



Health and Social Care (Re-committed) Bill: the NHS Future Forum and the Committee Stage Report

Bill 221 of 2010-12

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On 21 June 2011 the House agreed a motion re-committing certain clauses of the *Health and Social Care Bill* to the Public Bill Committee that had previously considered the Bill. The Committee met between 28 June and 14 July 2011 and agreed a number of Government amendments, introduced in response to the recommendations the 'NHS Future Forum'. Key changes are intended to clarify the Secretary of State for Health's overall responsibility for the NHS, to ensure good governance for the new groups that will be responsible for commissioning NHS-funded services, to strengthen duties to involve the public and health professionals in decision making, and to amend duties in relation to the role of competition and integration in the health service. The Bill is due to have its Report stage and Third Reading on 6 and 7 September 2011.

Thomas Powell

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Summary

The Government unveiled an extensive package of reforms to the NHS in England in its July 2010 White Paper *Equity and excellence: Liberating the NHS*. The 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. The *Health and Social Care Bill*, published on 19 January 2011, would give effect to those reforms requiring primary legislation. Measures include giving groups of General Practitioners responsibility for commissioning the majority of health services, the creation of an independent NHS Commissioning Board, and giving local authorities responsibilities for coordinating local NHS services, social care and health improvement. The Bill establishes Monitor as an economic regulator for the health sector, and the Bill, as introduced, would have given Monitor a duty to promote competition between providers of NHS-funded services.

While there was general agreement with the overall aims of the White Paper, there were significant concerns about a number of the Government's specific proposals for reform, particularly around the accountability and governance arrangements for commissioners and providers of health services, and the role of competition in the NHS. Following the Bill's first Committee stage, the Secretary of State for Health, Andrew Lansley, took the unusual step of announcing a pause in the legislation to conduct a 'listening exercise'. The Government appointed a group of experts from across health and social care, known as the NHS Future Forum, to listen to concerns and report back to Government.

The Future Forum concluded its eight-week listening exercise on 31 May 2011 and reported its findings on 13 June 2011. It made a number of detailed recommendations for changes to the Government's reforms and legislation, including that the Bill should be amended to make clear the following.

- The Secretary of State remains ultimately accountable for the NHS.
- GP commissioning consortia should be required to obtain "multi-professional advice" and be more accountable to the public.
- The legislation should strengthen the role of local council health and wellbeing boards in the commissioning process.
- Monitor's role in relation to competition should be significantly diluted in the Bill with additional safeguards brought forward to prevent private providers from 'cherry picking' patients.

The Government accepted the core recommendations of the NHS Future Forum and announced that the Bill would be partially re-committed, with certain clauses to be considered again by the Public Bill Committee that had previously scrutinised the whole Bill. The Committee held 12 sittings, meeting between 28 June and 14 July 2011. The Committee agreed Government amendments to clauses relating to the responsibility of the Secretary of State for Health for providing a comprehensive health service, and to the governance arrangements for commissioning groups. The Government announced that in future GP commissioning consortia would be known as 'clinical commissioning groups' (CCGs), with governing bodies to include at least one nurse and one specialist doctor. In addition, CCGs would be supported by clinical networks advising on single areas of care, and new 'clinical senates' providing multi-professional advice.

Although the Government maintained its original target for all CCGs to be established by April 2013 it accepted the Future Forum's recommendation that groups should not be authorised to take on commissioning budgets until they are ready and willing to do so. A

Government amendment would replace Monitor's duty to promote competition with a duty to prevent 'anti-competitive behaviour'. Other Government amendments related to the duties of commissioners to promote the NHS Constitution, patient involvement, and the integration of health services (and would introduce a new duty for Monitor to act with a view to enabling the integration of services, where it would improve the quality of care).

Section 1 of this paper provides an overview of the NHS Future Forum's listening exercise and the Government's response. Sections 2, 3 and 4 provide information about the re-committal motion and the Committee stage, including a summary of the key debates and amendments to the Bill agreed in the Committee.

There are two earlier Library research papers on the *Health and Social Care Bill*; the first, prepared for the Commons Second Reading debate, provides more detail on the Bill, and the background to the Government's proposals for reform ([RP 11/11](#), 27 January 2011); the second paper provides a summary of the Commons Second Reading debate on the Bill, on 31 January 2011, and the changes made during the Public Bill Committee's first consideration of the Bill, between 8 February and 31 March 2011 ([RP 11/31](#), 6 April 2011).

References to clause numbers in this paper relate to the version of the Bill as amended during the Public Bill Committee's first consideration of the Bill (Bill 177); this version of the Bill, the version as amended on re-committal (Bill 221), and an illustrative version of the Bill showing the changes that were made during re-committal, are available from the [Parliament website](#).

1 The NHS Future Forum and the listening exercise

On 4 April 2011, the Secretary of State for Health, Andrew Lansley, announced that the Government would use a “natural pause” in the legislation to conduct a listening exercise, following significant concerns about its programme of health service reforms. This followed calls from organisations, representing key groups of medical professionals, patients and policy experts, for greater accountability and transparency in the proposed system of GP-led commissioning, and demands for wider clinical involvement in decision making. There were also fears, expressed by the British Medical Association and the Royal College of General Practitioners in particular, that greater competition could undermine the delivery of integrated care to patients, and concerns that the Government’s proposed pace of transition was too fast. Influential figures in the Liberal Democrat Party also expressed concerns about aspects of the Government’s reforms and the Party’s Spring Conference voted for a motion demanding more accountability and openness in commissioning arrangements and for safeguards against the ‘cherry picking’ of health services by private sector providers.¹

On 6 April 2011 the Government appointed a group of 45 doctors, nurses, patient representatives and other experts from across health and social care, known as the ‘[NHS Future Forum](#)’, to listen to concerns and report back to Government. The Future Forum, chaired by GP and former Chair of the Royal College of General Practitioners Professor Steve Field, invited public comments on four broad themes:

- choice and competition;
- accountability and patients;
- advice and leadership; and
- education and training.²

Members of the Future Forum attended around 250 events and heard opinions on the Government’s plans for modernisation from over 8,000 people, including some 250 stakeholder organisations. It concluded its eight-week listening exercise on 31 May 2011 and reported its findings on 13 June 2011. It made a number of recommendations for changes to the Government’s reforms and legislation, including the following.

- New duties should be introduced for commissioners of NHS services to promote the rights of patients as set out in the NHS Constitution.
- The Bill should be amended to make clear that the Secretary of State remains ultimately accountable for the NHS.
- There should be additional requirements in the Bill to require GP commissioning consortia to obtain “multi-professional advice” to inform commissioning decisions and to be more accountable to the public.
- The legislation should strengthen the role of local council health and wellbeing boards in the commissioning process.
- Commissioning consortia should only take on their full range of responsibilities when they can demonstrate that they have the right skills, capacity and capability to do so.

¹ “NHS reforms face overhaul after Liberal Democrats’ rebellion”, *The Guardian*, 13 March 2011

² Further information about the Future Forum, its members, and the conduct of the listening exercise can be found here: <http://healthandcare.dh.gov.uk/>

Where commissioning consortia are not ready, the NHS Commissioning Board should commission on their behalf.

- Monitor's role in relation to competition should be significantly diluted in the Bill. Its primary duty to 'promote' competition should be removed and the Bill should be amended to require Monitor to support choice, collaboration and integration. Additional safeguards should be brought forward to prevent private providers from 'cherry picking' patients.³

1.1 The Government's response

The Secretary of State for Health announced that the Government accepted the core recommendations of the NHS Future Forum in a statement and summary response on 14 June 2011.⁴ The full *Government response to the NHS Future Forum report* (Cm 8113) was published on 20 June 2011 and this set out the Government's intention to make the following changes.

- Commissioners of health services would have to take active steps to promote the NHS Constitution, including the 18 week limit on waiting times.
- The Bill would make clear that "Ministers are responsible for the NHS overall".
- GP commissioning consortia would be known as 'clinical commissioning groups' (CCGs)⁵ and be required to have governing bodies with at least one nurse and one specialist doctor. In addition commissioners would be supported by existing and new clinical networks advising on single areas of care, such as cancer, and new 'clinical senates', in each area of the country, that would provide multi-professional advice on local commissioning plans. Both would be hosted within the NHS Commissioning Board.
- Clinical commissioning groups would also be required to have two 'lay members' and meet in public.
- The Bill would create a stronger role for health and wellbeing boards, with the right to refer back local commissioning plans that are not in line with local health and wellbeing strategies.
- Commissioning groups would all be established by April 2013 but would not be authorised to take on any part of the commissioning budget in their local area until they are ready and willing to do so.
- In relation to competition, Monitor's core duty would be to protect and promote the interests of patients, "not to promote competition as if it were an end in itself"; there would be new safeguards against price competition, 'cherry picking' and privatisation; there would be stronger duties on commissioners to promote (and Monitor to support) care that is integrated around the needs of users.⁶

³ A full list of the core recommendations of the NHS Future Forum can be found in Appendix 1.

⁴ [Written Ministerial Statement](#), 14 June 2011

⁵ Although the Bill still refers to GP 'commissioning consortia', the practice in the Committee and elsewhere is to now call these bodies 'clinical commissioning groups' (CCGs).

⁶ [Government's response to the NHS Future Forum](#) (Cm 8113) 20 June 2011

In addition the Government announced other measures to increase accountability, including that NHS foundation trusts would be required to hold public board meetings, and that there would be clearer duties across the health service to involve the public, patients and carers.

Some indication of these changes had been given in advance of the Future Forum's recommendations in a [speech](#) by the Prime Minister David Cameron on 7 June 2011. In this speech the Prime Minister set out what he had learnt from the listening exercise and gave a number of guarantees about the direction of Government policy on the NHS.

