



House of Commons
Health Committee

The use of management consultants by the NHS and the Department of Health

Fifth Report of Session 2008–09

*Report, together with formal minutes and oral
evidence*

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Current membership

Rt Hon Kevin Barron MP (*Labour, Rother Valley*) (Chairman)

Charlotte Atkins MP (*Labour, Staffordshire Moorlands*)

Mr Peter Bone MP (*Conservative, Wellingborough*)

Jim Dowd MP (*Labour, Lewisham West*)

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Mr Lee Scott MP (*Conservative, Ilford North*)

Dr Howard Stoate MP (*Labour, Dartford*)

Mr Robert Syms MP (*Conservative, Poole*)

Dr Richard Taylor MP (*Independent, Wyre Forest*)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom

Committee staff

The current staff of the Committee are Dr David Harrison (Clerk), Adrian Jenner (Second Clerk), Laura Daniels (Committee Specialist), David Turner (Committee Specialist), Frances Allingham (Senior Committee Assistant), Julie Storey (Committee Assistant) and Gabrielle Henderson (Committee Support Assistant).

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number, and these can be found in HC 28–i and HC 340–i.

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The Committee's 2008 Public Expenditure Questionnaire and management consultants

1. For many years the Committee has undertaken an annual *Public Expenditure Questionnaire (PEQ)* inquiry in which we have examined the Department of Health's expenditure. Each year we send the Department a questionnaire asking a range of finance-related questions. The answers relating to national and regional information are published in hard copy as well as on our website; we also include on our website spreadsheets containing a further breakdown of data relating to Primary Care Trusts.¹

2. Shortly after the publication of the PEQ in December 2008, we held an evidence session with senior Departmental officials, including the Permanent Secretary (Mr Hugh Taylor) and the NHS Chief Executive (Mr David Nicholson), to question them about the information contained in the PEQ and other matters related to public expenditure. In previous years we have held a second evidence session with the Secretary of State, accompanied by his officials; this year we decided to focus this second session on the NHS Operating Framework, but followed up a number of the issues raised in the PEQ session.

3. We have not in the past published a report following our PEQ sessions. However, this year we have decided to make an exception to our normal practice and to comment on the replies made by the NHS Chief Executive to our questions about the use of management consultants.

Use of management consultants by the Department of Health and the NHS

4. The National Audit Office (NAO) estimated that the NHS spent £0.6 billion on consultancy services in 2005–06, and that that is about a fifth of the entire public sector consultancy spending for that year. The NAO also estimated that the NHS was responsible for about a third of the increase in public sector consultancy expenditure between 2003–04 and 2005–06.²

5. In 2007–08 the NHS summarised accounts for the first time had separate disclosure of the amounts payable to external consultants in the NHS (prior to that, the costs were included in “miscellaneous expenditure”). The totals given in the summarised accounts, were £43.4 million for SHAs, £132.6 million for PCTs and £132.4 million for NHS Trusts, giving a total of £308.5 million. The Consolidated Accounts of NHS Foundation Trusts did not separately identify consultancy costs in 2007–08.

6. In our evidence sessions we questioned the officials about what types of firms were employed and their rates of pay. The cost per day of senior partners is usually in excess of £1,000, juniors £400–£500 (Q38). A wide range of firms are used, from the Big Four to small firms (Q36).

1 <http://www.publications.parliament.uk/pa/cm/cmhealth.htm>

2 Source NAO 2006 report

7. In answer to our questions, David Nicholson, the NHS Chief Executive, argued that consultants did a useful job, especially in undertaking work which NHS organisations and the Department did not have the skills to do themselves.

8. Mr Nicholson highlighted three important areas in which consultants had worked, pointing out that “there simply were not the people out there for us to recruit, so it was not an issue that we could get a lot of people to do these really very complicated technical things, so we had to use consultancy significantly”. These areas were the work of consultants on IT (as part of the *Connecting for Health* programme), the Commercial Directorate and turn-around teams.³

9. He stressed the benefits consultants had brought in respect of “turn-around”:

In terms of the turnaround we spent in excess of £50 million on the turnaround, and I have to say that turnaround moved us from half a billion deficit to one and a half billion surplus

The benefits had mainly come from improved implementation:

virtually none of the schemes that came up around getting ourselves back into financial balance came out of the brains of the consultants—most of the ideas came out of the NHS itself. What the consultancies gave us was the ability to execute some of these much better.

