Health Foundation parliamentary briefing
Briefing notes

Issues raised by the National Health Service (Amended Duties and Powers) Bill

These briefing notes have been prepared by the Health Foundation, an independent charity working to improve the quality of healthcare and are designed to be read in conjunction with the main briefing which is available at: www.health.org.uk/publications/issues-raised-by-the-national-health-service-amended-duties-and-powers-bill/

These briefing notes give a broad overview of some of the provisions in the National Health Service (Amended Duties and Powers) Bill and identifies some key issues that the drafting raises. These notes are not intended to give a comprehensive view of each clause and subsection within the clause but are instead intended to help give some guidance on what the provisions in the Bill might mean in practice.

Briefing notes

Please note

- NHS England is referred to as the NHS Commissioning Board – its legal name.
- The National Health Service (amended duties and powers) Bill is referred to as 'the Bill'
- The Health and Social Care Act 2012 is referred to as 'the 2012 Act'

Part 1: Amendments to sections within Part 1 of the National Health Service Act 2006, as amended by the Health and Social Care Act 2012

Clause 1: Duty on the Secretary of State to promote a comprehensive health service based on social solidarity

Under the current legislative framework, the Secretary of State has a duty to promote a comprehensive health service and continues to have ministerial accountability to parliament for the health service.[1] The Bill amends the existing duty on the Secretary of State to promote comprehensive health service to a duty to promote a comprehensive health service based on 'social solidarity'. The Bill would require the Secretary of State to ensure that the health service is a public service which delivers services of general economic interest and operates on the basis of social solidarity.

The Bill would ensure that arrangements between commissioners and providers of NHS-funded health services require effective cooperation between providers (and more specifically between providers of health services and providers of community care services).

The term 'social solidarity' is imported from European legislation and is not defined in the Bill. Before importing it into domestic legislation, there would need to be very careful consideration of what the term means to avoid unintended consequences.

[1] Explanatory Notes: Health and Social Care Act 2012. Chapter 7. Accessed via: http://www.legislation.gov.uk/ukpga/2012/7/notes/contents

Clause 2: Exercise of the Secretary of State's powers

The Bill inserts a new clause which would give the Secretary of State new duties in relation to co-operation and social solidarity. The Secretary of State would be required to exercise his or her powers under the National Health Service Act 2006 to promote the health service as an efficient service based on mutual cooperation and social solidarity and to ensure that any person who is concerned with commissioning or providing health services for the NHS:

- procures services in line with practices that the Secretary of State considers appropriate
- protects and promotes the right of patients to make choices to the extent that the exercise of choice is consistent with the overall interests of the health service
- does not engage in anti-competitive or other behaviour which the Secretary of State considers is against the interests of people who use health services.

There would need to be more clarity as to how the Secretary of State would define 'appropriate' practices and the penalties for non-compliance. The Bill would give the Secretary of State powers to adjudicate on complaints about anti-competitive behaviour or other behaviour contrary to the interests of the health service.

The Secretary of State would be able to publish guidance for health services commissioners and providers on the matters outlined above and those bodies would be required to have due regard to the guidance. The clause would give the Secretary of State powers to issue directions to any health service body to support the discharge of those functions (ie, patient choice and procurement). In clause 6 (NHS contracts), the Bill expands the definition of health service bodies to include NHS foundation trusts, which would potentially give the Secretary of State new powers to direct NHS foundation trusts. It is not entirely clear from the drafting whether it is intended to change the system architecture to give the Secretary of State direction-making powers over NHS foundation trusts (either on specific matters relating to clause 6 or more broadly). This is a critical issue which would need to be probed further.

Issues to consider

- There is a fundamental question as to whether the Secretary of State should be operationally (in addition to strategically) involved in the NHS.
- The general trend across most sectors has been to remove ministers from decisions on competition disputes – hence the establishment of independent competition authorities. Is it appropriate that the NHS should be different, even when compared to other public services?
- Clause 2 would give the Secretary of State new powers to direct NHS foundation trusts in relation to patient choice, procurement and behaviour which might be deemed against patient interests. If this was intentional, what does this mean for the role of NHS foundation trusts?