2 Re-committal of the Bill

Following earlier suggestions from Andrew Lansley and Nick Clegg that the Bill might need to be re-committed to the House of Commons for further scrutiny,⁷ the Government announced that the relevant parts of the Bill would be considered again by the Commons Public Bill Committee to ensure that Parliament had "sufficient opportunity to scrutinise the Government's proposed changes."⁸

The Government tabled a motion relating to the partial re-committal of the *Health and Social Care Bill* and this was debated on 21 June 2011. The motion set out the clauses that would be re-committed (largely relating to those areas of the Bill where the Government had announced its intention to make amendments) and that the proceedings in Committee would be concluded by 14 July 2011:

Re-committal

1. The Bill shall be re-committed to the Public Bill Committee to which it previously stood committed in respect of the following Clauses and Schedules—

(a) in Part 1, Clauses 1 to 6, 9 to 11, 19 to 24, 28 and 29 and Schedules 1 to 3;

(b) in Part 3, Clauses 55, 56, 58, 59, 63 to 75, 100, 101, 112 to 117 and 147 and Schedules 8 and 9;

(c) in Part 4, Clauses 149, 156, 165, 166 and 176;

(d) in Part 5, Clauses 178 to 180 and 189 to 193 and Schedule 15;

(e) in Part 8, Clause 242;

(f) in Part 9, Clause 265;

(g) in Part 11, Clauses 285 and 286;

(h) in Part 12, Clauses 295, 297 and 298.

2. Proceedings in the Public Bill Committee on re-committal shall (so far as not previously concluded) be brought to a conclusion on Thursday 14 July 2011.

3. The Public Bill Committee shall have leave to sit twice on the first day it meets.

During the debate on the re-committal motion the Minister of State for Health, Simon Burns, confirmed that the Government would re-commit 63 of the Bill's clauses, with about 35 of these needing to be amended (the remainder providing context in order for the Committee to

⁷ The Deputy Prime Minister Nick Clegg indicated that re-committal was likely during a speech on 27 May 2011: see "[Health Bill faces further delays as Clegg vows not to 'bounce' through legislation](#)", *Pulse Online*, 27 May 2011

⁸ [Written Ministerial Statement](#), 14 June 2011

have a “sensible debate” about the revisions). The Minister said he expected around 160 Government amendments to be tabled on 23 June 2011 and a further five new clauses. The Minister also promised that the Government would publish [briefing notes](#) to help explain the amendments and these were published on Monday 27 June 2011.⁹ The Shadow Secretary of State for Health, John Healey, and other Labour Members, argued that the whole Bill ought to be re-committed to ensure proper scrutiny.¹⁰

Precedents for re-committal

Although it is quite a rare procedure, there are precedents for re-committing Bills in full or in part.¹¹ It has been argued in the past that re-committal should be used only for parts of Finance Bills,¹² or for instances where inadvertent mistakes have been made by Standing Committees with regard to specific clauses. An example of the latter point is the *Consumers Guarantees Bill* in 1990, where the committee inadvertently introduced a clause which would have required a money resolution. However, re-committal has in fact been used in many different scenarios, and there are no precedents to prevent it being used in any given circumstances.

There are several precedents for the partial re-committal of Bills, although in the more recent cases re-committal was to a Committee of the whole House and after the re-committal, the House then proceeded to the Report stage (sometimes on the same day). Examples include the *Social Security Pensions Bill* (HC Deb, 11 June 1975, c461-2); the *Land Drainage Bill* (HC Deb 21 February 1961, c339-83); the *Legal Aid Bill* (HC Deb 28 March 1960 c1066-96); and the *Iron and Steel Bill* (HC Deb 4 March 1953, c404-523). There are also examples of Bills being partially re-committed to the Committee that had previously considered them (e.g. the *Mineral Workings Bill*, HC Deb 18 June 1951 c200; the *Criminal Justice (Scotland) Bill*, HC Deb 15 November 1949 c1939; and the *Borrowing (Control and Guarantees) Bill*, HC Deb 26 March 1946, c342).

The two most recent examples of full re-committal of a Bill to a Standing Committee are:

- *Hunting Bill 2002-03* – re-committal was discussed in the debate on a programme motion ahead of the Report stage. The re-committal motion was agreed without a division at the conclusion of the Report stage.¹³ Although the motion re-committed the whole Bill, its terms limited the degree to which the Committee could make amendments.
- *Planning and Compulsory Purchasing Bill 2002-03* – this was re-committed, according to the Government, because it was carried over to the following session. There were also, however, a large number of Government amendments throughout the Bill’s progression through Parliament.¹⁴ In this case, the motion merely sent the Bill to ‘a committee’, not to the same committee that had previously considered it.

3 The Committee stage on the Re-committed Bill

The Committee held 12 sittings, meeting between 28 June and 14 July 2011. During its first sitting on 28 June 2011 the Committee agreed a programme motion setting out the order in which evidence would be taken and clauses would be debated.¹⁵ Speaking for the

⁹ [HC Deb 21 June 2011 c198-201](#)

¹⁰ *Ibid.* c204

¹¹ Erskine May, 24th edition (2011), p.592-4

¹² See for instance [the debate on the Education Bill](#) on 22 April 1970.

¹³ HC Deb 30 June 2003 c38-144

¹⁴ HC Deb 10 July 2003 c545

¹⁵ [PBC Deb 8 March 2011 c515](#)

Opposition, Emily Thornberry said there had been insufficient time for Government amendments to be scrutinised by Members and witnesses, and tabled amendments to the programme motion that would have allowed evidence to be taken over three days, and for the Committee to hold 20 sittings in total before concluding on 14 July. She also said the Opposition fundamentally disagreed with the fact that only parts of the Bill were being re-examined by the Committee. The Labour whip Phil Wilson called for the “knives” to be removed (referring to the allocation of time motion that provided a set date for the Committee’s consideration of the Bill to be concluded). The Opposition amendments to the programme motion were defeated on division.¹⁶

There was one change to the membership of the Committee, with Fiona O’Donnell replacing the Shadow Health Minister Derek Twigg who was absent due to illness. Simon Burns, Minister of State for Health, and Paul Burstow, Minister of State for Care Services, spoke for the Government; Shadow Health Ministers Liz Kendall, Emily Thornberry and Owen Smith, and other Labour Members, spoke for the official Opposition. A full list of Members of the Committee is provided in Appendix 2 to this paper.

3.1 Evidence to the Committee

Oral evidence was heard on the first day, over two sittings, on 28 June 2011. Many of the witnesses who had attended the first Public Bill Committee returned to give evidence again, although there was substantially less time for questioning each witness. The Secretary of State for Health, Andrew Lansley, gave evidence at the end of the session. A full list of witnesses is provided in Appendix 3 to this paper. 55 written submissions (Associated Memoranda) were received from outside bodies and individuals.¹⁷

Opposition questions to witnesses focussed on the relatively short amount of time they had to read and comment on Government amendments and the extent to which the witnesses considered that the amendments reflected the Future Forum’s recommendations. With the exception of the trade union representatives, there was a broad consensus from witnesses that the Future Forum had done a good job of reflecting people’s concerns and that its recommendations would take the Bill in a better direction. However, there were concerns that additional measures to increase the accountability and transparency of commissioning decisions could lead to greater costs and bureaucracy, and that this risked slowing down the process of redesigning services and achieving efficiency savings.¹⁸

4 Amendments and debates on clauses

The Committee considered 63 of the Bill’s clauses, six schedules and eight new clauses. Over 200 amendments were tabled by the Government and Opposition. 175 Government amendments were agreed and there were 33 divisions. None of the Opposition amendments were successful although at various points Labour Members commented that during the previous Committee stage they had proposed changes that were similar to the Government’s amendments. Of the Government amendments, significant alterations were made to clauses in Parts 1, 3, 4 and 5 of the Bill, relating to the duties of the Secretary of State, the NHS Commissioning Board, Clinical Commissioning Groups and Monitor.

During the Committee stage, debates between the Opposition and Government frontbenchers concerned the extent to which Government amendments reflected the NHS Future Forum’s recommendations, and whether changes were significant or not. In particular, Opposition Members argued that the effect of the provisions in the Bill relating to the role of competition in the NHS were essentially unchanged.

¹⁶ [PBC Deb 28 June 2011 c6](#)

¹⁷ The Associated Memoranda are available on the [Parliament website](#).

¹⁸ The Hansard for the oral evidence sessions is available on the [Parliament website](#).

This section of the paper does not follow the exact order in which clauses were discussed; rather it deals with the clauses thematically, with the most significant areas of debate and amendment first, before minor and technical amendments, and those Opposition amendments where a formal vote took place.¹⁹

4.1 The Secretary of State's powers and duties

The Secretary of State's duty to provide or secure health services

Clause 1 of the Bill as originally drafted would have replaced the Secretary of State's current duty (under section 1(2) of the *NHS Act 2006*) to 'provide, or secure the provision of, services' with a indirect duty that, in exercising functions in relation to the NHS Commissioning Board or commissioning consortia, he must 'act with a view to securing the provision of services.' This reflected the fact that responsibility for commissioning and providing services (other than for public health) would be conferred on the Commissioning Board and what were then referred to as GP commissioning consortia (now known as clinical commission groups (CCGs)).

Opposition Members had raised questions during the previous Committee stage about the implications of this change for the accountability of the Secretary of State for the NHS.²⁰ The NHS Future Forum also recommended that the Secretary of State's responsibility for promoting a comprehensive health service should be made clearer. The Government's response to the Future Forum stated that the Bill would 'make explicit that the Secretary of State remains fully accountable for the NHS.'

The Government tabled [New Clause 1](#) which, for clarity, set out section 1 of the 2006 Act, as it would be revised, in its entirety. Like clause 1 of the original Bill, New Clause 1 would maintain the wording of sections 1(1) and 1(3) of the *NHS Act 2006* including the duty, dating back to the *NHS Act 1946*, that the Secretary of State is responsible for the promotion of a comprehensive health service. The key change from the original drafting of the Bill was in the wording of paragraph 1(2) of New Clause 1, which states that 'the Secretary of State must exercise his functions 'so as to secure that services are provided in accordance with this Act'. The Minister, Simon Burns, accepted that the Future Forum had been right to point out that the original drafting of the Bill was not clear enough and that in response the Government was amending the wording of the Bill "to remove any doubt that the Secretary of State remains ultimately accountable for the NHS".²¹

While this wording of paragraph 1(2) of Government New Clause 1 is closer to the original wording of the 2006 Act, like the original clause 1 of the Bill, it also omits the words 'to provide' from the Secretary of State's core duty. Liz Kendall proposed an amendment (Amendment 1) that would have reinstated the wording under section 1(2) of the 2006 Act, and this was negatived on division.²² During the debate on this amendment the Committee discussed the significance of removing the words 'to provide' and Simon Burns set out the Government's rationale for this change:

"Hon. Members have asked what removing the words "to provide" means. The short answer is that although the Secretary of State must ensure that the NHS services are provided by, for example, exercising powers over the NHS commissioning board and other bodies, he has no responsibility to provide those services himself."

