HOUSE OF LORDS
Library Note

# Health and Social Care Bill (HL Bill 92 of 2010–12)

This Library Note provides information on the Health and Social Care Bill which is due for second reading in the House of Lords on 11 October 2011. It summarises proceedings at the Bill's final stages in the Commons. The Note is intended to be read in conjunction with the House of Commons Library Research Papers *Health and Social Care Bill* (27 January 2011, RP11-11), *Health and Social Care Bill: Committee Stage Report* (6 April 2011, RP11-31) and *Health and Social Care (Re-committed) Bill: the NHS Future Forum and the Committee Stage Report* (30 August 2011, RP11-63), which provide background information and summarise proceedings in the Commons at second reading and committee stage.

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## 1. Introduction

The Health and Social Care Bill was introduced in the House of Commons on 19 January 2011. It received its second reading on 31 January 2011. Opening the debate, Andrew Lansley, the Secretary of State for Health, told the House of Commons that the purpose of the Bill could be expressed in one sentence: "to improve the health of the people of this country and the health of the poorest fastest" (HC *Hansard*, 31 January 2011, col 605). He said that while the previous Government increased funding for the National Health Service to the European average, it did not increase the quality of care:

> We spent more, but others spent better. In important areas, the NHS performs poorly compared with other countries. An expert study found that out of 19 OECD countries that were investigated, the UK had the fourth-worst death rate from conditions that are considered amenable to health care. If NHS outcomes were as good as the EU15 average, we would save 5,000 lives from cancer and 4,000 lives from stroke every year. We would also prevent 3,000 premature deaths from respiratory disease and 1,000 premature deaths from liver disease every year. This cannot go on: things have to change to protect the NHS and deliver better results for patients.
>
> (ibid, col 605)

The Bill aims "to change how NHS care is commissioned through the greater involvement of clinicians and a new NHS Commissioning Board; to improve accountability and patient voice; to give NHS providers new freedoms to improve quality of care; and to establish a provider regulator to promote efficiency. In addition, the Bill will underpin the creation of Public Health England, and take forward measures to reform health public bodies" (HL Bill 92–EN, Para 6).

The Bill's passage through the House of Commons was contentious. On 4 April 2011, following its Commons committee stage, Andrew Lansley made a statement in which he said he recognised there were concerns about some of the Bill's proposals. He informed the House:

> Our desire is to move forward with the support of doctors, nurses and others who work in the NHS and make a difference to the lives of so many of us, day in and day out. However, we recognise that the speed of progress has brought with it some substantive concerns, expressed in various quarters. Some of those concerns are misplaced or based on misrepresentations, but we recognise that some of them are genuine. We want to continue to listen to, engage with and learn from experts, patients and front-line staff within the NHS and beyond and to respond accordingly. I can therefore tell the House that we propose to take the opportunity of a natural break in the passage of the Bill to pause, listen and engage with all those who want the NHS to succeed, and subsequently to bring forward amendments to improve the plans further in the normal way.
>
> (HC *Hansard*, 4 April 2011, col 767)

On 6 April 2011 the Department of Health launched the NHS Future Forum, chaired by Professor Steve Field. On 21 June 2011, following publication of the Forum's report on 13 June 2011, the Commons agreed a motion re-committing specified clauses of the Bill to a Public Bill Committee. The Committee considered the Bill between 28 June and 14 July 2011 and agreed a number of Government amendments introduced in response to the recommendations of the NHS Future Forum. During two days of report stage, a number of amendments were debated in the House of Commons. There were several

divisions and a number of new clauses and amendments were agreed and added to the Bill (see Box 1 for the new clauses in the Bill). The Bill was then passed at third reading.

Since the completion of the Bill's passage through the House of Commons the Bill has been subject to further scrutiny, particularly at the main political parties' conferences. More broadly, commentators in the media have debated the Bill. Online, interest has been reflected in blogs. Twitter has been used to disseminate the case for and against the Bill and also embraced as a means of organising support and opposition for its forthcoming passage through the Lords. Ahead of the Bill's second reading in the Lords, the *Daily Telegraph* published a letter on 4 October 2011 signed by 400 public health specialists opposed to the Bill. The letter urged the House of Lords to reject the Bill (*Daily Telegraph*, 'Health Bill concerns; Letters to the Editor', 4 October 2011). It was also reported that Lord Owen and Lord Hennessy of Nympsfield have written to Crossbench Peers proposing an amendment that would refer parts of the Health and Social Care Bill to a Select Committee (*Independent*, 'David Cameron defends coalition NHS reforms', 4 October 2011).

The Bill is divided into two volumes. Volume I contains the clauses. Volume II contains the schedules to the Bill. As introduced to the House of Commons, the Bill contained 353 pages, made up of 281 clauses and 20 schedules. The Bill introduced to the House of Lords on 8 September 2011 now amounts to 445 pages, made up of 303 clauses and 24 schedules.

The House of Commons Library has produced three papers covering the background to the Bill and its passage through the Commons up to and including both committee stages: *Health and Social Care Bill* (27 January 2011, RP11-11), *Health and Social Care Bill: Committee Stage Report* (6 April 2011, RP11-31) and *Health and Social Care (Re-committed) Bill: the NHS Future Forum and the Committee Stage Report* (30 August 2011, RP11-63). This Note provides details of the debates on the Bill during report and third reading in the House of Commons. These are described in the sections below. In addition, the House of Lords Constitution Select Committee has examined the Bill. In its report, *Health and Social Care Bill* (30 September 2011, HL Paper 197) the Committee expressed concern about the Bill's implications for the Government's constitutional responsibilities with regard to the NHS.

The transcripts of the debates on the Bill so far, including those that took place on the first day of report stage on 6 September 2011 and on the second day of report stage (and third reading) on 7 September 2011 can be found through the Bill's page on the Parliament website. The Bill as introduced in the Lords and accompanying Explanatory Notes may also be found via the Bill's page: HL Bill 92 of 2010–12 and HL Bill 92—EN.

**Box 1: New clauses in the Bill added at report stage in the Commons**
(original Commons 'NC' number in brackets)

Clause 57 (1), Clause 97 (2), Clauses 110–112 (3–5), Clause 172 (6), Clause 257 (7), Clause 296 (8) and Clause 301 (9)

Details about each new clause can be found in Department of Health paper, *Briefing notes on Government amendments to the Health and Social Care Bill: Report stage (Commons)* (September 2011).

## 2. Report Stage Programme Motion

Introducing the Bill's programme motion, Simon Burns, Minister of State at the Department of Health, told the House of Commons that the Bill had "received extensive scrutiny in two House of Commons Committee stages". He then explained why the Government had decided to schedule two days for the Bill's report stage and third reading:

> Our first Committee stage, in February and March this year, lasted 28 sittings. It was the longest Committee stage of any Bill since the Criminal Justice Bill of 2002-03… Following a listening exercise and the work of the Future Forum, the Bill was re-committed to a further Committee stage of 12 sittings. If that had been a stand-alone Committee stage, it would have been the longest for any Bill sponsored by the Department of Health since 2003. All that means that the Bill has been scrutinised for a total of over 100 hours, and has been the subject of 40 Committee sittings—more sittings than there has been for any public Bill between 1997 to 2010. I will dwell on that point for a moment, and remind hon. Members of recent Health Bills that predate this Government.
>
> The Health Act 2009 was scrutinised over eight sittings, as was the Human Fertilisation and Embryology Act 2008. The Bill Committee for the Health and Social Care Act 2008, which among other provisions set up the Care Quality Commission, sat for 12 sittings, a number matched by the Health Act 2006. As the keener mathematicians among us might have realised, the total number of Commons Committee sittings for these four Bills was 40—the same number as for this single Bill. In these 40 sittings we had a great number of debates where the issues were fully debated, sometimes more than once.
>
> (HC *Hansard*, 6 September 2011, col 178)

As a result, Mr Burns said, the Government "feel strongly that two days on report is a thoroughly appropriate length of time".