Clause 3: Duty on the Secretary of State regarding provision of certain services

This clause would represent a fundamental change to the current relationship between the Secretary of State and the NHS Commissioning Board and CCGs. The Health and Social Care Act 2012 amended the existing duty on the Secretary of State to arrange for the provision of services directly by placing a duty directly on CCGs to arrange for the provision of certain health services.

The Bill would effectively revert back to the previous situation where the Secretary of State was given ultimate accountability to arrange for the provision of services. However, the Bill would give the

Secretary of State powers to delegate those duties to the NHS Commissioning Board and to give directions to the Board in relation to its performance.

The Bill would also give the Secretary of State powers to delegate the duty to arrange the provision of services to CCGs. The Secretary of State would be able to give directions to an individual CCG concerning the performance of the duty to arrange for the provision of services including hospital accommodation, medical, dental ophthalmic and nursing services and services for the prevention of illness.

Clause 4: High security psychiatric services

The Health and Social Care Act 2012 removed the duty on the Secretary of State to provide high security psychiatric services and instead placed that duty directly on the NHS Commissioning Board. The Bill would return the responsibility to arrange for the provision of such services to the Secretary of State, giving him or her powers of delegation to the NHS Commissioning Board. However, the Act gave the Secretary of State the power to give directions to both the NHS Commissioning Board but also to providers of high security psychiatric services. The power to direct providers of high security psychiatric services would no longer be included in the amended bill. It is not clear whether the removal of this power was intentional.

Issues to consider (clauses 3 and 4)

- While clauses 3 and 4 wouldn't represent a structural change, they would significantly change the relationship between the Secretary of State and the NHS Commissioning Board and also between the Secretary of State and clinical commissioning groups (in the case of clause 3).
- Clause 3 would potentially limit the independence of commissioners (both national and local) and would increase the power of the Secretary of State to direct the day-to-day delivery of services.
- Clause 3 would raise questions about the role of commissioners (both national and local) in the new system and whether this relationship change would bring the system back to a command and control model.

Clause 5: Power for Secretary of State to direct certain health service bodies

The Health and Social Care Act 2012 removed the ability of the Secretary of State to direct strategic health authorities (SHAs) and primary care trusts (PCTs) alongside their abolition. The Act did not give the Secretary of State the same broad power to direct the NHS Commissioning Board and CCGs as successor bodies. The Bill would give the Secretary of State powers to direct these organisations.

Issues to consider

- Clause 5 would give the Secretary of State a broad power to direct the NHS Commissioning Board and CCGs. As above, this would be a significant departure from the current system. What should the relationship between the Secretary of State and commissioners be? To what extent should the Secretary of State be able to get involved in day-to-day operational matters?
- It appears that the broad direction-making power wouldn't extend to NHS foundation trusts (although it would apply, as it does now, to NHS trusts). However, other provisions would reduce the freedom and autonomy of NHS foundation trusts. What should their role be in the future?

Clause 6: NHS contracts

Section 9 of the National Health Service Act 2006 lists a number of 'health service bodies' which can enter into an 'NHS contract'. An NHS contract is an arrangement between a commissioner (including CCGs and the NHS Commissioning Board) and health service bodies. NHS foundation trusts are currently not considered to be a 'health service body' for the purposes of an NHS contract.

The main distinction between an NHS contract and another form of contract is that it does not give rise to contractual rights or liabilities. Effectively this means that NHS contracts are not legally enforceable in the courts. In practice this means that a contract between a CCG and an NHS trust is not legally enforceable whereas a contract between a CCG and an NHS foundation trust is.

The Bill would add local authorities (exercising functions under the Health and Social Care Act 2012) and NHS foundation trusts to the list of health service bodies. However, it does not retain the addition of Health Education England which was included by the Health and Social Care Act 2012.

Commissioners would be able to give a provider an exclusive right to provide services for a defined period (not exceeding 10 years) but could remove that designation at any time.

