find was from Southampton University Hospitals. That trust lists cardiac surgery, vascular services, haematology, radiotherapy, children’s oncology and so on—all of the services that are provided. That is a useful benchmark, laid down in the procedures, that allows the public to look at what the hospital provides, and to see if it chooses in future not to provide some free services that it was thought it would provide. Opposition Members believe that is important. We assume that the NHS will provide comprehensive services, certainly in large hospitals.

We fear that when hospitals have greater autonomy they may start to shift the nature of the services they provide, for example, choosing to do more elective work with private patients, or less expensive work in areas that are less lucrative. That is a serious concern. The Minister said that the measure did not lower the bar, but I believe that there is a risk that it will do so. It is a lesser duty offering fewer guarantees that services and goods—spelled out previously as provided by a trust—will not be changed or reduced, either when the trust shifts to become a foundation trust, or later. It is clear that it could be done at a later stage. That prompts the question of why the Government want to do this. Why would they want to set a lower bar? Why would they want less public insight into what the trust provides? The answer is clear: they are interested in providing greater autonomy and less oversight of the trusts. As the Minister said, top-down management is to be eschewed at all points.
Owen Smith: The Minister said that the previous Government thought that top-down management was not the best way to deliver NHS services, which is why they shifted to NHS foundation trusts. The Government have said on myriad occasions that they are not in favour of top-down management. One man’s top-down management is another man’s oversight and surety for the public that the hospital will provide in future all the services it has in the past, and will not, in exercising increased commercial freedom, decide to drop some services, or increase provision where it may be more lucrative, for example, in respect of private patients. That is a simple test for the Minister. Can he guarantee that the stringency of the test will not be reduced, and that the measure will not lower the bar or have unforeseen consequences?

Jeremy Lefroy (Stafford) (Con): It is a pleasure to have you back in the Chair, Mr Hood. May I speak to the clause stand part, because the comments made by the hon. Member for Pontypridd concerns clause stand part? I listened carefully and he made an interesting point.

Jeremy Lefroy: Thank you, Mr Hood. I welcome the amendment. My hon. Friend the Minister made it clear that its introduction was partly motivated by the experience at the Mid Staffordshire foundation trust. What has emerged from the initial Francis report and the ongoing public inquiry is that the interaction between Monitor and the then Healthcare Commission, now the Care Quality Commission, was not sufficient. Monitor relied on the Healthcare Commission’s work, which was not adequate for those purposes. I therefore welcome two things in the Bill: the amendment and the duty on both Monitor and the Care Quality Commission to work together more closely. The amendment will make it clear to the CQC that it has to produce an in-depth report on any trust that is going for foundation-trust status and that Monitor has to take that seriously. Indeed, if the CQC has any concerns, Monitor should listen to them.

Owen Smith: As ever, the hon. Gentleman makes a thoughtful contribution. A moment ago, he said that he thought that this amendment would place a duty on the CQC to provide a detailed report. It does not actually say that. It simply says that it needs to be satisfied before it offers its imprimatur to the foundation trust. I assume that that involves some sort of paper assessment. If the hon. Gentleman looks at sections 12 and 20 of the Health and Social Care Act 2008, he will see that they are very vague about what it needs to do. Those provisions are not detailed enough for us to be certain that the CQC will do a detailed analysis.

Jeremy Lefroy: I can see the point that the hon. Gentleman is making. If we go into too much detail in primary legislation about what the CQC is supposed to do, we will end up with reams and reams of paper, just as we saw when we were asked about the Secretary of State’s responsibilities—in that instance, the detail came to 250 pages.

Jeremy Lefroy: The short answer is yes, I am concerned about the CQC’s work load. I am convinced that Ministers are considering that at the moment. Across the House, there is concern that the CQC has extremely onerous responsibilities and that is something that we must look at very carefully, as I am sure Ministers are doing at the moment.

Margot James: Thank you, Mr Hood. I am reassured that Ministers are considering the work load of the CQC, because it is an issue that concerns us all. I would like to put it on record that I have a slight concern about the leadership of the CQC. Should we extend ministerial inquiries beyond the current scope?