Liz Kendall, speaking for the Opposition, disagreed. She stated that her party would "oppose this programme motion because it fails to give hon. Members enough time to scrutinise one of the most important pieces of legislation of this Parliament and, indeed, of the 63 years of the NHS". She went on:

> It is one of the largest Bills of recent times and the largest ever in the history of the NHS, with 420 pages and more than 300 clauses. It is also one of the most controversial. It will force the NHS through a massive reorganisation, which is already happening even though the legislation has not been passed, when it should be focused on meeting the biggest financial challenge of its life and improving patient care. It also seeks to make fundamental changes to the way our NHS is run, driving competition into every part of the system whether or not it is in patients' best interests.
>
> (ibid, col 179)

Labour's Frank Dobson had criticised the Government for tabling over 1,000 amendments to the Bill (ibid, col 178). In response to the criticism, Simon Burns pointed out that 715 of the amendments were of a technical nature, replacing the name of one body that was repeated throughout the Bill. Liz Kendall followed up on this point, arguing

that the time available to MPs to scrutinise the remaining amendments was still inadequate:

> … three days before this debate, more than 1,000 new Government amendments were tabled, 363 of which are significant. They include a completely new set of proposals on whether local NHS services and, indeed, entire hospitals will be allowed to fail—proposals that could affect every constituency in England. It is a gross discourtesy to this House, not to mention to patients and NHS staff, to produce such important proposals and give such little time for scrutiny. I am sure that Members of the other place will take that into consideration in their deliberations on the Bill.
>
> (ibid, col 180)

The programme motion was agreed 299 votes to 232.

## 3. Report Stage (Day 1)

### 3.1 Monitor and the Continuation of Services

Report stage opened with debate on a number of Government amendments (new clauses 2 and 6 and amendments 90 to 107, 113 to 220 and 366 to 372) to Parts 3 and 4 of the Bill, which deal with the regulation of health and adult social care services, defining the role of the sector regulator Monitor and with the governance of NHS Foundation Trusts and NHS Trusts.

The briefing published ahead of the debate by the Department of Health explained the purpose of the amendments the Government had brought forward. To ensure continuity of access to NHS services:

- Commissioners would take the lead in securing continued access to NHS services overseen by the NHS Commissioning Board;
- Monitor would intervene proactively with the aim of supporting recovery and preventing providers becoming unsustainable, where possible;
- The previous Government's unsustainable provider regime for foundation trusts (FTs) established under the Health Act 2009, would be maintained but improved significantly;
- There would be a separate regime for companies that delivered essential NHS services, which would provide equivalent safeguards for patients and taxpayers; and
- The Secretary of State would retain a veto over proposals for securing access to NHS services in the event that a provider became unsustainable. Such a veto would be subject to certain criteria and would be expected to only be used in exceptional circumstances, primarily where either the proposals agreed by the NHS Commissioning Board and/or relevant clinical commissioning groups would fail to secure continued access to services or secure services of sufficient safety and quality or provide good value for money.

(Department of Health, *Briefing notes on Government amendments to the Health and Social Care Bill: Report stage (Commons)*, September 2011, p 3)

Opening the debate on these amendments Andrew Lansley reminded the House why the Government was developing the role of Monitor:

> The regulatory framework that we inherited from the previous Government simply did not do enough to protect patients. It lacked a way to protect patients' interests in relation to all types of provider. The previous Government set up two regulators—Monitor for foundation trusts and the Care Quality Commission—but forgot, or neglected, to create an explicit link between the two. They also left independent providers outside much of that regulatory oversight. We have proposed the development of Monitor as a health sector-specific regulator, establishing equivalent safeguards to protect patients' interests in relation to all types of provider.
>
> (HC *Hansard*, 6 September 2011, col 189)

Mr Lansley went on to explain the purpose of the group of amendments before the House:

> We have revised our plans for ensuring continuity of services with three principles in mind. The first is to protect patients' interests and improve outcomes; patients must be able to get the high-quality services they need. The second is to maintain local decision making and enhance democratic legitimacy; local authorities would have scrutiny of proposed service changes. The third is to deliver value for money. I am confident these revised proposals will deliver on those principles.
>
> (ibid, col 195)

He then described how the amendments improved the Bill:

> First, the Bill puts clinically led commissioning at the heart of securing high-quality services for local populations. It is therefore right that commissioners should have a leading role when continuing access to services is threatened. Our amendments therefore strengthen the role of commissioners. For the first time, commissioners will have an explicit role in working with Monitor to agree plans to secure continuity of services. There will also be an oversight role for the NHS commissioning board. Where issues involve more than one clinical commissioning group, it will be the board's role to co-ordinate agreement so that a joint plan is agreed.
>
> Secondly, commissioners will need to be supported in acting with providers to ensure that they have access to the scope, quality and choice of services they need. It is about promoting high-quality, effective and integrated services, as set out in clause 58. This will be the task of Monitor. If need be, when continued access to services is threatened because of failure occurring in a particular provider, Monitor will have a range of actions it can take. For example, it could take action to secure sustainability of essential services by adjusting prices. This would be necessary where a provider is otherwise unable to cover the costs of essential services—for example, because of lower patient volumes in more remote areas of the country. That was included in the Bill from the outset, and our amendments strengthen the provisions by ensuring that Monitor must agree the methodology with the NHS commissioning board…
>
> Thirdly, if a provider gets into significant difficulties, we have provided Monitor with powers to be able to try to turn around the provider. The aim would always be to support the recovery of the provider, wherever this was possible.

> Specifically, the amendments require Monitor to maintain an ongoing assessment of risk to the continued supply of NHS services. Monitor must then intervene proactively to help a provider to address problems and, where necessary, agree contingency plans with commissioners. New clause 2 and amendments 100 to 104 achieve this.
>
> Fourthly, we have put in place provisions to deal with the rare event of a provider no longer being sustainable in its current form. In that instance, the priority must be to secure continued access to the services patients need. This protection is particularly important in relation to foundation trusts, which of course are the principal providers of acute, emergency and specialist hospital services.
>
> So we have put forward amendments that would build and improve on the previous Government's regime established under the Health Act 2009. The improvements would ensure that foundation trusts do not revert to being NHS trusts and that commissioners take the lead in securing continued access to NHS services, and they would increase democratic legitimacy by allowing the Secretary of State to intervene in individual cases to protect patients' interests. At the same time, we are retaining Bill provisions to allow Monitor proactively to regulate to secure continued access of NHS services delivered by companies and social enterprises, through provisions on the health special administration regime, should these providers become unsustainable. New clause 6 and amendments 107, 188 to 193, 195 to 204, 217, 218 and 371 to 372 achieve this.
>
> Fifthly, it is essential that political accountability runs through what hon. Members will all know is central to our responsibilities to our constituents. Our plans therefore strengthen political accountability at both the local and national level. At a local level, the amendments enhance democratic legitimacy by extending local authority scrutiny to all NHS services. That is in contrast to previous proposals, where only designated services would have been subject to such scrutiny. At a national level, we will establish a process for the Secretary of State to veto proposals, in individual cases relating to unsustainable foundation trusts, if he decides that they do not secure continued access to NHS services and, as a last resort, to intervene where he believes that the NHS commissioning board or Monitor has failed to discharge its functions…The veto will ensure that the Secretary of State retains the powers needed to fulfil his role in promoting a comprehensive health service. Amendments 205 to 207 and 208 to 216 achieve this.
>
> (ibid, cols 196–198)

