

PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT

First Delegated Legislation Committee

DRAFT NATIONAL HEALTH SERVICE (LICENSING AND PRICING) (AMENDMENT) REGULATIONS 2015

Monday 30 November 2015

PUBLISHED BY AUTHORITY OF THE HOUSE OF COMMONS
LONDON – THE STATIONERY OFFICE LIMITED

£5.00

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

Friday 4 December 2015

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 2015

*This publication may be reproduced under the terms of the Open Parliament licence,
which is published at www.parliament.uk/site-information/copyright/.*

The Committee consisted of the following Members:

Chair: Ms KAREN BUCK

- | | |
|--|---|
| † Afriyie, Adam (<i>Windsor</i>) (Con) | † Mak, Mr Alan (<i>Havant</i>) (Con) |
| † Ansell, Caroline (<i>Eastbourne</i>) (Con) | † Malthouse, Kit (<i>North West Hampshire</i>) (Con) |
| † Cox, Jo (<i>Batley and Spen</i>) (Lab) | † Morris, James (<i>Halesowen and Rowley Regis</i>) (Con) |
| † Fitzpatrick, Jim (<i>Poplar and Limehouse</i>) (Lab) | † Neill, Robert (<i>Bromley and Chislehurst</i>) (Con) |
| † Foxcroft, Vicky (<i>Lewisham, Deptford</i>) (Lab) | † Parish, Neil (<i>Tiverton and Honiton</i>) (Con) |
| † Gummer, Ben (<i>Parliamentary Under-Secretary of State for Health</i>) | † Smyth, Karin (<i>Bristol South</i>) (Lab) |
| † Kirby, Simon (<i>Brighton, Kemptown</i>) (Con) | † Zahawi, Nadhim (<i>Stratford-on-Avon</i>) (Con) |
| † Leslie, Chris (<i>Nottingham East</i>) (Lab/Co-op) | Ben Williams, <i>Committee Clerk</i> |
| † Madders, Justin (<i>Ellesmere Port and Neston</i>) (Lab) | † attended the Committee |

First Delegated Legislation Committee

Monday 30 November 2015

[MS KAREN BUCK *in the Chair*]

Draft National Health Service (Licensing and Pricing) (Amendment) Regulations 2015

4.30 pm

The Parliamentary Under-Secretary of State for Health (Ben Gummer): I beg to move,

That the Committee has considered the draft National Health Service (Licensing and Pricing) (Amendment) Regulations 2015.

I will outline the Government's case to the Committee. Despite the significant pressure on the public finances as a consequence of the deficit, the Government have protected the national health service in real terms. As the Chancellor announced in the spending review last week, we will ensure that the NHS receives an additional £10 billion a year above inflation by 2020-21, with £6 billion front-loaded in the first two years of the six-year period. The settlement is a good one for the front-line NHS given the wider pressures on public spending, and it has been welcomed by NHS England and NHS providers.

The settlement is also a key part of our wider commitments for the system: to realise the NHS's ambitions, as set out in the five-year forward view and by Simon Stevens, the chief executive of NHS England; to ensure that the NHS has a sustainable, long-term future; and for patients to continue to have access to high-quality care free at the point of delivery. Such a plan should have buy-in throughout the House.

As hon. Members are aware and will, I am sure, collectively agree, the NHS faces multiple and unprecedented challenges, which illustrate the urgency of delivering on the five-year forward view. That is the NHS's own vision for its future, which we supported in the spending review. The vision includes understanding that an ageing population, many of whom have complex conditions, requires changes to how services are configured and delivered; that despite the Government's additional investment, resources are ultimately finite; and that the rapid pace of innovation in medicines, medical technologies and technologies more generally challenges how we deliver healthcare, whether to individuals or to communities.

The pressure of the changes can be seen in the number of patients being seen and treated in our hospitals and in the position of the finances in the acute sector. That is why we have made and will continue to make the necessary investment in the NHS. More broadly, such factors make it imperative that our health service does all it can to move to better, more sustainable ways of working as soon as possible. Changes to the way in which services are configured and delivered mean that in future much greater collaboration and integration will be required.

