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Health and Social Care Bill: Committee Stage Report

Bill 177 of 2010-12 (as amended; Bill 132 as introduced)

RESEARCH PAPER 11/31 6 April 2011

The *Health and Social Care Bill* had its Second Reading in the Commons on 31 January 2011. The Bill was considered in Public Bill Committee in 28 sittings, between 8 February and 31 March 2011. A large number of Government amendments were made, mainly minor and technical changes, although significant alterations were made to clauses 103 and 104 in Part 3 of the Bill, to prevent competition on price. No Opposition amendments were agreed.

This Paper summarises the Commons Second Reading debate and Committee stages and supplements the House of Commons Library Research Paper *Health and Social Care Bill* (RP 11/11), which was produced for the Bill's Second Reading.

A date for the Commons Report Stage and Third Reading has not yet been scheduled.

Thomas Powell

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Contents

Summary

The Bill is intended to give effect to the reforms requiring primary legislation that were proposed in the NHS White Paper *Equity and excellence: Liberating the NHS*. This White Paper set out the Government's aims to reduce central control of the NHS, to engage doctors in the commissioning of health services, and to give patients greater choice.

Measures in the Bill would give consortia of General Practitioners responsibility for commissioning the majority of health services, and create an independent NHS Commissioning Board. It would abolish Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) and transfer local health improvement functions from PCTs to local authorities. It would also give local authorities responsibilities for coordinating the commissioning of local NHS services, social care and health improvement

The Bill would introduce measures to promote competition between providers of NHS-funded services and would provide for all remaining NHS trusts to become foundation trusts.

The Commons Second Reading debate on the Bill on 31 January is summarised in section 2 of this paper. The Bill was considered in Public Bill Committee in 28 sittings, between 8 February and 31 March 2011. Following the examination of expert witnesses the Committee debated a large number of amendments tabled by the Opposition and the Government, and several new clauses.

No Opposition amendments were agreed. Of the Government amendments the vast majority of these were minor and technical changes, although significant alterations were made to clauses 103 and 104 in Part 3 of the Bill. The Government amendments to these two clauses removed the ability of Monitor (in its new role as the economic regulator for the health sector) to set maximum prices for treatments and services, preventing health service providers from competing on price. An amendment also specified that Monitor would not be able to set differential prices on grounds of a provider's ownership status.

During the Committee stage, one of the key debates between the Opposition and Government frontbenchers concerned the functions of Monitor as the economic regulator for the health service, and the extent to which competition, and the private sector, would be involved in commissioning and delivering services. The Committee also considered the role of the Secretary of State in securing the provision of health services; the impact of the reforms on the quality and integration of healthcare; and arrangements for wider public and clinical involvement in the commissioning and reconfiguration of services.

A short summary of the Second Reading and the Committee's questions to witnesses can be found in sections 2 and 3 of the paper. The changes the Committee made to the Bill, and the debates and divisions on the principal clauses and amendments, are summarised in section 4 of the paper.

1 Introduction

The Government's NHS White Paper, *Equity and excellence: Liberating the NHS*, published on 12 July 2010,[1] set out the Government's three key objectives for healthcare in England: to create a patient-led NHS; to improve healthcare outcomes; and to increase autonomy and accountability within the NHS.

The White Paper set out plans to give GP consortia responsibility for commissioning health services for their local communities, and to establish a national NHS Commissioning Board to support them in this role. The Board would also be responsible for those services not commissioned by GP consortia, such as specialist services currently commissioned at a national or regional level, and primary care services (including primary medical services provided by GPs).

Under the Government's reforms, there would be greater competition between providers, including the private and voluntary sector and staff-led social enterprises, so that in most sectors of care 'any willing provider' would be able to provide services. Remaining NHS trusts are expected to become foundation trusts by April 2014.

The Government also propose to give local authorities greater responsibilities for public health and to support integration across health and social care; new health and wellbeing boards are intended to bring democratic accountability to health services; a body called HealthWatch would be established to represent patient interests.

Following the establishment of the NHS Commissioning Board and GP consortia, PCTs and SHAs would no longer have NHS commissioning functions, and PCT responsibility for health improvement would be transferred to local authorities. As a result of these changes SHAs would be abolished from April 2012, and PCTs by April 2013. Community services currently provided by PCTs would be provided by NHS foundation trusts or other types of provider.

The *Health and Social Care Bill* was published in January 2011[2] and is intended to give effect to the reforms requiring primary legislation that were proposed in the NHS White Paper.

Part 1 of the Bill covers the health service in England and would:

- make provisions for the Secretary of State's duties to improve and protect public health, improve the quality of services, and to reduce inequalities;
- establish a framework for a comprehensive system of GP consortia, with responsibility for commissioning the majority of health services, and paving the way for the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs);
- create an independent NHS Commissioning Board, accountable to the Secretary of State, to allocate NHS resources to GP consortia, provide national leadership in commissioning, and promote patient choice; and
- place clear limits on the role of the Secretary of State in relation to the NHS Commissioning Board, and local NHS organisations, including a duty to promote the autonomy of health service bodies.

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1 Department of Health, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010.

2 The *Health and Social Care Bill 2010-11* as introduced is Bill 132, the Bill as amended in Committee is Bill 177; the clause numbers referred to in this paper relate to the Bill as introduced.

Part 1 of the Bill would also underpin the creation of a new public health service, Public Health England, within the Department of Health, and transfer local health improvement functions from PCTs to local authorities. It also contains a number of miscellaneous measures including amendments to the *Mental Health Act 1983*.

Part 2 of the Bill would make further provisions about public health, including the abolition of the Health Protection Agency.

Part 3 of the Bill covers the economic regulation of health care services and would:

- develop and expand the role of Monitor, currently the regulator of NHS foundation trusts, transforming it into the economic regulator for health (and possibly social care);
- introduce measures to promote competition between service providers;
- establish powers to ensure the continuity of certain designated health services;
- enable Monitor to promote competition and safeguard the continuity of services by creating a licensing system for all providers of NHS-funded services;
- establish a joint process (involving Monitor and the NHS Commissioning Board) for setting the tariff prices paid to providers of NHS services; and
- introduce insolvency arrangements for failing foundation trusts and a special administration regime to protect designated health services.

Part 4 of the Bill would provide for all remaining NHS trusts to become foundation trusts by repealing the legislation on NHS trusts, and the powers to 'de-authorise' foundation trusts. The Bill would also reform the foundation trust model, introducing new governance arrangements and removing restrictions on how they operate (including lifting the restrictions on borrowing and private work).

Part 5 of the Bill relates to public involvement and includes measures intended to increase local democratic legitimacy in health and social care. It would give local authorities the function of coordinating the commissioning of local NHS services, social care and health improvement. In particular, the Bill would:

- establish HealthWatch England as a statutory part of the Care Quality Commission, to 'champion' service users across health and social care, and create a network of local HealthWatch organisations;
- introduce a statutory duty for all upper-tier local authorities to: create a health and wellbeing board (HWB), and develop a new joint health and wellbeing strategy (JHWS); and
- change the legislation governing the Health Services Ombudsman to strengthen the arrangements for her to share information more widely.

Part 6 of the Bill makes consequential amendments to provisions on primary care services.

Part 7 of the Bill covers the regulation of health and social care workers.

Part 8 of the Bill reforms the functions of the National Institute for Health and Clinical Excellence (NICE), making it a non-departmental public body, reforming its role, and

extending its remit to social care (and changing its name to the 'National Institute for Health and Care Excellence').

Part 9 of the Bill changes the functions of the Health and Social Care Information Centre.

Part 10 of the Bill would abolish a number of arm's length bodies and advisory committees.

Part 11 of the Bill covers miscellaneous provisions, including: duties for key public bodies to co-operate with each other in performing their functions; and arrangements between the NHS Commissioning Board and the devolved authorities.

Part 12 of the Bill contains the final provisions of the Bill, such as details of commencement and territorial extent.

The full text of the Bill together with its explanatory notes can be found on the UK Parliament website.[3] A House of Commons Library Research Paper, *Health and Social Care Bill* (RP 11/11), provides background to the Bill, as introduced, and the Government's NHS reforms.

2 Second Reading debate

The Second Reading of the Bill in the House of Commons was on 31 January 2011. Introducing the Bill, Andrew Lansley, Secretary of State for Health, explained that the purpose of the Bill is "to improve the health of the people of this country and the health of the poorest fastest". He argued that despite record levels of funding the NHS had achieved relatively poor health outcomes compared to other countries.[4]

Kevin Barron, and a number of other Labour Members, intervened to question the Secretary of State's interpretation of the international comparators. Mr Barron pointed to research that showed that "those markers, some of which are not direct comparisons, are getting nearer to European targets."[5]

Regarding the new system of economic regulation, one of the most controversial aspects of the Bill, Andrew Lansley explained that the new economic regulator for health, Monitor, would have a duty to "protect and promote the interests of patients, through competition where appropriate and through regulation where necessary." In particular, he explained how the new system of regulation would ensure the continuity of essential "designated services" and set the "tariff prices" paid to providers for each type of treatment:

> Should a provider fail, there will be a transparent process for maintaining designated services, to ensure continuity of services for patients.
>
> Monitor will be empowered to set up a "risk pool", to which providers will pay a levy that will meet the costs of maintaining key services. There will also be a clear and transparent process for setting the NHS tariff for different services.[6]

Responding for the Opposition, the Labour Shadow Secretary of State for Health, John Healey, said there was a lack of support for the Government's reforms among the public and GPs, and noted the evidence for improvement in services, and public satisfaction with the NHS, over the past decade. He raised particular concern about the extended role of competition and private sector companies in health services, arguing that there was no

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3 Parliament webpage: *Health and Social Care Bill 2010-11*; the Bill as introduced is Bill 132, the Bill as amended in Committee is Bill 177.

4 HC Deb 31 January 2011 c605

5 *Ibid.*

6 *Ibid.* c616-7

mandate for these changes as they had not been set out in the Conservative or Liberal Democrat election manifestos, or in the Coalition Agreement:

> There is no mention of axing all limits on NHS hospitals treating private patients, so that NHS patients lose out; no talk or mention of undercutting on price, so that established NHS services are hit as new private companies cherry-pick easier patients and services; no mention of guaranteeing only selective hospital services, so that others can be closed and lost to local people without public consultation; and no mention of putting a new market regulator at the heart of the NHS with the principal job of promoting and enforcing competition. There is no mention in the Conservative manifesto of the biggest reorganisation of the NHS since it was set up more than 60 years ago.[7]

John Healey said that the Bill reflected Conservative rather than Liberal Democrat health policy:

> The Lib Dems' principal concern was to strengthen local and public accountability of health services, but the Bill seriously restricts openness, scrutiny and accountability to both the public and Parliament.[8]

He also argued that the changes proposed by the Bill would make it harder for the NHS to achieve its £20 billion efficiency savings and would waste money on reorganisation, while the introduction of "forced market competition" would risk harming patient services and the integration of care.[9] John Healey stated that there was a gap between what Minister were saying and doing, and that they were "in denial" about a number of risks of their reforms.[10]

Stephen Dorrell, chair of the Health Select Committee, outlined the "unprecedented challenge" facing the NHS to make 4% efficiency gains over the four years of this Parliament. He explained that he supported the Bill as it would be "inconceivable that we can deliver such an efficiency gain without delivering more effectively than we have done yet... greater clinical engagement with NHS commissioning."[11]

There was some cross-party support for the overall objectives of the Government White Paper, in particular its aims to improve patient choice, to devolve decision making, to reduce management costs and to measure performance against health outcomes.[12] There was also some debate about whether the Bill represented a continuation of the former Labour Government's reforms to increase patient choice.

Several backbench Conservative and Liberal Democrat Members praised the Government's plans to devolve power, cut bureaucracy, and to give local authorities a role in public health and the co-ordination of health and social care services. Opposition Members raised concerns about the scale and pace of the reforms, the increased role of the private sector, and the impact of GP commissioning and competition law on the delivery and integration of services. In particular, a number of Members noted evidence pointing to the negative impact of price competition on quality of health services. Members on both sides of the House referred to issues with local hospitals and services and drew attention to what they considered might be the positive or negative impacts of the reforms for their area.[13]

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7 *Ibid.* c619
8 *Ibid.* c622
9 *Ibid.* c626
10 *Ibid.* c627
11 *Ibid.* c630
12 *Ibid.* c654
13 *Ibid.* c693

Labour Shadow Health Minister, Derek Twigg, argued that the Secretary of State was ignoring serious warnings about the Bill from organisations representing health professionals and policy experts.[14]

Summing up the debate for the Government, Simon Burns attempted to "debunk" what he described as a number of myths about the Government's plans to reform the NHS. First he rebutted claims that the Conservative Party had not made its plans clear before the election, noting plans for patient choice of provider, GP commissioning and an independent NHS board, dating back to 2007.[15] He also said that the Government was totally committed to the values of the NHS, paid for through general taxation, free at the point of need, and based on clinical need not ability to pay.[16]

3 Committee Stage: oral evidence

Oral evidence was heard over four sittings held on 8 and 10 February 2011. There were a range of witnesses' from bodies representing health professionals and managers, from think-tanks and policy experts, and from regulatory agencies; there were also representatives from patients groups, health charities and local government. Witnesses from the Department of Health included the Secretary of State for Health, Andrew Lansley and the current Chief Executive of the NHS and newly appointed Chief Executive of the NHS Commissioning Board, Sir David Nicholson.[17] A full list of witnesses is provided in Appendix 2 to this paper. 139 written submissions (Associated Memoranda) were received from outside bodies and individuals.[18]

The evidence sessions focussed on a number of key areas of the Bill including the role of GPs in commissioning health services and the the use of the market and price competition in the NHS. There were also questions about the implications of reforms for efficiency savings, the integration of care, and access to services.

3.1 Efficiency savings

David Nicholson was asked what would happen to the NHS Quality, Innovation, Productivity and Prevention (QIPP) programme if clinicians focus on structural reorganisation; he responded that the authorisation of GP consortia by the NHS Commissioning Board would be dependent on their engaging with QIPP.[19]

Professor Chris Ham, Chief Executive of The King's Fund, noted that his organisation was concerned that major re-organisation of the NHS could make efficiency savings more difficult.[20] Dr James Kingsland, president of the National Association of Primary Care noted that there was a greater risk of failing to make efficiency savings if there was no change to the NHS.[21] Andrew Lansley told the Committee that giving hospitals and GPs more freedom would enable them to deliver greater efficiency.[22]

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14 *Ibid.* c694
15 *Ibid.* c698
16 *Ibid.* c699
17 The text of the evidence sessions is available on the *Health and Social Care Bill 2010-11* Parliament webpage.
18 The Associated Memoranda are available on the *Health and Social Care Bill 2010-11* Parliament webpage.
19 PBC Deb 8 February 2011 Q4
20 *Ibid.* Q61
21 *Ibid.* Q95
22 PBC Deb 10 February 2011 Q396

3.2 Economic regulation

Price competition

Committee members asked a number of witnesses whether there was a risk that competition on price could lead to a reduction in the quality of services. There was a general consensus that this was a risk; for example, Professor Julian Le Grand of the LSE, although generally supportive of the Government's reforms, noted that "so much evidence now shows that price competition is likely to lead to a lowering of quality."[23]

In his evidence to the Committee David Nicholson stated that pricing arrangements would ensure competition on quality, not on price:

> I do not accept the premise that the economic regulator is there to do price competition. The economic regulator and the pricing arrangements that we are going to have in place, which for most services will be a fixed tariff across the country, are about competition on quality, not on price. That is an important point for us to make.[24]

Andrew Lansley also emphasised that under the new system quality, not price, would be the basis of competition, and that patient choice, quality standards and incentives, and the Care Quality Commission's licensing process would ensure this. The Secretary of State also emphasised that most NHS activity, which is not purchased using fixed tariff prices, is currently subject to price competition.[25]

Competition law

A number of witnesses raised concerns about the extension of competition in the NHS, including trade union representatives and the BMA chair, Dr Hamish Meldrum.[26] Andrew Lansley defended the *Health and Social Care Bill's* provisions relating to economic regulation and competition, arguing that the wider application of competition rules to the NHS would not require all services to be put out to competitive tender, or prevent the creation of more integrated services:

> ...the application of competition rules does not stop people commissioning the service they look for. It does not require them to put it out to competitive tender all the time. They can specify the service they are looking for. It is transparent in the legislation that we allow them, for example, to create more integrated services and to commission on that basis but it does not allow them to engage in an abuse.[27]

He explained how Monitor and the new system of economic regulation would combat "abuses" of competition rules by providers and commissioners:

> ...the moment you start buying services from yourself, for example, by definition you have created an abuse and the competition rules would say that you can step in or somebody else who has been closed out by that can step in and bring a complaint. The same would be true if there was cartelisation on the part of providers of if there was a very large provider that was engaging in an abusive relationship with the commissioners and saying, "I'm going to push up the price of this service and there is nothing you can do about it because you can't go anywhere else." That is why you need Monitor for this purpose and why you need the people in Monitor to have the appropriate expertise, which is in competition rules and economic judgments. It is a

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23 PBC Deb 8 February 2011 Q44
24 *Ibid.* Q18
25 PBC Deb 10 February 2011 Q391-395
26 PBC Deb 8 February 2011 Q73
27 PBC 10 February 2011 Q397

> specific task. But it is not a task that gets in the way of delivering the best possible care and even of commissioning the services you are looking for.[28]

In response to a later question raising concerns about competitive tendering the Secretary of State addressed what he described as "myths" about competition rules:

> The urban myth was that the introduction of competition rules in the NHS would require everything to be put out to competitive tender. Myth one—competition rules already apply and the ones that really apply are EU public procurement rules. They already apply to primary care trusts, so there is no change there. The second myth is, actually, the only circumstances in which competition law bites is if you are trying to restrict provider access to commissioning services. For example, if you wanted to give a volume guarantee to a provider, you have to go through competitive tender in order to do that. If, however, you want to specify a service and there is the NHS tariff price, the any willing provider approach would be that you have a range of providers available to you as commissioners and to your patients exercising choice. You do not have to have a competitive tender for that purpose because if they meet the standard and the price, they can offer the service.[29]

3.3 GP commissioning

In his evidence to the Committee Andrew Lansley referred to examples of practice-based commissioning groups in Northamptonshire and Cumbria, and in Bexley and Redbridge in London, that had used their limited freedoms to commission effectively.[30] The Secretary of State dismissed concerns regarding potential conflicts of interest for GPs, asserting that competition rules would help to combat any such activity.