For the Opposition, Liz Kendall said that Monitor's proposed role still concerned professional bodies, patient groups, the public and MPs. She thought that creating Monitor as an economic regulator based on the examples of regulators in utilities, rail and telecoms was "wrong for the NHS" because:

> People's need for health care is not the same as their need for gas, water or telecoms. There is a fundamental difference between needs, ability to benefit, the complexity of services and the fact that they are far more interlinked. The NHS is not a normal market. It is not like a supermarket, or like gas or the railways. There are much more important issues at stake.
>
> (ibid, col 243)

With regard to Monitor's duties she expressed concern about the practical implications:

> The Government have made some minor amendments to Monitor's duties, but they will not ensure the integration and collaboration that many hon. Members recognise is vital to improving health, especially for patients with long-term and chronic conditions… Chapter 2 of part 3 contains 12 clauses that explicitly introduce competition law into primary legislation on the NHS for the first time. The clauses give Monitor sweeping powers to conduct investigations into NHS services; to disqualify senior staff in hospitals and other NHS services; and to impose penalties for breaches of competition law, including the power to fine services that are found to have broken the law up to 10 percent of their turnover. Not only that, but third parties, including competitors, can bring damage claims against those services.
>
> (ibid, col 243)

On the question of cost, she told the House that because the Government had failed to publish an impact assessment "we have no idea what the costs of setting up this huge new regulatory body will be" (ibid, col 245).

Responding to the Government's proposed new clauses 2 and 6, Ms Kendall claimed that rather than being about "securing continued access to services" the new clauses were "part of the Government's plan to create a market in which more services will be likely to fail" in order to get "new people" as providers into the NHS (ibid, col 245). She also expressed concern about the implications of the proposals for financially failing hospitals and for the ending of 'cherry-picking' by private providers. The removal of the Bill's 'designation' clauses, she said, were to be welcomed but did not go far enough:

> The new failure regime will be driven not by clinicians but by the economic regulator, Monitor. It will not give patients and the public a strong voice and it will not ensure effective local democratic accountability.
>
> In reality, Monitor will take the lead in deciding which services are essential for local people and therefore whether they should continue in any form; whether and how it should intervene to try to prevent services from failing; and, if a service cannot improve and needs to close, what will be put in its place.
>
> (ibid, col 246)

Stephen Dorrell, the former Conservative Health Secretary and now Chair of the Commons Health Select Committee, disputed the Opposition's interpretation. He said that the Government's amended proposals made it clear that "the central purpose of Monitor is not to be a blind economic regulator based on the assumption that the health service is simply another utility". As he understood it "the Bill gives effect to the basic commitment on which the Government were elected to ensure that the health service secures equitable access to high-quality health care for all patients regardless of their ability to pay" (ibid, col 208). Mr Dorrell welcomed the amendments:

> Until this Bill and the powers it gives to Monitor, regulatory bodies in the public sector had not had the opportunity to inquire into the sustainability of services provided by private sector providers. My right hon. Friend the Secretary of State made the point from the Front Bench that the role of Monitor under the Bill is to ensure first—if I may repeat myself—that foundation trusts are of a high quality when they are launched; secondly, that they are accountable for retaining their high standards; thirdly, that we intervene early if they start to go off the rails; and

> fourthly, that if they get into serious difficulty, we have the capacity, through Monitor, to continue to deliver continuity of service to those who rely on public health provision, whether from an NHS foundation trust or, as a result of the Bill, for the first time from the private sector. I regard that as a significant step forward in the delivery of continuity of care for NHS patients, whether provided, as the vast majority still will be, by public sector institutions or by some of the independent sector treatment centres introduced by the previous Government.
>
> (ibid, col 210)

Debbie Abrahams (Labour) was unconvinced by the Government assurances. She said the Bill remained "a threat to the future of the NHS". She said that the Bill would open up competition "under the guise of increasing patient choice and clinician-led commissioning" and because the NHS is a single payer health system she feared it would "inevitably lead to financial meltdown" (ibid, cols 204–5). Frank Dobson, a former Labour Health Secretary, concurred. He believed that the purpose of the Bill was "to shift us away from the basic collaborative approach to the provision of health care in this country and to substitute a large amount of competition, gradually involving more and more of the private sector and, I believe, privatisation". Mr Dobson suggested that asking an "essentially collaborative health care system" like the NHS to become competitive was "a bit like asking the Meat and Livestock Commission to promote vegetarianism" (ibid, col 214).

In an intervention Stephen Dorrell said he disagreed with the analysis: "if it is the policy purpose of this Bill to privatise the health service—which I do not for one moment believe it is—it will, I am sure, be as unsuccessful as all the other measures that went before it" (ibid, col 211).

However, John Pugh (Liberal Democrat) believed the House was right to be "sceptical about the blessings of the internal market in health" and right to be "worried about price competition" and right in "fearing competition law, including EU competition law" (ibid, col 217). Grahame M Morris (Labour) feared that under the plans "health would be considered a commodity and £60 billion of the NHS budget would be handed over to... clinical commissioning groups". He doubted that the groups would be open to Freedom of Information requests (ibid, col 225).

Mark Simmonds (Conservative) attacked Labour for their "complacency". He said the Opposition acted as if nothing needed to change. He assured the House that "almost all Members on the Government benches would not support the Bill if it was privatisation" (ibid, col 233). Addressing the amendments, Mr Simmonds said he supported them because "they ensure that equity of access continues, irrespective of whether the provider is in good financial state or not". He added "new clause 2 puts into place an essential mechanism… to protect patients and taxpayers… it also enables commissioners to replace services with higher quality and better value options" (ibid, cols 233–4).

Government new clause 2 was agreed to at division by 304 votes to 231. Government new clause 6 was agreed to without division and added to the Bill. Government amendments 87, 90–101, 105–106, 113–220 and 366–372 were added to the Bill without a division.

### 3.2 Other Amendments

#### 3.2.1 Amendment to Delete Part 3

The Opposition tabled a number of amendments called in this grouping. Liz Kendall spoke to amendment 10, which would delete the part of the Bill setting up Monitor. Ms Kendall argued that as currently drafted the Bill threatened "to pit doctor against doctor and service against service when they should be working together in the best interests of patients". She explained that "[o]ur view is that a far better approach than seeking to amend the Bill would be to delete part 3, because it is a fundamentally wrong way to treat our NHS. A few small changes to Monitor's duties would not alter what the Bill seeks to do, and that is why amendment 10 proposes deletion of part 3" (ibid, col 248).