¹⁹ References to clause numbers in this paper relate to the version of the Bill as amended during the Public Bill Committee's first consideration of the Bill (Bill 177); this version of the Bill, the version as amended on re-committal (Bill 221), and an illustrative version of the Bill showing the changes that were made to the Bill during re-committal, are available from the [Parliament website](#).

²⁰ [PBC Deb 5 July 2011 c221-2](#)

²¹ [PBC Deb 30 June 2011 c138](#)

²² *Ibid.* c149

The Minister noted that the Secretary of State's existing duty to provide did not even reflect the reality of how services are provided in the NHS under the current system:

"We should consider what a duty to provide means. A duty to provide involves having the premises and the staff necessary to offer health services directly. At present, the Secretary of State has a duty to provide, but even under the current system, that does not reflect the reality of a situation in which commissioning and provision rest with NHS bodies, not the Secretary of State. ...

It is worth noting that, subject to a few exceptions, the duty in section 1(2) of the 2006 Act to "provide or secure the provision of services", and the section 3 and 12 functions of providing or arranging the provision of particular services, have for many years not been fulfilled by the Secretary of State's providing or commissioning services directly. Those functions are delegated to SHAs and PCTs. Although there is a small amount of direct provision of community services by PCTs, that is due to cease, because PCTs are almost entirely commissioning bodies."²³

Speaking for the Opposition, Emily Thornberry stated that despite the Government's changes "we are no further forward than when the Bill first appeared in the original Bill Committee" and there would still be "obstacles in the way of the Secretary of State's direct accountability to the public, through Members of Parliament". Simon Burns responded that the Secretary of State could still be held to account by Parliament under the Government's reforms, stating that, in addition to the Secretary of State's mandate to the NHS Commissioning Board being placed before Parliament, the Commissioning Board would produce an annual report to Parliament, and the Government would still be held to account by Members asking questions in Parliament:

"Even in a modernised NHS, I do not think that there will be any changes [to parliamentary accountability]. Members will still be writing to Ministers about local health issues, about constituents' health problems and so on, and they will also raise health matters at Question Time and in debates, asking about the configuration of the service or whatever. I cannot see how there could be a reduction in the accountability of Ministers and the Government to Parliament in the area of health provision."²⁴

Opposition Members asked what the changes to section 1 of the NHS Act 2006 would mean for the legal liability of the Secretary of State for NHS services. Simon Burns responded that, again, in the Government's view there was no "sea change" from the current position, where in most cases legal action would be taken against providers or commissioners of services, not the Secretary of State.²⁵ He explained that the NHS Commissioning Board and clinical commissioning groups would have the primary legal responsibility to commission NHS services, and they, not the Secretary of State, would be legally liable for a failure to carry out that responsibility. However, Simon Burns noted that the Secretary of State would be liable, and could be the subject of a claim for judicial review by an affected member of the public, if he failed to carry out his statutory duty under the legislation, including his duty to exercise his functions so as to secure the provision of health services under proposed new section 1(2) of the 2006 Act.²⁶

The Department of Health has published a note explaining the consequences of changes to clause 1 of the *NHS Act 2006* for the future role and functions of the Secretary of State for

²³ *Ibid.* c146

²⁴ *Ibid.* c142

²⁵ *Ibid.* c146

²⁶ *Ibid.* c144

Health, together with a table setting out the Secretary of State's functions under the 2006 Act (as it would be amended by the Bill).²⁷

Other Amendments

Secretary of State's duty to keep health service functions under review:

The Committee also agreed Government [New Clause 2](#) (what is now clause 48 of the Bill as amended, Bill 221), which would introduce a new duty on the Secretary of State to keep health service functions under review. The Minister, Simon Burns, explained that the purpose of this new duty "is to make it clear in legislation that the Secretary of State is ultimately accountable for ensuring that the national arm's length bodies, such as the NHS Commissioning Board, Monitor and the Care Quality Commission (CQC), are performing their functions effectively. He noted that this duty is backed by powers of intervention in the event of significant failure and that the new clause also gives the Secretary of State the power to report on how the national level organisations have discharged their functions as part of his annual report on the performance of the health service."²⁸

Secretary of State's duty to reduce inequalities:

The Committee negated an Opposition amendment (Amendment 227) to clause 3 which would have given the Secretary of State a direct duty to reduce inequalities rather than a duty to have regard to the need to reduce inequalities.²⁹

Changes to Secretary of State's powers to intervene in NHS Commissioning Board and other NHS bodies:

During the previous Committee stage the Committee had agreed a Government amendment designed to ensure that Ministers could only intervene in the functions of Monitor where there was a 'significant' failure, and that the reasons for intervening would have to be explained publicly. The Minister explained that this was important to safeguard the regulator's independence and to ensure that intervention powers were used only when appropriate. The Committee agreed new Government amendments that would make similar changes relating to the NHS Commissioning Board (Amendments 80 to 83),³⁰ the CQC (New Clause 8), HealthWatch England (Amendments 200 to 203), the National Institute for Health and Care Excellence (NICE) (Amendments 218 to 220) and the Health and Social Care Information Centre (Amendments 221 to 223).

4.2 The NHS Commissioning Board and Clinical Commissioning Groups

In response to the recommendations of the NHS Future Forum, the Committee agreed Government amendments introducing a new duty for the NHS Commissioning Board and clinical commissioning groups (CCGs) to promote the NHS Constitution. Government amendments were also agreed that were intended to strengthen duties to promote patient involvement and the integration of services. In response to calls for multi-professional involvement in commissioning, Government amendments were agreed relating to governance arrangements for CCGs, and their duty to seek appropriate clinical advice.

Duty to promote NHS Constitution

The Committee agreed Government amendments ([Amendments 67 and 108](#)) that would place new duties on the NHS Commissioning Board and CCGs requiring them, when exercising their functions, both to act with a view to securing the provision of health services

²⁷ Department of Health, [Further information for legal professionals on clause 1 of the Health and Social Care Bill](#), 15 August 2011

²⁸ [PBC Deb 30 June 2011 c147](#)

²⁹ *Ibid.* c153

³⁰ [PBC Deb 5 July 2011 c273](#)

in a way that promotes the NHS Constitution, and to promote awareness of the Constitution among patients, staff and members of the public.

This followed a similar Opposition amendment during the previous Committee stage on the Bill, and the recommendation of the NHS Future Forum that the Bill be amended in this way. The Minister, Simon Burns, explained that these new duties would be additional to the existing duty under the *Health Act 2009* to “have regard” to the NHS Constitution, which would also be applied to the NHS Commissioning Board and CCGs (by virtue of the amendment made to the *Health Act* in paragraph 167 of schedule 5 to the Bill).

Liz Kendall said she was pleased that the Government had listened to people’s concerns but that it was a pity that the wording of the duty, to “act with a view to”, was not stronger. She also asked the Minister about the performance management of the waiting times commitments included in the NHS Constitution (such as the right to start non-urgent treatment within 18 weeks of referral from a GP). In response, Simon Burns said that data on waiting times that “has always been published, will, to the best of my knowledge, continue to be published.”³¹ This was followed by a debate about the pros and cons of waiting time targets, about whether the Government had changed its policy on targets, and about what constitutes a “politically motivated” or a “clinically justified” target.

Duty to promote patient and public involvement

The Committee agreed Government amendments ([Amendments 68 to 70 and 109 to 111](#)) relating to the duties of the NHS Commissioning Board and CCGs in relation to promoting individual patient choice and patient involvement concerning their care.

The NHS Future Forum called for stronger and clearer duties of public involvement to be written into the Bill focused on the principles of shared decision making between patients and clinicians. In particular the report of the Future Forum noted that the Commissioning Board’s duty to “have regard to the need to” promote patient involvement (as it was originally worded in the Bill) was not strong enough.

The Minister, Simon Burns, explained that Amendments 70 and 111 would clarify the language of the duties on the Commissioning Board and CCGs to promote patient involvement, and place them in separate sections of the *NHS Act 2006* to emphasise their importance.³²

Amendment 111 would create a new power for the Commissioning Board to provide specific guidance to CCGs on fulfilling their patient involvement duty, and would specify that CCGs must have regard to that guidance.

Amendments 70 and 111 would also create separate and distinct duties on the Board and the CCGs in respect of patient choice. Simon Burns explained that the Government had:

“...strengthened the obligation on the board and the CCGs by placing a new, more active requirement on them when exercising their functions—to act with a view to enabling patients to make choices on the health services that are provided to them.”³³

The Committee also agreed Government amendments ([Amendments 76, 78, 118, 119, 123 and 136](#)) which deal with the Commissioning Board and CCGs’ duties in relation to public involvement and consultation on service changes. The Minister explained that the

³¹ [PBC Deb 5 July 2011 c213](#)

³² *Ibid.* c228

³³ *Ibid.* c229

Government amendments were designed to strengthen arrangements in response to the recommendations from the NHS Future Forum.

The Bill as originally drafted would have required the Commissioning Board and CCGs to involve the public in decisions about changes to commissioning arrangements only where changes would have “a significant impact on the manner in which the services are delivered...or the range of health services available”. Government Amendments 76 and 118 would remove the word ‘significant’ from the public involvement duty on the Commissioning Board and CCGs. This would bring the duties into line with the current duty on NHS bodies to involve and consult patients and the public in section 242 of the *NHS Act 2006*.