I will provide some background to the draft regulations. The Health and Social Care Act 2012 introduced a new, independent, transparent and fair pricing system, which

requires Monitor and NHS England to collaborate to set prices and to develop further new payment models across different services. The intention was to create a more stable and predictable environment, allowing providers and commissioners to invest in technology and innovative service models to improve patient care.

Monitor has a specific duty to promote healthcare services that are efficient and effective and to maintain and improve quality. It achieves that by working with NHS England to regulate prices and to establish rules for local pricing and flexibilities. NHS England defines the units of service for which prices or rules will be specified. At all stages Monitor and NHS England have to agree elements of the tariff with each other.

The Act also includes a statutory basis for providers and commissioners to express formal objections to the methodology that Monitor proposes for calculating national prices, rather than to the price itself. Following comprehensive engagement with commissioners and providers, Monitor is required to publish a final draft of the national tariff and to allow 28 days for commissioners and providers to consider the proposals. Commissioners and providers may object formally to the proposed methodology for calculating national tariff prices for specified services.

Following the consultation, under existing rules Monitor calculates the percentage of commissioners objecting, the percentage of providers objecting and the percentage share of supply held by the objecting providers, which allows the objections of providers to be weighted proportionately to the nationally priced services. I hope that is clear. Each threshold is set at 51%. If any of those thresholds is met, Monitor cannot publish the national tariff and has either to put forward alternative proposals and publish them for consultation or refer the method and the objections received to the Competition and Markets Authority.

Let me explain how that process has worked in practice to date. Two tariff processes have taken place under the new arrangements, in 2014-15 and this year, 2015-16. No objection threshold was met when the first proposed national tariff was consulted on in 2014-15, and the tariff was published on time. For 2015-16, the objection tariff mechanism was triggered—the share of supply objection threshold was met, as 73.7% of providers by share of supply objected. As a result, the unexpired 2014-15 tariff remained in place, at a considerable cost to the health service and, ultimately, the taxpayer.

NHS England estimated that the system, and ultimately taxpayers, would face a significant cost pressure by continuing to pay 2014-15 tariff prices in future. The NHS cannot afford a repeat process of 2015-16 unless exceptional circumstances arise, because having the process subject to ongoing delays to resolve the pricing mechanisms for anything less would cause a significant level of instability, at a time when the NHS is trying to focus its energy on developing new, sustainable methods and models of care.

A criticism of the current payment mechanism has been that it acts as a barrier to delivering new care models—this is essentially the point of this debate—and especially out-of-hospital care models. Continuing to pay 2014-15 tariff prices would reinforce those barriers, so there would be less to invest in community services,

in improving access to mental health services, in primary care or in supporting seven-day services across the entire NHS.

The reality of the tariff-setting process is that a finite amount of money is available, which has to be allocated fairly across the system, even with the very considerable increase in funding that we proposed for next year of some £6 billion. It has to be allocated in a way that is most likely to benefit patients and to support the change to new models of care, which the NHS five-year forward view envisages. Monitor and NHS England need to be able to agree and publish a tariff in a timely manner to give the NHS the stability it needs to implement the five-year forward view.

The objection mechanism is intended to be triggered in exceptional circumstances. When the thresholds were prescribed in 2013, it was made clear publicly in the explanatory memorandum to the original regulations that the thresholds would be kept under review, given that there was no precedent from other sectors for what an appropriate threshold should be. Allowing providers to have their objection weighted according to their share of supply has allowed larger providers to use the objection threshold as a veto to protest if and when they disagree with a particular aspect of the method, or to changes to the pricing system outside the method. Therefore, in order to avoid future potential for disruption and consequential costs to the taxpayer and the system, and to ensure that as much resource reaches the front line as possible, the objection thresholds and share of supply have been revisited to provide a process that is as fair and stable as possible for all NHS providers and commissioners.