Issues to consider

- This amendment would represent a change in contractual arrangements for NHS foundation trusts but would also limit the powers of a CCG to take legal action.
- Further consideration would need to be given to the practicalities of treating local authorities as NHS commissioners and in particular how this might affect contractual arrangements for providers undertaking both health and social care services.

Payments between a commissioner and providers

The clause includes a new provision which aims to specify that for the purposes of the European Directive 2014/24/EU[2] of the European Parliament and the Council, any payment between a commissioner and a provider (for the purposes of the health service) may be designated as a grant.

The European Directive 2014/24/EU states that the award of public contracts by or on behalf of member state's authorities has to comply with the principles of the Treaty on the Functioning of the European Union and in particular, the free movement of goods, freedom of establishment and the freedom to provide services. However, there is a provision which states that the '*mere financing, in particular through grants of an activity, which is frequently linked to the obligation to reimburse the amounts received where they are not used for the purposes intended, does not usually fall within the scope of the public procurement rules*'.

It is questionable whether it is sufficient legally to specify that payments are grants when in practice they will be framed as contracts with payment given for the delivery of specific services. Even if this were possible, the transitional consequences of attempting to do this could bring uncertainty for those contracting with NHS foundation trusts in particular.

[2] Official Journal of the European Union (2014) Directive 2014/24/EU of the European Parliament and of the Council of 26 February 2014 on public procurement and repealing Directive 2004/18/EC. *Official Journal of the European Union*. 28.3.2014. Accessed via: http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32014L0024&from=EN

Issues to consider

- Aside from potential legal issues, there is a broader question about the extent to which the commissioning or procurement of NHS services should fall under the remit of European wide procurement legislation and what the perceived issues or barriers caused by the legislation actually are.
- Clause 1 recognises that anti-competitive behaviour may act against patient interests. If NHS procurement processes do not need to comply with broader procurement legislation, what does 'good' NHS procurement look like?
- Aside from potential legal issues as to the feasibility of the Bill's aim to remove the commissioning of NHS services from EU and domestic procurement legislation, there is a broader issue as to why robust procurement processes might be seen as a barrier to NHS commissioners. If the NHS is to be exempted from good practice procurement requirements which apply to other public services, what is it that makes NHS services special?

For information: European Directive 2014/24/EU

The Cabinet Office has recently consulted on draft Public Contract Regulations which will transpose the 2014 EU Public Procurement Directive into UK law.[3] In England, from 18 April 2016 a new 'light-touch' regulatory regime for health and social services contracts over €750,000 will sit alongside the NHS Procurement, Patient Choice and Competition Regulations 2013 made under Section 75 of the Health and Social Care Act.

Article 77 of the Directive (reserved contracts for certain services) allows member states to provide that contracting authorities may reserve the right for organisations to participate in procedures for the award of public contracts exclusively for those health, social and cultures services (where those contracts were equal or over €750,000). The intention of the article is to allow certain contracts to be reserved for competition by social enterprises.[4] Article 77 will not apply to NHS commissioning in England given the prohibition of favouring one type of provider.[5]

Part 2: Amendments to the financial powers of NHS foundation trusts and NHS trusts, as amended by the Health and Social Care Act 2012

Clause 7: Provision of goods and services by NHS foundation trusts

The Bill would change provisions in the Health and Social Care Act 2012 which describe the principal purpose of an NHS foundation trust. Under the 2012 Act, an NHS foundation trust cannot fulfil its primary purpose unless in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the

[3] Cabinet Office (2014) Consultation. Transposing the 2014 EU Procurement Directives. Cabinet Office. Accessed via: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/356492/Consultation_Document_UK_Transposition_of_new_EU_Procurement_Directives_Public_Contracts_Regulations_2015.pdf

[4] Semple, A (2014) New EU procurement directives: Comparing the final text to earlier versions. *Public Procurement Analysis*. Accessed via: http://www.procurementanalysis.eu/resources/New+EU+procurement+directives+-+comparing+the+texts.pdf

[5] NHS England (2014) Bulletin for CCGs: Issue 68, 25 September 2014. NHS England. Accessed via: http://www.england.nhs.uk/2014/09/25/bulletin-for-ccgs-issue-68-25-september-2014/

provision of goods and services for any other purpose. NHS foundation trusts are required to explain in their annual report the impact that non-NHS income has had on their NHS service provision. Any proposal by directors to increase the proportion of total income earned from non-NHS services by five percentage points requires agreement by more than 50% of the governors.