Integration of services

Dr Claire Gerada, Chair of the Royal College of General Practitioners said she welcomed proposals to put "GPs at the centre of planning the health service for the local population" but had concerns about the fragmentation of services and said she would rather see collaboration, co-operation, shared care and integration.[31]

Access to NHS services

The Committee raised concerns about whether the Bill would lead to greater regional variation, with different consortia offering different services, and whether this would lead to a less equitable provision for patients. David Nicholson responded to these concerns by stating that local commissioning guidelines, based on NICE quality standards, would help provide more consistency across the country.[32]

Public and patient involvement

A number of Members asked witness' about public involvement and the accountability of health service bodies, such as consortia, foundation trusts, and Monitor to the public. In particular, Members asked what the Bill would mean for service reconfiguration, with regard to on-going plans to close or downgrade services in certain NHS hospitals. Andrew Lansley explained how patient influence would be improved through the creation of HealthWatch and

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28 *Ibid.* Q398
29 *Ibid.* Q400
30 *Ibid.* Q377
31 PBC Deb 8 February 2011 Q94
32 *Ibid.* Q30

health and wellbeing boards.[33] He also said that any major reconfiguration would be the outcome of discussions between commissioners and health and wellbeing boards.

4 Committee Stage: summary of debates on clauses

Following the evidence sessions, the Committee examined the Bill clause by clause and debated amendments proposed by the Government and Opposition, and several new clauses. None of the Opposition amendments were agreed although a large number of Government amendments were made. There were 100 divisions, and the Chair, Mike Hancock, noted that it "is believed to have been the longest-sitting Committee in the House since 2002".[34]

Simon Burns, Minister of State for Health, and Paul Burstow, Minister of State for Care Services, spoke for the Government; Shadow Health Ministers Derek Twigg, Liz Kendall and Emily Thornberry, and other Labour Members, spoke for the official Opposition. A full list of Members of the Committee is provided in Appendix 1 to this paper.

The Committee agreed a programme motion on 8 February 2011 setting out the order in which the clauses would be debated (this was revised on 8 March 2011 to allow the consideration of a large number of Government amendments tabled at this point[35]). On a number of occasions Opposition Members commented that the Government was not providing a sufficient amount of information for the Committee to take decisions about the Bill. On the last day of the Committee stage (31 March 2011), Derek Twigg referred to press reports speculating that the Government was planning to introduce significant further amendments to the Bill at later stages. Emily Thornberry asked the Chair, Mike Hancock, if Committee proceedings could be extended to the following week in order to scrutinise these further amendments; in response the Chair noted the "genuine concerns" that had been raised but explained that the Committee's sittings could not be extended.[36]

This section of the paper does not follow the exact order in which clauses were discussed; rather it deals with the principal clauses, and the most significant areas, starting with the changes to clauses 103 and 104 in Part 3 of the Bill, to prevent competition on price, before turning to the debates on the 'cherry-picking' of services. This is followed by a summary of the other clauses that were voted on and where there was a substantive debate, in broadly chronological order. The summary of each debate begins with a very brief account of the provisions in the Bill being discussed and ends with the outcome of any divisions. The House of Commons Library Research Paper *Health and Social Care Bill* (RP 11/11) provides further background to the main clauses debated during the Public Bill Committee Stage, as do the explanatory notes accompanying the Bill.[37]

4.1 Tariff pricing, price competition and 'cherry-picking'

Clauses 103 and 104 in Part 3 of the Bill provide the NHS Commissioning Board and Monitor with powers to set the tariff prices paid to providers. This would be a joint process, with the Board responsible for the design of the structure of pricing (deciding the types of services for which the national tariff would apply), while Monitor would be responsible for setting prices, in order to promote fair competition and drive-up productivity.

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33 PBC Deb 10 February 2011 Q375

34 PBC Deb 31 March 2011 c1310; the *Criminal Justice Bill 2002-03* was considered over 32 sittings between December 2002 and March 2003.

35 PBC Deb 8 March 2011 c515

36 PBC Deb 31 March 2011 c1210

37 *Explanatory Notes to the Bill* [Bill 132-EN]

Clause 103: Price payable by commissioners for NHS services

Clause 103 outlines how prices would be specified for the payment of health services. As it was originally drafted it allowed for services to be covered by a maximum price, with flexibility to negotiate below that price. This clause was interpreted by many commentators as indicating the introduction of competition on price, and a number of those contributing to the Second Reading debate and the Committee's evidence sessions raised concerns that this could undermine the quality of services.

On 3 March 2011 the Ministers of State Simon Burns and Paul Burstow wrote to Committee Members to explain that the Government's "policy on competition in the NHS is, and always has been, that it should be based on quality rather than price." The letter also announced that they had tabled amendments to clarify this policy, by removing the ability of Monitor to set maximum prices; and specifying that Monitor would not able to set differential prices on grounds of ownership.[38] The letter provided the following background to the Government amendments to clause 103 regarding price competition:

> Under the existing legislative framework, Ministers have had complete freedom to introduce price competition should they so wish; the Bill as currently drafted continues to allow for the possibility of tariffs to be set as maximum prices, rather than set solely as fixed prices.
>
> However, while the Government's intention not to introduce a general policy of price competition is clear, it is none the less a possibility that Monitor could in future seek to pursue a different approach, subject to agreement with the NHS Commissioning Board. This is not a scenario that we have considered to be at all likely; and in the Operating Framework, we made clear a range of safeguards and conditions that had to be met before prices could be treated as a maximum. However, to ensure clarity in this area, the amendments we have laid will remove the possibility of Monitor setting maximum prices.

These points were reiterated by Simon Burns, speaking to the amendments (Amendments 187 to 191 and 193 to 203), in the name of Government and Opposition front-benchers, that removed references to a 'maximum price'. The Committee agreed these amendments without division. However, Derek Twigg noted that while the Government was denying it wanted price competition "all the facts point in the opposite direction".[39]

Clause 104: The national tariff

The Bill would allow for some flexibility in setting the tariff price paid for a service in various circumstances. For example, Monitor would be able to specify different prices depending on whether the service was designated (under Monitor's powers to preserve continuity of services), or to reflect the higher unavoidable costs some providers face compared with others. Commissioners and providers could also agree to vary prices. Derek Twigg moved amendments (Amendments 204, 205, 613 and 614) to remove Monitor's power to set differential prices, and to ensure that commissioners and providers could only agree to vary prices where the NHS Commissioning Board approved it. These amendments reflected Opposition concerns that Monitor might set a higher tariff price for services provided for new entrants, who "by definition, will not be NHS providers".[40] In particular, Opposition Members noted that the impact assessment to the Bill appeared to refer to measures to correct market distortions favouring established NHS providers:

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38 Simon Burns read out this letter to the Committee during the 12th sitting of the Committee on Thursday 3 March 2011 (PBC Deb 3 March 2011 c484-5)

39 PBC Deb 22 March 2011, c983

40 *Ibid.* c993

> Once the net distortion facing different provider types is better understood, the tariff methodology could be developed in such a way as to move towards a fairer playing field by setting different prices for different providers in order to recognise different levels of implicit subsidies.[41]

These amendments were negatived on division.[42] However, the Committee agreed to Government amendments (Amendments 191 to 193 and 561 to 564) to remove Monitor's ability to vary prices by reference to whether a provider is in public or private ownership. Simon Burns responded to Opposition concerns by explaining that it had never been the Government's intention "to set a differential price to entice new entry or favour particular types of provider".[43] The Committee agreed a number of other Government amendments (Amendments 198 to 190, 400 and 552 to 557) to clause 104, and to a new clause (new clause 16). These amendments allow for the national tariff to include rules on payments for services, to clarify how services in the tariff can be specified, and to clarify that the national tariff does not cover public health services.[44] The Committee agreed that the clause stand part of the Bill on division.[45]

Cherry-picking

Simon Burns responded to a point raised by John Pugh about 'cherry-picking': where non-NHS provider could take on easy cases and leave more complex, and expensive, procedures to be carried out by the NHS:

> He made a point about cherry-picking and asked whether Ministers would strengthen the rules to prevent non-NHS providers from targeting profitable procedures while leaving the less lucrative work to the NHS. The answer is yes. We are establishing the economic regulator to ensure that NHS-funded health care works in the best interests of patients and taxpayers. That will include ensuring that prices are set fairly and do not allow any one type of provider a particular advantage. The key to avoiding cherry-picking is to set accurate prices that fairly reflect costs, and clear and transparent rules that require providers to accept any patient who has chosen to be referred to them, unless there are clear and justifiable clinical grounds to do otherwise. We expect Monitor to do both and for the national commissioning board to enforce the rules through contracts.[46]

During the debate on clause 103, Derek Twigg argued that despite Government assurances the Bill did not address concerns about the cherry-picking of services by private sector companies, and the danger this posed to the financial stability of NHS hospitals:

> Nothing in the Bill rules out cherry-picking. Let us be clear what we are talking about with cherry-picking, and it is important to separate the various comments of the Minister and his hon. Friends. It is about bidding only for services that present less complex problems—in other words, healthier patients—and about private providers choosing certain profitable services or people to compete over, taking away activity from existing providers and so undermining the financial stability of NHS trusts, which have to provide unprofitable services, so endangering local hospitals. We have, again, a charter for putting hospitals—I hate to use the phrase—out of business. One of the

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41 *Ibid.* 964; see DoH, *Combined impact assessments*, 19 January 2011, para B108, page 52

42 *Ibid.* c986 and c994-5

43 *Ibid.* c992; as noted earlier, this point was also made in the letter Simon Burns read out to the Committee during the twelfth sitting of the Committee on Thursday 3 March 2011 (PBC Deb 3 March 2011 c484-5)

44 *Ibid* c985-6 and 995

45 *Ibid.* c999

46 PBC Deb 15 March 2011, c715

> consequences could be that NHS trusts stop providing services that they cannot make a profit from, and do not want them designated.[47]

There were wider debates about the role of competition in the provision of health services, and competition law, during the debates on clauses relating to the role and functions of Monitor (clauses 52 and 60 in particular).

4.2 The functions of the Secretary of State

Part 1 of the Bill covers the health service in England and clauses 1 to 4 make provisions for the Secretary of State's duties to improve and protect public health, improve the quality of services, and to reduce inequalities.

Clause 1: The Secretary of State and the comprehensive health service

With regard to the duty to promote the comprehensive health service, clause 1 of the Bill refers to the Secretary of State's new public health functions (clauses 7 and 8 place a new duty on the Secretary of State for Health to protect public health through the insertion of new sections 2A and 2B into the *NHS Act 2006*). Clause 1 also replaces the Secretary of State's current duty (under section 1 of the NHS Act 2006) to 'provide, or secure the provision of, services' with a indirect duty to 'act with a view to securing the provision of services.' This reflects the fact that responsibility for commissioning and providing services is conferred on the NHS Commissioning Board and GP commissioning consortia elsewhere in the Bill.

Derek Twigg proposed an amendment (Amendment 31) which would have inserted that the Secretary of State was accountable to Parliament for his public health functions. Simon Burns argued that the amendment would have no practical effect as "The Secretary of State's accountability to Parliament is already integral to the Bill." Amendment 31 was negatived on division.

Derek Twigg put forward an amendment (Amendment 33) to remove the word 'commissioning' from the National Commissioning Board, although, the substantive debate on commissioning took place on clause 5. There was also an Opposition amendment (Amendment 34) to replace the reference to 'commissioning consortia' in clause 1 and insert 'primary care trusts'. Derek Twigg argued that this was consistent with the Opposition's approach to reform the existing PCT structure, to create a slimmed down version with greater involvement of clinicians, and to avoid the cost of "organisation disruption".[48] Simon Burns noted that what the Opposition suggested was "clearly unacceptable"[49], and Amendments 33 and 34 were negatived on division.

The Committee debated an Opposition amendment (Amendment 35) to include 'NHS providers and providers to the NHS' to the bodies listed in clause 1, and would give the Secretary of State a direct role in relation to providers, rather than via the NHS Commissioning Board and commissioning consortia, as envisaged by the Government.[50] Derek Twigg argued that this amendment was designed to ensure that the Secretary of State retains the power to drive improvements in the NHS and to secure the provision of specific services. Simon Burns responded that this amendment ran counter to the Government's vision "for an NHS where providers are free to decide how to develop their services" and are free from political interference.[51] The Amendment was negatived on division.

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47 PBC Deb 22 March 2011 c983
48 PBC Deb 15 February 2011 c201
49 *Ibid.* c204
50 *Ibid.* c212
51 *Ibid.* c213

The Committee briefly considered three Government amendments to clause 1, described as "minor and technical" and relating to the Secretary of State's research and public health functions. The amendments were agreed to without a division.[52]

The clause stand part debate on clause 1 was an opportunity for members of the Committee to set out their general positions on the Bill and the Government's health reforms more generally. In particular, Derek Twigg raised questions about the accountability of the NHS to the public, via the Secretary of State and Parliament, arguing that it was the Government's intention to reduce accountability as part of its "ideological" commitment to a "completely free market".[53] There was some debate about the use of the phrase 'to act with a view to securing the provision of services'.[54] Kevin Barron, a former chair of the Health Select Committee, noted concerns about the cost of reorganisation and uncertainty about the outcome of reforms.[55] Other issues raised included concerns about price competition, accountability for decisions about hospital reconfigurations, and the future of hospitals that fail financially.[56] Nick de Bois welcomed the opportunity that clause 1 provided to end central "micromanagement" and to "move back to the front line, with professionals in charge and a high degree of localism".[57] In his response, Simon Burns addressed concerns about accountability by explaining that the Bill would make the NHS "far more transparent than it is now, and the accountability to Parliament far greater than it is now".[58] As an example the Minister cited the proposal for the Secretary of State's annual mandate to the NHS Commissioning Board to be laid before Parliament, and debated and questioned by the House. The Minister also confirmed that Members would continue to be able to hold the Secretary of State and the Department of Health to account through parliamentary questions and debates, and to write to Ministers regarding policies and issues concerning their constituents.[59] The Committee divided on the question that the clause, as amended, stand part of the Bill, and it was agreed.

Clause 2: The Secretary of State's duty as to improvement in quality of services

Clause 2 of the Bill introduces a new duty for the Secretary of State to act 'with a view to securing continuous quality improvement in services' provided by the NHS.

Liz Kendall proposed three amendments to clause 2 (Amendments 36, 37 and 39). Amendment 36 would replace the phrase 'with a view to securing' with 'to secure', and was intended to make the duty "clear, specific, strong and coherent".[60] Amendment 39 was intended to give the Secretary of State a clear responsibility to ensure NICE quality standards are implemented, and would have required the Secretary of State to 'seek to deliver' these, rather than just have regard to them. There was a lengthy debate on the amendments, including a discussion about the possibility of achieving 'continuous improvement'. Responding for the Government, Simon Burns noted that while the Opposition amendments appeared "superficially attractive" their approach would "undermine the devolved responsibility that the Bill seeks to establish and bring responsibility for provision of NHS services back to Whitehall".[61] The Amendments were negatived on division.