We consulted on a range of proposals to change the objection thresholds, including the option of removing the share of supply threshold and increasing the objection percentages for clinical commissioning groups and relevant providers of NHS care services, either to 66% or to 75%. The Department received a total of 221 responses to the consultation from a range of stakeholders. That is a positive response rate, and we thank all those who took the time to contribute to that complicated consultation. We are not deaf to the concerns raised by stakeholders, which is why the package of measures set out in the spending review seeks to address some of the issues that have been raised.

Some 46% of respondents to our consultation, including many commissioners and mental health providers, agreed with our proposal that the objection mechanism should be revised to provide greater clarity to the system ahead of the coming financial year. However, 52% of respondents opposed the proposal. The majority of those were providers, who gave 123 responses. They felt that the process worked as intended and that it was too early to make any changes. Respondents believed that the current system had not existed long enough to enable proper evaluation and assessment. There were also calls for deeper and more timely engagement and transparency on tariff proposals.

The tariff development process is still evolving. Monitor and NHS England continually evaluate how to improve their processes, including engagement, and will include this process in that evaluation going forward. We also welcome the recent proposals from NHS providers on improving the process and look forward to continuing the dialogue.

We considered in detail all responses to the consultation. However, as I outlined, our main concern must be to address the financial health and future sustainability of the overall system and to ensure that the collective system focus is on delivering the vision and the new models of care set out in the five-year forward view. That will require the NHS to shift its perspective from managing organisation-based issues to an approach based on system management—for example, through implementing new models of care that provide properly integrated services for patients.

This is about funding patient care rather than building systems and institutions. As such, our focus must be on securing a tariff settlement for 2016-17 that is fair, that supports the development of new, sustainable models of care, and that is achieved in enough time to be effectual for the coming year. NHS England has indicated that a repeat of the 2015-16 process could have a negative impact on planned investment in areas such as mental health and community services, which would have serious implications for the health service as a whole. That is not acceptable to the Government, and we will not allow it for either patients or the taxpayer, who is funding these considerably increased resources for the NHS. We will keep under review the need for any further changes to ensure that the system operates optimally in patients' interests.

The regulations will remove the share of supply threshold and increase the objection thresholds for providers and commissioners from 51% to 66%. We believe that removing the share of supply threshold creates a fair balance in the system as a whole, while still allowing for objections to be heard. All providers of NHS services will continue to play a crucial role in the tariff development process. Furthermore, the changes made through the regulations will create the stability that is necessary for the tariff-setting process, while retaining a comprehensive development mechanism that will allow for prices to be set in a fair, transparent and consistent way, taking into account the views of all providers.

In summary, the intention behind the objection mechanism was that the threshold should be high enough to prevent any unnecessary delay to the tariff caused by objections that were not sufficiently representative, but low enough to highlight systematic issues with the method, rather than issues with the prices themselves. We now consider that the objection percentage for providers and commissioners should be higher but remain consistent for commissioners and providers in the interest of fairness. The regulations will retain the ability of commissioners and providers to object to the proposed method during the statutory consultation, while requiring levels of objection to be more significant to prevent Monitor from publishing the national tariff. That means that the national tariff can be published early enough to give all stakeholders the certainty needed to make the necessary planning changes locally.

I acknowledge and appreciate the strong opposition to these changes from some providers. However, we believe that changes are necessary to avoid further significant disruption to financial planning in the NHS. The regulations, along with the generous spending review settlement, will create stability for the system as a whole, so that the NHS can channel its energy into delivering the five-year forward view. Money spent on resolving disagreements on the tariff is money taken

[Ben Gummer]

away from patient care. That cannot be right, and I hope all hon. Members will support us in making what we feel are necessary changes. I commend the regulations to the Committee.