The Bill would require an NHS foundation trust to ensure that its total income from the provision of goods and services provided to individuals for non-health service functions, or where charges are made, is not greater than a percentage of its total income (as directed by the Secretary of State).

The Bill would require foundation trusts to ensure that non-health service functions do not have an adverse impact on the ability of the trust to carry out its principal purpose and that health service patients benefit from private income or charges with a requirement to account for its non-health service income in the annual report alongside an assessment of the impact. The Bill appears to give less power (compared to the current legislation) to the council of governors whose role would be limited to providing comment and informing Monitor rather than having an explicit vote on proposals to increase private income.

The Bill would not amend the section in the Health and Social Care Act 2012 that removed the provisions in the National Health Service Act 2006 which limited the total income of an NHS foundation trusts derived from private charges to not be greater than the proportion of the total income it received in its base year.[6]

Issues to consider

- People raise concerns that an increase in private work might have a negative impact on the quality or access arrangements for NHS services. There is a broader question as to the extent to which the Secretary of State should have a role in minimising the impact of private patients on the availability and access arrangements for NHS services.
- The current legal arrangements effectively provide for a maximum level of 49% private income whereas the Bill could create uncertainty for providers leaving private income limits to the discretion of the Secretary of State. This could risk instability and financial uncertainty for NHS foundation trusts if the income cap could be changed easily and without parliamentary scrutiny.
- The Bill would appear to give NHS foundation trust governors a weaker role in decision-making on private income generation. Is this intentional and is it right to shift control of decision-making from governors (which include patients and local people) to the Secretary of State?
- If the intention is to allow caps on a case-by-case basis how would this apply in practice? For example, would it be fair to set a cap based on historical precedent which might benefit organisations which have already well-established private services? If a blanket cap was to be applied, what would be the process for setting it?

[6] The base year was taken as the first full financial year that an organisation was an NHS trust. If the organisation had been an NHS trust throughout the financial year ending with 31st March 2003, the base year was taken as that year or in the case of a mental health NHS foundation trust, that proportion or 1.5% if greater.

Clause 8: NHS income and provision of goods and services

The Bill would give the Secretary of State direction making powers to determine the percentage of an NHS trust's total income that could come from the provision of charges or goods and services which are not for the purpose of the health service (aka private income) or to set a higher percentage. In practice, the Secretary of State could do this anyway through broader direction-making powers. Every NHS trust would be required to ensure that the provision of private goods or services or charges does not impact on the ability of the trust to carry on its principal purpose and health service patients who are provided with services benefit from the trust's provision of such services.

There was not an equivalent private patient income cap on NHS trusts so on the one hand the clause would level the playing field between NHS trusts and NHS foundation trusts but on the other it could be viewed as a threat to income growth for current NHS trusts.

Issues to consider

- While NHS foundation trusts had restrictions on their private income, NHS trusts did not have this same restriction (in some cases leading to incentives not to become an NHS foundation trust if private income was higher than the NHS foundation trust cap).
- This clause would provide more consistency between NHS foundation trusts and NHS trusts in how private income is considered.

Part 3: Amendment of provisions in the Health and Social Care Act 2012 relating to competition and procurement in the health service and connected amendments

Clause 9: NHS trusts provision of non-health services

The Bill would intend to ensure that no legally enforceable procurement obligations could be imposed on NHS commissioners in relation to any arrangement which is proposed to take effect or takes effect by way of an NHS contract. The clause would seek to amend the Public Contracts Regulations 2006 (which will be replaced by the updated public procurement regulations) to exclude services included within an NHS contract from the procurement legislation.