Jeremy Lefroy: I do not want to continue too much on the CQC, because I want to address the point made by the hon. Member for Pontypridd—I hope I have the pronunciation right.

Owen Smith: Excellent.

Jeremy Lefroy: The hon. Gentleman made a valid point in referring to the change to section 33(2) of the 2006 Act. Under the Act as it stands—this point relates to the whole clause rather than the specific amendment—foundation trusts will be able to extend their remit into areas that they were not originally authorised for or to withdraw from them without, as I see it, going back for re-authorisation. I stand to be corrected on that. I will explain the relevance of the amendment. If what I have
referred to happened—I am thinking not so much about the withdrawal from areas of service, but about the addition of further areas of service by a foundation trust—what responsibility would the CQC have in investigating whether that foundation trust was capable and up to engaging in those new areas of activity, which might be substantial? That is a genuine question, because the amendment does not deal precisely with that point. Bearing in mind the shortage of time today, I will now conclude my remarks.

Debbie Abrahams: It is lovely to see you in the Chair, Mr Hood. My remarks will focus on what the Secretary of State has said about employees being given the option of a management buy-out of a foundation trust. Underpinning that proposal is the need for funds, so I want to know where those funds will come from. Usually, the source would be venture capital or private equity companies, so an employee buy-out would create not what the Government described as akin to a social enterprise, but a private equity-owned hospital.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): My hon. Friend poses an interesting question to the Minister about where the equity will come from for any social enterprise model, mutual or co-operative that employees wish to take on. Is there any suggestion that the Department for Business, Innovation and Skills will give grants to those organisations to engage, via the back door, with a potential localised privatisation and co-opting the co-operative model for other purposes?

Debbie Abrahams: That is a good question. Those are the sorts of things that we still do not know about. If there is a need to obtain funding from private equity companies, the majority shareholder will have the right to dictate how the organisation is run. Even if the employees can structure funding as debt secured on the assets, the lender is still likely to dictate the terms to ensure that the interest is paid. Can the Minister answer that question? Will he also explain how the views of the community, who are ultimately the users of the services, will be taken into account in that process?

Paul Burstow: I will start with that question because it is important to give a slightly broader context. Foundation trusts are already required to have governors and members. They are required to have a governance structure that is outward looking to their local communities. With the Bill, the Government are further strengthening the role of governors in holding to account the boards of directors of foundation trusts, further to increase transparency in the way in which they operate. In fact, that partly answers the question asked by the hon. Member for Pontypridd about how the public and the public interest would be protected if a foundation trust decided to change the mix of services that it provided. It also in some ways answers the question asked by the hon. Member for Stafford. However, it is not the only answer to those questions, and I will rehearse some of the others.

As the hon. Member for Oldham East and Saddleworth has said at earlier stages, to understand a clause in the Bill, one often needs to look at several clauses to see the context. In that regard, we need to take into account the role of commissioners in maintaining continuity of service, in assuring themselves of the quality of service and in ensuring that identified population needs are translated into commissioning plans that in turn are delivered by providers that are commissioned to deliver the services. Other clauses provide for the role of overview and scrutiny, which ensures that providers can also be called to account in that way. A number of other provisions, over and above those in this part of the Bill about FTs’ governance, answer the questions that the hon. Gentleman and my hon. Friend asked about transparency.

Owen Smith: I take the point about commissioners having a role in determining whether the mix of services is satisfactory, but the clause changes the nature of authorisation from an ongoing process to a one-off process. Does that mean that we have less control over the subsequent changes post-authorisation—post-licensing? If a comprehensive list of services will no longer be required up front, as it is under existing legislation, will the commissioners not consequently have less insight when it comes to judging any subsequent changes?

Paul Burstow: The answer to both questions is no, and I will explain why. The hon. Gentleman has talked a lot about our emphasis on autonomy, which seemed to me to be an area of agreement between us, because the previous Administration decided to pursue the same direction in their FT policy. Of course, with autonomy must come greater accountability, which is why we have set out in the Bill the enhancements on which I have elaborated.