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52 *Ibid.* c221
53 *Ibid.* c221-2
54 *Ibid.* c228
55 *Ibid. c227*
56 *Ibid.* c231-3
57 *Ibid.* c234
58 *Ibid.* c247
59 *Ibid.* c247
60 PBC Deb 17 February 2011 c257
61 *Ibid.* c272

Liz Kendall moved an amendment (Amendment 38) intended to "more clearly define the factors that make up a high-quality service" and the Committee discussed some of the problems defining quality that had been raised by witnesses giving evidence to the Committee. This amendment was negatived on division. An Opposition amendment to include a duty to ensure people in a local area are consulted before significant changes to their health services was withdrawn as it was decided to bring it back for consideration at the Report Stage. This followed a number of suggestions from Committee members about how the amendment could be improved to focus on changes to "strategic services at a regional level".[62]

Clause 3: Reduction of inequalities

Clause 3 would impose a duty on the Secretary of State to consider the need to reduce inequalities in respect of the benefits that may be obtained from the health service. During the debate on clause stand part Opposition Members raised a number of concerns about the Bill's impact on equality of access to services, and in particular Emily Thornberry raised concerns that the development of GP consortia and removal of strategic direction would lead to greater regional variation in services.[63] She also cited evidence to the Committee from the Chair of the Royal College of GPs and Unison about risks of widening health inequalities.[64] Simon Burns reminded the Committee that the Bill is the first piece of NHS legislation to include a duty to reduce inequalities in the health services. Responding to an amendment moved by Emily Thornberry that defined specific inequalities that the Secretary of State must address, the Minister explained the Government's decision not to take this approach:

> The duty, as currently drafted, has been kept purposefully broad to capture all types of inequality that may affect individuals, including those listed in the amendment. Personally, I would have thought that, in the light of that information, hon. Members would welcome the way in which we have drafted the Bill, rather than the way that the Opposition have drafted their amendment. It would be a mistake to limit the scope to specific areas. Furthermore, the issues in the amendment are already covered, in large part, by duties under the Equality Act 2010, which apply to all public bodies, including the Secretary of State. To reproduce them in the duty would simply replicate existing legislation, which, I must say, in the context of those comments, seems unnecessary.
>
> The coalition Government are fully committed to the Equality Act 2010, and we have already started to implement it. The equality duty will come into force on 6 April and the ban on age discrimination from 2012. We have been clear that the 2010 Act applies to all existing and all proposed health bodies, as well as providers of NHS services.[65]

The Opposition amendments were negatived on division and clause 3 was ordered to stand part of the Bill.

Promotion of autonomy

Clause 4 states that the Secretary of State should act with a view to promoting autonomy in the health service. It identifies two constituent elements of autonomy: freedom for health service bodies (such as commissioning consortia) to exercise their functions in a manner they consider most appropriate, and not imposing unnecessary burdens on those bodies. Clause 19 (section 13(E)) imposes a similar duty on the NHS Commissioning Board.

Emily Thornberry proposed a number of amendments to clause 4, clause 19, and other parts of the Bill to remove references to 'autonomy' and replace these with 'collaboration and

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62 *Ibid.* c296
63 *Ibid.* cc301-2
64 *Ibid.* c305
65 *Ibid.* cc322-3

integration' and 'cooperation'. She noted that the amendments reflected the need for collaboration and integration of services, not autonomy and competition:

> Co-operation and collaboration, not autonomy and competition, should be at the heart of the NHS and of the Bill. We need to make it clear that services that work together and collaborate are desirable and will not be threatened by competition law.[66]

Emily Thornberry referred to concerns from the Nuffield Trust, RCGP, BMA and others about the possible fragmentation of services. In his response, Simon Burns explained the Government's commitment to the principle of autonomy:

> It is about eliminating the political micro-management that constrains the freedom of hard-working professionals to focus on what matters most to us all: improving outcomes for patients. If we want to improve outcomes in the NHS, we need to empower our front-line professionals. The Bill confers functions directly on the bodies most capable of discharging them. The principle is about giving those bodies the freedom to exercise their functions, so long as that is consistent with the interests of the health service and patients.[67]

Although the Minister sympathised with the intention he challenged the assumption behind the amendments, that integration can only happen at the expense of autonomy, and that the Bill weakens the legislative framework for collaboration and integration. He went on to outline various parts of the Bill, and existing legislation, that promote collaboration and impose duties to co-operate. He also noted that clause 179 provides for health and well-being boards to encourage integrated working.[68] The amendments were negatived without division and the Committee agreed that the clause stand part of the Bill.

Protection and improvement of public health

With the consideration of clause 7, regarding the Secretary of State's duty as to the protection of public health, Emily Thornberry moved new clause 1, which would establish Public Health England. She criticised the Government for not including its proposal for Public Health England in the Bill, and for "pushing through the Bill" while still consulting on its public health plans. Paul Burstow, the Minister for Social Care, responded that clause 1 was superfluous and would create an "unnecessary degree of bureaucracy". He explained that Public Health England, "as a state function of the Department of Health", will not be established by primary legislation. The new clause was not voted on and question that clause 7 stand part of the Bill was put and agreed to.

Clause 8 would place duties on the Secretary of State and local authorities in relation to the improvement of public health. Speaking for the Opposition, Emily Thornberry, moved a number of amendments (Amendments 22, 23 and 25) focussed on replacing the word 'may' with 'must', with regard to the Secretary of State's duties, in order to "beef up" the powers vested in the clause. Paul Burstow argued that the clause was adequately clear as it stood and the amendment was negatived on division.[69] Emily Thornberry introduced another amendment to clause 8 (Amendment 67), designed to ensure that any funding allocated to local authorities the purpose of improving public health was only spent on activities consistent with this purpose (which she described as the "ring-fencing" amendment). Although the amendment was withdrawn without a vote, it led to a debate on public health in which Paul Burstow explained that this funding would be administered under the *Local Government Act 2003* and that, subject to the outcome of consultation on the public health

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66 PBC Deb 1 March 2011, c331
67 *Ibid.* cc332-3
68 *Ibid.* cc333-4
69 *Ibid.* cc391-3

White Paper, the Government would attach conditions to the use of grants. The Minister also highlighted evidence to the Committee from the LGA and RCGP supporting the Government's intention to transfer responsibility for public health improvement to local authorities.[70]

Clause 14: The Secretary of State's powers to direct local authorities

Clause 14 enables the Secretary of State to make regulations (subject to affirmative procedure) requiring a local authority to exercise certain public health protection and improvement functions. The Committee agreed to Government amendment to clause 14 so that regulations to require a local authority to exercise any of the public health functions of the Secretary of State would relate to the 'health of the public', rather than the 'protection of the public'.[71]

4.3 The NHS Commissioning Board

The Bill would establish the NHS Commissioning Board as a national body responsible for allocating NHS resources to GP consortia, providing national leadership in commissioning, and promoting patient choice support. The Board would also commission those services not commissioned by consortia, including primary medical, dental, ophthalmic and community pharmaceutical services, in order to avoid any potential conflict of interests for GP consortia.[72]

Clause 5 in Part 1 of the Bill would establish the NHS Commissioning Board as a new non-departmental public body, accountable to the Secretary of State. Schedule 1 relates to membership of the Board. Clause 11 would give the Secretary of State powers to require the Board to commission certain services. Clause 19 provides for further functions of the Board.

Clause 5: The role of the Board in the reconfiguration of services

Liz Kendall proposed an amendment (Amendment 43) to clause 5, to add that the Board must lead in the reconfiguration of services, where it has responsibility, and must have regard to the 'principles and values of the NHS Constitution'. She explained that the amendment was intended to give the Board clear responsibility for reconfiguration and noted evidence to the Committee from the Health Foundation that there was a lack of evidence that GPs had been able to lead large hospital reconfigurations. Simon Burns noted that the reconfiguration of services are predominantly a matter for the NHS locally, working in conjunction with clinicians, patients and other stakeholders, and "that would apply equally to changes in those services for which the NHS commissioning board is responsible."[73] He later explained that the Board would lead on "substantial service change for those services that it commissions, such as specialised services like major trauma care."[74] Liz Kendall also raised concerns that there would not have to be public consultation on changes to 'non-designated' services, to which the Minister replied that "all providers must involve patients and the public under section 242 of the 2006 Act. That may include formal consultation, depending on the nature of the change."[75] The amendment was negatived on division.

Membership of the Board

The Opposition proposed a number of amendments to Schedule 1 of the Bill, which makes provision for the membership of the Board. In particular, these amendments were intended to

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70 *Ibid.* c396
71 *Ibid.* c432
72 DoH, *Equity and excellence: Liberating the NHS* (Cm 7881) 12 July 2010, para 4.10-4.11, pages 30-33
73 PBC Deb 1 March 2011 c347
74 *Ibid.* c349
75 *Ibid.* c348

ensure the Appointments Commission, rather than the Secretary of State, appointed the chair of the NHS Commissioning Board, to include representatives of particular groups on the Board, and to make certain appointments subject to the affirmation of the Health Select Committee. Following debate the Opposition withdrew the amendments, noting that it was important that further work was done on the subject of accountability so that the matter could be raised again at the Report Stage. The Committee divided on one Opposition amendment to Schedule 1, which would have required the publication of interim accounts of the Board, in addition to the Bill's existing provision regarding consolidated annual accounts of the Board; this amendment was negatived.[76]

Secretary of State's powers to require the Board to commission certain services

The Board may also be required to commission other services as outlined in new section 3B of the *NHS Act 2006* (inserted by clause 11). These include dental services, services for members of the armed forces and their families, services for those detained in prison and other services as may be prescribed (the Explanatory Notes to the Bill state that these might include 'specialised services' for rare conditions, which are currently commissioned nationally by SHAs because of their low volume and high cost).

Liz Kendall moved three "probing" amendments (Amendments 74, 108 and 109) to clause 11, to "explore the rationale and processes for defining which service are best commissioned at a national level".[77] Amendment 74 related to dental services and Kevin Barron expressed concern about whether dental services could be commissioned effectively at a national rather than a local level. Amendment 108 would have added veterans' healthcare to the list of services the Board may be required to commission. In response to Amendment 108 Simon Burns explained that clause 11 included a reference to members of the armed forces because demands in this area could be unpredictable, whereas "the health needs of the vast majority of veterans are very much the same as those of the wider population and are best met and commissioned on a local basis."[78] Amendment 109 would have required the Board to commission those services covered by the 'specialised services national definitions set'. The Minister attempted to reassure the Opposition that the Secretary of State would take account of the national definitions set when deciding what other services to require the Board to commission. These amendments were negatived on division.[79]

Liz Kendall also introduced an amendment (Amendment 77) that would require the Secretary of State to consult with commissioning consortia and health and well-being boards when determining what services are commissioned by the Board. This amendment was negatived on division.[80]

Clause 19: Other functions of the Board

Clause 19 of the Bill makes further provisions relating to the functions of the Board, and includes new section 13A, which requires the Secretary of State to publish and lay before Parliament a document to be known as 'the mandate' before the start of each financial year. Sections 13L to 13P set out additional functions of the Board including arrangements for public involvement, for collecting and processing information, for publishing a business plan, and for producing an annual report (to be laid before Parliament).

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76 *Ibid.* c383
77 *Ibid.* c418
78 *Ibid.* c424
79 *Ibid.* c425-6
80 *Ibid.* c432

Public involvement and accountability of the NHS Commissioning Board

Emily Thornberry moved a number of amendments to clause 19, several of which she described as "probing", relating to the accountability of the Board, introducing requirements for wider public involvement. These amendments were withdrawn following a debate about the Bill's existing duties within the Bill relating to public and patient involvement.[81] Emily Thornberry also proposed an amendment (Amendment 168) to introduce a duty for the Board to make arrangements to ensure proper public consultation over "significant reconfigurations" of services, where the reconfiguration would affect more than one commissioning consortium. Simon Burns believed the amendment was unnecessary as consortia would be under a legal obligation to make arrangements to involve members of the public on major changes to services resulting from their commissioning plans.[82] The amendment was negatived on division.

Emily Thornberry proposed an amendment (Amendment 132) to require the Board to have regard to reports or recommendations from local HealthWatch organisations, the HealthWatch England committee or local authorities. In his response, Paul Burstow set out various ways in which HealthWatch can influence the Board including under clause 166 of the Bill, which would insert a new section 45A into the *Health and Social Care Act 2008*, enabling HealthWatch England to exercise the function of providing information and advice to the NHS commissioning board.[83] The amendment was negatived on division.[84]

Strategic planning

Emily Thornberry introduced an amendment (Amendment 172) to clause 19, to impose a duty on the Board to take responsibility for regional strategic planning, in partnership with commissioning consortia and health and wellbeing boards. Opposition Members had argued for the importance on regional strategic planning of health services in earlier amendments (Amendment 43 to clause 5), and repeated their concerns that GP commissioning consortia would find it hard to take the lead on reconfiguring services across large geographic areas (such as specialist cancer, cardiac and stroke services). In particular, Emily Thornberry read out comments from a report by the King's Fund, highlighting the need for strong, strategic commissioning to deliver essential changes to specialist hospital services.[85]

John Pugh, argued that the amendments "go to a central and crucial issue of the legislation,"[86] and that given the untried nature of the Government's plans to balance competition and collaboration: "we need to have, if not something like a regional health authority, some kind of backstop that surveys the region and ensures that all the clinical networks are in place and that they all work."[87] This was followed by a discussion of whether the National Commissioning Board would develop a regional structure. The Minister, Simon Burns, commented that the amendment would represent a return to central "command and control". Although he referred to the involvement of the NHS Commissioning Board in developing plans for service changes, he outlined that it was the Government's intention "to put patients and clinicians in the driving seat".[88]

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81 PBC Deb 3 March 2011 c443
82 *Ibid.* c454
83 *Ibid.* c442
84 *Ibid.* c478
85 *Ibid.* c464
86 *Ibid.* c464
87 *Ibid.* c465
88 *Ibid.* c469-70

Emily Thornberry described the Minister's view as being "a free market, red in tooth and claw description of patients and doctors making decisions...".[89] The Opposition amendment was negatived on division.

Emily Thornberry proposed an amendment (Amendment 165) to clause 19, to impose a duty on the Board to ensure effective workforce planning, and highlighted their concern about responsibility for this function once Strategic Health Authorities were abolished. Simon Burns said that the Government had issued a consultation paper which proposed to establish a body called Health Education England. This body, the Minister explained, would "support health-care providers and offer national oversight of work force planning, education and training." He went on to say it would support education and training, value for money, skills development and security of supply and focus on those issues that need to be managed nationally and cannot be delivered by local provider skills networks." The Minister noted that the consultation ended 31 March 2011 and that the results of this would be reflected in a Bill in the next Session.[90]

Emily Thornberry asked if current structures would be abolished before any new structures were in place. Simon Burns acknowledged this was a crucial area, and that without pre-empting the outcome of the consultation, the Government would table an amendment "that provides reassurance about the role that the commissioning board will play in these matters" in the future:

> Under section 258 of the 2006 Act, the Secretary of State is under a duty to exercise his functions
>
> > "so as to secure that there are made available such facilities as he considers are reasonably required by any university which has a medical or dental school, in connection with…clinical teaching".
>
> The Government amendment to schedule 4 to the Bill will apply the same duty to the board and consortia, to reflect their responsibilities in the future for commissioning the majority of health services.[91]

Emily Thornberry withdrew the amendment but noted that the Opposition would return to the matter.[92]

Power to make grants

The Committee agreed to a Government amendment (Amendment 93) to clause 19, to allow the Board to make grants to voluntary organisations that provide or arrange services that the Board would be responsible for commissioning. The Minister explained that this amendment "mirrors the power that the Secretary of State has now under section 64 of the *Health Services and Public Health Act 1968*."[93] The Committee agreed a Government amendment (Amendment 94) to give a similar grant making power to commissioning consortia.[94]

Contractual arrangements with external bodies

Emily Thornberry introduced an amendment (Amendment 152) to clause 19 that would ensure that, if the Board chose to outsource any of its functions to external bodies, the same duties to abide by the *Freedom of Information Act 2000* and the *Equality Act 2010* would be

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89 *Ibid.* c473
90 *Ibid.* c476
91 *Ibid.* c477
92 *Ibid.* c478
93 *Ibid.* cc478-9
94 PBC Deb 8 March 2011 c554

included in any contract with the outsourcing company. It would also ensure that external body would be subject to the same requirements on the Board with regard to remuneration of employees. The Minister explained that the Equality Act's prohibition on discrimination by employers or service providers applies to all bodies, whether public or private, including any contractor of the board.[95] With regard to Freedom of Information, he noted:

> The position in respect of the Freedom of Information Act is different from that in respect of the board's public sector equality duty; however, the duty under that Act to respond to requests for information would apply to the board regardless of what arrangements it makes for the exercise of its functions. When the NHS commissioning board entered into a contract with another person to exercise its functions on its behalf, it would remain responsible for ensuring compliance with those duties.[96]

Emily Thornberry thanked the Minister for his comments but noted the Opposition might have further questions which they would come back to at "another stage".[97]

Clause 19: Clause stand part debate

During the clause stand part debate Derek Twigg summed up the Opposition's concerns:

> This is a major clause, and we are against it being part of the Bill. We are against it because we want to undermine the Bill and because we think the provision will undermine the national health service. It is a big change, and not a positive one. We are concerned about how accountable the NHS commissioning board will be to patients, the public and Parliament, and about how autonomous and independent it will be from the Secretary of State. We do not understand what the relationship will be between it and regional bodies, and we have not had adequate answers on that. We are concerned about what will happen to training if regional bodies are got rid of.[98]

This debate also provided the opportunity for Ministers to set out the Government's position with regard to price competition, and Simon Burns read out a letter he sent to Members of the Committee about this issue earlier that day (3 March 2011). The wider debate about setting tariff prices and competition on price is set out in the summary of the debate on clause 103. The Committee divided and agreed the question that the clause, as amended, stand part of the Bill.