The Minister, Simon Burns, said Amendment 119 was important, as it “responds to the recommendation by Future Forum that the NHS Commissioning Board should place particular emphasis on the plans that prospective CCGs have for involving the public when considering applications for authorisation.” The amendment “would require CCGs to include in their constitutions a description of the arrangements they have made to fulfil their duties in respect of public involvement and consultation and a statement of the principles that they will follow in implementing those arrangements.”³⁴

Amendment 123 would require CCGs to explain in their annual commissioning plans how they propose to discharge their duty to involve and consult the public. Amendment 136 would require the Commissioning Board to consider how well CCGs had discharged this duty, when it conducts its annual performance assessment of each CCG.

Duty to promote integration

The Committee agreed Government amendments ([Amendments 73, 74 and 117](#)) relating to the duty of the NHS Commissioning Board and CCGs to promote integration between health services and between health and social care services.

The Bill as originally introduced would have placed a duty on the Commissioning Board to exercise its functions with a view to encouraging CCGs to work closely with local authorities in arranging for the provision of services. The NHS Future Forum emphasised the importance of collaboration and integration between different care sectors and settings.

The amended section would strengthen the duty of the Commissioning Board so that it must act with a view to securing integration between health and social services. The amendments would also introduce a duty to act with a view to securing that health services are provided in an integrated way, and to securing the integration of health and health-related services such as housing that might have an effect on the health of individuals. Amendment 117 puts the same duty to promote integration on CCGs. The Minister noted that this was the first time that a Government had proposed in primary legislation a duty requiring NHS commissioning bodies to promote integration.³⁵

Liz Kendall said she was still concerned about the duties to promote integration as they were set out in the Government’s amendments:

“The proposals remain weak. It is unclear why the duties to promote integration relate only to quality and inequalities in access and outcomes. Why not consider promoting integration where we think it might help to deliver more efficient services that would

³⁴ *Ibid.* c258

³⁵ *Ibid.* c243

secure better value for money, particularly considering the financial situation of the NHS?”³⁶

Wider clinical and public involvement in commissioning

One of the core aims of the Government’s NHS reforms was to engage doctors in the commissioning of services by giving consortia of General Practitioners responsibility for the majority of the NHS commissioning budget. There were concerns following the publication of the Bill, from organisations representing specialist doctors, nurses, allied health professionals, and GPs themselves, that the legislative duties on NHS commissioners to seek multi-professional advice needed to be strengthened. These concerns were reflected in the recommendations of the NHS Future Forum.

Duty on commissioners to obtain appropriate clinical advice

The Committee agreed Government amendments ([Amendments 71, 72, 112 to 114 and 135](#)) relating to the duty on the NHS Commissioning Board and CCGs to obtain appropriate clinical advice.

The Minister, Simon Burns, set out how the Government amendments would address calls for multi-professional advice:

“Amendments 71 and 112 change the wording of the duties of the commissioning board and the clinical commissioning groups, under proposed new sections 13G and 14O respectively, to “obtain” appropriate advice. Rather than being required to make arrangements with a view to obtaining advice, the board and the CCGs will be directly required to obtain advice, which is a much clearer and stronger duty.

Amendments 72 and 113 place a more direct duty on the board and the CCGs to obtain advice appropriate for enabling them to discharge effectively their functions from a broad range of professionals with expertise in the prevention, diagnosis or treatment of illnesses, and in the protection or improvement of public health. (...)

Amendment 114 introduces a new power for the board to issue guidance to CCGs on the discharge of their duty to obtain advice...

Amendment 135... requires the board to include in its annual performance assessment of CCGs an evaluation of how effectively they have fulfilled their duty to obtain advice.”³⁷

The Minister also pointed to the non-legislative ways in which the Government proposed to introduce a wider range of clinical advice for commissioners in performing their functions such as extending clinical networks and establishing clinical senates:

“...extending clinical networks—bringing together experts to provide advice on distinct areas of care, such as cancer or maternity services—and establishing clinical senates, which will bring together a range of multiprofessional experts across particular parts of the country to provide cross-cutting advice on strategic commissioning decisions.”³⁸

Liz Kendall commented that the Government amendments were an admission that they had got their initial proposals wrong and reminded the Committee that during the previous Committee stage Opposition Members had argued strongly that the Commissioning Board and commissioning groups should take advice and input from a range of health professionals. She also raised four issues with what the Government proposed: the

³⁶ *Ibid.* c245

³⁷ *Ibid.* c234-5

³⁸ *Ibid.* c234

complexity of the system of commissioning advice, particularly with the involvement of clinical networks and senates; the absence of any references to the need for advice from community health professionals; the lack of information about funding arrangements for clinical networks and senates; and finally, the status of the advice provided by these different groups.³⁹ The Minister responded that networks and senates would be non-statutory advisory bodies and that information about funding would have to wait until the publication of the new Impact Assessment on the Bill (expected to be published when the Bill goes to the Lords).⁴⁰

Liz Kendall's concerns about the development of structures for multi-professional commissioning advice leading to greater complexity echoed evidence to the Committee from the NHS Confederation and Royal College of GPs. However, the Minister emphasised the Government's view, that clinical networks and senates would not be new organisations or new forms of bureaucracy:

“...this is not creating additional bureaucracy. The changes that we are making to the Bill do not create any extra statutory organisations. Clinical senates and networks, as I said during the previous debate, are not new organisations in their own right. They will be hosted by the NHS commissioning board, minimising bureaucracy while maximising benefits for patients.”⁴¹

Governance arrangements for clinical commissioning groups (CCGs)

The Committee agreed Government amendments ([Amendments 95 to 106](#)) relating to the governance of CCGs. The Government introduced these amendments in response to calls for there to be wider representation of other health professionals and lay members on the governing boards of CCGs, and to ensure good governance and transparency in decision making.

Government Amendments 96 and 97 would require CCGs to publish their constitutions and to give the NHS Commissioning Board a power to publish guidance on the publication of these constitutions. Government Amendment 102 would add that each CCG should set out specific arrangements in the constitution for ensuring transparency in the decisions of the group and the manner in which those decisions are made.

Government Amendment 98 would require that governing bodies of CCGs include ‘lay persons’ (defined as individuals who are not health care professionals) and allow regulations to specify types of clinicians who must be represented. The Minister, Simon Burns, explained that the Government had committed that CCG boards should include, as a minimum, a doctor working in secondary care and a registered nurse and that the regulations would ensure this was reflected in legislation. With regard to representation of lay persons on CCG boards, the Minister stated that regulations would require there to be two lay members, each with specific responsibilities:

“one... will champion the interests and rights of patients and one with the appropriate expertise to take an informed and independent view of the performance of the CCG against its financial responsibilities. The latter will act in the role of a non-executive director with responsibility for audit with a dedicated sub-committee of the governing body.”⁴²

Government Amendment 104 would require that CCG boards meet in public, except when discussing confidential issues.

³⁹ *Ibid.* c235-6

⁴⁰ *Ibid.* c238

⁴¹ *Ibid.* c237

⁴² *Ibid.* c285

Liz Kendall commented that this group of Government amendments represented “an unbelievable U-turn”, following Ministers’ rejection of Opposition concerns about the governance of commissioning groups when the Bill was first in Committee.⁴³ She introduced an amendment (Amendment 5) that would have delivered some duties similar to the Government amendments (that CCG boards must meet in public and include representation from a “range of clinicians”, for example). Despite what the Minister described as similarities between the Opposition and Government aims, Liz Kendall said she would press the amendment to a vote because the Government had “failed to give us enough time to scrutinise the legislation”. She also commented that, unlike the Government amendment, Opposition Amendment 5 would not lead to “excessive detail and micro-management” in setting out governance arrangements for CCGs. Amendment 5 was negated on division.⁴⁴ Two further Opposition amendments (Amendments 52 and 53), that would have required CCGs to have regard to the NHS pay scales agreed following recommendations by the NHS Pay Review Bodies, and to agreements made by the NHS Staff Council, were also negated on division.

During the debate on the amendments to clause 21, Liz Kendall raised concerns about how secondary care doctors, nurses and lay members would be selected. While welcoming the Government amendment requiring CCGs to meet in public she asked what sort of confidential matters might still be discussed in private. The Minister responded that confidential matters could include a range of things, such as: “...matters relating to employees or commercially sensitive topics, in line with the issues specified in the *Public Bodies (Admission to Meetings) Act 1960*.” Liz Kendall also reflected that the NHS Future Forum would be “hugely disappointed” that the Government had “completely ignored” its recommendation that all providers of services to NHS patients should also meet in public and publish their agendas.⁴⁵

Opposition Members raised concerns about safeguarding children arrangements and Liz Kendall said the Bill was completely unclear about who will be responsible for this within the NHS. The Minister, Simon Burns, responded that it was important to put the Government’s response on the record:

“We will ensure that clinical commissioning groups and the NHS commissioning board are required to make arrangements to safeguard and promote children’s welfare and maintain providers’ responsibilities for safeguarding. Furthermore, we will explore with our key partners how best to ensure that professional leadership and expertise for safeguarding children is retained in the new system, including the continuing key role of named and designated safeguarding professionals...”⁴⁶

Other Amendments

Duties of the NHS Commissioning Board

Clause 5 of the Bill would establish the NHS Commissioning Board. The Minister, Simon Burns, explained that Government amendments (Amendments 55 and 56) to clause 5 would make changes to the Commissioning Board’s core duty that were consequential on changes in New Clause 1 (and the Secretary of State’s duty “to secure that services are provided”) and to make reference to the Secretary of State’s public health functions:

“Amendment 55 replaces the current drafting of “act with a view to” with the words “secure that services are provided”, thus restoring the alignment between the drafting of the Secretary of State’s and the board’s overarching duties. Amendment 56 sets out

⁴³ *Ibid.* c286

⁴⁴ *Ibid.* c290

⁴⁵ *Ibid.* c287

⁴⁶ *Ibid.* c293

the Secretary of State's public health functions, which were originally in clause 1 of the Bill but would be removed by the introduction of new clause 1. The provision is restated here because this is the first place in the Bill in which a clause distinguishes between the Secretary of State's NHS and public health functions."