4.44 pm

Justin Madders (Ellesmere Port and Neston) (Lab): The Opposition are deeply concerned about the regulations, and we hope the Government will consider their position as a matter of urgency. There are four principal reasons for our concerns, which I will outline before going into more detail about the regulations. I will welcome any responses the Minister can give.

The first area of concern is the removal of the share of supply percentage as part of the objection mechanism, which will create an imbalance. It will, for example, give a large NHS teaching hospital with a turnover of more than £1 billion the same voting weight as a private minor injuries unit with a turnover of just £150,000.

Secondly, the regulations effectively disband the tariff objection mechanism entirely, as it would be mathematically impossible to trigger the mechanism even if every NHS trust and foundation trust objected. Every NHS trust and foundation trust taken together would constitute 62% of providers, but the regulations establish a 66% threshold to trigger the objection mechanism.

Thirdly, the regulations effectively silence those on the NHS frontline in tariff setting. Setting the tariff without an effective mechanism for those delivering patient care to object could constitute a risk to patient safety and care quality.

Finally, the regulations directly contradict assurances given by Earl Howe on behalf of the Government during the passage of the Health and Social Care Act, when he said:

“I am clear that we must have a process for adjudicating on Monitor’s proposals if a sufficient number of those who will be affected by them object; otherwise, in these circumstances, either Monitor would have no way of proceeding with disputed proposals or those affected would have no other way of disputing proposals other than by judicial review.”—[*Official Report, House of Lords*, 6 March 2012; Vol. 735, c. 1740.]

In addition to those four major areas of concern, I have heard nothing of substance from the Minister today to suggest that anything is wrong with the objection mechanism as it stands. The Minister said the mechanism inhibits new models of care, but I am afraid he did not set out why. The Department of Health certainly did not put that forward as a justification in its consultation document. It actually said that the current system allows a

“relatively small number of large trusts”

to disrupt NHS planning, but that is simply not borne out by the facts. The last objection—indeed, the only objection—was made by 37% of all providers, which is, granted, not a majority, but which is still a reasonable amount. However, when we consider that, between them, those providers carry out about 75% of all NHS work, it is clear that this is not a fringe group seeking to disrupt things for the majority and that those involved do a significant proportion of all NHS work. That 37%—or 75%, depending on which way we want to count it—actually had a point, because the Government

changed their plans as a result of the objections that were made. We therefore question whether it is embarrassment rather than effectiveness that is driving these proposals.

Let us take a moment to consider the current system and whether there really is a fundamental problem that needs to be fixed. The national tariff is the payment system for the majority of secondary care in England, and it covers £72 billion of the overall £116 billion NHS budget. It therefore affects all acute hospital, ambulance, community and mental health NHS providers and the care they can deliver.

The tariff is set annually by NHS England and the health sector regulator Monitor. To date, the objection mechanism has been a vital safeguard in the national tariff. It allows NHS providers and commissioners to formally lodge objections to the methodology used to develop the tariff.

The methodology is based on historic service costs, inflation and required efficiency savings. If 51% of commissioners or providers, either individually or based on the proportion of services they provide, object to the proposed tariff, the objection mechanism is triggered. That is not a low bar, and a significant amount of concern must exist across the sector for the mechanism to be used. It is designed not to be triggered regularly by a minority, and, indeed, it has not been. Rather, it is a patient safety alarm, reserved for use when providers and/or commissioners feel that the proposed tariff prices will not allow them to deliver safe and high-quality NHS services. It is clear from what we have heard today that, when it is used, it actually works.

In 2014-15, the mechanism was triggered for the first time, with 75% of providers, calculated by share of supply, objecting. Their reasons were substantial, and the decision to object was taken reluctantly. As the Minister said, the objection is to be used in exceptional circumstances only, so it is worth looking at the circumstances of that objection to understand why it was exceptional.