We need to bear in mind the CQC’s history. It was established in legislation in 2008 and it adopted its current role as a body that licenses against essential standards in October last year. The business planning and the work to determine the level of resources that it would require were done under the previous Administration. It is a matter that deserves proper scrutiny and it will probably get such scrutiny in due course. We need to be careful what we say about CQC delivering its responsibilities, which is why we are undertaking reviews of cases such as Winterbourne View and will bring the findings back to the House. We also expect the Select Committee on Health to do its work in that regard.

Let me deal with the questions about authorisation moving from an ongoing to a one-off process. At the heart of the Opposition’s misunderstanding of this part of the Bill—one of many misunderstandings—is the question whether the licensing regime forces providers to do things. Monitor will have the power to enforce licensing conditions. The hon. Gentleman seemed to suggest that it would not, so I draw the Committee’s attention to clauses 105 to 111. His misunderstanding about the licensing regime is worrying, so let me say a little about the enforcement powers that the Bill provides.

Monitor will have the power to enforce licence conditions; it will be able to take actions including fining, requiring providers to take action or requiring them to undo actions that they have already taken. A clear range of powers is available to Monitor. As for the suggestion that somehow the Government are interested in lowering the bar and reducing accountability, nothing could be further from the truth. We want more oversight of FTs and, as I have explained, we are strengthening local accountability. We want organisations to become foundation
trusts only when they are clinically and financially sustainable, which is what the tests that I have already outlined are all about. We are not lowering the bar; with this amendment and this clause we are making it clear on a statutory basis that Monitor needs to engage with the CQC in discharging its ongoing legal duties concerning essential standards of safety and quality.

I end with a brief reference to the questions from the hon. Member for Oldham East and Saddleworth about changing the status of organisations, although I am not sure that that is directly related to the clause and the matters before the Committee. If on reflection and after rereading her comments in Hansard I see that it is, I will write to her.

Liz Kendall: Autonomy has been mentioned frequently by the Minister and by his fellow Minister of State, the right hon. Member for Chelmsford, who told the Committee why he opposed the creation of foundation trusts when they were initially established. I want to remind Members that the Secretary of State criticised foundation trusts the last time.

Owen Smith: I confess that I am not wholly convinced by the remarks of the Minister, the hon. Member for Sutton and Cheam. He suggested that the reason why I argued that this was a lowering of the bar—shifting from the ongoing process with an up-front listing to a one-off process at the beginning of the authorisation through the licence conditions—was that I had misunderstood what was in the Bill in respect of Monitor's ability to enforce conditions. I do not think I misunderstood that for one second. I will read the relevant clause, as the Minister clearly is not sufficiently familiar with it to understand it himself.

The Minister said that Monitor will have the powers to enforce conditions. Absolutely. However, clause 98, on standard conditions, states:

"NHS trusts will not be able to vary their price".

He questioned whether they would ever be able to improve the capacity of the NHS because of "the limitations of the Government's proposals on commissioning and the price mechanism in health care transactions."—[Official Report, 7 May 2003; Vol. 404, c. 766.]

That is not the kind of autonomy and liberty that the Opposition want. I wanted to put on the record the reason why Conservative Members voted against foundation trusts the last time.

Paul Burstow: NHS trusts will not be able to vary their price.

Owen Smith: That is helpful to have further illumination on the mysteries of amendment grouping. Thank you very much, Mr Hood.

Amendments 194 and 196 are minor technical amendments. They do not change policy, but together they will remove any ambiguity on the approval requirements for organisational mergers and acquisitions involving foundation trusts and NHS trusts. Clauses 165 and 166 apply to organisational mergers and acquisitions where two whole trusts merge or one trust acquires another.

 Clause 165 addresses mergers between a foundation trust and another foundation trust or an NHS trust; and clause 166 addresses a foundation trust’s acquisition of another foundation trust or an NHS trust. The current wording of clauses 165(2) and 166(2) requires each applicant to attain the approval of the majority of its governors before a merger or acquisition can take place. The amendments are needed to clarify that the requirements for governor support apply only to foundation trusts. I beg to move that the clause, as amended, stand part of the Bill.