Issues to consider

- The principles behind this clause appear to be similar to those under clause 6 (NHS contracts) and again focus on the extent to which NHS commissioning should be subject to broader legislation relating to procurement.
- NHS commissioners have been subject to these procurement rules for many years (ie, the regulations pre-date the 2012 Act and the Section 75 Regulations) and are required to act transparently, treat economic operators equally and to act in a non-discriminatory way. What aspects of the current procurement legislation are seen as problematic? What does this mean for the role of NHS commissioners?

Clause 10: Repeals: Monitor's powers

The Bill would repeal the following provisions in relation to Monitor

62(2) In carrying out its main duty, Monitor have regard to the likely future demand for health care services.

62(3) Monitor must exercise its functions with a view to preventing anti-competitive behaviour in the provision of health care services for the purposes of the NHS which is against the interests of people who use such services.

62(10) Monitor must not exercise its functions for the purpose of causing a variation in the proportion of health care services provided for the purposes of the NHS by reference to whether those persons are in the public or private sector.

67(3a) Monitor must ignore functions under section 111 and 113 (intervention powers to impose additional licensing conditions on foundation trusts) when exercising its competition and pricing functions (i.e information from Monitor's regulatory arm should not influence the competition and pricing functions).

72-80 Competition provisions

- (72) Functions under the Competition Act 1998 – *Giving Monitor concurrent functions with the Competition and Markets Authority under part 1 of the Competition Act 1998 to conduct investigations where it has reasonable grounds for suspecting that organisations have abused a dominant market position or acted to prevent, distort or restrict competition.*
- (73) Functions under Part 4 of the Enterprise Act 2002 – *Giving Monitor powers to make market investigation references to the Competition and Markets Authority if it suspects any features of a market might prevent, restrict or distort competition.*
- (74) Competition functions: supplementary: *providing that when Monitor carries out its concurrent competition functions, it would only have regard to its general duties that are shared with the Competition and Markets Authority.*

- (75) Requirements as to procurement, patient choice and competition – *giving the Secretary of State powers to make regulations imposing requirements on the NHS Commissioning board and CCGs in order to ensure good practice in relation to procurement, to ensure the protection and promotion of patients' rights to make choices and to prevent anti-competitive behaviour.*
- (76) Functions under Section 75: Investigations, declarations and directions – *outlining what can be included in the regulations about Monitor's powers to investigate and remedy breaches of the regulations.*
- (77) Requirements under Section 75: undertakings – allowing regulations to confer on Monitor a power to accept undertakings in lieu of issuing a direction or declaring an arrangement ineffective under section.
- (78) Guidance – *requiring Monitor to issue guidance on compliance with Section 75 regulations and on how those regulations are enforced.*
- (79) Mergers involving NHS foundation trusts – *avoiding legal uncertainty by clarifying that the merger control regime under the Enterprise Act 2002 applies to NHS foundation trusts.*
- (80) Co-operation with the Office of Fair Trading – requiring Monitor and the Competition and Markets Authority to cooperate in exercising their concurrent functions.

Effectively these repeals seek to remove Monitor's powers in relation to the Competition Act 1998 and the Enterprise Act 2002 as well as removing the powers of the Secretary of State to make regulations in relation to procurement, patient choice and competition (ie, the Section 75 regulations).

Issues to consider

- The regulations made under Section 75 of the 2012 Act are an evolution from the Principles and Rules for Co-operation and Competition (PRCC) which were first published in 2007. The regulations as well as the PRCC, when in effect, contained principles such as fair procurement and patient choice. Is the intention of the Bill to remove these requirements from commissioners or would there be plans to reinstate the PRCC as guidance rather than regulations?
- Do the attempts to dilute competition mean that NHS providers are considered as the major provider? What role do social enterprises or third sector roles have in the revised system?
- What is the role of patient choice under this system? Would choice be limited to NHS providers?
- If NHS foundation trusts are designed to be independent organisations, should they be regulated and managed as independent businesses or be subject to a more tailored regime?
- Fundamentally, what is the role of NHS foundation trusts and NHS trusts and is it believed that a preferred provider model is required to meet the challenges the system faces?