Mr Lansley responded to the Opposition amendment 10. He said:

> The impact of removing part 3 would be to expose the NHS to the full force of competition law, as I described earlier, without the safeguard of a health sector regulator and without any sensitivity to the needs of patients, health services and our NHS. It should not be beyond the wit of Opposition Members to recall the impact on the health service and, in particular, on pharmacy services, when the Office of Fair Trading undertook an inquiry into the provision of pharmacy services from a competition perspective without any reference to the health perspective… That is what happened in the past and it is important that it does not happen in the future. We must have a health sector-specific regulator to see the health-related aspects of such matters.
>
> Labour's amendment 10 would potentially expose the NHS to practices that we do not wish to see. That would include paying over the odds for private sector services, as the previous Government did when they paid £250 million extra to the independent sector for operations that were never carried out; the cherry-picking of easier operations by the private sector, which is an issue in the NHS because the previous Labour Government let it happen; unreformed payment by results, losing the focus on outcomes and integration; and the retention of a system of payment based on price. We are not introducing payment by results; we are reforming it. Payment by results, as implemented by the Labour party, was simply payment for price and volume, not for quality.
>
> (ibid, cols 199–200)

Amendment 10 was defeated at division by 302 votes to 232.

#### 3.2.2 Competition Amendments

A number of amendments sought to restrict the scope of Monitor's duty in regard to competition and the applicability of competition legislation to the NHS. Andrew George's amendments provided that Monitor's role to "ensure that anti-competitive behaviour is kept in its box is balanced by looking at the impact of competitive behaviour that might undermine the ability of NHS services to collaborate". He explained:

> The underlying purpose of amendments 1207 and 1208 is to neutralise or balance the new duty on Monitor to prevent anti-competitive practices that are against the interests of the people who use the services—in other words, patients—by also applying a duty to prevent anti-collaborative practices that would have the same effect. The Government say that that would result in

> Monitor preventing all practices that were against the interests of patients, but I disagree. Some unsafe practices would be neither competitive nor anti-competitive. The amendments would result in there no longer being a focus mainly on dealing with anti-competitive practices. I believe that that would strengthen the role of the regulator. This is a question of putting competition in its box, and it is important to ensure that it is put properly in its box, properly defined, and that the lid is put on. The purpose of the amendments is to achieve that outcome.
>
> ... The important point here, which others have articulated, is that certain services clearly need to integrate. An example is acute emergency trauma centres. If the orthopaedic, paediatric or ophthalmology services were removed from such essential centres, their ability to deal with a wide range of emergencies would be fundamentally undermined. They serve populations of between 250,000 and 500,000 people—sometimes more—and they are absolutely essential. We must ensure that we do not end up with a regulator that allows them to be undermined by imposing a duty on them not to act in an anti-competitive manner.
>
> (ibid, col 249)

Responding, Mr Lansley said: "[o]n securing continuing access to essential services, we are in exactly the same place. If a service is essential, it will be the responsibility—and, indeed, the objective—of the commissioners of that service to make it clear that they expect the regulator, or the administrator on the regulator's behalf, to secure access to those services" (col 250).

Amendments 1219 and 1220 tabled by John Pugh (Liberal Democrat) sought to apply the Enterprise Act 2002 to mergers of the activities of foundation trusts with businesses but exclude those between foundation trusts. In response the Health Secretary said he was unconvinced the amendments would address the problems inherent in the current regime:

> There is currently legal uncertainty as to when and where the 2002 Act would apply to mergers of foundation trusts. As a result, under the current arrangements for the review of mergers involving foundation trusts by the Co-operation and Competition Panel, there is always a potential risk of duplication—or worse still, double jeopardy. The risk arising from a separate regime for foundation trusts would be increased where a trust's activities extended beyond Monitor's remit—for example, where a foundation trust provided social care or supplied goods. Consolidating oversight of foundation trust mergers under the Enterprise Act, as proposed by the Bill, would avoid the risk of double jeopardy and eliminate the uncertainty of the current approach.
>
> (ibid, col 203)

The amendments tabled by John Pugh and Andrew George were not put to the vote and were not added to the Bill.

### 3.3 Monitor's Transitional Powers Over Foundation Trusts

The Government tabled a number of amendments to extend Monitor's intervention powers over foundation trusts (FTs) until 2016. Paul Burstow, Minister of State, said new clauses 3, 4 and 5 and amendments 88, 89, 108 to 112 and 282 and 285 "would give additional time for foundation trusts' governors to build the capability that they need to be able to hold their boards to account". These amendments were proposed in response to

the Future Forum's concerns about the readiness of foundation trusts' governors to take on the new role and would allow "time for their governance arrangements to become fully effective" (ibid, cols 278–9).

For the Opposition, Owen Smith said the amendments summed up the confusion that surrounded Monitor's role:

> Monitor retains its role in trying to keep FTs from failing, but it also takes on a role in exiting them from the market and helping other providers—Bupa, perhaps, or Helios, which we know are sniffing around the Department of Health right now—to step into the breach. Chinese walls, competition and confusion: those are the key words for this botched Bill.
>
> (ibid, col 280)

New clauses 3, 4 and 5 were added to the Bill without a division. Amendments 88 and 89, 108–112 were also agreed to without division.

### 3.4 NHS Foundation Trusts

The Bill would repeal the restriction on the amount of income a foundation trust can earn from private charges. This is known as the 'private patient income cap' (HL Bill 92–EN, Para 1008). This was the subject of Andrew George's new clauses 19 and 22. Mr George explained the dangers of repealing the cap:

> The removal of the cap will give more scope for NHS trusts to compete in the market, which will make them more likely to be considered undertakings for competition law purposes, even in respect of NHS services which the hospitals claim their private work subsidises, thus allowing competition law to reach further and more firmly into the NHS. The Government briefing does not even dispute that fact, as far as I can see. Also, if NHS foundation trusts can muscle in on the private market, rather like the BBC, private providers will feel more justified in arguing for the right to compete for far more NHS services, and the courts may well agree.
>
> (HC *Hansard*, 6 September 2011, col 282)

New clause 19, he said, would make the Secretary of State, within three years of royal assent, make regulations that prevent foundation trusts from being able to provide services other than those of the health service. This "would phase out the reserving of beds for paying patients in NHS hospitals by 2015". New clause 22, he added, "would put a bar on foundation trusts offering private services that would compete with their NHS provision" (ibid, cols 282–3). Caroline Lucas (Green) spoke in support of the new clauses, which she co-sponsored. She said that the "bottom-line" was that NHS hospitals should treat NHS patients. She argued: "I do not believe that we have adequate spare capacity sloshing about in the system to justify private queue-jumping into NHS hospitals". She added that private treatment should only be offered when there was surplus provision in the system (ibid, col 291).

Opposition amendment 1165 proposed to delete the clause (clause 162 in the Bill currently before the House of Lords) that abolished the cap. Opposition Health spokesperson Emily Thornberry said that the Government's plan would "mean that our national health service, where people are tended by our NHS-trained doctors using our NHS equipment, will be full of private patients, who are able to pay more" (ibid, col 284). The Opposition recognised that the cap needed changing but wondered why it needed to

be lifted completely. Removing the cap, she added, would inevitably lead to EU competition law becoming applicable (ibid, col 284). The amendment was supported by Liberal Democrat John Pugh. He agreed that abolishing the cap altogether would mean "foundation trusts will run on the wrong side of state aid rules, and that their activity will be perceived as economic activity under EU competition law. The more they subsidise general NHS services, the more they will be perceived as engaging in economic activity" (ibid, cols 291–2). Chris Leslie and Diana Johnson (both Labour) also spoke in support of the amendment.