10. He noted that circumstances had in recent months changed dramatically and the Department currently had

a programme both in terms of the Commercial Directorate and in Connecting for Health to significantly reduce the amount of consultancy we use across the board, and you will see that come down significantly over the next six months or so.

The Department has now “set up a thing called IMAS (NHS Interim Management and Support), which you may or may not have come across, which is an internal consultancy. So we have developed an internal consultancy where we use our own people across the NHS now to do this kind of work and they are currently working in 23 organisations.”

11. Our key questions addressed the issue of collecting and publishing information about the use of consultants. In December 2006 the Treasury issued guidance for the Spring 2007 departmental reports, placing a requirement on Departments to include information on consultancy spending. The Department of Health now collects such information about its own use, but not about the NHS’s use of consultants.

12. The questions and answers to Mr Nicholson during the PEQ evidence session in December 2008 were as follows:

Q70 Dr Stoa: How much money are you spending on external management consultancy at the moment? I could not find that in any of the tables. Do you have any figures?

Mr Nicholson: No. We have not so far collected that information centrally. We have started to think about how we might do it but I think the numbers we have got are so unreliable at the moment that we are not satisfied that we have got that number right.

Q71 Dr Stoate: Is that not a cause for concern, because they are rather expensive.

Mr Nicholson: That is why I think we need to get the numbers right. Absolutely.

Q72 Dr Stoate: If you have not collected them, it is difficult to know if they are right or wrong.

Mr Nicholson: Yes. We think we need to know how much money the NHS is spending on management consultancy and we have started the process of collecting the information. I agree with you, we should have collected it in the past, but we did not....⁴

13. However, when we questioned Mr Nicholson in 2009 during the second evidence session (on the NHS Operating Framework) we heard a different story. He seemed to claim that collecting information would lead to micromanagement of the NHS.

Q30 Sandra Gidley: ...Mr Nicholson [you were] before us in December and said that the Department had never had never tried to keep track of how much the NHS is spending on consultancy services. Why not?...

Mr Nicholson: I am happy to say again why we did not do it. From the centre we desperately try not to micromanage what the NHS does and consultancy can be literally from a very small amount of money to help a particular part of an organisation get better, whether it is environmental health or all sorts of things for which we use consultancy, right the way through to using the big firms (Q36).⁵

He added

Centralising organisations all over the world start off by collecting detailed information in this way and then they start to use it to micromanage organisations; we do not think that is the right thing to do.”⁶

14. We also asked the officials how they ensured that the consultants provided value for money and whether “there should be some sort of external peer review of consultants’ reports or some way of ensuring that the taxpayer is getting value for money”. Mr Taylor told us:

It depends where the spend occurs. If the money is spent in the Department, either on programmes or on admin then the expenditure is monitored and we publish the spend figures.⁷

4 Q 70–72 (11 December 2008, HC 28–i)

5 Q 30 (11 March 2009, HC 340–i)

6 Q 31, (11 March 2009, HC 340–i)

7 Q 35, (11 March 2009, HC 340–i)

and

in the Department we have our own internal function that certainly looks at use of consultancy within the Department and we are obviously subject to NAO review. And we have our own internal protocols to ensure that if a consultancy contract is let it is let with strict adherence to procurement rules, and we do look to try and evaluate internally within our finance and other directorates whether we are getting good use of the money we are paying to consultancy organisations.⁸

15. However, this was not the case with NHS spending on consultants. Mr Taylor told us that it was for individual boards and the Audit Commission to look at the way that NHS organisations spend their money

We believe that with the responsibility of individual boards to make sure that they get value for money, with the responsibility of the Audit Commission to monitor this and to make sure that through their scoring systems they have every year that they make sure that the individual organisation is getting value for money. We think that is a better way of doing it than of collecting pennies from every single organisation in the country to bring up to a complete national whole....(Q36).