The amendments were agreed on division.⁴⁷ During the stand part debate on clause 5, the Opposition raised general concerns about the cost and complexity of the Government's proposed changes. In particular, Liz Kendall said that it was a disgrace that the Committee had not been provided with a revised Impact Assessment to reflect changes to the proposed commissioning structure; she asked a series of specific question about cost:

"What are the estimated costs of retaining the clusters of SHAs and PCTs? That was not included in the costs in the Government's previous impact assessment. What will the NHS commissioning board, with its new roles and responsibilities, cost? How many extra staff will it have? How many clinical commissioning groups will there be and what administrative or management staff will they have? I have the same questions about clinical networks. They already exist, so he should be able to tell us what their administrative costs are now. How many new clinical senates will there be? What area will they cover? How many staff will they have? Crucially, what are the opportunity costs of all those new bodies?"⁴⁸

The Minister replied that a new Impact Assessment would be published when the Bill leaves the Commons to go to the Lords, and that accurate answers on cost could not be given until then.⁴⁹

Duties of clinical commissioning groups (CCGs)

The Committee agreed Government amendments ([Amendments 57, 58 and 59](#)) to clause 9. Amendments 57 and 58 would clarify that a clinical commissioning group (CCG) has responsibility for commissioning care not only for patients who are registered with a GP practice included in the membership of the CCG, but for people usually resident in the area covered by the CCG who are not registered with a GP practice. Amendment 59 would ensure that the Government specify in regulations that a CCG also has responsibility for ensuring that it commissions emergency services to meet the reasonable requirements of anyone in the area that it covers.

Emily Thornberry said she was pleased that the Government had listened to Opposition concerns in this area and that "part of a bad Bill is now better".⁵⁰

Secretary of State's mandate to the NHS Commissioning Board

The Committee agreed Government amendments (Amendments 60 to 66) to clause 19, relating to the Secretary of State's mandate to the NHS Commissioning Board. Amendments 60 and 62 would clarify that the Secretary of State's mandate to the NHS Commissioning Board would be a multi-year document, rather than be issued afresh each year.

Amendment 64 would make it explicit that, in setting the mandate for the Commissioning Board, the Secretary of State has to consult HealthWatch England. The Minister explained that Amendments 60, 62 and 64 were a response to concerns raised during the listening exercise, and the particular emphasis the Future Forum had placed on involving patients and the public in decision making.

⁴⁷ [PBC Deb 30 June 2011 c155-6](#)

⁴⁸ *Ibid.* c162

⁴⁹ *Ibid.* c161

⁵⁰ *Ibid.* c190

The remainder of the amendments in this group related to financial matters, including a requirement for the Secretary of State to specify, as part of the mandate, the capital and revenue resource allocations that will be made to the Commissioning Board (in line with standard Government accounting practice).

Liability of the NHS Commissioning Board and CCGs for the exercise of their functions

The Committee agreed Government amendments (Amendments 77, 80 and 120 to 122) which the Minister, Simon Burns, described as being minor and technical amendments. Simon Burns explained that this group of amendments would clarify that any arrangements the NHS Commissioning Board and CCGs make to get support in the exercise of their functions would not affect their statutory responsibility for making commissioning decisions. In response to concerns from Members that a CCG could outsource its commissioning functions to a private company, Simon Burns stated that this would be unlawful and could not happen.⁵¹

Financial arrangements for the NHS Commissioning Board

The Committee agreed a group of technical amendments (Amendments 84 to 94, 107, 124, 137, 141, 142 and 147) that would make changes to the NHS Commissioning Board's financial powers and duties, as set out in clause 20. This group of amendments included a number that were consequential to the changes to the financial responsibilities of CCGs in clause 23. The Minister, Simon Burns, explained that the amendments were necessary for two reasons:

“first, to better to reflect the fact that resource allocations are the primary means by which budgets are set in the NHS and for applying financial controls; and secondly, to clarify the NHS commissioning board's responsibility for the overall spend by NHS commissioners.”⁵²

Powers to generate income

Liz Kendall introduced two amendments (Amendments 4 and 9) that would have placed a duty on the Secretary of State to publish guidance for both the NHS Commissioning Board and CCGs that they must abide by when they are raising any additional income under the *Health and Medicines Act 1988*. She explained that the amendments were intended to safeguard against the possibility of CCGs being able to generate additional income through charging for core health services. The Minister sought to reassure the Committee that the powers that the Opposition were attempting to amend would not allow the NHS Commissioning Board or CCGs to charge patients for services that they receive from the NHS. Liz Kendall explained that based on experience of reassurances given to the Opposition during the previous Committee stage she did not take the Minister's current reassurance at face value. She pressed for a vote on the amendments, which were negated on division.⁵³

Government amendments agreed without debate

A number of Government amendments relating to the duties of the NHS Commissioning Board and CCGs were agreed to without debate; specifically amendments relating to new duties for CCGs to promote medical research and innovation ([Amendments 115, 116](#) and [New Clause 3](#)), and for CCGs to involve health and wellbeing boards when preparing their commissioning plans ([Amendments 125 to 134](#) and [138 to 140](#)). Government amendments would also clarify that any additional performance payments made by the Commissioning Board to CCGs must be based on the quality or outcomes of services they commission,

⁵¹ [PBC Deb 5 July 2011 c269](#)

⁵² *Ibid.* c275

⁵³ *Ibid.* c272

rather than CCG's financial performance ([Amendments 145 and 146](#)).⁵⁴ The Minister, Simon Burns, wrote to the Chair of the Public Bill Committee to provide background to the Committee on these amendments, explaining that they were made in response to views expressed during the listening exercise.⁵⁵

4.3 Competition and economic regulation

Monitor: competition and integration

The NHS Future Forum reflected stakeholder and public concern about the original wording of the Bill regarding the role of competition in the NHS. The Bill as introduced would have given Monitor, as the new economic regulator for the NHS, a duty to promote competition where appropriate. While recognising the important role competition could play in enabling patient choice, the Future Forum said that Monitor's role in relation to competition should be significantly diluted in the Bill. In particular it was recommended that Monitor's primary duty to 'promote' competition should be removed and that the Bill should be amended to require Monitor to support choice, collaboration and integration.

In response to the Future Forum's recommendation the Government introduced an amendment ([Amendment 149](#)) to replace Monitor's duty to promote competition where appropriate, with a duty to prevent 'anti-competitive behaviour'. Amendment 149 would also require Monitor to act with a view to enabling integration within health services and between health and social care, where it would improve quality of care, and patient access and outcomes. A further Government amendment ([Amendment 148](#)) was introduced that would give Monitor a general duty to promote the provision of health services that are economic, efficient and effective, and that maintain or improve the quality of services.

The Committee debated whether the Government amendments represented a significant change to the provisions of the Bill relating to competition, and revisited debates (familiar from the previous Committee stage) about the extent to which the Bill would extend competition and the role of the private sector in the NHS. Speaking for the Opposition, Owen Smith argued that Monitor's role in promoting competition would be effectively unchanged by the Government amendments:

"In truth, and despite the extensive changes that we have seen from the Government, I contest that Monitor is essentially unchanged in form and function, in instinct and intent, and in power and purpose. Some of the words have been changed, or juggled about; some have been moved up and some have been moved down, but the core of Monitor's role is completely unchanged.

That, as we all know—we in Committee and others outside the Committee have endlessly said so—introduces a much greater degree of competition into the NHS between the public, private and voluntary sector providers..."⁵⁶

Referring to the change in the wording of the Bill "to say that Monitor would no longer be promoting competition", but preventing "anti-competitive practices", Mr Smith described this as "the other side of the same coin—there is not a scintilla of difference between them." In response, the Minister, Simon Burns stated that Monitor's powers, duties and functions had been "changed fundamentally"⁵⁷, and that Monitor's main duty would be to protect and promote the interests of people who use health care services, not by promoting competition, but by promoting the economic, efficient and effective provision of health care services:

⁵⁴ *Ibid.* c303-4

⁵⁵ [Deposited Paper 2011-1201: Letter dated 12 July 2011](#)

⁵⁶ [PBC Deb 7 July 2011 c308](#)

⁵⁷ *Ibid.* c334

“...the Government amendments propose that Monitor’s main duty would be to protect and promote the interests of NHS users. Monitor would achieve that by using its functions—including licensing and pricing—to promote economic, efficient and effective provision of NHS services. It would work alongside other organisations to secure sustained and improved quality of care. It would have the statutory powers needed to address anti-competitive and potentially anticompetitive practices that could act against the interests of NHS users. Last, but by no means least, it would also work with commissioners to promote integration of health care services and between health and health-related or social care services, where that was in the best interests of patients. That is a clear role for Monitor, in line with the recommendations of the Future Forum.”⁵⁸

The Minister gave two examples of how Monitor’s role in addressing anti-competitive behaviour would be different from the role that it would have had in promoting competition:

“Monitor could not, for example, choose to disapply a particular set of licence conditions in a certain group of providers to make it easier for them to enter the market. Similarly, when considering with the NHS commissioning board how services should be specified and bundled for the purposes of the national tariff, Monitor will not be able to take account of whether specifying the services in a particular way would encourage competition per se.”⁵⁹

The Committee agreed Government Amendments 148 and 149 to clause 56 and what the Minister described as technical amendments (Amendments 154, 155, 191 and [New Clause 5](#)) consequential to the changes proposed in the Amendments 148 and 149. The Committee agreed a Government amendment (Amendment 158) to clause 67, which would permit the Secretary of State to regulate the procurement practices of the NHS Commissioning Board and CCGs. The amendment would change the wording of the requirement on the Commissioning Board and CCGs not to ‘act in a manner that would (or be likely to) prevent, restrict or distort competition,’ to a requirement not to ‘engage in anti-competitive behaviour’ against patients’ interests.⁶⁰

The Committee also agreed to a Government amendment ([Amendment 156](#)) to clause 58, which would require Monitor to have regard to the desirability of providers of NHS services co-operating to improve the quality of services. The Minister, Simon Burns, gave the example of a hip-replacement patient transferring from hospital to receiving physiotherapy or after-care in the community, and the need to ensure this type of transfer occurred smoothly.⁶¹

The Committee negated an Opposition amendment (Amendment 40) that would have removed Monitor’s duty to promote competition and replaced it with a duty to promote ‘collaboration and integration’ within health services.⁶²

Monitor: patient, public and clinical involvement

The Committee agreed Government amendments ([Amendments 150 and 152](#)) intended to strengthen patient and public involvement, and clinical engagement, in relation to Monitor. Amendment 150 would require Monitor to secure that patients and the public are ‘involved to an appropriate degree’ in decisions about the exercise of its functions. Amendment 152 would require Monitor to seek advice from a range of relevant healthcare and public health professionals.