Responding for the Government, Simon Burns started by pointing out the cap only currently applied to foundation trusts, not NHS trusts. He said that "keeping the cap would damage the NHS and patients' interests. Removing it would allow foundation trusts to earn more income to improve NHS services" (ibid, col 288). Arguing that the cap was introduced as a compromise to win over Labour backbenchers in 2002–03, Mr Burns added:

> The cap is arbitrary and unfair. Several NHS trusts that are not subject to the private patient income cap have private incomes well in excess of many foundation trusts. Last year, four of the top 10 private income earners were NHS trusts—that is, without a cap. A few FTs have high private incomes simply because they did a few years ago. The cap locks FTs into keeping private income below 2002–03 levels and means that last year about 75% of FTs were severely restricted by caps of 1.5 percent or less. Meanwhile, patients at the Royal Marsden benefit from its cap being 31 percent, and it has consistently been rated as higher performing by the Care Quality Commission.
>
> (ibid, col 288)

The Minister said that existing safeguards, and those to be introduced, would protect patients. For example "NHS commissioners will remain responsible for securing timely and high-quality care for NHS patients. The Bill will make FTs more accountable and transparent to their public and staff, allowing us to require separate accounts for NHS and private income and giving communities and governors greater powers to hold FTs to account in performing their main duty, which is to care for NHS patients". The foundation trusts will retain "their principal legal purpose—to serve the NHS" (ibid, col 288).

Following the conclusion of the debate Andrew George withdrew his new clauses but stated he would vote for amendment 1165. The House divided on amendment 1165. It was defeated by 292 votes to 239.

The first day of report stage concluded with amendments 403 to 1117 being agreed to without division. These amendments replaced the words 'commissioning consortium' with 'clinical commissioning group' at each occurrence in the Bill.

## 4. Report Stage (Day 2)

### 4.1 Abortion and Health Services

The second day of report stage commenced with debate on amendments 1, 2, 1221 and 1180 tabled by backbencher Nadine Dorries (Conservative). These proposed changes to counselling services available to pregnant women considering an abortion. Ms Dorries explained the amendments were "not about restricting access" and that she did not want a "return to the days of Vera Drake-style back-street abortionists" (HC *Hansard*, 7 September 2011, col 365). She explained that amendment 1 was "about medical practitioners making to a woman who presents at their surgery or organisation an offer of

independent counselling, not compulsory counselling" and that under the amendment counselling would be delivered to the patient in 24 to 48 hours (ibid, cols 365–6). Ms Dorries asked MPs "to put themselves in the shoes of a 16-year-old girl who turns up at that clinic and does not know what to do. She is pregnant and panicking":

> Some of her friends tell her to have an abortion and some tell her not to. She does not want to tell her parents because she is scared of doing so. Her boyfriend is saying to her, "You've got to have an abortion and get rid of it." That is a mish-mash of the four or five stories a day that we hear in my office. The girl starts vomiting in the morning and carries on all day. She feels sick and ill and cannot think straight. She is not sleeping because she is scared stiff. She has not gone to school for more than a week because she thinks that people there will be able to tell that she is pregnant. She is out of her mind with worry. She turns up at a clinic and is told, "Sorry, that one appointment's been taken. You'll have to go to Richmond." The girl does not even know where Richmond is, and she has never even been to hospital without having her mum with her.
>
> I would like hon. Members to think about what it is like for that 16-year-old girl, and what they have against a GP or somebody else offering that girl an hour's counselling so that she can talk through the issues and reach the right conclusion for her, non-advised.
>
> (ibid, cols 370–1)

Ms Dorries said there was evidence to suggest that only 8 percent of women in Primary Care Trusts who attended counselling then decided not to proceed with the abortion, so she did not intend the amendment to be a device to lower abortion rates (ibid, col 370). She concluded her comments with reference to "the tactics that have been employed in this House to thwart the amendment". She claimed:

> I received a message informing me that the former Member for Oxford West and Abingdon [Dr Evan Harris] had approached the Deputy Prime Minister's office and exerted pressure. In fact, he tweeted exactly that, saying that he had applied pressure on the Deputy Prime Minister, who had now forced the Prime Minister to make a climbdown. Basically, a Liberal Democrat—in fact, a former MP who lost his seat in this place—is blackmailing our Prime Minister and our Government. Our Prime Minister is being put in an impossible position regarding this amendment. Our health Bill has been held to ransom by a former Liberal Democrat MP, who has focused on this amendment.
>
> (ibid, col 378)

In response several MPs challenged her on the appropriateness of the amendment. Chris Bryant (Labour) said, notwithstanding its purpose, abortion should be debated "in the round", rather than "appending something to this kind of Bill" (ibid, col 368). Gavin Shuker (Labour) also questioned whether an amendment to a Health Bill was the right vehicle in which to divide the House (ibid, col 370). Dr Phillip Lee (Conservative) said that despite supporting the principle behind the amendments he did not think it was appropriate to debate the proposal in the context of the Bill (ibid, col 375).

For the Opposition, Diane Abbott described the amendment as "a shoddy, ill-conceived attempt to promote non-facts to make a non-case" (ibid, col 380). She said that the amendment was wrong in its premise "that tens of thousands of women every year are either not getting counselling that they request, or are getting counselling that is so poor that only new legislation can remedy the situation". She noted that the British Medical

Association, Royal College of Obstetricians and Gynaecologists and the Department of Health all currently issued counselling guidance. Legislation simply was not needed. Ms Abbott concluded:

> There is no evidence base for the amendments, and on the basis of all the recent polls there is no substantive support for amendments of this nature. Legislation addressing the issues raised by Government Members is already in place. This House should have more respect for the medical profession and for the vulnerable women who put themselves forward for abortion in one of the most difficult periods in their lives, rather than support an amendment of this nature, which is spurious and baseless. I urge the House emphatically to reject the amendment.
>
> (ibid, col 383)

Anne Milton, Parliamentary Under-Secretary of State at the Department of Health, responded for the Government. She told the House there was "no evidence base for the amendments and on the basis of all the recent polls there is no substantive support" (ibid, col 382). She said that legislation addressing these issues was already in place. In terms of each amendment the Government's position was that:

> Amendments 1 and 2 would fragment the service by splitting responsibility for the commissioning of counselling and for the commissioning of the rest of the service. If they and amendment 1221 were to be made, clinical commissioning groups and local authorities would have different but overlapping duties in relation to independent counselling, and the definition of "independent" would be different for each. We would have a fragmented service, which none of us wants. Most women go to their GP, which is not the same as a clinical commissioning group, or they self-refer to an abortion provider, so amendment 1221 would not work.
>
> ... Amendment 1180 would oblige the Government to make regulations requiring NICE to produce guidance on abortion services. It would also oblige NICE to make specific recommendations in the guidance. That conflicts with other provisions in the same clause that prevent central interference in the substance of the NICE recommendations. Clearly that would seriously damage the independence of NICE and its reputation for evidence-based guidance. The second part of the amendment would require health or social care bodies, or private providers of abortion services, to comply with all recommendations made by NICE, which would effectively mean that NICE was setting essential requirements for abortion services, which is not its job or function. That is the role of the Care Quality Commission, and those standards and qualities are driven by good commissioning.
>
> (ibid, cols 383–4)

Ms Milton then responded to an amendment tabled by Dr Julian Huppert (Liberal Democrat). Amendment 1252 would oblige organisations offering abortion advice to follow the evidence of a medical body specified by the Secretary of State. Ms Milton said that the Government did not support it. She added:

> We intend to ensure that the independent counselling offered to women follows the highest standards of good practice. My hon. Friend's amendment 1252 is therefore unnecessary, as well as, we believe, unenforceable as currently

> drafted. It does not define 'information or advice', and crucially, it does not mention independent counselling.
>
> (ibid, col 384)

However, she said the amendments highlighted some important issues, such as quality standards and what is meant by independent. She stated the Government's intention to consult "widely and publicly" to inform proposals to improve services for women (ibid, col 384).