Conclusions and recommendations

16. We agree with Mr Nicholson's comments in December 2008 that the NHS should know how much it is spending on management consultants. The information must be collected locally and it would be a simple matter to bring this together centrally. We do not accept Mr Nicholson's subsequent argument that the central collection of such information would inevitably lead to more micromanaging. Making such spending subject to public monitoring might improve the way consultants are used. **We recommend that the Government collect centrally lists of**

- **the management consultants employed by the Department of Health, SHAs, PCTs and acute, ambulance and mental health trusts, indicating the projects they are employed on, their duration, cost and purpose;**
- **the top ten daily rates paid by each category of organisation.**

We will ask for this information annually and publish it in the PEQ. Monitor, the regulator of Foundation Trusts, should collect similar information for Foundation Trusts which we will also publish in the PEQ.

17. It is important to know whether the NHS and Department of Health are getting value for money from the contracts agreed with management consultants. We do not believe the present system which relies on internal systems and the NAO (in respect of the Department) and the Audit Commission (in respect of NHS organisations) is adequate. They do not undertake a thorough and systematic assessment of the value of the work done by the consultants. Research carried out for the Department of Health by academic institutions and individuals is always subject to peer review; a similar practice should apply

to work done by management consultants as part of the condition of the contract. **We recommend that a sample of contracts with management consultants agreed by all categories of NHS organisation and the Department should be subject to external peer review. This should include an assessment of the value of the consultants' output. The external peer review might be put out to tender through the National Institute for Health Research which the Department uses in respect of R and D contracts.**

Formal Minutes

Thursday 30 April 2009

Members present:

Mr Kevin Barron, in the Chair

Charlotte Atkins
Mr Peter Bone
Sandra Gidley
Stephen Hesford

Dr Doug Naysmith
Dr Howard Stoate
Mr Robert Syms
Dr Richard Taylor

Draft Report (*The use of management consultants by the NHS and the Department of Health*), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 17 read and agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Thursday 7 May at 9.30 am

Witnesses

Thursday 11 December 2008

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Evidence session on Public Expenditure on Health and Personal Social Services 2008 (HC 28–i)

Mr David Nicholson CBE, NHS Chief Executive, **Mr Hugh Taylor CB**, Permanent Secretary, **Mr David Flory**, Director General NHS, Finance, Performance and Operations, and **Mr Richard Douglas**, Director General Finance and Chief Operating Officer, Department for Health

Ev 1

Wednesday 11 March 2009

Evidence session on the Operating Framework for the NHS in England (HC 340–i)

Alan Johnson MP, Secretary of State, **Mr David Nicholson CBE**, NHS Chief Executive and **Mr Hugh Taylor CB**, Permanent Secretary, Department of Health

Ev 22

List of written evidence

The memorandum was published as Public Expenditure on Health and Personal Social Services 2008—Memorandum received from the Department of Health containing Replies to a Written Questionnaire from the Committee, (HC 1190, Session 2007–08)

1 Supplementary note to Question 37 (HC 340-i)

Ev 42

List of Reports from the Health Committee

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2008–09

First Report	NHS Next Stage Review	HC 53 (Cm 7558)
Second Report	Work of the Committee 2007–08	HC 193
Third Report	Health Inequalities	HC 286
Fourth Report	Top-up fees	HC 194

Session 2007–08

First Report	National Institute for Health and Clinical Excellence	HC 27 (Cm 7331)
Second Report	Work of the Committee 2007	HC 337
Third Report	Modernising Medical Careers	HC 25 (Cm 7338)
Fourth Report	Appointment of the Chair of the Care Quality Commission	HC 545
Fifth Report	Dental Services	HC 289 (Cm 7470)
Sixth Report	Foundation trusts and Monitor	HC 833 (Cm 7528)
First Special Report	National Institute for Health and Clinical Excellence: NICE Response to the Committee's First Report	HC 550

Session 2006–07

First Report	NHS Deficits	HC 73 (Cm 7028)
Second Report	Work of the Committee 2005–06	HC 297
Third Report	Patient and Public Involvement in the NHS	HC 278 (Cm 7128)
Fourth Report	Workforce Planning	HC 171 (Cm 7085)
Fifth Report	Audiology Services	HC 392 (Cm 7140)
Sixth Report	The Electronic Patient Record	HC 422 (Cm 7264)