The basis for the objection was an unrealistic efficiency requirement for the fifth year in a row, making it impossible for providers to cover their costs, as well as changes to the way specialised services were paid for, significantly reducing essential funding for the care of some of the most vulnerable patients, such as those suffering from cancer. That would have introduced a marginal rate for specialised services, whereby providers would have been paid just 50% of the tariff price for services that exceeded their own projections of patient demand. Such projections are not a perfect science, in particular as conditions that require specialised treatment proliferate as our population grows and ages. It simply would not be safe or sustainable for providers to agree to carry out some of the most complex and cutting-edge treatment in the NHS at half the agreed cost. The proposals also sought the continuation of a punitive lower rate for emergency admissions, which effectively penalises hospitals for admitting patients in accident and emergency despite such demand increasing.

The objection allowed NHS England and Monitor to go back to the drawing board and return with a solution: they moved £500 million over to providers from the commissioning side, increased the marginal rate for specialised services to 70% and allowed providers the option of remaining on the previous year’s tariff. NHS Providers, the association of NHS trusts and foundation

trusts, highlights that the commission now forecasts a budget surplus of £500 million this year and providers project a deficit of £2 billion to £2.5 billion. The mechanism was triggered responsibly and produced a better overall outcome for the NHS. Will the Minister therefore explain the rationale for changing the law to make the important elements of the tariff objection process effectively redundant, when this year's experience shows that the process enabled a better outcome for the NHS and patients alike?

I will turn to the regulations, which, in a nutshell, we consider to be unbalanced, risky and rushed. They simultaneously remove the providers' ability to object on a weighted or share of supply basis, and raise the threshold for triggering the objection mechanism to 66%. That has two effects. First, it gives every licence provider the same say over the tariff. Non-NHS providers who deliver just 4% of NHS tariff services will, in the future, have as much influence over how the NHS tariff develops as NHS trusts and foundation trusts even though they provide just a fraction of those services. What is the Minister's rationale for not distinguishing between the NHS public providers for whom the national tariff is a matter of fundamental importance and non-NHS providers for whom it is of peripheral relevance?

Secondly, the regulations increase the trigger threshold from 51% to 66%. That, along with the ability of providers to vote for share of supply being removed, will mean that even if all NHS trusts and foundation trusts object to a proposed tariff, they would account for only 62% of all providers. That is the 62% of providers who deliver 96% of all services under the NHS, so 96% of all NHS services could effectively be denied a voice and a transparent mechanism of opposition.

By removing the weighted vote from NHS trusts and foundation trusts, I do not think it is possible to suggest that the intent behind these regulations can be anything other than to remove the objection mechanism in all but name. I therefore ask the Minister why the Government who introduced the 2012 Act recognised that it was fair to give providers the right to object to the tariff and a greater voice to those providing the most tariff services, but this Government take a different view?

That the NHS is under an unprecedented period of financial pressure is beyond dispute, even with the additional funds announced in the comprehensive spending review for NHS England's budget next year. We know that 80% of all providers are currently in deficit, with a provider sector deficit of about £2.2 billion by the end of the year looking likely. It is therefore not the time to seek to stop providers from being able to raise concerns about unviable tariff prices. The stakes we are dealing with are too high and the risks to patient care and safety are real.

As I set out earlier, if the objection mechanism had not been triggered last year, the providers' finances would be in an even more parlous state than they are now. In the light of those risks, it is vital that we understand in full the potential impact of the regulations. It seems irresponsible that the regulations have been laid so rapidly, without an impact assessment having been prepared.

The Lords Secondary Legislation Scrutiny Committee noted that the consultation on these regulations, which relate to a highly complex area of NHS policy, ran for just 29 days, from 13 August to 11 September. The Department suggested to that Committee that such a

short window of time during a summer holiday period was appropriate because it had forewarned informed bodies. However, that is not an appropriate basis on which to conduct proper, meaningful and transparent consultation and I hope that the Minister will acknowledge that.