Dr Huppert responded by saying he accepted the Government's answer but would seek to speak to the Minister in greater detail. He urged the House to reject Nadine Dorries' amendment. Frank Field (Labour) advised Nadine Dorries not to press her amendment to a vote. He said that although he supported her "I believe the Minister has dealt with it" (ibid, col 385).

Amendment 1221 was rejected at division by 368 votes to 118. The remaining amendments were withdrawn.

### 4.2 Secretary of State's Duties

Following the division Paul Burstow opened debate on a further group of Government amendments to clauses regarding the duties of the Secretary of State. The Bill proposes changing the statutory wording of these duties:

> Section 1(2) of the NHS Act requires the Secretary of State, for the purposes of promoting a comprehensive health service (as set out at subsection (1)), to "provide or secure the provision of services in accordance with this Act". The Bill replaces this with a duty to "exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act". This reflects the fact that the commissioning and provision of services will no longer be delegated by the Secretary of State, but will be directly conferred on the organisations responsible. The Secretary of State's role is to ensure that these functions are being carried out effectively, he retains ultimate responsibility for securing the provision of services through the exercise of his functions, such as his powers to set objectives for commissioners (for example by setting the mandate under new section 13A), to oversee the effective operation of the health service and to intervene in the event of significant failure (see new section 13Z1).
>
> (HL Bill 92–EN, Para 67)

Responding to concerns about this, the Secretary of State's duty to promote autonomy in services, and their implications for a free health service, Mr Burstow said it was absolutely "not the Government's intention in this Bill to allow the Secretary of State to wash his hands of the NHS". He assured the House that the "Government believe in a comprehensive, tax-funded NHS that is free at the point of use, based on need and not ability to pay. Nothing in this Bill will change that". He added:

> I want to reassure hon. Members that there is no question but that the vast bulk of NHS-funded health care will continue to be delivered by NHS bodies that are bound by law and their constitutions to remain as public sector bodies and to fulfil a primary duty of providing services to the NHS. Indeed, the Bill contains a new

> provision—for the first time—specifically to prevent any future Secretary of State or NHS bodies from acting to promote the private sector over the public sector.
>
> (HC *Hansard*, 7 September 2011, col 400)

The Secretary of State, Mr Burstow continued, would remain legally and politically accountable for a comprehensive health service and would remain able to intervene to ensure that a service is provided. The legal requirements that services should be free except where already specified had been retained but now included "requirements, too, on securing continuous improvement in the quality of services, on promoting research and the use of evidence learned from research and, for the first time ever, on the need to have regard to the need to reduce health inequalities" (ibid, col 400). The Secretary of State would have, he explained, "further powers... to impose standing rules by which the NHS commissioning board and clinical commissioning groups must operate, which will be subject to scrutiny and control by parliament" (ibid, col 401).

The Government's position remained that "it should not be the job of Ministers to provide directly or commission NHS services... It should be the role of front-line professionals, who should have the freedom to focus on driving up quality of care, free from interference by Ministers in operational decisions—something that all parties in this House have said that they want to see". The Bill, however, contained "a number of back-stop provisions to make it absolutely certain that any future Secretary of State will not be able to turn a blind eye to failings of service provision" (ibid, cols 401–2). It was not envisaged, however, that the Secretary of State would intervene "other than in exceptional circumstances" (ibid, col 402). Mr Burstow repeated his earlier assurances:

> The position is clear: we are giving the NHS more freedoms and autonomy—something that many of us in the House have for many years argued should take place—and we are increasing its accountability. We are making watertight the obligations to provide a comprehensive health service that is free to all, based on need and not ability to pay.
>
> (ibid, col 402)

Owen Smith, for the Opposition, disagreed. He maintained that "the changes to the Bill, even in its third iteration, will fundamentally diminish the political accountability of the Secretary of State. As with the competition issue, the critical change is one that has been profoundly contested by the Government, but we think it is very clear. With respect to the changes introduced after the pause, we think the Bill still places at one very large step removed from the Secretary of State the fundamental duty to provide or secure the provision of health services in England, removing the duty that was placed on the Secretary of State by the National Health Service Act 2006, the National Health Service Act 1977 and all NHS Acts since 1946" (ibid, cols 417–18). He said that in spite of the Government's amendments to the Bill:

> The Secretary of State is still, as the Minister put it, washing his hands by divesting himself not of the NHS but of a direct duty to provide a comprehensive health service. That is the distinction which the Minister failed to make today. The Secretary of State is palming off that precious duty, which has been placed upon successive Secretaries of State, and handing it on, via the mandate, to a quango and to unelected commissioning bodies.
>
> (ibid, col 418)

Andrew Lansley intervened to ask whether Mr Smith knew of a time when the Secretary of State had "actually directly provided" health services, as his Department had failed to find an occasion (ibid, col 418). Following a further exchange, Owen Smith argued that the Opposition's point was that under the Bill, "save for in cases of crisis or emergency, the Secretary of State will not have responsibility for running the day-to-day operations of the NHS" (ibid, col 419). He went on to say that lawyers would have a "field day" in interpreting the Bill's meaning:

> The key thing is that eight months, two Bills and 1,500 amendments later, we are still debating clause 1 and its legal interpretation. That is testament to just how badly botched this Bill has been and just how alarming it is for many people—patients and NHS staff—that we, the legislature, do not understand, or have divided views about, our understanding of the critical responsibility of the Secretary of State.
>
> (ibid, col 421)

Andrew George (Liberal Democrat) disputed the Government's contention that the Secretary of State was not currently required by the 1946 Act to provide and secure effective health provision. He said more assurances from the Government were needed:

> ... we require the guarantee that, if all else fails and the whole system does not provide what we believe needs to be put in place to provide for a comprehensive health service, the Secretary of State will be there. There would be no harm in putting that word back in the Bill in one form or another. I do not understand the obstinacy, and in my view there is no legal impediment to the Government doing so.
>
> (ibid, col 438)

Mr George then spoke to his amendments regarding the Secretary of State's duties to intervene and to promote autonomy:

> New clauses 16 and 17 would remove the independence of the commissioning groups from the NHS board by restoring the Secretary of State's power to delegate functions to NHS commissioners and direct them where appropriate. That allows the restoration of the Secretary of State's duty to provide or secure provision of the health service as per the 1946 Act, which used those very words. That would restore fully accountable spending in respect of the £80 billion of taxpayers' money that goes through that route. We cannot provide a duty without providing the power, so the two things are clearly linked.
>
> Amendment 1197 would delete clause 4; it involves the "hands off" issue that has been raised before. Clause 4 would otherwise prevent the Secretary of State from directing clinical commissioning groups and the NHS commissioning board. Amendment 1198 would delete the same duty in respect of the NHS commissioning board, but would not interfere with clinical commissioning group autonomy.
>
> (ibid, cols 439–40)

Simon Hughes (Liberal Democrat) supported his colleague, saying there was both a "political argument for keeping the definition the same as it has been throughout the history of the NHS" and a legal argument "because there is a specific power to provide" (ibid, col 439). Caroline Lucas (Green) also supported Mr George, claiming as it stood

there was “no legal duty on the Government to provide health services. The new hands-off clause limits the Government’s ability to intervene should health care provision be deemed inadequate” (ibid, col 442).