4.4 GP commissioning consortia

The Bill would establish GP commissioning consortia as corporate statutory bodies, authorised to act by the NHS Commissioning Board. These consortia would be responsible for commissioning the majority of health services and would pave the way for the abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs).

Clauses 9 and 10 in Part 1 of the Bill would amend section 3 of the *NHS Act 2006* to provide for the duties and powers of consortia as to commissioning certain health services. Clauses 21 and 22 would make further provision about the establishment and functions of consortia, For example, clause 21 includes a requirement that every consortium has a constitution (sections 14A to 14D and 14J), and also provides for variations to constitutions (14E and 14F) and the merger and dissolution of consortium (14G to 14I). Schedule 2 of the Bill makes further provision about consortia and what must be included in their constitution. Provisions under clause 22 include a requirement that consortium must prepare a 'commissioning plan'

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95 PBC Deb 3 March 2011 c480
96 *Ibid.* c481
97 *Ibid.* c482
98 *Ibid.* c482

setting out how it proposes to exercise its functions, particularly with regard to discharging its duties to ensure continuous improvement in health outcomes, and its financial duties.

Clause 9: Commissioning consortia responsibilities

Grahame M. Morris, speaking for the Opposition, moved amendments (Amendments 68 and 69) to clause 9, which sought to ensure that the definition of those persons for whom a commissioning consortia would have responsibility extended to the entire population living within an area, not just those registered with GPs within the consortia. Simon Burns said that this extended responsibility would be covered by regulations, which may already allow for a consortium to be assigned responsibility for "people who live within the consortium's area and who are not registered with any GP's practice, or people who are present within the area and need emergency care."[99] The Opposition amendment was negatived on division.

The Committee agreed a Government amendment (Amendment 4) to clause 9 intended to ensure the proper operation of the current NHS continuing care arrangements. This technical amendment would widen the scope of regulation making powers to allow consortia commissioning responsibilities to be determined either by reference to an area or to practice registration, both current or previous.[100]

Clause 21 and Schedule 2: Establishment and membership of commissioning consortia

Liz Kendall moved amendments (Amendments 182 and 183) to sections 14E and 14F of clause 21; these amendments would require the Board to publish and consult on the criteria used to determine whether a consortium can vary its constitution and make it clear that the Board may vary the constitution of a consortium only if that consortium agreed. Paul Burstow responded that under sections 14E and 14F the Board would already have to make regulations, subject to parliamentary approval, setting out the criteria it uses in this area, and to consult a consortium about any changes. However, the Minister noted that there may be occasions when the Board might have to make change to a consortium without its agreement and used the example of extending the area covered by a consortium to ensure there was a comprehensive system of commissioning consortia across the country. The amendments were negatived on division.[101] The Opposition tabled a similar amendment (Amendment 185) to section 14H that provides for a consortium to apply to the Board to be dissolved, this was negatived on division.[102]

Liz Kendall introduced an amendment (Amendment 174) to Schedule 2 that would specify that consortia have a board, that board membership should include patient, clinical and local government representatives, and that the board must meet in public. She explained that this amendment went to the heart of the Opposition's concerns about the governance structure for commissioning consortia, and the absence of a formal requirement for anyone other than GPs to be involved in commissioning.[103]

John Pugh noted that he was not against the idea of commissioning consortia but that he was concerned that consortia consisting solely of GPs would be unable to commission all local services (citing the example of dentistry); there were questions about how GPs would performance manage themselves and avoid conflicts of interest, and about what would happen if one or more practice within a consortium failed.[104] Nick de Bois, Jeremy Lefroy and Kevin Barron also highlighted the importance of clinical involvement and representation on

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[99] *Ibid.* c411
[100] *Ibid.* c413
[101] *Ibid.* cc501-3
[102] *Ibid.* c504
[103] *Ibid.* c507
[104] *Ibid.* cc508-10

consortia.[105] Responding to the proposed amendment, Paul Burstow noted that "A lack of prescription in the Bill does not equate to a lack of governance" and outlined a number of existing provisions in the Bill, including: section 14O of clause 22, which provides that consortia would be under a duty to seek appropriate advice from health experts; section 14P, which places a duty on consortia to involve patients in planning and development of services; and sections 14X, 14Z3 and 14Z4, which give the Board the powers to assist a consortium in the event of a constituent practice losing its primary care contract.[106]

Liz Kendall quoted from one of the Health Select Committee's reports on Commissioning (HC 513-I, 2010-11) regarding the need for greater public engagement in commissioning and for GPs to draw on specialist knowledge.[107] She also raised the question of consortia delegating responsibilities to committees or sub-committees that would allow commissioning functions to be carried out by voluntary and private sector bodies. Paul Burstow responded that:

> The question of subcontractors being bound by consortia duties and where that is in the Bill is an important matter, and I want to ensure that it is clearly on the record. Consortia are still responsible for any subcontractor task; subcontractors act on behalf of the consortia. That is a matter of public law that is well established, so no specific reference to it is needed. Furthermore, there will be contractual support from the commissioning board in the form of draft model contracts for that sort of activity.[108]

Liz Kendall acknowledged that the amendment might not be perfect, but stressed the need to find "a balance between ensuring that there are effective boards that have the right members, and that individual consortia are not micro-managed." She withdrew the amendment and committed to bring the matter back on Report, after further consideration.[109]

Schedule 2: Pay and conditions of commissioning consortia employees

Emily Thornberry introduced three amendments (Amendments 155, 156 and 157) to Schedule 2 to ensure that consortium and their contractors have regard to the recommendations of the NHS pay review bodies and pension scheme when determining their employees' pay and conditions. She explained that the purpose of the amendments was to ensure some protection for NHS staff when they are transferred to a consortium, and that reasonable terms and conditions apply when a consortium outsources work to another organisation. Simon Burns stated that the amendments were unnecessary as there were already protections for public sector staff terms and conditions under the Transfer of Undertakings (Protection of Employment) (TUPE) Regulations 1981 and 2006, and the principles of the Cabinet Office statement of practice on transfers involving public sector staff.[110]

Simon Burns also explained that the Government intends that GP commissioning consortia would be classed as employing authorities for the purposes of access to the NHS pension scheme, from April 2012.[111]

The Minister went on to explain that consortia must be free to remunerate as they determine, within the confines of their budgets, and with a requirement to publish information relating to

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105 *Ibid.* c510
106 PBC Deb 8 March 2011 cc517-8
107 *Ibid.* cc521-524, Health Select Committee, *Commissioning* (HC 513-I 2010-11), 18 January 2011, para. 96.
108 *Ibid.* c525
109 *Ibid.* c526
110 *Ibid.* c531
111 *Ibid.* c531

remuneration.[112] He also noted that making each contractor employed by a consortium subject to the same guidance and regulations as direct employees would be impractical and leave consortia at the risk of judicial review.[113] The Opposition amendments were negatived on division.

The Committee agreed a Government amendment (Amendment 106) to make what was described as a "minor change" to Schedule 2. The amendment extends the responsibility of commissioning consortia accountable officers to ensure the consortium complies with its obligation to provide the Board with such information as the Secretary of State may require from all consortia (as opposed to from a single consortium or group of consortia).[114] The Committee agreed Schedule 2, as amended.

Emily Thornberry introduced an amendment (Amendment 138) to clause 22 to give commissioning consortia a duty to public involvement in decisions about the health services that are commissioned for their areas. This was followed by a long debate about public involvement with Ministers arguing that existing provisions such as section 14P already include such a duty. Emily Thornberry withdrew the amendment but noted that the Opposition would return to the issue at another stage.[115]

Emily Thornberry moved an amendment (Amendment 159) to introduce a duty for consortia to consult staff in the exercise of its functions and to work in partnership with employers and staff side representatives in implementing new contracts. She noted that the text of the requirements set out in the amendment were similar to those in the procurement guide for commissioners published by the Department of Health in June 2010. Simon Burns responded that the duty would duplicate existing statutory requirements to engage with staff set out in the NHS Constitution. The amendment was negatived on division.[116]

The Committee agreed a Government amendment to remove subsection (3) of section 14V of clause 22, allowing the Board to obtain assistance in producing commissioning guidance, as clause 225 would provide the Board with the necessary powers.[117]

Clauses 22 and 23: Commissioning consortia and conflicts of interest

Liz Kendall moved amendments (Amendment 211 and 217) to introduce procedures for the management of conflicts of interest in commissioning arrangements. The first of these would amend clause 22 to ensure that the Board's guidance for commissioning consortia must include procedures for the management of conflicts of interest; the second would amend clause 23, so that consortia must ensure that conflicts of interest are managed to prevent members benefiting financially from the consortium's commissioning arrangements.

Simon Burns argued that the regulation making power in clause 63 would be stronger that that proposed by Amendment 211. He explained that clause 63 allows for regulations to impose requirements on both the Board and consortia so that when commissioning services they adhere to good procurement practice. In particular, regulations may impose requirements relating to the management of conflicts between the interests involved in the commissioning of services and the interests involved in providing them.

In addition, the Minister set out the following new and existing measures intended to manage potential conflicts of interests:

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112 *Ibid.* c531
113 *Ibid.* c531
114 *Ibid.* cc532-3
115 *Ibid.* c543
116 *Ibid.* c546
117 *Ibid.* c558

> paragraph 4 of new schedule 1A to the National Health Service Act 2006, inserted by schedule 2 to the Bill, requires each consortium to set out its arrangements for managing potential conflicts of interest. Consortia will have the flexibility to specify their own arrangements, but it will be the role of the board to review and approve those arrangements as appropriate.
>
> As part of the establishment process for consortia, the NHS commissioning board must be satisfied that the applicants have made appropriate arrangements to ensure that the consortium will be able to discharge its functions. The board will review consortia constitutions for evidence that clear arrangements are in place to discharge their functions, including promoting choice and managing potential conflicts of interest. If the board is not satisfied that the proposed arrangements are adequate, it will simply not establish the consortium.
>
> Doctors are also bound by a duty under General Medical Council guidance that any commercial interest GPs might have in a company must not affect how they refer or prescribe for a patient. If they do decide that it is most clinically appropriate to refer a patient to a company in which they have an interest, they must inform the patient of that interest.

A number of Opposition Members asked if private companies would be able to support consortia in their commissioning role and also provide services. Simon Burns replied:

> …yes, a company could assist with commissioning and be involved in provision, but—there is a but—only if all regulations and requirements are being fulfilled; furthermore, as I said, there are protections, including those of the GMC, by which it has to abide in order to minimise a conflict of interest.[118]

Liz Kendall explained why the Opposition was not reassured by Government responses:

> Let me explain why the Opposition are not satisfied with the Minister's explanation. He frequently asked why we are complaining now, when this has always been the case and nothing much is changing. The General Medical Council already requires GPs to disclose whether they have an interest in a particular company to which they refer a pensioner, and the hon. Member for Central Suffolk and North Ipswich has said that GPs are already able to refer someone to a private provider where they or one of the colleagues work. The difference, though, is that GPs do not currently have responsibility for commissioning £80 billion-worth of the NHS budget. For all their faults, as well as some of their benefits, primary care trusts have a board, a chair, and executive and non-executive directors. The new body being established has no requirement to involve a GP, let alone any other provider, on its commissioning board. That is why we are so concerned. (…)
>
> We are concerned because, although some of the issues may be the same, the point is that the Bill changes the structures that deal with them and the accountability in those structures, and for the first time it gives GPs a role as commissioners of services, not just providers. There is no GMC requirement, as I understand it, for a GP to disclose anything involving a conflict of interest in terms of commissioning. It is about the provision of services, which is why we have tabled the amendments.[119]

The Opposition amendments to clauses 22 and 23 were negatived on division.

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[118] *Ibid.* c570
[119] *Ibid.* c572

Government amendments to clause 22: Consortia commissioning plans

The Committee agreed to a series of Government amendments (Amendments 96, 97, 98, 101, 103 and 105) with respect to consortia commissioning plans. Subsection (1) of section 14Y requires every consortium to prepare a commissioning plan before the start of each financial year. These amendments would allow the Board to direct new consortia to prepare a plan covering the period between their establishment and the end of the financial year, and present a single definition of 'financial year'.

Simon Burns also introduced an amendment (Amendment 99) to give consortia the ability to revise their commissioning plans once they are published, and to consult relevant health and wellbeing boards when making significant revisions. The amendment was agreed on division.[120]

The Committee agreed to five other Government amendments (Amendments 100 to 105) to clause 22, reflecting minor technical changes or corrections to inaccuracies in the original drafting of the Bill.[121]

Clause 23: Financial arrangements and quality premiums for commissioning consortia

Clause 23 sets out the financial arrangements for commissioning consortia. The clause includes provisions for a 'Quality Premium' to be top-sliced from existing GP practice income streams (under section 223L) with payments expected to be made in respect of good performance and withheld if a consortium failed to achieve good enough outcomes and financial control in its commissioning.

Liz Kendall argued that the Bill allows for "performance-related bonus payments" to be made by the Board to GP commissioning consortia, and that "the money could go into the GPs' private pockets and not be reinvested in patient care." She introduced an amendment (Amendment 225) to remove the powers to allow the Board to make payments to consortia based on performance. Liz Kendall referred to similar concern about "bonus payments" from the Royal College of GPs and the Royal College of Nursing.[122]

Simon Burns argued that the amendment would remove a key incentive for improving quality — pointedly noting that such payments would be an incentive rather than a bonus.[123] The Minister also stressed that the quality premium would be funded from existing resources and would "quite clearly be separate from the payments to GP practices for providing primary medical services".[124] However, Liz Kendall questioned the detail of the policy and the evidence for its introduction.[125] The amendment was negatived on division.

Abolition of PCTs and SHAs

Clauses 28 and 29 of the Bill provide for the abolition of Strategic Health Authorities and Primary Care Trusts. There was no debate on these clauses and the Committee agreed them on division.

4.5 HealthWatch and independent advocacy services

Part 5 of the Bill would establish HealthWatch England as a statutory part of the Care Quality Commission, to 'champion' service users across health and social care, and create a network of local HealthWatch organisations. Local HealthWatch organisations would take

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120 *Ibid.* c578
121 *Ibid.* cc578-9 and c582
122 *Ibid.* c585
123 *Ibid.* cc590-1
124 *Ibid.* c591
125 *Ibid.* c593

over the functions of Local Involvement Networks (LINks) (which would cease to exist) in promoting and supporting public involvement in the commissioning, provision and scrutiny of local health and social care services.

Clause 166, 167 and Schedule 13: HealthWatch

Clause 166 would amend Schedule 1 to the *Health and Social Care Act 2008* and establishes HealthWatch England as a statutory committee of the Care Quality Commission (CQC); and would make provision about HealthWatch England's purpose, its exercise of functions and other related matters. The clause includes a power for the Government to set out in regulations how the HealthWatch Committee should be appointed. Clause 167 provides for the establishment and form of local HealthWatch organisations.

The Committee agreed a number of technical amendments (Amendments 415 to 424) relating to clauses 166 and 167, and Schedule 13. Some of these related to minor changes although Paul Burstow noted that amendments 419 and 422, in particular, were important:

> Amendments 419 and 420 ensure that the meetings of HealthWatch England and of local healthwatch organisations generally have to be held in public. Amendments 421 and 422 ensure that members of HealthWatch England and local healthwatch organisations are barred from being Members of the House of Commons and of the Northern Ireland Assembly.[126]

While broadly welcoming the establishment of HealthWatch England the stand part debate provided an opportunity for Opposition Members to raise certain reservations about HealthWatch England's lack of independence: from the Care Quality Commission, of which it would be a part, and the Secretary of State, who would appoint its chair.