The consultation is all the more extraordinary because not only was it done at a time of year when people are not traditionally about, but the Department has completely ignored its responses. The 221 commissioners and providers that were able to respond in the consultation timeframe delivered a pretty unambiguous verdict: 82% of respondents stated that the objection threshold should not be raised from 51%, and just shy of two thirds—65%—disagreed that the weighted vote of providers should be removed. Another point that came out of the consultation, as the Minister highlighted, was that it is too soon to evaluate properly the effectiveness of the current system. Will he explain in his closing comments why he has shown complete disregard for the views of the bodies responsible for planning and delivering NHS services? What level of response would be needed for a different reaction—85%? Ninety per cent.?

If passed, the regulations will effectively make the statutory consultation process the sole means for providers and commissioners to raise concerns about any risk associated with the proposed tariff. Given the clear evidence that the Government have not been effective in their consultation on the matter, does the Minister agree that providers and commissioners have every right to be concerned that their views will not be heard through a consultation process alone in the future?

The Department has set a damaging precedent with the consultation on the regulations, and strong assurances must be offered on how the tariff consultation process will respect and respond to concerns expressed by those working at the NHS coalface. There was clearly a rationale for introducing the tariff objection system in the first place, and I struggle to see what has changed in the past few years to warrant this change, other than the system being seen to do what it was set up to.

Our fundamental concern is that the regulations appear to remove the ability of those providing services on the NHS frontline to raise an early warning signal that proposals will not be sustainable. We know that efficiency savings proposed in the five-year forward view are at best challenging, at worst impossible, and there will be a temptation to pile more and more of those savings through this system. Without an effective mechanism in place to force a pause in such proposals, there is a real risk to the safety and quality of patient care and the sustainability of local health economies. In the words of the House of Lords Secondary Legislation Scrutiny Committee:

"The opposing views of the Department and the major Providers are a significant cause for concern and raise the question whether these Regulations may imperfectly achieve their policy objective."

For that reason and the others I have set out, the Opposition strongly believe that the regulations are unbalanced, risky, rushed and should not be passed.

4.57 pm

Ben Gummer: I thank the shadow Minister for taking the care—I mean this in all sincerity—to look at a complicated area of health economics and for providing me with so many questions and challenges; he is right to

[Ben Gummer]

do so. It is good for the House that we are considering the regulations in such detail, because the mechanism by which the tariff operates lies at the heart of how the NHS has worked not only since the 2012 Act but for several decades, under different Administrations.

I will provide a quick gloss for why the tariff is a difficult mechanism to get a perfect line on at any one time. It is, by its nature, a complicated beast, encompassing a huge number of procedures. Having to set a price is a function of the NHS, which is effectively a monopoly purchaser. The tariff is not the product of a whim of Monitor. Monitor does not sit down one day and say, "I believe the tariff for a cardiac procedure should be x, and for a knee joint procedure it should be y," although I know the shadow Minister is not suggesting that to be the case. The tariff goes through a rigorous costing process to try to understand what advances in efficiency and medical technology can be brought to bear and how the costs of different procedures have gone down, remained the same or increased. At the termination of that process, which involves clinicians all the way through and a whole gamut of health economists, the tariff is put to providers across the country.

There is a balance that we have to strike as a Government. It was acknowledged in the passage of the 2012 Act—which I remember, though mercifully I was not on the Public Bill Committee that scrutinised it—that the changes would need to be finessed over time. That was the nature of the reforms to the health economy that were proposed and then passed by Parliament. The initial thresholds of 51% were not drawn scientifically, but on the basis of probing Ministers and Parliament and on the understanding that they would have to be reviewed in future. It is important that we get the balance between the tariff setting and the tariff challenge absolutely correct.

The situation that we have found ourselves in, as the hon. Gentleman said, is that a proportion of providers that do not represent in totality a significant number—a proportionate majority—can challenge the tariff successfully if it is not in their interest. It is our judgment that at the moment we are not correctly balancing the ability to challenge and the threshold at which we find that ability to challenge, and the interests of commissioners who are acting on behalf of patients and of taxpayers.