In response to Andrew George’s amendment to delete clause 4, Paul Burstow said that the Bill provided powers for the Secretary of State to intervene and “as a last resort” to “make sure services are provided” (ibid, col 440). Earlier Mr Burstow had said the “specific purpose of the autonomy duty is to free front-line professionals to focus on improving outcomes for patients rather than looking up to Whitehall”. The Government disagreed, he said, with the widely-circulated legal advice provided by 38 Degrees (a campaign group) about how this duty would be interpreted in court. The Government’s view was that “[i]t would be sufficient for the Secretary of State to demonstrate that he had reasonable grounds for concluding that a course of action was the most effective way to act in the interests of the health service and fulfil a duty imposed on him by, for example, clause 1 or a new section 1A in the Bill” (ibid, cols 403–4). He stated “we are certain that clause 1 is watertight in framing the legal responsibilities of the Secretary of State” (ibid, cols 403–4). However, he later added:

> I have already made it clear to those who are concerned about clause 4 and the possibility, which we do not accept, that it will lead to a hands-off approach that we are willing to listen to and consider the concerns that have been raised and make any necessary amendment to put it beyond doubt that the Secretary of State remains responsible and accountable for a comprehensive health service, which we all want to see.
>
> (ibid, col 454)

#### 4.2.1 Additional Duties

A number of amendments (for example 1240, 1241, 1169 and 1183) sought to revise the duties of the Secretary of State. For example amendment 1169 was supported by Rushanara Ali (Labour) who thought the Secretary of State’s duty was currently “insufficient to tackle the health inequalities in our society” (ibid, col 448). The amendment would require the Secretary of State to lay an annual report before Parliament on progress towards ending health inequalities. Responding to the amendments Paul Burstow said the Government could not support them. He said “I know that the amendments are well meant, but they would make the duties undeliverable. The Secretary of State cannot improve quality and reduce inequalities in isolation, and the duties have to reflect that” (ibid, col 405).

### 4.3 Clinical Commissioning Groups (CCGs)

Part 1 of the Bill provides for the creation of CCGs, by grant of an application to the NHS Commissioning Board. It is these bodies that would be responsible for commissioning the majority of health services.

The Opposition tabled new clauses 10 and 11 which sought reductions in the CCGs’ administrative costs and to introduce targets for reducing health inequalities. Owen Smith spoke to the new clauses, which he said were based on the premise that “[i]t is just possible that CCGs will make duff decisions with which local residents disagree” (ibid, col 423). He then explained their purpose:

> ... in new clause 11, we have decided to ask the Government to put their money where their mouth is. The Minister asked earlier why we had chosen an “arbitrary” figure of 45% for a cap on the volume of expenditure on administration by CCGs.

> The answer is simple: it was the number that the Secretary of State came up with. He said that that was how many percentage points he was going to trim off the administration and bureaucracy costs of the NHS. He boasted that he could deliver 45% savings, so we are calling on him today to put his money where his mouth is and legislate for that. Let us measure him against that, because there is not going to be much else that we can hold him accountable for.
>
> We have tabled new clause 10, on waiting times, because targets and standards absolutely matter in the NHS. No matter what the Government keep telling the public, we still believe in clinical targets, including some that the Government would denigrate as "bureaucratic" or "administrative" targets. In new clause 10, we ask the Government to take the power to set transparent regulations relating to waiting times.
>
> (ibid, col 424)

Mr Smith then spoke to the Opposition's new clause 14. This, he explained was "designed to prevent those who shout the loudest under the new fragmented system from gaining the most, and from gaining an inequitable share of health care resources. That has been a traditional concern of health care policy under different Governments, and it remains a concern of the Opposition... new clause 14, alongside amendment 5, which would delete clause 10, would make the people in the area of a CCG its primary responsibility. Regulations would allow CCGs provision for other people, such as those on their practice lists, but they would always remain responsible for the people in their area" (ibid, col 425).

A number of contributions queried whether CCGs would be required to meet in public. Helen Jones questioned an earlier contention by Paul Burstow that "a CCG's governing board must meet in public" (ibid, col 409). Owen Smith (Labour) doubted the Minister was correct. He quoted from schedule 2 which, he said, meant "[m]eetings will therefore be held in public unless the consortium decides on a whim that it is not in the public interest for the public to come to the meeting" (ibid, col 414). He added "I have no doubt that there will be many instances when CCGs will determine that it is not in the public interest that the public be admitted to their meetings—in particular, for example, when they are discussing hospital reconfigurations or closures, and changes to public services that people consider to be vital in those areas". He urged the Government to amend the Bill (ibid, col 414). Among backbench contributions, Lyn Brown and Joan Walley (both Labour) expressed concern about the accountability of the CCGs (ibid, col 435). David Ward (Liberal Democrat) contended however that what the Bill required of CCGs was a public sector standard (ibid, col 414). Paul Burstow responded that the Bill allowed "local authorities to exercise judgment about confidentiality. We are applying the same principles in that regard in exactly the same way as to PCTs, with the additional provision that for the first time all these arrangements must be published" (ibid, col 415).

Andrew George spoke to a number of amendments he had tabled. He explained to the House the purpose of his new clause 18, which was to "impose a new duty on the CQC [Care Quality Commission], the NHS Commissioning Board and clinical commissioning groups not to undermine existing NHS services in an unplanned way through the operation of competition". New clause 20, he said, "would ban the wholesale outsourcing of commissioning work with regard to clinical commissioning groups... The commissioning process is a public function, not a private function. The amendment therefore seeks to change schedule 2 in different ways to prevent private entities on clinical commissioning group committees and sub-committees from commissioning and

making other decisions" (ibid, col 441). He then set out the purpose of some of his other amendments:

> Amendments 1184 to 1188 and 1195 would demote choice to being a subsidiary duty of commissioners to tackling fair access and tackling inequality of outcomes. They relate to page 17 of the Bill. The priority of choice over inequity and inequality was introduced by the Government after the pause and the NHS Future Forum report as a way of promoting competition in ways other than through the role of Monitor. The amendments would reverse that priority for the NHS commissioning board.
>
> Amendment 1211 provides that clinical commissioning groups should be more coterminous with local authorities than is the case under the Bill. The Minister said that there is no intention that clinical commissioning group boundaries will cross local authority boundaries. However, we all know that district councils do not cross local authority boundaries. In Cornwall, for example, we are likely to move from one PCT to three clinical commissioning groups, which will make the streamlining of the pathways between health and social care a lot more difficult. The purpose of amendment 1211 is to enforce that point.
>
> (ibid, col 442)

Caroline Lucas (Green) tabled amendments concerned with charges in the NHS. Ms Lucas told the House that her amendment 48 offered "Members the chance to return the NHS to its core ideals by making all health services in the UK, including dental care, eye care and prescriptions, free at the point of delivery based on each individual's needs and not their ability to pay" (ibid, col 443). Earlier Paul Burstow said of the amendment that it "has always been possible for Ministers to provide for charges for certain health services". He argued "[u]nder the current system, there are extensive exemptions: about 60 percent of the English population do not pay prescription charges, but—it is an important but—NHS charging raises over £1 billion a year of revenue that is ploughed back into services for patients, and it does make an important contribution to the overall affordability of the NHS. Therefore, I cannot accept the amendment" (ibid, cols 405–6).