Jeremy Lefroy, the Member for Stafford, raised the importance of patient involvement in the context of events at Mid-Staffordshire NHS Foundation Trust and urged to Government to look at any recommendations in this area that emerged from the current inquiry headed by Sir Robert Francis QC. Paul Burstow replied that this was the Government's intention but that depending on the point at which the inquiry publishes its findings the Government might have to consider a second Bill in this session.[127] The Committee agreed to the question that the clause, as amended, stand part of the Bill, without a division.

Clause 170: Independent advocacy services

Clause 170 requires local authorities to make arrangements for the provision of independent advocacy services for complaints relating to the provision of health services, transferring this duty from the Secretary of State.

The Committee agreed a number of amendments (Amendments 426 to 432) to this clause, without division or debate. Amendment 427 specifies that arrangements under section 223A 'may not provide for a person to make arrangements for the provision of services by a Local HealthWatch organisation.'[128]

This change may reflect some concerns about proposals for HealthWatch to provide advocacy services for NHS complaints, expressed during the Government's consultation process. These concerns related to potential conflicts of interest with the role of HealthWatch in the commissioning decision making process, and its potential to undermine existing advocacy services. The Government's December 2010 *Legislative Framework* responded to

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[126] PBC Deb 10 March 2011 c616
[127] *Ibid.* c622
[128] *Ibid.* c646

these concerns by stating that the Government would 'provide flexibility concerning whom local authorities will commission NHS complaints advocacy services from...'.[129]

Clause 171: Requests, rights of entry and referrals

The Committee agreed to a minor amendment (Amendment 433) to clause 171.[130] This clause would allow the Secretary of State to make regulations to impose a duty on health and social care services-providers to respond to requests for information, and to reports or recommendations, made by local HealthWatch organisations, and to allow local HealthWatch to enter and view premises.

Clauses 173 and 174: Annual Reports and transitional arrangements

The Committee agreed to four minor and technical Government amendments (Amendment 434 to 437) to these clauses, relating to local HealthWatch annual reports, and to transitional arrangements for these bodies.[131]

4.6 Local authority overview and scrutiny functions

Clauses 175 to 183, in Part 5 of the Bill, deal with local authority overview and scrutiny functions. Clause 175 would give local authorities flexibility, from April 2013, to discharge their health scrutiny powers in the way they deem to be most suitable – whether through continuing to have a specific health Overview and Scrutiny Committee (OSC), or through a suitable alternative arrangement. To enable this flexibility, this clause would confer the health overview and scrutiny functions directly on the local authority.

Emily Thornberry moved two amendments (Amendments 358 and 359) to the clause. The first amendment would have ensured the current OSC structure was maintained. The second amendment was more central to Opposition concerns about whether the Bill would result in OSCs only being able to refer proposed changes to NHS services to the Secretary of State if they were 'designated' as essential services. Speaking to this amendment, Emily Thornberry set out the current powers of OSCs to refer any substantial changes to services to the Secretary of State:

> Section 244 of the National Health Service Act 2006 also relates the duties of NHS bodies to consult relevant overview and scrutiny committees about proposals for substantial variations to services, known as service reconfiguration. Section 244 gives relevant overview and scrutiny committees the power to refer proposals for substantial variations to services to the Secretary of State for determination. Since 2003, those referral powers have been available for many service reconfigurations. It must be said that there have been few actual referrals. The local authorities have used their powers wisely and carefully.[132]

Paul Burstow explained how local authorities would be involved in changes to NHS services under the system introduced by the Bill:

> How are local authorities involved in changes to NHS services? First, they will use the health and well-being board to discuss changes. Secondly, the local authority will use its scrutiny function to discuss changes. Thirdly, for service changes that are substantial or designated, the scrutiny function of the local authority can start a process

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129 DoH, *Liberating the NHS: Legislative framework and next steps* (Cm 7993) 15 December 2010, para 2.42-2.43

130 PBC Deb 10 March 2011 c646

131 *Ibid.* cc647-8

132 *Ibid.* c656

> of appeal. There are a number of aspects to that scrutiny function and it will be referred to the local council for a full vote. (...)
>
> If the vote agrees to continue with the appeal, it is then referred to the NHS commissioning board. If the local authority disagrees with the commissioning board, it may then refer to the Independent Reconfiguration Panel and to the Secretary of State. The Secretary of State will ask for advice from the Independent Reconfiguration Panel. Acting on the advice, the Secretary of State can reject the appeal, ask for the proposer of the change to reconsult and, in some circumstances, stop the service change.
>
> Undesignated services are obviously not subject to the third stage that I have just described. Every local authority must be consulted by Monitor—a very important point—on their designation guidance and by the relevant commissioners in applying that guidance once it is in place and is used to designate services. We will come back to the details. I do not propose to provide the detailed response to that debate, which we will properly have when we get to the relevant clauses.[133]

In response to a further questioning from Emily Thornberry, about whether only designated services would be able to be referred to the Secretary of State in future, Paul Burstow responded:

> It is right that those services which are not designated should have more flexibility to reconfigure. We have debated that already. They will, of course, still be subject to section 242 duties to consult the public on changes to services, and overview and scrutiny committees will of course be able to conduct their scrutiny of such reconfiguration decisions. So the answer is yes, only designated, through regulations; but local authorities' role in which services are designated is also very important. These are a series of interlocking clauses that provide a change in the nature of the scrutiny but actually strengthen it, because decisions about designation are ones that local authorities have a direct say over as well.[134]

Both Opposition amendments to clause 175 were negatived on division. The Chair of the Committee asked if the Minister could write to the Committee clarifying his answers to Emily Thornberry.[135] The Committee agreed to a Government amendment (Amendment 438) making transitional provisions, and to new clause 4, making amendments to the *NHS Act 2006* consequential to clause 175.[136]

The Committee agreed to a minor and technical Government amendment to clause 176, that would ensure that representative of the relevant GP consortia are required to be included in the health and well-being board.[137]

Emily Thornberry proposed an amendment (Amendment 367) to clause 177, which imposes a duty on local authorities and commissioning consortia to produce a joint health and well-being strategy (JHWS). The amendment would have replaced the word 'may' with 'must', so that local authorities and commissioning consortia 'must' include a statement about how health and social care commissioning could be more closely integrated in their JHWS. The Minister argued that the Government's wording is intended to give local commissioners the

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133 *Ibid.* c659
134 *Ibid.* c660
135 *Ibid.* cc661-2
136 *Ibid.* c661
137 *Ibid.* c662

flexibility to decide whether such a statement is helpful for their area. The amendment was negatived on division.[138]

During the clause stand part debate on clause 177 the Opposition raised concerns about the lack of formal powers of health and well-being boards to ensure that commissioning consortia abide by JHWS. Paul Burstow argued that there would be a clear legal duty for commissioners to have regard to the JHWS. The Committee agreed on division that the clause stand part of the Bill.[139]

The Committee agreed some minor and technical Government amendments (Amendments 442 to 448) to clauses 178, 179, 181 and 183, which introduce a statutory duty for all upper-tier local authorities to establish a health and well-being board (HWB), and cover some of the functions of HWBs.[140]

4.7 Monitor and the economic regulation of health services

Part 3 of the Bill would re-establish Monitor, the body that currently regulates NHS foundation trusts, as the economic regulator for the health sector.[141] In this expanded role, Monitor would have three core functions: to promote competition where appropriate, to regulate prices for NHS funded services, and support the continuity of services. To support its functions, Monitor would have the power to license providers of NHS-funded care. The *Legislative Framework* compared Monitor's new role in regulating healthcare, to that of Ofcom or Ofgem in regulating the communication and energy markets.[142] The *Explanatory Notes* to the Bill state that the legislation 'draws upon lessons from the utilities, rail and telecoms industries, borrowing provisions where applicable, but tailoring others to the particular circumstances of the health sector.'[143]

Clause 51 and Schedule 7: Establishing Monitor as economic regulator

Clause 51 states that Monitor continues to exist, but ceases to be known as the Independent Regulator of NHS Foundation Trusts. Instead, its formal name would be 'Monitor'. The clause also gives effect to the Schedule 7 which provides details of the membership of Monitor and the process for appointments.

Liz Kendall explained that Labour Members opposed clause 51 and subsequent clauses that establish Monitor as an economic regulator for the whole health sector. During the clause stand part debate on clause 51 she focussed her criticism on the provisions of the Bill that would, as she described it, remove Monitor's current responsibility for regulating foundation trusts.[144] She argued that by 2016, when all NHS trusts would be expected to have become foundation trusts (FTs), that:

> The safety net currently provided by Monitor and the SHAs will no longer be there and FT governors alone will act as the back-stop in dealing with problems if and when they arise.[145]

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138 *Ibid.* cc670-2
139 *Ibid.* cc673-4
140 *Ibid.* cc675-86
141 The Department of Health and the Department for Communities and Local Government are discussing whether to extend the system of economic regulation to the social care sector. The Bill contains provisions to extend the remit of Monitor to social care if this is considered to be appropriate in the future.
142 DoH, *Equity and excellence: Liberating the NHS* (Cm 7881), 12 July 2010, para 4.26-4.30, pages 37-39
143 *Explanatory Notes to the Bill* [Bill 132-EN], para. 491
144 PBC Deb 15 March 2011 c689
145 *Ibid.* c690

She also asked if the Minister could give a firm guarantee that every foundation trust would have governors with the necessary quality and experience.

Simon Burns put the removal of Monitor's foundation trust-specific compliance framework in the context of its new role as sector-wide economic regulator:

> The purpose of the current compliance framework is to ensure that each foundation trust complies with its terms of authorisation, which include ensuring the effective governance and the continuing financial viability of individual FTs; however, no equivalent regulation exists for other types of provider. Under our reforms, all types of provider will be licensed by Monitor. Regulation will be focused on protecting the services that are important for the NHS, wherever they are provided, rather than on any one type of organisation.[146]

He went on to address concerns about foundation trust's internal governance:

> ...the Bill significantly strengthens the internal governance of foundation trusts and makes them more directly accountable for the results that they achieve by strengthening the role of local governors and members and placing clear duties on foundation trust directors. To my mind, that will reduce the need for external oversight from Monitor and free foundation trusts to innovate and respond to the needs of patients.[147]

Liz Kendall also asked about Government assessments of the ability of all NHS trusts to achieve foundation trust status. The Committee agreed on division that clause 51 stand part of the Bill.

Monitor and public accountability

Liz Kendall introduced a number of amendments (Amendments 480, 483, 484 and 488) to Schedule 7, which she said were designed to ensure that Monitor, which would be a "hugely powerful organisation", would have "a degree of accountability to patients and the public" that was at the moment "completely lacking".[148] Amendment 480 would introduce a general duty for Monitor to involve and engage patients and the public. Amendment 483 would ensure Monitor's board included a patient representative appointed by HealthWatch England. Amendment 484 would ensure the board met in public and Amendment 488 would require Monitor to hold an annual meeting of its members.

Simon Burns said that amendment 480 was unnecessary as "Monitor will be expected to take into account the views of patients and the public" in delivering its general duties to protect and promote the interests of people who use health services. He also referred to its duties to engage with HealthWatch on its functions relating to designated services and licensing. Opposition Members questioned whether HealthWatch would be as strong and independent as consumer regulators in other sectors and highlighted similar concerns in the memorandum submitted to the Committee by the King's Fund.[149]

Regarding Amendment 484 the Minister responded that, like the NHS Commissioning Board, Monitor would be subject to the *Public Bodies (Admission to Meetings) Act 1960*, meaning that it must hold board meetings in public. He went on to explain that there would "be times

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[146] *Ibid.* c691
[147] *Ibid.* c691
[148] *Ibid.* c694
[149] Memorandum submitted by The King's Fund (HS 100), para 13

when it is inappropriate for the board meetings to be held in public—for example, when discussing issues of confidentiality—but the 1960 Act makes provision for such cases."[150]

In response to Amendment 483 Simon Burns said: "A patient representative from HealthWatch is unlikely to have the required level of expertise in economic regulation to provide scrutiny and challenge in a way that adds value."[151] The Amendment was negatived on division.

Monitor: financial flexibilities

Liz Kendall moved amendments (Amendments 485 and 487) to delete powers in Schedule 7 for Monitor, with the consent of the Secretary of State, to borrow money temporarily by way of overdraft, and for the Secretary of State to make additional payments to Monitor. Liz Kendall raised particular concerns about how much the budget of Monitor would increase. Simon Burns explained that Monitor might need to use the financial flexibility provided for in the Bill if there were delays in collecting its licence fees, and to deal with any other cash-flow problems it may encounter. He also explained that these powers replicated existing powers that Monitor has under paragraph 9(1) of Schedule 8 to the NHS Act 2006, to which Opposition Members said that the powers of Monitor outlined in the current Bill were fundamentally different.[152] The Amendment was negatived on division.

The Opposition moved an amendment (Amendment 486) to Schedule 7 to remove Monitor's general power to "do anything which appears to it to be necessary or expedient for the purposes of, or in connection with, the exercise of its functions." Simon Burns said Monitor needed flexibility and independence to carry out its functions but noted it would have duties to act in a proportionate way and to consult on significant proposals. The amendment was negatived on division and the Committee agreed to the schedule, on division.[153]

Clause 52: General duties of Monitor and the role of competition in the NHS

Clause 52 sets out the general duties of Monitor, and its principal overarching duty: to exercise its functions so as to protect and promote the interests of people who use health care services, by promoting competition where appropriate and through regulation where necessary. There was a lengthy debate in Committee about the clause, which covered the role of competition law in the NHS.

Liz Kendall moved an amendment (Amendment 179) to delete the references to competition and regulation in clause 52, restating Labour Members concerns about the overall approach of turning Monitor into an economic regulator. She asked who would decide where competition is appropriate in the new system, and noted her concern that once competition law has been specifically applied to the NHS it could be lawyers rather than GPs, patients, or the national commissioning board, who decide.[154]

Simon Burns stressed that Monitor would be expected to pursue its "overarching objectives" to protect and promote the interests of people who use health care services, and as a result Monitor would be free to uses regulation, even at the expense of promoting patient choice and competition.[155] The Minister highlighted specialised surgery as an example of where competitive tendering would not always be appropriate:

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[150] PBC Deb 15 March 2011 c696
[151] *Ibid.* c698
[152] *Ibid.* cc701-2
[153] *Ibid.* cc707-8
[154] *Ibid.* c709
[155] *Ibid.* c714

> Commissioning for several providers to compete on quality would not always be appropriate, such as in highly specialised surgery, for example, where concentrating services in specialist centres may be necessary to ensure patient safety, or where additional regulation may be needed to secure access to essential hospital services where there is no alternative provider. Our proposed approach would ensure that Monitor is under an express obligation to strike a balance between promoting competition on quality, where appropriate, and intervening through regulation only where necessary.[156]

Regarding the Opposition's more fundamental concern about the implications of the Bill for the application of competition law to the NHS, Simon Burns provided the following explanation:

> EU and British competition law was also raised in the debate. All the Bill does is add Monitor as an enforcement body. The Office of Fair Trading already has the relevant powers in respect of the health care sector. The Bill does not introduce any new competition law or extend the applicability of current UK and EU competition legislation. ...
>
> As NHS providers develop and begin to compete actively with other NHS providers and with private and voluntary providers, UK and EU competition laws will increasingly become applicable. The safeguards offered by those laws will therefore apply equally to all providers. In the health care sector, 90% of health care provision has been delivered by public providers fulfilling a largely social function. Organisations fulfilling a purely social function are not for profit and are not considered to fall within the definition of undertakings, so they are not subject to EU competition rules. Markets have been developing only in certain limited sectors over the past decade, as, for example, in elective care. However, in a future where the majority of providers are likely to be classed as undertakings for the purposes of EU competition law, that law and the protections it offers against anti-competitive behaviour will apply.[157]

Liz Kendall asked whether the Minister had taken legal advice on the compatibility of the Bill with EU competition law, what it would mean for commissioners and providers, and if he would publish this. The Minister confirmed that the Government had taken advice but that he would like to think about whether to publish this as "one has to look very carefully at what they are asking in order fully to consider the implications."[158]

The Minister also responded to a question from John Pugh about international evidence for establishing an economic regulator and cited "established models of economic deregulation in other UK public services and in health systems in the Netherlands, Germany and parts of the USA."[159] The amendment was negatived on division.

During the clause stand part debate on clause 52 a number of Opposition members set out their concerns about the proposals for Monitor to become the economic regulator for the health sector. These concerns focussed on the negative impact competition law might have on the quality and integration of care, and the potential cost of legal challenges to commissioning decisions. Members highlighted evidence to the Committee from the BMA, the King's Fund and others to support their case.