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)

Oral evidence

Taken before the Health Committee

on Thursday 11 December 2008

Members present:

Mr Kevin Barron, in the Chair

Sandra Gidley
Dr Doug Naysmith

Dr Howard Stoate
Dr Richard Taylor

Witnesses: **Mr David Nicholson CBE**, NHS Chief Executive, **Mr Hugh Taylor CB**, Permanent Secretary, **Mr David Flory**, Director General NHS, Finance, Performance and Operations, and **Mr Richard Douglas**, Director General Finance and Chief Operating Officer, Department of Health, gave evidence.

Q1 Chairman: Good morning. Welcome to the only evidence session on the public expenditure questionnaire that we are doing this year. You will be aware that a lot of work has gone into the book that has been published but we may want to ask one or two questions about the effects of recent events in the economy as well. At the start, could I ask you to give us your name and the current position you hold.

Mr Douglas: Richard Douglas, Director General Finance and Chief Operating Officer, Department of Health.

Mr Taylor: Hugh Taylor, Permanent Secretary at the Department of Health.

Mr Nicholson: David Nicholson, currently the Chief Executive of the NHS.

Mr Flory: David Flory, Director General NHS, Finance, Performance, Operations.

Q2 Chairman: Thank you once again for coming along. The Institute for Fiscal Studies says the Pre-Budget Report has effectively cut somewhere in the region of £37 billion out of the Spending Review for the next three years, from 2011–12 through to 2013–14. Do you agree with their figure?

Mr Taylor: I do not think we can say that yet. Certainly as far as the implications for the Department of Health and for the NHS are concerned we know what we have to do over the next couple of years, and we will have to wait until decisions are made on the public expenditure growth in the SR period beyond that—although there are some clear signals in the PBR that growth is going to be slow.

Q3 Chairman: Clearly reducing expenditure is going to be on the agenda.

Mr Taylor: At the moment, what we are looking at over the next two years continues to be significant increases in planned growth in the NHS and in the other sectors for which we are responsible, but the implications of the PBR are that beyond that growth is at any rate going to slow. We will have to wait until we are clearer about what that is going to mean for the services for which we are responsible but, yes, one of the things we are all doing now is looking ahead, recognising that we have a pretty strong platform for the next two years on which to spend

some time thinking about the implications of potentially lower levels of growth for the system, which in one sense is a more positive position than the Department has been in previous times of economic downturn.

Q4 Chairman: You are not looking at any particular areas for saving expenditure at this stage?

Mr Taylor: We will be looking at efficiency across the board. Clearly we will be expected to contribute to the planned cash efficiency savings which were announced as part of the PBR for 2010–11, and the big focus for us in the Department is going to be looking ahead to the SR period beyond that, which, reading the runes, means that we are going to have to look very hard at efficiency and productivity across the system.

Q5 Chairman: There is an estimated £5 billion of additional value for money savings planned in 2010–11. What is your share of that? How are you going to manage that?

Mr Taylor: That is still under discussion with the Treasury at the moment. We will, I am sure, be expected to make a decent contribution to that but it is not possible to say yet what that is going to be. The details of how that £5 billion is to be distributed across Department allocations will come out in the Budget.

Q6 Chairman: How descriptive will be your area of defence, as it were, in terms of that less should come from the health budget. Will you be talking about specific areas of health expenditure or just generally the national pot?

Mr Taylor: In one sense, we will be looking across the board. Obviously health received a bigger share of growth at the Budget 2008 in the previous SR, so we will be expecting the Government to come looking at us for greater efficiency. We have made allocations which we think are prudent in the circumstances while giving a very strong platform for growth in the NHS, and we will be looking to assess central budgets, for example, for 2010–11, but we are not at the stage yet where we are saying that we are targeting particular areas—although, as David and colleagues can explain, we have a very big

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programme aimed at efficiency across the NHS already. It is a question of intensifying and deepening that.