⁵⁸ *Ibid.* c355

⁵⁹ *Ibid.* c335

⁶⁰ [PBC Deb 12 July 2011 c443](#)

⁶¹ [PBC Deb 7 July 2011 c388](#)

⁶² *Ibid.* c386

Variation in public and private sector provision of health services

The Committee agreed Government amendments ([Amendments 75, 153, 160 and 171](#)) in relation to a new duty on the NHS Commissioning Board and Monitor not to exercise their functions for the purpose of causing a variation in the proportion of services provided by the public or private sectors, or based on some other aspect of their status or ownership model. The Committee also agreed Government [New Clause 4](#) which would impose a similar duty on the Secretary of State.

The Minister, Simon Burns, described this as an important group of amendments, because it put “beyond doubt” the Government’s commitment not to privatise the NHS. He noted that the NHS Future Forum highlighted concerns that the Bill, as drafted, “could lead to some people maintaining that there would be a possible privatisation of NHS services or some sort of dogmatic preference for the private sector.” He explained that the amendments would prohibit any policy designed with the purpose of varying the market share of any particular sector or provider:

“The amendments would prevent the commissioning board, Monitor, and in certain circumstances the Secretary of State, from having a deliberate policy aimed at encouraging the growth of the private sector over existing state providers, or vice versa.”⁶³

Liz Kendall described the Government amendments as a “fig leaf” and an attempt to convince people that the Government did not have a plan to increase private sector provision in the NHS while other parts of the Bill concerning competition “will be much more powerful than this weak amendment in changing the way in which services are provided.”⁶⁴

Cherry picking

The NHS Future Forum reflected concerns that introducing greater competition in the health service could lead to ‘cherry picking’, where a new non-NHS provider could profit by only offering routine services or procedures, or selecting “easier” patients, leaving more complicated and expensive cases to be dealt with by the NHS. The Government accepted that there should be new safeguards against cherry picking and introduced amendments with regard to the setting of tariff prices paid to the providers of NHS services, and to Monitor’s licensing regime for providers.

Tariff pricing safeguards against cherry picking

The Government introduced a large number of amendments ([Amendments 164 to 170, 172 to 188](#), and [New Clause 7](#)) in Part 3, Chapter 5, of the Bill, relating to the setting of tariff prices and intended to prevent cherry picking. The Committee ran out of time to consider these amendments during its tenth session, on 12 July 2011, and due to the programme motion the amended clauses were ordered to stand part of the Bill without debate. However, in a debate earlier that day, the Minister, Paul Burstow, provided an overview of how this package of amendments (and a number of non-legislative interventions) was intended to enable Monitor to prevent cherry picking:

First, the prevention of cherry-picking is supported by wider changes to Monitor’s duties. For example, the amendments will, if accepted, place a specific duty on Monitor to ensure, when setting the national tariff, that providers receive fair reimbursement for their work, taking into account the clinical complexity of the cases that they treat and the range of services that they offer.

⁶³ [PBC Deb 5 July 2011 c250-1](#)

⁶⁴ *Ibid.* c253

That will be complemented by the duty our amendments will place on the NHS commissioning board to standardise service specifications across the country with the aim of increasing the number of services subject to national tariffs.

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

Taken together, the proposals will give Monitor the power to act to prevent and combat cherry-picking by adjusting tariffs.

Kevin Barron and other Opposition Members expressed concern that the Committee had not had time to debate these important clauses and amendments, and expressed hope that Members of the House of Lords would give the matter “the proper scrutiny it deserves”.⁶⁵ The Minister wrote to the Committee to provide further background on the Government’s amendments on pricing.⁶⁶

Licensing regime safeguards against cherry picking

The Committee agreed [New Clause 6](#) (in Chapter 4 of the Bill, which sets out Monitor’s licensing regime), which the Minister, Paul Burstow, explained would require Monitor to include an anti-cherry-picking condition in all licences:

“The condition will work by requiring licence holders to act transparently when using criteria to determine patient eligibility for particular services, for accepting or rejecting referrals and for determining the manner in which a patient is to be treated. That transparency requirement will apply wherever services are subject to patient choice of provider.

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

Thirdly, as I have noted, such transparency will provide Monitor with the information it needs to work with the NHS commissioning board to assess the impact of patient selection on the variation between providers in the cost of delivering services. It will, therefore, enable such bodies to work together to adjust the tariff according to the case mix any one provider chooses to treat, which will ensure fair reimbursement for efficient services. The net result will be to minimise the scope for private providers to profit from cherry-picking the simplest, cheapest cases at the expense of NHS hospitals and patient choice.”⁶⁷

Opposition Amendments regarding cherry picking

Liz Kendall introduced two Opposition amendments (Amendments 3 and 6) which would have required the NHS Commissioning Board and CCG to have regard to the interdependency of services and the impact that any change in the provision of a service might have on the financial and clinical sustainability of other services. She explained that

⁶⁵ [PBC Deb 12 July 2011 c494](#)

⁶⁶ [Deposited Paper 2011-1331: Letter dated 27 July 2011](#)

⁶⁷ [PBC Deb 12 July 2011 c480-1](#)

the amendments were necessary to ensure that cherry picking of services could not happen as she was not convinced that the Government's amendments would be enough.⁶⁸

The Minister responded that while he understood the intention behind the Opposition amendments they were not necessary as the new duties they would introduce would be impractical to place in primary legislation and were already a key part of good commissioning. The Opposition amendments were negated on division.⁶⁹

Other Amendments and debates on competition and economic regulation

During the clause stand part debates on clauses 55, 64 to 66 and 69, Committee members discussed the extent to which the Government's approach to competition in the NHS differed from policies under the previous Labour Government,⁷⁰ how competition law currently applied to the NHS and if this would change as a result of provisions in the Bill,⁷¹ and the evidence for the efficacy of competition in improving health services.⁷² Opposition Members asked about Monitor's budget for undertaking its new role as an economic regulator, and the Minister replied that it would be in the range of £50 to £80 million a year.⁷³ The Committee agreed these clauses, and Schedule 9, on division, without amendment.

The Committee agreed two minor and technical Government amendments (Amendment 157 and 225) to clauses 63 and 295, relating to the Secretary of State's powers to direct Monitor in the event that it fails to perform its functions.⁷⁴

The Committee negated an Opposition amendment (Amendment 236) to clause 68, which would have removed Monitor's power to declare a commissioners' arrangement for the provision of health services to be ineffective, where they had failed to comply with procurement regulations. Liz Kendall argued that this power should be removed as the Bill would not guarantee that Monitor would consider quality alongside issues of efficiency. The Minister, Simon Burns, said that it was important for Monitor to be able to declare arrangements for a service ineffective if a failure to comply with regulations was having a significant impact on patients.⁷⁵

Financial failure regime and the designation of services

During the debate on amendments to clause 56, Liz Kendall noted that the Government's had said it would withdraw its proposals for a failure regime for NHS providers, and for commissioners to apply to Monitor to designate which services should be protected from financial failure. She reminded the Committee that the Government had not yet presented its revised plans for a failure regime and asked if the Government would present its amendments in this area in time for the Commons Report stage.⁷⁶ The Minister, Simon Burns, responded that the Government would not rush its proposals for a failure regime, as it was complex and they wanted to "get it right", but he said he was confident that amendments would be brought forward in time for them to be debated on Report.⁷⁷ Owen Smith introduced an amendment (Amendment 47) to clause 113, that would have retained existing provisions

⁶⁸ [PBC Deb 5 July 2011 c222-3](#)

⁶⁹ *Ibid.* c227

⁷⁰ [PBC Deb 7 July 2011 c310](#)

⁷¹ *Ibid.* c315; [PBC Deb 12 July 2011 c401-2, c414-5, c454-55](#)

⁷² [PBC Deb 7 July 2011 c352 and c364](#)

⁷³ *Ibid.* c343

⁷⁴ *Ibid.* c393

⁷⁵ [PBC Deb 12 July 2011 c445-8](#)

⁷⁶ [PBC Deb 7 July 2011 c363](#)

⁷⁷ *Ibid.* c380

for the failure of NHS foundation trusts in section 52 of the *NHS Act 2006*. This amendment was negated on division.⁷⁸

Mergers involving NHS Foundation Trusts

Clause 71 would apply the merger control regime for enterprises in the UK to mergers involving NHS foundation trusts, under which the Office of Fair Trading (OFT) can review mergers, to test whether they give rise to a substantial lessening of competition. The Minister, Paul Burstow, explained that the OFT would have discretion not to review mergers where patient benefits outweighed any adverse effects on competition. The Minister went on to provide an explanation of the impact of the clause for mergers involving NHS foundation trusts:

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

In practice, this would mean that the OFT would consider fewer mergers between foundation trusts than the panel currently does. A single regulator would present a significant improvement on the current arrangement, whereby both the Co-operation and Competition Panel and the OFT could end up considering the same merger as has happened for a merger of foundation trusts that also have significant private incomes.⁷⁹

Liz Kendall and other Opposition Members said that the figures quoted by the Minister had not been mentioned before, and Labour Members were concerned that the clause would apply a merger regime that had “nothing to do with the NHS” and would give the OFT, “a body that has no expertise, knowledge or influence on the NHS”, the responsibility to make decisions on mergers of hospitals. For the only time during the Committee’s scrutiny, the vote on this clause was tied (with the Liberal Democrat Member John Pugh voting against) and, in accordance with precedent, the Chair voted with the Ayes in order to preserve the Bill as presented to the House (and that clause 71 stand part of the Bill).⁸⁰