We consulted on three different thresholds, including a continuation of 51% and a higher threshold of 75%. We took a slightly different view from the hon. Gentleman of the outcome of the consultation. He mentioned some figures, but I merely repeat that 46% of respondents to the consultation, many of whom were commissioners and mental health providers, agreed that the tariff needed to be changed. Those who opposed a change to the tariff were, not surprisingly, providers. That is their right and it is not surprising in many instances that they chose to do so. One should question, however, whether it is right that 37% of providers by number—even if they make up a larger proportion by revenue—have the ability to challenge the tariff set by Monitor in its extensive process and consultation. That tariff also has to be used by commissioners on behalf of patients.

There are two effects. The first is to delay the implementation of the tariff at all, which creates massive financial uncertainty in the system. I am conscious that,

with time, with the 51% threshold and given the number of providers able to reach the bar, that that would become a constant. Financial planning in the NHS would therefore become less about planning and more about responding to challenge after challenge. Secondly, and perhaps more importantly for why we need to look at things again, we have to balance the interests not only of providers by number and revenue throughout the entire sector, but of commissioners, the people buying care on behalf of local people. In order to buy that care, the commissioners are using a significant part of the revenue raised in taxes.

Members of all parties understand that achieving the move that we all want to a care system based on primary care, strong community services, full integration with social care and increasing resource committed to mental health services is about addressing the balance between providers and others modes of care rather more subtly that has been done in the past. I think we agree on that.

The question is how we go about that. That process will bring some challenges to some providers, who will have to do things more efficiently and differently. That is in the nature of creating a more productive NHS. It is precisely the kind of productivity challenge that Simon Stevens indicated in his five-year forward view.

Our contention is that we have to create a realistic objection threshold that can be met if there is overwhelming response to a tariff in one particular area that is unfair, but that, on the other hand, does not create a continued roadblock because a proportion, even a smaller proportion within the NHS as a whole, continues to hold up tariff changes—the tariffs discovered scientifically by Monitor.

Jim Fitzpatrick (Poplar and Limehouse) (Lab): The Minister is being generous and patient in the way in which he is trying to explain this to the rest of the Committee, because we are not all quite as well briefed as my hon. Friend the Member for Ellesmere Port and Neston. However, the Minister seems to be saying—he will forgive me if I have got this wrong—that we have moved to 66% because there was an agreement, or an understanding, that 51% was basically a finger in the air, and we would have to adjust it at some point in the future. The Minister wants to remove what he sees as a veto by providers, whereas my hon. Friend says that if all the providers got together, they would never reach the 66%. So what is the gap between the two?

Ben Gummer: That is not entirely the gloss I would give to my comments.

There is no veto to all providers, because we are talking about 66% of providers in total meeting the objection threshold. This means that one particular bloc in the healthcare system as a whole that uses the tariff—it is not just used by NHS providers—will not be able to block the proposed tariff. Currently a smaller proportion of NHS providers—it is not even the full number—can block the tariff. It is not a scientific process, but in trying to balance the interests of commissioners and a healthy provider sector, which incidentally we will fund considerably more in years to come, we feel it is not right to give an objection threshold of 51%, and that we need to show a more significant number. That is why 66% of all providers would have to meet the objection threshold.

I would not like to speak for Earl Howe, who I know spent many hours explaining this matter and going through it in detail during the passage of the 2012 Act, but I think it was understood at the time—this was why the Bill developed as it did during its gestation—that, as with any health economy, the regulations would need to be finessed as issues emerged. To be blunt, we are at a time when NHS spending has gone up over the past few years, although it has been under significant pressure, as the hon. Member for Ellesmere Port and Neston said, because of changing demographics, and the way in which the tariff system and the changes made in the 2012 Act have enabled the tariff and the whole health economy to operate has allowed us to manage funds in an efficient manner.