Liz Kendall noted that the debate on clause 52 was one of the most important during the passage of the Bill and gave a detailed analysis of what she saw as the fundamental

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156 *Ibid.* c715
157 *Ibid.* c718
158 *Ibid.* c719
159 *Ibid.* c718

questions about the role of Monitor.[160] In particular she asked whether it was right to model the regulation of the NHS along the lines of the economic regulation in the gas, electricity, rail and telecoms industries. She noted five key differences between healthcare and these other sectors:

- quality is harder to judge in health care than it is in the utilities or other industries;
- health services are far more interlinked than services in the gas, electricity or telecoms industries;
- there is a smaller number of providers in the utilities and telecoms industries, meaning that "it is relatively easy for a national regulator to have good information on each provider and to understand and to predict much more easily the impact of a provider's actions. In contrast, there will be thousands of different providers in the NHS and social care";[161]
- the complexity and inter-related nature of health services means that "It is far more difficult to set prices in health care than it is in the utilities, rail or telecoms industries";[162]
- users of gas, electricity and telecoms are the purchasers, but in health care, the commissioners are the purchasers, and the Government want the commissioners to be GPs.[163]

Liz Kendall said that the consequences of applying what she described as a fundamentally incorrect model to the NHS would be that GPs would be "driven by Monitor's duties to and powers to promote competition and by competition law, not by patients' needs. She also raised concerns that the Government's proposals would lead to health care becoming more fragmented, with "different parts of patient pathway... contracted out to different organisations."[164] She also emphasised the point, raised in earlier debates, about the consequences of competition law for commissioners and providers of services, and the increased costs under the new system.[165]

In his response Simon Burns agreed that the health sector is very different from the utilities sector and commented on the specific differences outlined by Liz Kendall:

> ...we have taken elements where appropriate from other regimes. Where it is not appropriate, we have customised the details, such as the special administration regime, to take fully into account the different situation, circumstances, mechanisms and mechanics of the NHS. It is true that quality is hard to judge in health... Our plans will radically increase transparency about outcomes, which is why there will be fixed prices, so competition is on quality.
>
> ...it is not true that regulation is harder with more providers. Competition works better with more providers and leads to less work for regulators to tackle anti-competitive behaviour. She also said that it is difficult to set prices. Again, I would agree that it is. Setting prices is an extremely complex issue. We already have a national tariff, and

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160 *Ibid.* cc736-47
161 *Ibid.* c739
162 *Ibid.* c740
163 *Ibid.* c740
164 *Ibid.* c742
165 *Ibid.* cc742-47

> Monitor will have the specialised expertise to develop it further, independent of Government. I welcome that as a positive move forward.[166]

The Minister then went on to address Liz Kendall's concerns about the impact of competition law on the integration of care:

> The hon. Lady said that competition law would prevent vertical integration by providers. If I cannot assure her, I tell her that that is not the case. Competition law does not prevent a provider from expanding its range of services. Indeed, patient choice and competition on quality would strengthen incentives for providers to work together in integrating services when that would improve quality.

He also attempted to clarify the issue of how competition law would apply to GPs, making the distinction between GP commissioning consortia and GP practices:

> The hon. Lady also said that commissioners—GP consortia—will become undertakings for the purposes of competition law. Commissioners, when purchasing services for the purpose of the NHS, will not be acting as undertakings. GP practices, when competing for services as providers, will be acting as undertakings and that is exactly the same position as now. [167]

Simon Burns introduced Government amendments (Amendments 373 to 375), which he described as minor and technical amendments, to clarify that Monitor should have equal regard to future and current demand in carrying out its functions, and that Monitor's remit should extend to health care services that could also be included in adult social care packages. Opposition Members raised concerns about any future extension of Monitor's functions to adult social care (the Bill contains provisions to extend the remit of Monitor to social care if this is considered to be appropriate in the future). Amendment 373 was agreed without a vote, Amendments 374 and 375 were agreed on division.[168] The Committee divided, and agreed that the clause as amended stand part of the Bill.[169]

Clause 54: Matters for Monitor to have regard to

Clause 54 provides a list of the considerations to which Monitor must have regard when carrying out its specific functions.

The Opposition moved an amendment (Amendment 481) to clause 54 that would ensure that Monitor must have regard to the need for enhancing collaboration and integration between health and social care services, and the impact that its actions affecting one service could have on related services. The amendment was negatived on division (this division was notable in that the Liberal Democrat Member for Southport, John Pugh, voted with Opposition Members).[170] The Opposition also introduced amendments (Amendments 166 and 167) to ensure that Monitor must have regard to future NHS workforce needs, and to make provision for staff training. The amendments were negatived on division.[171]

There was a lengthy clause stand part debate on clause 54. Liz Kendall made two main points about the clause, firstly that balancing the different issues that Monitor must have regard to would be "extraordinarily difficult". In particular she noted that there are "inherent conflicts between the need to balance fair access with competition", and difficult trade-offs between trying to improve the quality and efficiency of services. Secondly she was

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166 *Ibid.* cc765-6
167 *Ibid.* c766
168 *Ibid.* cc722-4
169 *Ibid.* c773
170 *Ibid.* c778
171 *Ibid.* c782

concerned about where authority finally lay for making these difficult decisions, referring to evidence to the Committee from the King's Fund that "these provisions do not make it clear how the balance between these various duties and considerations should be struck and how conflicts between Monitor's policies and those of the Care Quality Commission and NHS Commissioning Board, for example, should be resolved".[172]

Simon Burns noted that the final subsections of the clause are intended to help ensure that Monitor works effectively with other parts of the system:

> Monitor would have to take account of the way in which the Secretary of State and the NHS commissioning board performed their relevant statutory duties. The clause is to ensure that, in its role as economic regulator, Monitor would work in a way that had regard to, and complemented, the roles and responsibilities of other key players in the system. I believe that it is right to leave it to Monitor to consider and balance those things.[173]

However, the Minister acknowledged that "trade-offs" between demands for quality and efficiency have always existed in the NHS and there was no way to "legislate them out of existence", but that the Bill allows trade-offs to be managed fairly and transparently "to minimise any tensions and problems".[174] The Committee agreed on division that the clause stand part of the Bill.

Clause 57: Duty to carry out impact assessments

The Committee agreed, on division, to Government amendments (Amendments 377 and 378) intended to clarify clause 57 and remove unnecessary duplication.[175]

Clause 59: Failure to perform functions

The Committee agreed, on division, to Government amendments (Amendments 495 to 497). Simon Burns explained these changes would ensure that: the Secretary of State could only direct Monitor when he considered that a failure to perform its functions was significant; he could not intervene in relation to the performance of its functions in a particular case; and that where he did intervene he must publish his reasons for doing so.[176] The Committee agreed, on division, that the clause as amended stand part of the Bill.

Competition and patient choice

Clauses 60 to 68 of the Bill are intended to provide Monitor with powers intended to ensure that competition and patient choice operate effectively.

Clause 60: Functions under the Competition Act 1998

Clause 60 would give Monitor concurrent powers with the Office of Fair Trading (OFT) to apply the *Competition Act 1998* in relation the provision of healthcare in England (Chapter I of Part I of this Act prohibits undertakings from reaching agreements that prevent, restrict or distort competition; Chapter II prohibits undertakings from abusing a dominant position in a market. There are similar provisions under EU law).

On the clause stand part debate on clause 60 a number of Opposition Members raised concerns about the implications of competition law increasingly becoming applicable to the NHS, including increasing costs arising from legal challenges, the role of private sector

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172 PBC Deb 17 March 2011 cc788-9; See Memorandum submitted by The King's Fund (HS 100), para 13
173 *Ibid.* c799
174 *Ibid.* c803
175 *Ibid.* c820
176 *Ibid.* cc826-7

providers and whether monopoly providers might be subject to EU state-aid rules. Liz Kendall raised the issue of Monitor gaining the same powers as the Office of Fair Trading to impose penalties for breaches of competition rules. She summed up the Opposition's view that the question of "where competition should be applied should be based on evidence and decided on by policy, not by lawyers or Monitor and certainly not in the courts—whether in this land or another."[177]

Simon Burns noted that the Committee had already discussed many of the issues concerning competition in the NHS. He observed there had been competition within the health service under the previous Government and that competition law has always applied to the provision of health care services, "where providers are performing an economic function."[178] Addressing specific points raised by the Committee, the Minister explained that the European Commission, not Monitor, was responsible for enforcing state aid law. Regarding the use of fines and penalties he explained that:

> That ability would act as a deterrent, and take away unlawful gains that might be made by providers engaged in that sort of activity. It is entirely consistent with normal regulatory practice in other sectors. Fines are rarely used, but they deter anti-competitive behaviour that is against the interests of patients and taxpayers.[179]

The Committee agreed that the clause stand part of the Bill on division.

Clause 61: Functions under Part 4 of the Enterprise Act 2002

Clause 61 would give Monitor concurrent powers with the OFT under Part 4 of the *Enterprise Act 2002*. These powers would enable Monitor to carry out market studies and to make market references to the Competition Commission, if it has reasonable grounds for suspecting that any features of a market prevent, restrict or distort competition.

Liz Kendall asked about Government proposals to merge the OFT and the Competition Commission. Simon Burns noted that any changes to these bodies would be made in future legislation but promised to write to the Committee with further details.[180] The Committee agreed that the clause stand part of the Bill on division.

Clause 62: Competition functions: supplementary

Liz Kendall introduced an amendment to remove a subsection of the clause relating to the *Company Directors Disqualifications Act 1986*, which would give Monitor concurrent powers with the OFT to disqualify directors from competition infringements. Liz Kendall used the discussion of this amendment to probe whether this would apply to commissioning consortia and who would be considered directors. Simon Burns clarified that this part of the clause would not apply to consortia and that the definition of directors is "a member of senior staff in an NHS provider who is performing a director-like role." The amendment was withdrawn

The Committee agreed a minor Government amendment (Amendment 379) and the Committee agreed that the clause as amended stand part of the Bill, on division.

Clause 63 and 64: Requirements as to good procurement practice

Clause 63 would enable the Secretary of State to make regulations setting rules for the Board and GP consortia to ensure good procurement practice and protect choice and competition with regard to healthcare services. Clause 64 sets out Monitor's powers to investigate and remedy breaches of the regulations.

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177 *Ibid.* c868
178 *Ibid.* cc869-70
179 *Ibid.* c871
180 *Ibid.* c874

Simon Burns introduced a number of Government amendments (Amendments 498 to 503), two new clauses (new clauses 7 and 8) and a new schedule (new Schedule 2), relating to this part of the Bill, which the Committee agreed.

Speaking to the amendments to clause 63, Simon Burns explained that amendments 498 to 499 would remove the scope for regulations to include requirements on commissioners to promote competition – replacing that with "strong and clear provision for regulations to include prohibitions on anti-competitive conduct."[181]

Simon Burns explained that Amendments 500 and 501 would extend Monitor's powers under clause 64 so that, in addition to being able to investigate potential abuses following a complaint by an interested party, it would be able to initiate its own investigations, where it had reasonable grounds to do so.[182]

The Committee agreed Government Amendments 502 and 503, which would remove Monitor's power to direct the NHS Commissioning Board or commissioning consortia to put the provision of services out to tender, where the existing arrangements for these services are deemed "ineffective". Simon Burns explained the reasons for these changes:

> With the extension of patient choice, however, the need for tendering would diminish in any event. Moreover, the remaining powers for Monitor to set aside a contract where there has been a serious breach of the regulations and to direct the commissioner to put in place measures to prevent or mitigate further breaches should provide sufficient of a deterrent effect. Powers for Monitor to go further and direct the commissioner to put services out to tender would be unnecessary.[183]

Simon Burns set out the reasons for introducing new clauses 7 and 8 and new Schedule 2:

> I also propose to introduce, via new clause 7 and new schedule 2, a power to allow Monitor to accept undertakings—that is, commitments—from commissioners if they have breached regulations under clause 63. Monitor could accept those undertakings in lieu of issuing a direction or of declaring an arrangement ineffective. (...)
>
> Finally, new clause 8 would place Monitor under a duty to set out how it would apply regulations made under clause 63 to commissioners, by publishing guidance. It would require Monitor to consult the NHS commissioning board in doing that, and to seek approval for the guidance from the Secretary of State. The duty would ensure that commissioners are clear on the rules and the behaviour expected of them.[184]

The Opposition moved two amendments (Amendment 493 and 494), which would have removed reference in clause 63 to regulations imposing requirements with regard to competitive tendering, and would have removed Monitor's powers to declare arrangements for the provision of services ineffective under clause 64. The amendments were negatived on division.[185] The Committee agreed that clause 63 and 64, as amended, stand part of the Bill.[186]

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[181] *Ibid.* c878
[182] *Ibid.* c878
[183] *Ibid.* c883
[184] *Ibid.* c881
[185] *Ibid.* c880 and c884
[186] *Ibid.* c881 and c884

Clause 65: Mergers between foundation trusts

Clause 65 would ensure that mergers between foundation trusts should be subject to the Office of Fair Trading (OFT) and the Competition Commission's merger controls. The Committee agreed that the clause stand part of the Bill, on division.[187]

Clauses 66 and 67: Review by the Competition Commission

Clause 66 would require the Competition Commission to carry out a review of the development of competition and regulation in public healthcare services every seven years. Simon Burns introduced a new clause (new clause 9) to give the Commission powers to collect information to inform its reviews.[188] The Committee agreed a minor Government amendment (Amendment 381) to clause 67, relating to considerations relevant to publication.[189] The Committee agreed that the clauses as amended stand part of the Bill, on division.[190]

Designation of services

Clauses 69 to 73 cover the designation of services. Clause 69 provides for commissioners (GP consortia and the NHS Commissioning Board) to make an application to Monitor for a service to be designated, to ensure the continuity the service in the event of provider failure (by means of a special administration regime). The clause provides that commissioners may apply for a service to be designated only if they can demonstrate that the service is necessary to meet the health needs of their populations and that there is no alternative provider of that service.

The Opposition noted the importance of this clause,[191] and tabled a number of amendments (Amendments 474, 475, 477 and 478). Amendment 474 would have the effect that all services were classed as 'designated services', with the onus on commissioners to apply to Monitor to undesignated a service. Amendments 477 and 478 sought to ensure there was proper consideration to the wider effects that designation of a service may have on patients, in terms of access, needs and outcomes, and on other services.[192] In particular, Derek Twigg raised concerns about staff and equipment if one service in a hospital was designated and others were not.[193] Simon Burns responded that the clause already required the commissioners to have regard to the current and future need for a service. He also noted that the impact on non-designated services would be an important consideration for commissioners when consulting on applications to designate services: "because it is integral to consideration of whether the withdrawal of a particular service would impact on the health of the population in the absence of alternative providers."[194] These amendments were negatived on division.[195]

The Committee agreed to a number of Government amendments to clause 69 (Amendments 504 to 508) and new clauses 10, 11 and 14, intended to ensure the process of designation operated efficiently and to deal with how complaints would be made against Monitor's decisions. Amendment 504 was a minor, technical amendment to clarify the drafting of the clause. Amendments 505 to 508 would make changes to what Monitor would be required to do when it issues a notice of its decision on an application to designate a service. If Monitor grants an application, then amendment 507 would require that notice to contain details of the

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187 *Ibid.* c886
188 *Ibid.* cc886-7
189 *Ibid.* c889
190 *Ibid.* c888 and c889
191 PBC Deb 22 March 2011, c894
192 *Ibid.* c909
193 *Ibid.* c911
194 *Ibid.* cc915-6
195 *Ibid.* c908 and c919

right to complain against its decision. If Monitor refuses an application, amendment 508 sets out what the notice of refusal must contain the reasons for the refusal and explain the right to appeal against the decision. The new clauses would deal with how complaints would be made against Monitor's decisions, for example, new clause 10 would govern how complaints could be made in relation to Monitor's decision to grant an application for designation.[196]

On the clause stand part debate Derek Twigg noted that the designation of services had not received much attention compared to other aspects of economic regulation. He asked a number of questions about how the designation process would work and commented that the Committee were being asked to make decisions about the clause without having the necessary detail.[197] Liz Kendall highlighted evidence to the Committee from the newly appointed Chair of Monitor, who had commented that Monitor had not yet developed guidelines for the designation process.[198]

Derek Twigg raised concerns about whether GP consortia would have the technical skills and evidence base to make the case for designation, and if Monitor would have the local knowledge to decide on applications. He also commented that responsibility for unpopular cuts and service closures was being passed from the Secretary of State to Monitor.[199] Grahame M. Morris expanded on this point:

> Rather than decisions about closures being made on clinical grounds or as part of the strategic planning at PCT or SHA level, under the new arrangements, the market will decide... If a nearby service is failed by the market, the Bill will prevent any centrally dictated rescue of that service, no matter what public opinion or, indeed, local representatives might think.[200]

Responding to these concerns Simon Burns stated that "GPs are ideally placed to make decisions on which services need additional regulation, as they have the hands-on clinical knowledge and expertise regarding the needs of their patients".[201] The Minister noted that under the proposed new system decisions about services would be made locally, and would be opened up "to an unprecedented degree of transparency and democratic scrutiny". He also said the Government's proposals would end "the hidden subsidies that have been used in the past to prop up failing and inefficient providers".[202] The Committee agreed that the clause stand part of the Bill on division.[203]

Clause 70: Appeals to the tribunal

The Committee disagreed to clause 71 after Simon Burns explained that the Government no longer wished the clause to stand part of the Bill, having been replaced by five, "more comprehensive", new clauses (new clauses 10 to 14) on complaints and appeals.[204]

Clause 71: Reviews and removals of designations

Simon Burns introduced a number of Government amendments to clause 71 (Amendments 510 to 515). The Minister explained that Amendments 512 to 515 were minor and consequential changes, and that the purpose of Amendments 510 and 511 was to allow

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196 *Ibid.* c920
197 *Ibid.* c927
198 *Ibid.* c902; see PBC Deb 10 February 2011, Q217
199 *Ibid.* c928
200 *Ibid.* cc931-2
201 *Ibid.* c946
202 *Ibid.* c948
203 *Ibid.* c952
204 *Ibid.* c953

Monitor to set the regulatory periods for which services would be designated.[205] The Committee agreed the amendments on division.[206]

Licensing arrangements

Clauses 74 to 102 provide Monitor with powers to run a licensing regime for providers of health services.