Q7 Chairman: Is the Department and/or the National Health Service looking at the possible impact of the recession in terms of health needs and health demands—areas around unemployment, falling incomes and things like that? There are correlations between unemployment and ill health and there have been for many decades. Are you looking at the areas of possible demand on the healthcare system that this could create?

Mr Taylor: Yes, we will be looking at that. Of course a lot depends on the depth and length of any economic downturn. If it is relatively short-lived I do not think we necessarily expect the health impacts to be all that profound, but the evidence suggests that the most significant impact on health demand is in the area of mental health. That is associated potentially with unemployment but also particularly with indebtedness. There is a very interesting report which was produced recently, a Foresight report on mental capacity and wellbeing, which drew attention to the evidence relating to associations between levels of personal debt and mental disorders, to do with essentially having control over one's life. If anything, the evidence is stronger in relation to that than in relation to low levels of income. If we were to have a long period of downturn, then we would expect that to have some impact. Of course we are already making extra investment in areas like improving access to psychological therapies. We are increasing the number of therapists associated with that, we are increasing the level of investment, and we would expect that to have an impact over the period that we are talking about, but we will be looking at that and other areas of potential demand. It is very difficult to estimate what the impact on behaviours in relation to health (for example, abuse of alcohol, tobacco, and so on) would be in a period of long downturn. There are other potential impacts on demand.

Q8 Chairman: Mental health, wellbeing is important. The other area in terms of future impact on health budgets of course is that of the ageing population, and there are issues around immigration as well with which you will be familiar and which are geographical on occasions. Also, there rumours we are hearing on NICE guidance on new drugs, and that is a very fertile area for debate and movement at the moment. Are you making any assumptions about the impact it is going to have on future health service budgets?

Mr Taylor: We do make regular assessments of the impacts of ageing on health and, in particular, social care. Of course we have been running a significant engagement programme, leading up to a planned Green Paper next year, on the future funding of care and support systems, which in many ways is where the biggest impact of ageing may fall. We have been working with stakeholders and others in relation to a forward look in relation to services for people with dementia and the impact that would have on the

NHS, and I am sure that will be published shortly. We are looking forward to try and do some thinking about future demands on the system. Unquestionably the impact of new drugs will be felt. We can look at that reasonably well because of the length of the pipeline in terms of new drugs coming onto the market, and it is important in that connection that we have just negotiated a new deal under PPRS, the pricing scheme, where we have effectively agreed to take out from 2010–11 to reduce prices so that we get a recurrent saving of around £450 million a year which will help us in that, and we have negotiated a new system under which pharmaceutical companies will be able to introduce new drugs to the market at a more flexible price and come back to NICE to get a reappraised price depending on effectiveness. We are introducing a number of measures which should help us to manage increased demand for new drugs over that period, but this is the sort of planning we would do in relation to any future SR period and of course this will be given added significance in point by the essentially more pessimistic outlook in terms of growth which the PBR, at the moment anyway, marks out for us.

Q9 Chairman: Where will the money come from for the increased funding for NICE for its new duties? I think it is going to increase one-third. £30 million I think is the figure.

Mr Taylor: That has already been programmed into our current—

Q10 Chairman: Is that in addition to the current budgets? We are talking about current budgets of two years ago, when—

Mr Taylor: We have planned an increase for NICE in relation to the new activities that they will be expected to undertake as a result of the Next Stage Review, and that is planned into the current SR period effectively.

Q11 Chairman: That has been in addition to what the Treasury were talking about NHS expenditure two years ago.

Mr Taylor: In the light of the Spending Review that we had last time, we have looked at our priorities across the board. One of the things that we anticipated to some extent was that we were running a Next Stage Review and that is one of the things that has fallen out of that, so there is a certain amount of pre-planning.

Chairman: Right. We will move on.

Q12 Sandra Gidley: Last year the Secretary of State told us that a surplus of around £2 billion was reasonable. I think we are probably predicting a similar surplus this year but that does not include the Foundation Trusts' surpluses which are heading for about £3 billion. If you add that together and you have a surplus of £5 billion, is that reasonable or unreasonable? What criteria would you use in making that judgment?