I am conscious that others may want to speak, so I want to cover some of the other issues that the hon. Gentleman raised. He mentioned patient safety. I hope that I can place the issue in the larger context of all our reforms around the Care Quality Commission, introducing a simple grading system that gives complete transparency, and our additional funding to the commission over the past five years. By everyone's estimation, the commission has improved its performance significantly, although we all want to it to improve still further.

We believe that patient safety is ensured by a raft of measures, not just by increasing NHS funding, but by increasing transparency on outcomes, by better regulation and inspection, and by giving a voice to NHS workers—giving them freedom to speak out through the whistleblowing champions that we have introduced and the efforts we are making to bring in a learning culture in the NHS. We are making those efforts in order to develop an NHS that learns from mistakes, can point out and shout about failures in patient safety, and can improve patient care in an iterative process.

That cannot, and can never be, about just pumping money in at one end and expecting to get improved care out at the other. We know that increased resources are one component, but to characterise tariff as a patient safety alarm is itself a little alarmist. It is one part of a health economy. As I explained, it is set by clinicians and economists, and the whole architecture that the Government have tried to reinforce and in parts introduce is there to underpin patient safety in the round. This is merely one component of that.

The hon. Gentleman raised specialised services. He could also have raised the issue of emergency admittances. Both those things are being looked at in the current tariff proposals. I understand the concerns that he raised, and I know that officials and Monitor will have heard them.

I must finally address the consultation process itself. I am not sure that the hon. Gentleman's characterisation is fair on this. The consultation lasted a month. I do not think we can count a Spanish summer as happening in the NHS in the way he might suggest, as if everyone had vanished and was unable to respond. We received a significant number of responses. Given the fact that there are roughly 147 NHS acute trusts and a significantly larger number of commissioners—we are not talking about thousands, however—receiving 221 responses is good. They were full responses and I was completely open about their nature and the fact that, frankly, they were split, if not 50:50, about as close to 50:50 as a public consultation gets, on the quality of the Government's

proposals. The Lords sits in the summer months in a way that the House of Commons does not when we are back in our constituencies, but the 20-day scrutiny period is significant, and their lordships will have looked over it with due care and attention.

I understand the hon. Gentleman's concerns about the nature of the changes, and it is understandable that he wishes to raise them. In part, they are the objections of some providers, and I am glad that he has brought them to the Committee's attention, but I hope that, after this discussion, he understands that the regulations are part of a larger balance between different parts of the NHS to ensure that the additional money that we are putting into the NHS—the NHS budget will exceed half a trillion pounds over the course of this Parliament—goes towards reforming the system, new models of care and the primary, social, community and mental healthcare that all our constituents want improved on the ground. This tariff reform will help the process by ensuring that a bloc of providers cannot obstruct that change without significant enough numbers.

Justin Madders: I am grateful to the Minister for his gracious comments at the start of his speech. Does he accept that, under the regulations, if all NHS providers objected, they still would not reach the objection threshold? Can he explain why NHS providers are being put on an equal footing with non-NHS providers?

Ben Gummer: I hope the hon. Gentleman understands that the tariff, because it is a set price across the entire sector, has to treat every provider with equality. We cannot have a tariff of one price that accounts for one provider differently from another. All providers operate under the same tariff system, which means that no single bloc in the NHS or the healthcare system can obstruct tariff reform.

In summary, I hope that the Committee understands why these changes are necessary. They have been consulted upon in full, which is why I continue to commend these regulations to the House.

Question put,

The Committee divided: Ayes 9, Noes 6.

Division No. 1]

AYES

Afriyie, Adam	Malthouse, Kit
Ansell, Caroline	Morris, James
Gummer, Ben	Neill, Robert
Kirby, Simon	Parish, Neil
Mak, Mr Alan	

NOES

Cox, Jo	Leslie, Chris
Fitzpatrick, Jim	Madders, Justin
Foxcroft, Vicky	Smyth, Karin

Question accordingly agreed to.

Resolved,

That the Committee has considered the draft National Health Service (Licensing and Pricing) (Amendment) Regulations 2015.

5.14 pm

Committee rose.