The Chair: We will do clause stand part when we get there.
Owen Smith: On a point of order, Mr Hood. I may stray into clause stand part territory.

The Chair: For the convenience of the Committee, we will take clause stand part with this group of amendments.

Owen Smith: That makes sense because these are not straightforward technical amendments, as the Minister says—not least in light of the Committee's utter confusion earlier this week on mergers.

Paul Burstow: On the Opposition side.

Owen Smith: No, I do not think the confusion has been caused by Opposition Members. We have been entirely clear.

As my right hon. Friend the Member for Rother Valley has said, we have exposed the Government's confusion on which regulator will look at mergers at which juncture. The amendments seek to address which sorts of mergers between which sorts of bodies ought to be looked at by the regulator, and clause 165 provides that any foundation trusts wishing to merge must apply to the regulator under section 56 of the 2006 Act.

That prompts this straightforward question: which regulator? The 2006 Act does not specify which regulator foundation trusts are to look to. We heard last week that the OFT will look at some mergers and that Monitor will look at some mergers via, or in conjunction with, the Co-operation and Competition Panel. I would be grateful if the Minister could clear that up, because last week he clearly said that the threshold that will be applied—

Paul Burstow: Tuesday.

Owen Smith: The Minister is right, but it feels like a week ago.

The threshold that will be applied is that set out in the Enterprise Act 2002. The Minister told us for the first time that the cut-off at which the OFT, rather than Monitor, will be employed to review a merger is where turnover is more than £70 million or where more than 25% of the market would be supplied.

The Minister also said that mergers between foundation trusts would always be looked at by Monitor. Having already been asked which regulator is meant in section 56 of the 2006 Act, the Minister also said that FT to FT mergers would be subject to Monitor. Is it not right, however, that the Co-operation and Competition Panel will look at NHS trust to FT mergers in future? I think that is the case. FT to FT mergers will be the preserve of the OFT, but FT to non-FT NHS trust mergers will be the preserve of Monitor, which is what I understand to be the case from information from the CCP.

If that is the case, how can it be right that the £70 million turnover threshold applies, because that is the arbiter as to where it is the responsibility of Monitor or the OFT? Some NHS trusts, and certainly the FTs with whom they are potentially merging, will have a turnover of more than £70 million. I will be grateful if the Minister looks at that.

The Minister prompted me to go back and look at the Enterprise Act 2002, because he was absolutely right—I apologise—that it is in the Act, not in regulations, that the £70 million figure is cited; it appears in section 23. Section 28 of the 2002 Act refers to the turnover test. As I said on Tuesday, I am slightly surprised that the revenues expended by an NHS trust should be considered as turnover. That is peculiar, because turnover usually suggests a commercial entity, which of course is what is meant in the Act. The explanatory notes state:

“The test will apply to turnover in the UK, and will be set initially at £70 million, but this figure will be alterable by statutory instrument.”

I therefore presume that that has not been altered since the 2002 Act and that the figure of £70 million is still in place. The explanatory notes continue at point 119:

“The test will be determined by reference to the turnover of the enterprise being taken over”—

this is the good bit—

“(i.e. if the turnover of the target company exceeds £70 million, the merger qualifies for investigation).”

That underlines the point that we made about mergers on Tuesday. The application of that sort of language and legislation to mergers between NHS trusts makes it all the more likely that the courts will, subsequently to the Bill, interpret them as being increasingly commercial ventures and therefore subject to far more stringent review from competition law. I ask the Minister to comment on that again in the light of what I have just read out. Does he think that we are wholly wrong about it and that it is not possible that the courts may take a more hard-line view in future on whether NHS trusts engage in commercial or NHS activities?

On mergers, the Minister said that

“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.”—[Official Report, Health and Social Care (Re-committed) Public Bill Committee, 12 July 2011; c. 456.]

That again prompts a key question that my right hon. Friend the Member for Rother Valley raised on Tuesday. What on earth is the expertise that the OFT has to engage in commercial or NHS activities?

10.25 am

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

Adjourned till this day at One o'clock.