Clause 77, 84 and 89: Licence conditions

The Committee agreed to minor and technical Government amendments (Amendments 382 and 449) to this clause regarding exemptions to providers from the need to hold a licence from Monitor.[207] The Committee agreed to Government amendments (Amendments 383, 450 and 516) to clauses 84 and 89 regarding notice of decisions to revoke a licence, and to the setting and modification of licence conditions.[208]

Clause 90: Licence conditions: supplementary

Simon Burns introduced Government amendments (Amendments 385, 451, 452) to clause 90, which sets out an illustrative list of the major types of licence conditions that Monitor may wish to include in its provider licences. The Minister explained that the amendments would strengthen and clarify clause 90(1)(c) "to make it clear that Monitor can require licensed providers to take specific actions and to take actions of a general type or in a manner specified by Monitor, and that Monitor can define the period in which such actions can be taken." Derek Twigg asked for examples of where similar powers are available to other regulators, and about redress, should a provider or commissioner think a decision under these powers was unreasonable. Simon Burns said he would write to Derek Twigg. The Committee agreed the amendments on division.[209]

In the clause stand part debate Derek Twigg commented that clause 90 raised what he said were important issues regarding Monitor's powers to impose conditions, and to require 'incumbent providers' to grant access to their services to other providers. He also asked if this requirement to grant access would apply to GP surgery facilities as well as hospitals. Simon Burns responded that Monitor must decide if it practical to provide such access, and with regard to GPs stated that this would be extremely unlikely to apply with regard to a GP surgery. The Committee agreed the clause stand part without a division.[210]

Clauses 91 to 102: Minor amendments

The Committee agreed a large number of minor Government amendments (Amendments 386 to 397 and 410 and 411, 455 to 467) to clauses 91, 92, 93, 99, 101 and 102, and to Schedules 8 and 9 (clause and schedule relating to designation conditions and enforcement action).[211] Derek Twigg moved an amendment (Amendment 611) to clause 102, that would have maintained Monitor's powers to intervene in foundation trusts in section 52 of the NHS Act 2006. This amendment was negatived on division.[212]

Clauses 105 to 112 and Schedule 10: Minor amendments

The Committee agreed a large number of minor and technical Government amendments (Amendments 194 to 99, 200 to 203, 404 to 406, 544 and 565 to 74) to clauses 105 to 111,

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[205] *Ibid.* c953
[206] *Ibid.* c955 and c959
[207] *Ibid.* c962
[208] *Ibid.* cc962- 3
[209] *Ibid.* cc965-6
[210] *Ibid.* c971
[211] *Ibid.* cc971-3
[212] *Ibid.* c977

and to Schedule 10.[213] Simon Burns explained that Amendment 544 to clause 105 would clarify that when the NHS Commissioning Board is developing the list of services to be covered by the national tariff it must specify the services in standard units to be used in the national tariff document.[214]

Insolvency and health special administration

Clause 113 to 119 make provisions for a failure and special administration regime for health service providers, to ensure the continuity of designated services. Clause 113 would remove the existing (and non-operational) failure arrangements for foundation trusts set out in sections 53 to 55 of the *NHS Act 2006* and would provide for the Secretary of State to make secondary legislation to apply existing corporate insolvency procedures to foundation trusts (foundation trusts are public benefit corporations which are currently outside of the scope of the *Insolvency Act 1986*). Simon Burns explained the purpose of the clause:

> The clause provides for the Secretary of State to make regulations to apply relevant parts of insolvency and company legislation to foundation trusts for the purposes of rescuing an insolvent foundation trust as a going concern or ensuring an orderly winding-up of its affairs in the best interests of creditors as a whole.[215]

Derek Twigg commented that the Opposition were strongly opposed to this measure and that it seemed as if the "present Government will celebrate failure [of a foundation trust] as a successful market function". He moved amendments (Amendments 615), which he argued would "seek to ensure that the final decision on whether a trust enters insolvency remains with Monitor".[216] Responding, Simon Burns emphasised that insolvency procedures "will be the last resort when intervention by FT governors, commissioners and Monitor has not succeeded in turning around the affairs of a failing provider, and will apply only in relation to non-designated services." He went on to set out the various pre-insolvency interventions that could be applied. [217] The amendment was negatived on division; the Committee agreed three minor Government amendments (Amendments 519 to 521). During the clause stand part debate a number of Members argued that the introduction of insolvency provisions would make it easier to close hospitals, to which Simon Burns responded, in an apparent reference to designated services, "the whole purpose of the Bill and the clause is to protect, not close, essential services".[218] The Committee agreed, on a division, that the clause as amended stand part of the Bill.

4.8 NHS Foundation Trusts

The Government has indicated that it wants all NHS trusts to have achieved foundation trust status by April 2014.[219] Reforms to the role of Monitor would reduce its specific oversight of foundation trusts and clauses 136 to 165 in Part 4 of the Bill include measures intended to strengthen foundation trusts' internal governance and to increase the accountability of governors and directors. During the Committee stage Ministers acknowledged that Monitor's current controls may potentially apply up to 2016, at least to recently authorised foundation trusts.[220]

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213 *Ibid.* cc999-1006
214 *Ibid.* c1000
215 *Ibid.* c1012
216 *Ibid.* c1011
217 *Ibid.* c1013
218 *Ibid.* c1034
219 DoH, *NHS Operating Framework for 2011/12*, 15 December 2010, paras 2.23-2.26
220 PBC Deb 15 March 2011 c692. This confirmed the position set out in Sir David Nicholson's letter to the NHS on 15 December 2010: *Equity and Excellence: Liberating the NHS – Managing the transition and the 2011/12 Operating Framework,* p8

Clause 136: Governors

Clause 136 would make explicit the duty of foundation trust governors to hold the board of directors to account and give governors the power to require the trust's directors to attend meetings. Liz Kendall moved an amendment (Amendment 640) to require the Care Quality Commission (CQC) to ensure that governors were 'equipped with the skills and knowledge they require'. She commented that this would give CQC similar powers to those that Ofsted has in assessing school governing bodies. Paul Burstow indicated that he had sympathy with the intentions of the amendment but argued that if it were accepted the clear responsibility of governors set out in the clause would be "diluted".[221] The amendment was negatived on division. The Committee agreed minor Government amendments (Amendments 522 to 525 and 575) to clauses 136, 139 and 148, without division.[222]

Clause 150: Income from private health care

Clause 150 would repeal the restriction on the amount of income a foundation trust can earn from private charges, otherwise known as the 'private patient income cap'. Derek Twigg noted that the clause greatly worried the Opposition and that "Removing the private patient income cap would lead foundation trusts to change from being NHS organisations that treat some private patients to being the same as a private provider that can also treat NHS patients."[223] He also argued that without the cap foundation trusts would become more like commercial undertakings and therefore competition law would become more applicable to their activities. Opposition Members also noted that the clause might lead to private patients being favoured over NHS patients. Paul Burstow replied that Monitor would have a specific responsibility to protect and promote the patient interest and that the primary purpose in law for foundation trusts is to provide goods and services for the NHS.[224] John Pugh asked whether there were adequate remedies and restraints if foundation trusts got the balance between the provision of NHS and private treatment wrong. He also asked about NHS-trained and employed staff, with NHS pensions, working primarily for private units, and the Minister said he would write to the Member about this.[225] The Committee negatived an Opposition amendment (Amendment 624) and agreed a minor Government amendment (Amendment 526). The Committee agreed that the clause, as amended, stand part of the Bill on division (John Pugh voted against, with Opposition Members).

The Committee agreed to a large number of minor and technical Government amendments (Amendments 527 to 35, 540 to 43, 576 to 92 and 635 to 38) to clauses 156, 157, 161 to 165 and Schedule 12, without divisions.

4.9 The regulation of health and social care workers[226]

Clauses 193 to 215 in Part 7 of the Bill would make changes to the three health and social care arm's-length bodies. It would:

- abolish the General Social Care Council and transfer its functions to a new Health and Care Professions Council;
- make changes to the governance and functions of the Council for Healthcare Regulatory Excellence; and
- abolish the Office of the Health Professions Adjudicator.

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221 PBC Deb 24 March 2011, c1049
222 *Ibid.* c1056
223 *Ibid.* c1073
224 *Ibid.* c1089
225 *Ibid.* c1091
226 This section of the paper is by Manjit Gheera.

The Committee debated Part 7 (clauses 196 to 215) of the Bill during its 25th and 26th sittings.[227]

Clause 198: The Health and Care Professions Council

The Committee divided for amendments moved by Emily Thornberry to clause 198 on the proposed Health and Care Professions Council (the Council) which would replace the current Health Professions Council (HPC). The amendments (Amendments 547 and 548) sought to change the name of the new Council to the Social Work and Health Professions Council to reflect the Council's remit to regulate social workers. The Member stated that the omission of social work from the title had invoked "a great deal of anger" amongst the profession and had been described as an "insult".[228]

In response, the Care Services Minister, Paul Burstow, assured the Committee that the new name had been a matter of considerable debate and that the Government believed that the 'Health and Care Professions Council' accurately reflected the functions of the Council. Moreover, he pointed out that the 15 professionals currently regulated by the HPC were not specifically mentioned in the current name and "it would not be right to single out one profession and place it above all others."[229] The Minister did however seek to reassure the Committee that social work would not be the forgotten profession as the new regulator name would be supported by the strapline: "Regulating health, psychological and social work professions".[230]

Emily Thornberry was not convinced that the Minister's explanation would appease the social work profession, and moved the amendment to a vote. The amendment was negatived on division.[231]

Clauses 200 and 207: Fitness to practice appeals

Emily Thornberry proposed two amendments (Amendments 647 and 648) to clauses 200 and 207. The amendments would retain the current position that rights of appeal from a fitness to practice decision would be to the first tier tribunal for care standards instead of the High Court, as proposed in the Bill. The Member argued that the high cost of instructing solicitors and barristers for a High Court appeal would act as deterrent to social workers and reduce access to justice.[232]

Paul Burstow sought to explain why the Government believed that the amendments were based on a flawed understanding of the system. He contended that the appeal process in the Bill would in fact be far more flexible than the General Social Care Council's (GSCC) current appeals process. This was because, unlike the GSCC, which can only deal with matters relating to competence, the Council would be able to give full consideration to the range of social work practice relating to both conduct and competence. Furthermore, unlike the GSCC, which is limited to removing, suspending or admonishing a social worker, the new Council would, in appropriate cases, support social workers in England to improve their practice, for example, through the use of conditions on registration. He also informed the Committee that the Bill's proposals were based on recommendations from the Council for Healthcare Regulatory Excellence's independent review of the GSCC, which in 2009 recommended the changes.[233]

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227 Thursday 29 March 2011
228 PBC Deb 29 March 2011 c1132
229 *Ibid.* c1133
230 *Ibid.*
231 *Ibid.* Ayes 10, Noes 13
232 *Ibid.* c1136
233 *Ibid.* c1138

The Minister did concede that "taken as a whole... the cost of a small number of social workers who appeal to the High Court will increase as a result of the appeal process."[234] However the Government viewed the changes as offering many more advantages than the current GSCC processes.

Emily Thornberry pushed the amendments to a vote, which was negatived on division.[235] Clauses 200 to 207 were ordered to stand part of the Bill.[236]

Clause 212: Establishment of voluntary registers

The Paul Burstow moved a minor Government amendment (Amendment 593) to clause 212.[237] The Committee divided and agreed the question that the clause, as amended, stand part of the Bill.[238]

Clause 215: Abolition of the Office of the Health Professions Adjudicator

A new Office of the Health Professions Adjudicator (OHPA), to adjudicate on fitness to practice cases brought before it by the General Medical Council (GMC) and the General Optical Council (GOC), was established by the Labour Government under Part 2 of the *Health and Social Care Act 2008*. It was expected to take up its role in relation to GMC cases from April 2011 and then, in due course, to take on the adjudication role in relation to health professionals from the other health regulators. However, following a consultation exercise, the current Government announced it was not persuaded that the creation of OHPA was the most appropriate and proportionate way forward in terms of adjudication and had decided not to proceed with setting up the OHPA. Clause 215 would repeal Part 2 of the 2008 Act and abolish the OHPA.

Owen Smith commented that, despite reforms to GMC procedures, maintaining the existing regulatory arrangements, did not address the recommendation of the Shipman Inquiry, headed by Dame Janet Smith, that there should be an independent adjudicator, separate from the regulatory and investigating body for doctors. The Committee agreed the clause on division.[239]

Schedule 14: Consequential amendments

The Government moved a number of consequential amendments (Amendments 594 to 598) to Schedule 14. These were agreed by the Committee without division.[240]

4.10 The National Institute for Health and Care Excellence (NICE)

Clauses 216 to 233 in Part 8 of the Bill would re-establish the National Institute for Health and Clinical Excellence (NICE) as a non-departmental public body (it is currently a Special Health Authority) and re-name it the 'National Institute for Health and Care Excellence', reflecting the extension of its remit to social care (it would still be known as NICE). Its primary purpose and function would be to provide advice to both the NHS Commissioning Board and the Secretary of State to enable them to discharge their respective quality improvement functions; the Government has tasked NICE with developing a suite of quality standards to achieve this.

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234 *Ibid.* c1139
235 *Ibid.* c1140; Ayes 10, Noes 13
236 *Ibid.* cc1140-1
237 *Ibid*. c1144
238 *Ibid.* c1157; Ayes 10, Noes 13
239 *Ibid.* c1163-4
240 *Ibid.* c1164

The Committee had substantive clause stand part debates on clauses 217 and 218, relating to the general duties of NICE and quality standards, but agreed these, with minor Government amendments (Amendments 599 and 600), without division. Several Members noted they were sceptical about whether NICE would be able to carry out its extended functions with what the Minister confirmed would be an 11% budget reduction. Liz Kendall said she was concerned that responsibility for deciding which treatments should be funded would move from NICE to GP commissioning consortia, exposing GPs to pressure from patients keen to access expensive drugs, and increasing the "post code lottery".[241] Owen Smith asked what the impact of the changes to NICE would be on Wales; he noted that the All Wales Medicines Strategy Group (AWMSG) relied heavily on NICE guidance, and that if NICE no longer issued mandatory guidance, or if there was less NICE guidance on specific drugs, the AWSMG would have to "pick up the tab and try to do that role for Wales".[242]

Paul Burstow outlined the Government's proposals to introduce a new value-based approach to the pricing of medicines when the current pharmaceutical price regulation scheme expires in 2013; noting that as his Department had just concluded its consultation on these plans it was not possible to provide detail of how the new system would operate. He confirmed that prior to the introduction of this new system consortia would be under the same obligations as PCTs in respect of paying for drugs recommended by NICE.[243] In response to the points raised by Owen Smith, he said Wales would "have access to NICE products and may also contract independently with NICE for Wales-specific products."[244]

The Committee debated an Opposition amendment (which was later withdrawn) to clause 221, about the status of NICE advice and guidance. In response to questions from Owen Smith, Paul Burstow confirmed he would write to Members about budgetary planning by commissioners in advance of implementing NICE guidance, and about arrangements for "exceptions committees".[245] The Committee agreed minor Government amendments (Amendments 601 to 603) to clause 221, and agreed that the clause, as amended, stand part of the Bill on division.[246] The Committee also agreed technical Government amendments (Amendments 605 and 606) to clause 233 and Schedule 16.[247]

4.11 Health and adult social care services: information

Clauses 234 to 257 in Part 9 of the Bill would establish the Health and Social Care Information Centre (HSCIC), which is currently a Special Health Authority, as a non-departmental public body. In its role collecting data to support central bodies in discharging their statutory functions, it would have powers to require data to be provided to it when it is working on behalf of the Secretary of State or the NHS Commissioning Board. The HSCIC would also be able to consider additional requests from other arm's-length bodies, and carry out those data collections if specific criteria are met. It would have a duty to seek to reduce the administrative burden of data collections on the NHS, with powers to support this.