On the same issue Ms Lucas also spoke to amendment 1181, which she said raised "serious concerns about the way in which CCGs will be able to charge for services". She feared that it was possible under the proposals that a CCG could decide a service was no longer to be provided free by the NHS and then charge for it (ibid, col 445). Responding for the Government, Paul Burstow said "I want to be very clear that nothing in the Bill enables the board or clinical commissioning groups to charge for services provided as part of the comprehensive health service. Services will remain free at the point of need, except where legislation specifically allows for charges to be made—for example, prescription charges and charges for dentistry. The Government have also committed not to introduce any new charges" (ibid, col 405).

### 4.4 Education and Training for NHS Staff

In December 2010 the Government issued a consultation about education and training for NHS staff. The document *Liberating the NHS: developing the healthcare workforce* closed to comments in March 2011. In regard to this issue Paul Burstow, the Minister, told the House the Government had already "committed to introduce at a later stage in the Bill's proceedings an explicit duty for the Secretary of State to maintain a system for professional education and training. Work is ongoing and an amendment will be tabled in the House of Lords" (HC *Hansard*, 7 September 2011, col 406).

Owen Smith said that the Opposition had tabled amendments in lieu of the Government's. Amendment 7 would retain Strategic Health Authorities (SHAs) "until and unless we know precisely what the Government will put in their place in respect of training and administration" (ibid, col 427). SHAs, he said, "have a key role in education and training, including, crucially, hosting deaneries and in work force planning" and:

> It is therefore scandalous that we come to this juncture, many months after we started our debates on the Bill, with SHAs—the repositories of the training and planning function in the NHS—on the verge of being abolished.
>
> (ibid, cols 425–6)

He criticised the Government for having "absolutely no idea what they will replace the education and training facilities with" and for having "the temerity to come to the House today and inform us that a new amendment is to be tabled in the House of Lords to deal with this crucial part of the Bill" (ibid, cols 425–6). Opposition new clause 13, he said, would oblige providers "to make provision for training and work force planning for their own staff". He said:

> As the Minister might say if he intervened on me, Monitor may well have powers, under the pricing clauses, to pay less under the tariff to providers who do not engage in training, but nothing in the Bill compels new entrants—especially private providers—to give their staff any training, or to deal with any costs that the NHS has traditionally had to bear for the education of the work force.
>
> (ibid, col 427)

However, in response to the amendments Mr Burstow said the Government's approach would "be more effective and more precise than the long-term measure of simply blocking the abolition of strategic health authorities, so amendments 7 and 47 will not do" (ibid, col 406).

Opposition amendment 7 was defeated at division by 318 votes to 240. Opposition amendment 1176 was defeated at division 304 votes to 255.

New clauses 1, 7, 8 and 9 were agreed to without division and added to the Bill. Amendments 49–85, amendments 221–365 and amendments 373–402 were agreed to without division.

**5. Third Reading**

Following completion of report stage, Andrew Lansley, the Health Secretary, moved that the Bill be given a third reading. He described the NHS as "among our most valued and loved institutions" but said that what mattered most to patients was:

> ... not only how the NHS works, but, more importantly, the improvements that the modernisations will energise—a stronger patient voice, clinical leadership, shared NHS and local government leadership in improving public health, and innovation and enterprise in clinical services. Everyone will benefit from the fruit that the Bill and the reforms bring. There will be improved survival rates, a personalised service tailored to the choices and needs of patients, better access to the right care at the right time, and meaningful information to support

> decisions. The Bill provides the constitution and structure that the NHS needs to work for the long term.
>
> (ibid, col 490)

He referred to the Bill's "long passage" but said "we have done throughout, and will continue to do, what all Governments should do—listen, reflect, then respond and improve". He thanked the NHS Future Forum for its work and outlined how its input had improved the Bill. He ended by observing:

> The intensity of debate and the brightness of the spotlight shone upon the Bill have made it a better Bill than when it was first laid before the House. I believe that it will set the NHS in England on a path of excellence, with empowered patients, clinical leadership and a relentless focus on quality. Let us look at what we have already achieved as a Government: more investment in the NHS, higher quality despite increased demand, waiting times remaining low, MRSA at the lowest level ever, mixed-sex accommodation breaches plummeting, and thousands more people getting access to cancer drugs. The Bill will pave the way for even more progress towards the world-class NHS that patients want, which will be able to deliver results that are truly among the best in the world. I commend it to the House.
>
> (ibid, col 491)

John Healey, the shadow Health Secretary, responded for the Opposition. He described the Bill as "giving health reform a bad name". The Bill was "unwanted and unnecessary", adding that it was "reckless to force through the biggest reorganisation in NHS history at the same time as finances are tight and pressures on the health service are growing". He said that "the big quality and efficiency challenges that the NHS must meet, and the changes that the NHS must make for the future, will be made harder and not easier because of the Bill" (ibid, col 492). In reference to the NHS Future Forum he agreed that changes had been made to the Bill "but they make the NHS plans more complex, more costly and more confused. Millions of pounds will be wasted on new bureaucracy when it could and should be spent on patient care". He said that the Bill amounted to a long-term plan "to see the NHS broken up as a national public service, and set up as a full-scale market" as "the new regulator would enforce competition law on the NHS for the first time". Furthermore the Bill "betrays a founding principle of the NHS. For 65 years, people have known that the Secretary of State and the Government whom they elect are responsible for the definition and provision of a comprehensive health service" (ibid, col 492). He concluded:

> These are the wrong reforms at the wrong time, driven by the wrong ideology. Labour will continue to lead the challenge against these plans in the other place, and we will oppose this Bill tonight on Third Reading.
>
> (ibid, col 493)

Dr Sarah Wollaston (Conservative) spoke of health inequalities, but was critical of those opposed to the amended duties of the Secretary of State:

> There has been real scaremongering about, in particular, the difference between the duty to provide and the duty to secure provision, but I believe that the wording simply reflects the reality. The key issue is the line between the ability to step in if

> things go wrong, and the very real need for politicians to step back and let clinicians and patients take control.
>
> (ibid, col 493)

Rosie Cooper (Labour) thought the Bill was “high on autonomy and low on accountability”. The Bill was “supposed to be built on the principles of efficiency, reducing bureaucracy and cutting out waste, yet I do not believe it achieves any of them. In fact, in practice it does the opposite” (ibid, col 494). She said there could have been another way: “The Government could have achieved the changes they said they wanted without all this structural mayhem, such as by reducing the number of primary care trusts, changing the make-up of the boards and putting clinicians firmly in the driving seat, but perhaps that was not macho enough” (ibid, col 495).

Nicky Morgan (Conservative) echoed those who thought there had been misinformation spread by those opposed to the Bill:“Having served on the Bill Committee, it is a great sadness to me that that message, and the fact that patients will be at the heart of the NHS, has been lost in the months of scaremongering” (ibid, col 495). Stephen Dorrell regarded the Bill as building “upon the same policies that were pursued by Labour in government: a policy of the extension of commissioning to act on behalf of the patient and the taxpayer; a policy to promote the development of foundation trusts as the best way of delivering care”. He argued that the Bill “takes 20 years of consistent development of policy and converts the words of Labour Ministers into reality. That is why I support its Third Reading tonight” (ibid, col 497). Michael Meacher (Labour) was the final speaker. He criticised the Government’s handling of the Bill, which he said had been “a monumental abuse of the principles of accountability in this House. It was sprung on an unsuspecting nation after an election in which there was no mention whatsoever of these proposals” (ibid, col 497).

The Bill received its third reading by 316 votes to 251.

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