For information: The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013

The regulations impose requirements on the NHS Commissioning Board and CCGs in order to ensure good practice in relation to the procurement of NHS services, to ensure the protection of patients' rights to make choices regarding their NHS treatment and to prevent anti-competitive behaviour by commissioners. The regulations give commissioners a general duty to secure the needs of the people who use services, improve the quality of services and improve the efficiency of services including through integrated provision.

The regulations also establish:

- a general requirement for the procurement of health care services to be carried out in a transparent and proportionate manner and for all providers to be treated equally. Commissioners should establish and apply proportionate and non-discriminatory criteria.
- requirements in relation to transparency in the award of contracts for the provision of health care services. A CCG or the NHS Commissioning board are required to publish a contract notice unless it is satisfied that the services can only be provided by one provider
- a contract can't be awarded where conflicts or potential conflicts of interest between the provider and the commissioner affect the integrity of the contract
- commissioners are prohibited from engaging in anti-competitive behaviour except where it is in the interests of people who use NHS health care services
- commissioners are required to offer a choice of alternative provider following a referral to a health service provider in accordance with the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012
- powers for Monitor to investigate and take enforcement action in relation to breaches of the regulations.

History

The regulations have evolved from the Principles and Rules for Cooperation and Competition (PRCC) which were first published by the Department of Health in 2007 as part of the 2008/2009 NHS Operating Framework. The PRCC was intended as guidance for system managers, commissioners and providers on the expected behaviours and rules governing cooperation and competition. As well as outlining plans to develop an independent competition panel, the document set out 10 principles that would apply from April 2008.

Key provisions included a requirement that commissioners should contract with the provider best able to meet the needs of their local population and both commissioners and providers were required to foster patient choice. With regard to mergers and acquisitions, the guidance stated that these transactions were acceptable when in the best interest of patients and taxpayers, as long as sufficient choice and competition remained to ensure high quality services[7].

The Department of Health updated the PRCC, initially in 2010, to take into account the coalition government's plans outlined in *Equity and excellence: liberating the NHS*. While the 10 principles remained similar to those published in 2007, the role of choice and competition within the NHS was strengthened. In 2007, one of the principles related to 'fostering choice'. In the revised guidelines, commissioners and providers would be required to promote patient choice with specific reference to the policy of 'any willing provider'. There was also a new requirement stating that commissioners and providers should not reach agreements that would restrict commissioner or patient choice against the interests of patients or taxpayers.[8]

In February 2013, the Secretary of State made the National Health Service (Procurement, Patient Choice and Competition) Regulations. The regulations required the NHS Commissioning Board and CCGs to ensure good practice in relation to the procurement of NHS health care services. The regulations required commissioners to prevent anti-competitive behaviour and to ensure the protection of patients' rights to make choices.[9] Following concern that the regulations would require commissioners to use competitive tendering for more services and that the regulations marked a significant change from the previous guidance[10] the government made new regulations with the intention of putting beyond doubt the government's intention that competition should be used in the interest of patients and that there was no requirement to put all contracts out to competitive tender.[11]

[7] Department of Health (2007) *Principles and rules for cooperation and competition (PRCC).* Department of Health. Accessed via: https://www.gov.uk/government/publications/principles-and-rules-for-cooperation-and-competition

[8] Department of Health (2010) *Principles and rules for cooperation and competition.* Department of Health. Accessed via: https://www.gov.uk/government/publications/principles-and-rules-for-cooperation-and-competition

[9] The National Health Service (Procurement, Patient Choice and Competition) Regulations 2013. Accessed via: http://www.legislation.gov.uk/uksi/2013/257/contents/made

[10] House of Lords Secondary Legislation Committee (2013) 30th Report of Session 2012-13. HL Paper 136. The Stationery Office. Accessed via: http://www.publications.parliament.uk/pa/ld201213/ldselect/ldsecleg/136/13602.htm

[11] Department of Health (2013). Changes to the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013. Accessed via: http://media.dh.gov.uk/network/357/files/2013/03/Changes-to-the-National-Health-Service-Regulations-2013.pdf

Clause 11: Exemptions from the Competition Act 1998

The Bill seeks to dis-apply the Competition Act 1998 in relation to the NHS or Secretary of State functions by specifically stating that people commissioning or providing services for the purpose of the health service shall not be considered an 'undertaking' for the purposes of the Competition Act 1998 and that the Enterprise Act 2002 would not apply to any proposed merger involving an NHS trust or an NHS foundation trust.