In the clause stand part debate on clause 236, establishing the HSCIC as a statutory body, Emily Thornberry raised concerns about patient confidentiality and also questioned reports that the Government intended to end funding for the General Lifestyle Survey, and the health and NHS satisfaction questions in the British Social Attitudes Survey. Paul Burstow replied

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[241] *Ibid.* c1171
[242] *Ibid.* cc1176-7
[243] *Ibid.* cc1180-1
[244] *Ibid.* c1182
[245] *Ibid.* c1197
[246] *Ibid.* c1199
[247] *Ibid.* cc1204-6

that no decisions had been made on funding but that he would write to her to address her question.[248]

The Committee agreed to what Paul Burstow described as "substantive" Government amendments (Amendments 674 to 676) to clause 238. The Minister explained that Amendments 675 and 676 clarify that directions made under clause 238 and requests made under clause 239 cannot specify that information should be collected and disseminated as an alternative to publication, other than in limited circumstances set out in clause 243. The amendments also clarify that the restrictions on disseminating information imposed under clause 243 should not interfere with the right of any other lawful authority to disseminate under other legislative provisions.[249]

The Committee agreed the following Government amendments relating to the HSCIC:

- minor and technical amendments (Amendments 677 to 682) to clauses 239, 241 and 242;[250]
- a large number of amendments (Amendments 686 to 98) to clause 243, relating to the publication of information by the HSCIC;[251]
- amendments (Amendments 699 to 701) to ensure that every three years the HSCIS conducts a review of the burdens that data collection might have placed on the system;[252] and
- amendments (Amendments 702 to 704) to clause 254 and Schedule 18.[253]

The Committee also agreed minor Government amendments (Amendments 672 and 673) to clause 234, which sets out how the Secretary of State or the NHS Commissioning Board may prepare and publish information standards.[254]

4.12 Abolition of certain public bodies

The Committee debated a number of clauses in Part 10 of the Bill, concerning the abolition of the Alcohol Education and Research Council (clause 258); the Appointments Commission (clause 259); the National Information Governance Board for Health and Social Care (clause 260); the National Patient Safety Agency (NPSA) (clause 261); and the NHS Institute for Innovation and Improvement (clause 262). All these clauses, apart from clause 261, were agreed without division. During the debate on clause 261 Opposition Members raised a number of concerns about the impact on patient safety of abolishing the NPSA. During the debate Paul Burstow confirmed that although the Government's original intention had been to abolish the NPSA by September 2011, in order to maintain continuity in service and to work through staff transfer issues, they were now working on the basis of 31 March 2012 as the point at which the Agency would be abolished.[255]

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[248] PBC Deb 31 March 2011 c1220
[249] *Ibid.* cc1223-4
[250] *Ibid.* c1228 and c1232
[251] *Ibid.* cc1240-41
[252] *Ibid.* c1243
[253] *Ibid.* c1245
[254] *Ibid.* c1215
[255] *Ibid.* c1260

4.13 Transfer of property, liabilities and staff

Clauses 274 and 275, in Part 11 of the Bill, deal with the transfers of property, liabilities, and staff that would take place as a result of changes made in the Bill. Schedule 21 details the types of property transfers that the Secretary of State can make, or can direct the board or qualifying company, which can be partly or wholly owned by the Government for NHS purposes, to make. Such transfers would generally be from existing bodies that would be abolished to new or existing bodies; for example, PCT property may be transferred to commissioning consortia.

In the clause stand part debate on clause 274, Derek Twigg stated that "the top-down reorganisation [of the NHS] will probably have the single biggest impact on property owned by the NHS", and "that it is potentially the largest single change in NHS history." Derek Twigg and John Pugh asked a number of questions about the impact of the clause, which Simon Burns responded as follows:

> The hon. Gentleman [Derek Twigg] also asked what will happen to unwanted properties. Everything will have to be transferred somewhere, and no property will be abandoned. He also asked about private sector joint ventures to be set up and discussions held. I can tell him that discussions are under way within the Department and with the Cabinet Office. We have not had discussions with the private sector.
>
> The hon. Gentleman asked about unitary and metropolitan councils. Clause 274(9)(b) relates to unitary authorities, so property can be transferred to them provided that it is for public health service, which I hope reassures him.

The Minister also addressed questions about PFI and LIFTCo schemes (LIFTCo schemes are joint ventures between the private sector and the NHS to provide modern primary care facilities):

> The hon. Gentleman [Derek Twigg] and my hon. Friend the Member for Southport [John Pugh] have mentioned PFI and LIFTCo. PFI deals could be transferred, as could NHS shares in LIFTCo, but discussions are still ongoing and the most appropriate solution in both cases will depend on individual circumstances.[256]

Derek Twigg also asked about the value of the NHS estate, to which Simon Burns responded that he would write to the Member. The Committee agreed a number of Government amendments to clause 274 and Schedules 21 and 22 (Amendments 706 to 711, 748 and 749) and, on division, that clause 274, as amended, stand part of the Bill.

4.14 Regulations, orders and directions

The Committee agreed Government amendment (Amendment 729) to clause 277 regarding regulations, orders and directions, and also discussed new clause (New Clause 19 to 21) in connection with the fluoridation of water supplies. Kevin Barron said that it was "a disgrace" that the Committee had to debate important new clauses, schedules and amendments while the timetable motion required them to finish at 4pm, on the final day of the Committee stage, 31 March 2011. Paul Burstow replied that the Government did not intend to make new fluoridation schemes more or less likely. He explained the new clauses would transfer responsibility for consulting and deciding on schemes from SHAs to local authorities, "putting in place a fair and practical way to discharge the function once the strategic health authorities are abolished" and this "would make decisions on fluoridation more democratically accountable."[257]

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[256] *Ibid.* c1279
[257] *Ibid.* c1284

4.15 Clauses, New Clauses and New Schedules agreed but not debated

In accordance with the programme order the Committee stage debate was concluded at 4pm on Thursday 31 March 2011.[258] The Chairman put the questions necessary for the disposal of the business to be concluded at that time (Standing Order No. 83D), and the following Government amendments were made without debate:

- Amendments 607, 717 and 730 to clause 277;[259]
- Amendments 718, 719 and 731 to 733 to clause 279, agreed on division;[260] and
- Amendments 608 and 720 to 724 to clause 280.[261]

The Committee also agreed New Clauses 2 to 5, 7 to 14, 16, 17, and 19 to 25. New Clauses 5 and 17 were agreed on division,[262] and New Schedules 1 and 2.

4.16 Other amendments and New Clauses

The Government made a large number of other amendments to the Bill, most of which it described as being minor, technical or correcting:

Clause 38: Role of the Board and Consortia in respect of emergencies

Liz Kendall raised the question of where responsibility for emergency planning would lie under once SHAs are abolished, and during the transition to the new system. Simon Burns explained that under clause 38 there would be clear requirements on NHS bodies, including the Board, consortia, and providers to be prepared and to ensure compliance. The Minister said he would write to Liz Kendall explaining what is happening now and what would happen during the transition. Liz Kendall did not push the issue to a vote but commented that the Opposition would bring the matter back for further scrutiny at the Report Stage.[263]

Clause 39: Secretary of State's emergency powers

The Committee agreed Government amendments (Amendments 222 to 224). Paul Burstow explained the purpose of these "minor, consequential and correcting" amendments was to ensure that references to the NHS bodies to which the powers would apply were correct (in new section 253 of the NHS Act 2006).[264]

Clause 43: Pharmaceutical services expenditure

This clause would make provision for pharmaceutical services expenditure. In response to a number of points raised by Kevin Barron, Paul Burstow wrote to Mr Barron to provide further information.[265]

Clause 47: Functions in relation to biological substances

Clause 47 would transfer some UK-wide functions in relation to biological substances currently carried out by the Health Protection Agency. Jim Shannon asked about the impact on the Department of Health, Social Services and Public Safety (DHSSPS) in Northern

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[258] *Ibid.* c1285
[259] *Ibid.* cc1285-6
[260] *Ibid.* c1286
[261] *Ibid.* c1287
[262] *Ibid.* c1305
[263] PBC Deb 8 March 2011, c594-99
[264] PBC Deb 17 Mach 2011, c828
[265] PBC Deb 8 March 2011; letter dated 21 March 2011 (Deposited Paper 2011/590)

Ireland. Paul Burstow noted that the changes had been discussed and agreed with the devolved Administrations and promised to write to the Member with further details.[266]

Clause 50: Co-operation with bodies exercising functions in relation to public health

Clause 50 would require co-operation between the Secretary of State and others engaged in health protection activity, to ensure a joined-up approach to fighting the spread of disease and other dangers to health. The Committee agreed to a minor and technical amendment to ensure clause 50 applies across the UK, including the areas covered by the Governments of the devolved Administrations.[267]

Clauses 128, 130, 133 and 134: Financial assistance in health special administration cases

The Committee agreed a number of minor Government amendments (Amendments 410, 411, 413, 414 and 468 to 471) to these clauses.[268]

Clause 185: Care trusts

Clause 184 would amend section 77 of the *NHS Act 2006* to make it possible for NHS foundation trusts or commissioning consortia and local authorities to form care trusts, and to abolish the direct role of the Secretary of State in the process of forming or disbanding a care trust. Emily Thornberry raised concerns that the Government's reforms would disrupt existing arrangements between PCTs and local authorities that have integrated functions. The Committee agreed the clause on division.[269]

Clause 192: Lists of performers of pharmaceutical services and assistants

The Committee agreed to minor and technical amendments to this clause, and to some consequential provisions.[270]

Clause 269: Arrangements between the Board and Northern Ireland Ministers

The Committee agreed a technical Government amendment (Amendment 705) without division.[271]

Schedules 4 and 5: Amendments to the NHS Act 2006 and other enactments

The Government tabled a large number of amendments to Schedules 4 and 5 (Amendments 225 to 341 and 494). Paul Burstow explained that the amendments were all minor and technical changes to the NHS Act 2006, the vast majority consequent to the abolition of PCTs and SHAs in clauses 28 and 29 of the Bill. Opposition Members commented that the large number of Government amendments reflected the Government's rush to introduce the legislation, and that this had led to a change in the programme motion to accommodate debate on the amendments.[272]

Schedule 20: Amendments relating to relationships between the health services

The Committee agreed a number of technical Government amendments (Amendments 734 to 797) to Schedule 20.[273]

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[266] *Ibid.* c604
[267] PBC Deb 10 March 2011, c607
[268] PBC Deb 24 March 2011, cc1043-5
[269] *Ibid.* c1116
[270] PBC Deb 10 March 2011, c607
[271] PBC Deb 31 March 2011, c1270
[272] PBC Deb 17 March 2011, c840
[273] PBC Deb 31 March 2011, c1270

New clause 2: Certification of death

The new clause would have the effect of replacing the reference to 'primary care trusts' (PCTs) in section 19 of the *Coroners and Justice Act 2009* with 'local authorities'. This section requires PCTs in England to appoint medical examiners to introduce a unified system of death certification for all deaths that do not require coroners, post mortems or inquests. Derek Twigg noted concerns of The Local Government Group about new clause 2:

> The Local Government Group has concerns about the uncosted change to the 2009 Act, which, it feels, has not been adequately consulted on or had a thorough impact assessment. The question is about how this additional requirement on councils squares with the commitment for no new burdens. This will be a wholly new requirement for local authorities and, given that the system will not be up and running before the abolition of PCTs, councils will be faced with the introduction of a largely untested process.[274]

Paul Burstow noted that the Government had embarked on a consultation about the public health responsibilities of local authorities, and their resourcing, but that he would write to Members to provide further information.[275]

Clause 276: Power to make consequential provisions

The Committee agreed technical Government amendments (Amendments 712 to 716) to clause 276.

[274] PBC Deb 17 March 2011, c840
[275] *Ibid.* c842

Appendix 1 – Members of the Public Bill Committee

Chairs:
Mr Jim Hood; Mr Mike Hancock; Mr Roger Gale; Dr William McCrea

Members (24):
Debbie Abrahams (Oldham East and Saddleworth) (Labour)

Mr Kevin Barron (Rother Valley) (Labour)

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Labour)

Mr Steve Brine (Winchester) (Conservative)

Mr Simon Burns (Chelmsford) (Conservative: Minister of State, Department of Health)

Paul Burstow (Sutton and Cheam) (Liberal Democrat: Minister of State, Department of Health)

Dan Byles (North Warwickshire) (Conservative)

Stephen Crabb (Preseli Pembrokeshire) (Conservative: Government Whip)

Nick de Bois (Enfield North) (Conservative)

Margot James (Stourbridge) (Conservative)

Liz Kendall (Leicester West) (Labour: Shadow Health Minister)

Jeremy Lefroy (Stafford) (Conservative)

Nicky Morgan (Loughborough) (Conservative)

Grahame M. Morris (Easington) (Labour)

Dr Daniel Poulter (Central Suffolk and North Ipswich) (Conservative)

John Pugh (Southport) (Liberal Democrat)

Jim Shannon (Strangford) (Democratic Unionist Party)

Owen Smith (Pontypridd) (Labour)

Anna Soubry (Broxtowe) (Conservative)

Julian Sturdy (York Outer) (Conservative)

Emily Thornberry (Islington South and Finsbury) (Labour: Shadow Health Minister)

Karl Turner (Kingston upon Hull East) (Labour)

Derek Twigg (Halton) (Labour: Shadow Health Minister)

Phil Wilson (Sedgefield) (Labour: Opposition Whip)

Appendix 2 – Witnesses to Public Bill Committee oral evidence sessions

Date	*Witness*
Tuesday 8 February 2011	Sir David Nicholson, Chief Executive, National Health Service (and NHS Commissioning Board)
	Stephen Thornton, CBE, Chief Executive, the Health Foundation; Dr Jennifer Dixon, Director, the Nuffield Trust; Professor Julian Le Grand, London School of Economics
	Tim Gilling, Deputy Executive Director, Centre for Public Scrutiny; Chris Ham, Chief Executive, King's Fund; Dr Hamish Meldrum, Chairman, BMA Council, British Medical Association
	Michael Sobanja, Chief Executive, NHS Alliance, Dr James Kingsland, President, National Association of Primary Care and Dr Claire Gerada, Chair, Royal College of General Practitioners
	Cllr Mike Roberts, Rushmoor Borough Council and a member of the Community Wellbeing Board, Local Government Association, and Andrew Cozens, Strategic Director of Children, Health and Adult Services, Local Government Association
	Nigel Edwards, Acting Chief Executive, NHS Confederation
	Karen Jennings, Assistant General Secretary, Unison; Nick Parrott, Health Policy Specialist, Unite; and Rehana Azam, National Officer, GMB
Thursday 10 February 2011	David Bennett, Chief Executive, and Sonia Brown, Chief Economist, Monitor; Sue Slipman, Director, Foundation Trust Network, and Sir Stephen Bubb, Chief Executive, Association of Chief Executives of Voluntary Organisations (ACEVO)
	Sir Andrew Dillon, Chief Executive, National Institute for Health and Clinical Excellence (NICE) and Richard Douglas, Director General of Policy, Strategy and Finance, Department of Health

Don Redding, Policy Consultant, National Voices

Paul Farmer, Chief Executive, Mind; Steve Ford, Chief Executive, Parkinson's UK; Sarah Woolnough, Head of Policy, Cancer Research UK; Annwen Jones, Chief Executive, and Jenny Bogle, Target Ovarian Cancer; and Paul Jenkins, Chief Executive, Rethink

Cynthia Bower, Chief Executive, and Jill Finney, Director, Care Quality Commission

Sir Richard Thompson, President, Royal College of Physicians; Dr Peter Carter, Chief Executive and General Secretary, Royal College of Nursing; John Black, President, Royal College of Surgeons, and Matt Jameson Evens, Co-Chair, Remedy UK

Rt Hon Andrew Lansley CBE MP, Secretary of State for Health; Simon Burns MP, Minister of State for Health; and Paul Burstow MP, Minister of State for Care Services, Department of Health.