Reviews by the Competition Commission

Liz Kendall introduced two amendments (Amendments 235 and 237) to clauses 72 and 73, which would have deleted the requirement for the Competition Commission to review the development of competition in the NHS, and the powers for the Commission to impose penalties on NHS bodies that do not comply with its requests for information. These amendments were negated and the Committee agreed on division that these clauses, and the related clause 74, stand part of the Bill.⁸¹

Monitor’s powers to set license conditions on NHS providers

The Committee agreed Government amendments (Amendments 159 to 163) to clause 100 and 101. These clauses relate to Monitor’s powers to run a licensing regime for providers of NHS services and set out the purposes for which Monitor can set or modify licensing conditions. In line with other changes to Monitor’s duties, Amendments 159 and 161 would

⁷⁸ [PBC Deb 12 July 2011 c493](#)

⁷⁹ *Ibid.* c456

⁸⁰ *Ibid.* c464

⁸¹ *Ibid.* c470-1

replace references to exercising functions for the purpose of ‘promoting competition’ with a references to ‘preventing anti-competitive behaviour’.⁸²

Government amendments (Amendments 162 and 163) to clause 101 were intended to address concerns about Monitor’s power to require that a provider grant access to its facilities to another provider, and that this might have resulted in NHS providers being forced to hand over access to their facilities and equipment to private providers. The Minister, Paul Burstow, explained that the Government amendments would mean Monitor would “not now have power to regulate access to facilities as a mechanism for increasing competition, even where that would help to increase patient choice.”⁸³ The Minister explained that as a consequence of its amendments to clause 101 the Government had to make an amendment (Amendment 190) to clause 147:

Amendment 190 will confirm that the definition of “facilities” is the same as that set out in the 2006 Act, so that amendments 162 and 163 do not contradict existing principles and rules for co-operation and competition, principle 7 of which prohibits unreasonable refusal to supply services where such a refusal would restrict choice or competition against the patient interest.⁸⁴

4.4 Other Amendments

Foundation Trusts

Paul Burstow introduced a Government amendment (Amendment 193) to clause 156 relating to the authorisation of NHS foundation trusts. The Minister explained that the amendment would place a requirement on Monitor to gain assurances from the CQC about the quality of services provided by a NHS trust before it gained authorisation as a foundation trust (putting an existing voluntary agreement between Monitor and the CQC on a statutory footing). The Minister said this would help to reassure people that the Government’s commitment for all NHS trusts to achieve foundation trust status would not lead to a “lowering of the bar in Monitor’s stringent tests, including in the way in which the quality of services is considered during the application process.”⁸⁵ The Minister also introduced Government amendments (Amendments 198, 224 and 226) to clauses 176, 295 and 297, which would remove the 2014 deadline for all NHS trusts to achieve foundation trust status.⁸⁶

The Committee also agreed a Government amendment (Amendment 192) to clause 149, requiring boards of directors of NHS foundation trusts to hold their meetings in public.⁸⁷

The Committee agreed what the Minister described as minor and technical amendments (Amendments 194 and 196) to clauses 165 and 166, which deal with mergers and acquisitions between a foundation trust and another foundation trust or an NHS trust. The wording of clauses 165(2) and 166(2) require that foundation trusts obtain the approval of the majority of their governors before a merger or acquisition can take place. The purpose of Amendments 194 and 196 was to clarify that the requirements for governor support apply only to foundation trusts. During the clause stand part debate on these clauses Committee Members also discussed the merger control regime applied to the NHS more generally by clause 71.⁸⁸

⁸² *Ibid.* c479

⁸³ *Ibid.* c480

⁸⁴ *Ibid.*

⁸⁵ [PBC Deb 14 July 2011 c512](#)

⁸⁶ *Ibid.* c544

⁸⁷ *Ibid.* c511

⁸⁸ *Ibid.* c520-539

HealthWatch England and Local HealthWatch

The Committee agreed a Government amendment (Amendment 199) to clause 178, to require the CQC to formally respond in writing to advice received from HealthWatch England. The Minister, Paul Burstow, said the Government had tabled the amendment in response to calls to strengthen the status and influence of HealthWatch England as an advocate for patients. He acknowledged that the amendment was essentially the same as Opposition Amendment 348, which had been rejected when the Public Bill Committee previously considered the Bill.⁸⁹ The Committee also agreed a Government amendment (Amendment 205), in clause 179, which would ensure that HealthWatch England, like other NHS bodies, is subject to the public sector duties in the *Equality Act 2010*.⁹⁰

Government amendments (Amendments 231 and 232) to Schedule 15 were agreed, with the intention of ensuring that local healthwatch organisations are representative of their local community. Amendment 231 would require the person appointing local healthwatch members to act with a view to securing that those members are representative of the area they serve.⁹¹

The NHS Future Forum reported concerns about the extent to which local health and social care bodies would voluntarily pay heed to the outputs from local healthwatch organisations. The Committee agreed a Government amendment (Amendment 230) in clause 180, which would create a duty on those responsible for commissioning, providing, managing or scrutinising local care services to have regard to the views, reports and recommendations from local healthwatch organisations.⁹²

Joint Strategic Needs Assessments and Health and Wellbeing Strategies:

The Committee agreed Government amendments (Amendments 206 to 210) to clauses 189 and 190, which would require local authority health and wellbeing boards to involve the public and patients (through local healthwatch organisations) when preparing joint strategic needs assessments or health and wellbeing strategies. Amendment 209 would impose a duty on local authorities and clinical commissioning groups (and, through them, health and wellbeing boards) to have regard to statutory guidance when preparing such strategies.⁹³

A number of minor and technical Government amendments (Amendments 212 to 217) were made to the provisions governing which joint strategic needs assessments and joint health and wellbeing strategies the local authority, the NHS Commissioning Board and CCGs must have regard to.⁹⁴

5 The timetable for change

The decision to use a pause in the legislation to listen to concerns, and the changes made to the Bill during re-committal, have had an impact on the Government's timetable for change. In its response to the NHS Future Forum the Government confirmed that target dates for a number of statutory changes due to take place in April 2012 had been extended by up to a year.⁹⁵

⁸⁹ *Ibid.* c558

⁹⁰ *Ibid.* c564

⁹¹ *Ibid.* c566

⁹² *Ibid.* c568

⁹³ *Ibid.* c570

⁹⁴ *Ibid.* c582

⁹⁵ Page 60 of the [Government's response to the NHS Future Forum](#) (Cm 8113) provides a table setting out key dates in the timetable for change.

The Government extended the deadline for Monitor to begin taking on its new regulatory powers from April 2012 to October 2012.⁹⁶ The target date for HealthWatch England and local healthwatch bodies to be established, and for the NHS Commissioning Board to be fully established as a statutory body, was also extended from April to October 2012.

The dates for the abolition of Strategic Health Authorities (SHAs) and the establishment of Public Health England, originally planned for April 2012, have now been pushed back to April 2013. The Government also confirmed that the NHS Trust Development Authority and Health Education England will now assume their full powers by April 2013.

The Future Forum recommended that commissioning groups should only take on their full range of responsibilities when they had demonstrated that they had the right skills, capacity and capability to do so. The Government has said that while clinical commissioning groups would all be established by the original target date of April 2013 they would not be authorised to take on commissioning budgets in their local area until they are “ready and willing to do so”.

The Government has asked the Future Forum to continue a second phase of consultation with patients, service users and professionals focusing on four themes: information; education and training; integrated care; and public health.⁹⁷ In particular, the Government has committed to a “careful transition process” on changes to medical education and training, in order to avoid instability and to maintain high standards of governance during the transition.

The Chief Executive of the NHS (and Chief Executive designate of the NHS Commissioning Board), Sir David Nicholson, published an update for NHS managers on the transition to the new system on 20 June 2011.⁹⁸ He acknowledged that there had been a period of “significant uncertainty” but offered assurances that the new arrangements “will increase stability and provide greater flexibility.” Key points from this update include the following.

- As alterations to accountability arrangements during a financial year “would present a significant risk”, the decision has been taken to retain SHAs until the end of 2012/13, in the form of four clusters by October 2011. The four clusters will be in line with the NHS Commissioning Board geographical areas and not cut across existing SHA boundaries.
- The update mentions the “need to re-establish local momentum for clinical commissioning”, emphasising that pathfinders “must remain at the forefront of modernisation.” It is still expected that all GP practices will be members of either a commissioning group or ‘shadow’ commissioning group (with local arms of the Commissioning Board undertaking some of their functions) by April 2013.
- There is confirmation that Primary Care Trust (PCT) cluster areas “will be reflected in the initial arrangements for the local arms” of Commissioning Board, which will oversee established commissioning groups and commission some of the services under the jurisdiction of the Commissioning Board. However, arrangements “would require significantly less capacity than PCT and SHA clusters.”

⁹⁶ The Government also announced that Monitor would continue to have transitional powers over foundation trusts until 2016; its role as regulator of foundation trusts had previously been expected to come to an end in 2014.