Clause 12: Mergers of NHS trusts or foundation trusts to require the consent of the Secretary of State

The clause would amend the merger control regime to require the Secretary of State to be the ultimate decision maker on merger decisions. Currently for NHS foundation trusts, it is the Competition and Markets Authority who has responsibility for assessing merger decisions under the Enterprise Act 2002.

Issues to consider (for clauses 11 and 12)

- Legally, the process for exempting the NHS from the Competition Act 1998 or the Enterprise Act 2002 might be more complicated than simply expressing an intention on the face of the Bill. In particular, there are specific thresholds which would trigger action under a European-wide framework. Primary legislation cannot prevent provisions from being declared contrary to European legislation.
- To what extent should there be competition between providers of NHS-funded care?
- To what extent should NHS providers (including NHS foundation trusts) be considered as part of a single organisation rather than independent organisations which compete with each other?
- If NHS foundation trusts are exempted from external scrutiny for merger and competition decisions, what happens if they act in an anti-competitive fashion? What happens if they intend to merge with a large private sector provider? Would that bring the decision-making process back into the remit of the Competition and Markets Authority?

Clause 13: Regulations requiring NHS trust and foundation trust mergers to be in patients' interests

The Bill would give the Secretary of State powers to make regulations which require him or her to provide approval in writing for any mergers involving an NHS trust or an NHS foundation trust or the acquisition or disposal of significant property by an NHS trust or an NHS foundation trust. The Bill would give the Secretary of State powers to issue guidance about the circumstances in which an acquisition or disposal of property by an NHS trust or an NHS foundation trust would be deemed 'significant' and the processes that an NHS trust or NHS foundation would need to follow.

Issues to consider

- Does amending the merger decision making process to give the Secretary of State the final decision risk political interference? Currently, there is a clear decision-making process by competition authorities (in the case of NHS foundation trusts).
- Should there be a distinction between the process to be followed for NHS trusts versus NHS foundation trusts?

- What is it about NHS trusts that make them different to other public sector bodies?
- What role should competition considerations have in a merger decision-making process?
- How robust would the amended merger decision making process be and, given the weak evidence on the effectiveness of mergers in the NHS, would this provide a robust test?
- Would an increased role for the Secretary of State in decision-making for NHS foundation trust mergers risk additional judicial reviews?
- What role would the arm's length bodies, including Monitor as the sector regulator, have in providing advice on proposed mergers? Would the Cooperation and Competition Panel be retained within Monitor?

Part 4: The NHS and national or international agreements

Clause 14: NHS exemptions from the proposed Transatlantic Trade and Investment Partnership Treaty (TTIP)

The Bill would clarify the intention to prevent NHS health service bodies being subject to the proposed Transatlantic Trade and Investment Partnership Treaty (TTIP). Clause 14 states that 'no ratification by a Minister of the Crown of the proposed TTIP shall cause any legally enforceable procurement or competition obligations to be imposed on any NHS body entering into any arrangement for the provision of health service under the National Health Service Act 2006 in England and other acts of legislation for Scotland, Wales and Northern Ireland.'

Issues to consider

- To what extent is there cross-party and cross-country agreement on the interests of the UK when negotiating the TTIP?
- If the NHS was subject to the TTIP, what would be the real threats? To what extent would investor-state dispute settlements apply?
- Are there aspects of health care which should be subject to the TTIP? For example, the provision of private services by NHS providers, particularly where there is an international aspect of service provision?

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See also the main briefing, available at: www.health.org.uk/publications/issues-raised-by-the-national-health-service-amended-duties-and-powers-bill/