⁹⁷ <http://healthandcare.dh.gov.uk/new-forum/>

⁹⁸ [Letter from NHS Chief Executive Sir David Nicholson on transition arrangements following the NHS Future Forum report and the Government’s response to it \(20 June 2011\).](#)

- It is currently planned that the Commissioning Board will be established as a Special Health Authority in “shadow form” in October 2011, before assuming its authorisation role from October 2012 and its remaining functions from April 2013.
- The update document highlights the aim of offering “all existing staff in commissioning organisations a potential pathway into the new system.”
- In relation to providers, the document states that “a full FT sector is crucial to the overall reforms.” Nevertheless there is a recognition that some trusts will not be able to achieve the 2014 deadline, with arrangements made for a specific later transition date in those cases.
- A national team will establish the NHS Trust Development Authority (NTDA) during 2012. This will oversee the remaining non-FTs from April 2013 once SHA clusters have been abolished, with more details on the transition published in due course.
- Monitor has been afforded transitional powers up to 2016 or for up to two years post-authorisation for those organisations becoming FTs after the original deadline.
- Any Qualified Provider will now be implemented in a phased way, with the initial focus on community and mental health from April 2012. Guidance on the further roll-out to areas “where there is evidence from patients that increasing choice and allowing new providers to enter the market will improve quality” was published in July 2011.⁹⁹
- Consideration will also be given to mechanisms for contracting integrated services, with end of life care and long-term conditions identified as possible areas.
- It is proposed that Health Education England will be created in “shadow” form during 2012/13 before taking full responsibility for education and training from April 2013. SHA clusters are expected to work with local employers to develop commissioning plans for this area for 2012/13.
- The document identifies the four sources of informatics support across the system: dedicated teams within local and national organisations; inter-organisational shared services: the Information Centre; and a national shared informatics resource to support organisational teams and deliver infrastructure support for areas deemed to be best delivered nationally.
- The integral role to be played by NHS leaders in communication and engagement is noted, with an acknowledgement that 'it is imperative to reorganise these functions' in light of reductions in the size of such teams across PCTs and SHAs.
- Local Authority Shadow Health and Wellbeing Boards that have joined the early implementer network are urged to examine issues such as: governance; services for key groups; health inequalities and public engagement. The DH will soon outline statutory guidance regarding health and wellbeing strategies, following a period of stakeholder engagement.
- Public Health England will be an executive agency within the Department of Health from April 2013.

⁹⁹ Department of Health, *Liberating the NHS: greater choice and control - Government response. Extending patient choice of provider (Any qualified provider)*, July 2011

- HealthWatch England and local healthwatch organisations should be established from October 2012, with local healthwatch and local authorities assuming responsibility for patient advocacy from April 2013.¹⁰⁰

David Nicholson said that NHS managers planning the transition must “remain mindful” that the *Health and Social Care Bill* remains subject to ongoing parliamentary scrutiny and that any actions taken should “represent reasonable preparatory steps which do not pre-empt the proper parliamentary process.”

¹⁰⁰ See also [NHS Confederation Health Policy Digest](#)

Appendix 1 – Core recommendations of the NHS Future Forum¹⁰¹

- **The enduring values of the NHS and the rights of patients and citizens as set out in the NHS Constitution are universally supported and should be protected and promoted at all times.** The Bill should be amended to place a new duty on the NHS Commissioning Board and commissioning consortia to actively promote the NHS Constitution. In addition, Monitor, the Care Quality Commission, the NHS Commissioning Board and commissioning consortia should all set out how they are meeting their duty to have regard to the NHS Constitution in their annual reports.
- **The NHS should be freed from day-to-day political interference but the Secretary of State must remain ultimately accountable for the National Health Service.** The Bill should be amended to make this clear.
- **Patients and carers want to be equal partners with healthcare professionals in discussions and decisions about their health and care. Citizens want their involvement in decisions about the design of their local health services to be genuine, authentic and meaningful. There can be no place for tokenism or paternalism.** The declaration of ‘no decision about me, without me’ must become a reality, supported by stronger and clearer duties of involvement written into the Bill focused on the principles of shared decision-making.
- **Because the NHS ‘belongs to the people’ there must be transparency about how public money is spent and how and why decisions are made.** The Bill should require commissioning consortia to have a governing body that meets in public with effective independent representation to protect against conflicts of interest. Members of the governing body should abide by the Nolan principles of public life. All commissioners and significant providers of NHS-funded services, including NHS Foundation Trusts, should be required, as a minimum, to publish board papers and minutes and hold their board meetings in public. Foundation Trust governors must be given appropriate training and support to oversee their Trust’s performance – until governors have the necessary skills and capability to take on this role effectively, Monitor’s compliance role should continue.
- **GPs, specialist doctors, nurses, allied health professionals and all other health and care professionals state that there must be effective multi-professional involvement in the design and commissioning of services working in partnership with managers.** Arrangements for multi-professional involvement in the design and commissioning of services are needed at every level of the system. The Bill should require commissioning consortia to obtain all relevant multi-professional advice to inform commissioning decisions and the authorisation and annual assessment process should be used to assure this. In support of this, there should be a strong role for clinical and professional networks in the new system and multi-speciality clinical senates should be established to provide strategic advice to local commissioning consortia, health and wellbeing boards and the NHS Commissioning Board.
- **Managers have a critical role to play in working with and supporting clinicians and clinical leaders.** Experienced managers must be retained in order to ensure a smooth transition and support clinical leaders in tackling the financial challenges facing the NHS.
- **There should be a comprehensive system of commissioning consortia but they should only take on their full range of responsibilities when they can demonstrate that they have the right skills, capacity and capability to do so.** The assessment of the skills,

¹⁰¹ [NHS Future Forum recommendations to Government](#), 13 June 2011

capacity and capability of commissioning consortia must be placed at the heart of authorisation and annual assessment process. Where commissioning consortia are not ready, the NHS Commissioning Board should commission on their behalf but provide all necessary support to enable the transfer of power to take place as soon as possible.

- **Patients want to have real choice and control over their care that extends well beyond just choice of provider.** Building on the NHS Constitution, the Secretary of State should, following full public consultation, give a 'choice mandate' to the NHS Commissioning Board setting out the parameters for choice and competition in all parts of the service. A Citizens Panel, as part of Healthwatch England, should report to Parliament on how well the mandate has been implemented and further work should be done to give citizens a new 'Right to Challenge' poor quality services and lack of choice.
- **Competition should be used as a tool for supporting choice, promoting integration and improving quality and must never be pursued as an end in itself.** Monitor's role in relation to competition should be significantly diluted in the Bill. Its primary duty to 'promote' competition should be removed and the Bill should be amended to require Monitor to support choice, collaboration and integration.
- **Private providers should not be allowed to 'cherry pick' patients and the Government should not seek to increase the role of the private sector as an end in itself.** Additional safeguards should be brought forward.
- **The duties placed on the Secretary of State, the NHS Commissioning Board and commissioning consortia to reduce health inequalities are welcome. These now need to be translated into practical action.** The Mandate for the NHS Commissioning Board, the outcomes frameworks for the NHS, public health and social care, commissioning plans and other system levers and incentives must all be used to help reduce health inequalities and improve the health of the most vulnerable.
- **Local government and NHS staff see huge potential in health and wellbeing boards becoming the generators of health and social care integration and in ensuring the needs of local populations and vulnerable people are met.** The legislation should strengthen the role and influence of health and wellbeing boards in this respect, giving them stronger powers to require commissioners of both local NHS and social care services to account if their commissioning plans are not in line with the joint health and wellbeing strategy.
- **Better integration of commissioning across health and social care should be the ambition for all local areas.** To support the system to make progress towards this, the boundaries of local commissioning consortia should not normally cross those of local authorities, with any departure needing to be clearly justified. The Government and the NHS Commissioning Board should enable a set of joint commissioning demonstration sites between health, social care and public health and evaluate their effectiveness.
- **Most NHS staff are unfamiliar with the Government's proposed changes to the education and training of the healthcare workforce. Those who are aware feel that much more time is needed to work through the detail.** The ultimate aim should be to have a multi-disciplinary and inter-professional system driven by employers. The roles of the postgraduate medical deaneries must be preserved and an interim home within the NHS found urgently. The professional development of all staff providing NHS funded services is critical to the delivery of safe, high quality care but is not being taken seriously enough. The National Quality Board should urgently examine how the situation can be improved and the constitutional pledge to 'provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed' be honoured.

- **Improving the public's health is everyone's business but should be supported by independent, expert public health advice at every level of the system.** In order to ensure a coherent system-wide approach to improving and protecting the public's health, all local authorities, health and social care bodies (including NHS funded providers) must cooperate. At a national level, to ensure the provision of independent scientific advice to the public and the Government is not compromised we advise against establishing Public Health England fully within the Department of Health.
- **Clinical leaders, managers and all those who care about the success of the NHS agree that quality, safety and meeting the financial challenge must take primacy and the pace of transition should reflect this.** To ensure focused leadership for quality, safety and the financial challenge, the NHS Commissioning Board should be established as soon as possible.

Appendix 2 – 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)

Fiona O'Donnell (East Lothian) (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: Shadow Health Minister)

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)

Phil Wilson (Sedgefield) (Labour: Opposition Whip)

Appendix 3 – Witnesses to Public Bill Committee oral evidence sessions

<i>Date</i>	<i>Witness</i>
Tuesday 28 June 2011	<p>Professor Stephen Field, Chair, NHS Future Forum; Dr Kathy McLean, Clinical Advice and Leadership, NHS Future Forum</p> <p>Mike Farrar, Chief Executive, NHS Confederation; Professor Chris Ham, Chief Executive, the King's Fund; Dr Jennifer Dixon, the Nuffield Trust</p> <p>Dr David Bennett, Chair and Interim Chief Executive, Monitor; Sonia Brown, Chief Economist, Monitor; Sue Slipman, Director, Foundation Trust Network; Cllr Dr Gareth Barnard and Andrew Cozens, Local Government Association</p> <p>Dr Hamish Meldrum, Chairman, British Medical Association; Dr Peter Carter, Chief Executive and General Secretary, Royal College of Nursing; Sir Richard Thompson, President, Royal College of Physicians; Professor Sir Neil Douglas, Chairman, Academy of Medical Royal Colleges</p> <p>Dr Clare Gerada, Chair, Royal College of General Practitioners; Dr David Paynton, Joint Clinical Lead, Royal College of General Practitioners; Dr Mike Dixon, Chairman, NHS Alliance; Michael Sobanja, Chief Executive, NHS Alliance</p> <p>Paul Jenkins, Chief Executive, Rethink and the Richmond Group; Jeremy Taylor, Chief Executive, National Voices; Ciarán Devane, Chief Executive, Macmillan Cancer Support; Neil Churchill, Chief Executive, Asthma UK; Baroness Barbara Young, Chief Executive, Diabetes UK; Joe Korner, Director of Communications, Stroke Association</p> <p>Gail Adams, Head of Nursing, UNISON; Rachael Maskell, National Officer, UNITE</p> <p>Rt Hon. Andrew Lansley MP, Secretary of State for Health; Rt Hon. Simon Burns MP, Minister of State for Health; Paul Burstow MP, Minister of State for Care Services</p>