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Mr Nicholson: We have tried all the way along, right from just over two and a half years ago, to think about the NHS finances in more like five-year than two-year or one-year elements so that we can get a proper financial plan and a proper financial going. When we started the process, we judged that it was very important, given the experience that we had had in the past, that the NHS produced a sustainable surplus—for a whole variety of reasons that I can go into if you want. Our assessment was that around about 1% might be a reasonable amount, or perhaps slightly more than that if you were going into a period of sustained lower growth. This year we have said to people that they have to think about their finances in five years. We think it would be prudent from our perspective to take a 1% surplus into the next spending review period, 2011–12—that is excluding the Foundation Trusts’ surplus—and that is what we expect to happen. That is not plucked out of the air. We have done extensive work with the NHS to see how much of the surplus they would like to draw down in the next two years. The NHS have told us that they would like to draw down around about £400 million in year one. We have not got to the final figure for year two yet, although we are very flexible. If they want to draw down more than that, we would not see that necessarily as a problem. Therefore 1% broadly, which could be between £1.5 billion and £2 billion, for the NHS—

Q13 Sandra Gidley: Is this drawing down a higher level version of the reallocating of funds between Trusts which used to go on locally?

Mr Nicholson: No. I think you have to understand that the surplus is not kept in a safe in Richmond House. It is not here, it is not with me: it is out there in the system. That £1.8 billion that we are delivering this year is out there in the system and it is for individual organisations to decide how they deal with that. It is there at the moment. It is not a matter of allocating it. We do not think it is either prudent or sensible to say to organisations, “Do what you like.” I do not think that would help the financial planning of the NHS in any way at all. We have said that we want to do it in a planned way. David has been talking in particular to NHS organisations about what they would think would be a suitable planned draw down and that is the conclusion we have come to.

Q14 Sandra Gidley: Last year I believe you said that we needed some financial headroom in order to transform services.

Mr Nicholson: Yes.

Q15 Sandra Gidley: That is all very well but there is not much sign of some of those services being transformed on the ground. But given the financial crisis and that the Treasury has to find some money somewhere for something, is this money not all in danger of being clawed back?

Mr Nicholson: I think it is needed even more.

Q16 Sandra Gidley: Within the NHS?

Mr Nicholson: Yes, absolutely. Whilst I could point to areas where there has been service transformation, you are absolutely right it has not been wide enough or deep enough to make it happen. If you are trying to manage the major changes in service that, for example, we are trying to do in London, you will need financial headroom to do that. You will not be able to do it without it, so it is even, in my view, more vital than it has been in the past that we have it and we spend it over the next two years.

Q17 Sandra Gidley: Do the Treasury not have form on this? Have they not already taken some of the £4.2 billion capital underspend from last year back into the coffers? How can we be reassured that the money allocated to the NHS is safe?

Mr Nicholson: I tend to focus on the money we have got rather than on the money we may or may not have had. In terms of the money we have got and keeping that into a place, all I can say is that we have a financial strategy over the next five years to make it happen. That strategy is laid out in the operating framework. The last two secretaries of state have said publicly that the surpluses should stay where they lie and that it should up to the local organisations to follow them through. We agreed the operating framework and the financial allocations both with the Treasury and Number 10. I do not know what else I could do in those circumstances to make sure that we have control over our own affairs going forward.

Q18 Sandra Gidley: Are you saying that under the current circumstances there is no way the Treasury can say, “Well done lads for saving the money. Let’s have some of it back”?

Mr Nicholson: I think we have done everything that we can to secure that position. You had better ask the Treasury.

Q19 Sandra Gidley: We might.

Mr Taylor: Just to be clear, the SR is the SR. 2009–10 is the position as was. But we are unquestionably, as I have said, going to have to make a contribution towards efficiency savings in 2010–11 and the NHS is absolutely up for that. That is open and out there. We are not trying to hide that away. Our job is to give as much certainty and planning to the NHS as we can, which is what we have done through the operating framework.

Q20 Sandra Gidley: Can I come back to Foundation Trusts, because they seem to be keeping quite a large chunk of money which, given your previous definition, would sound unreasonable. They would say that they are carrying some of the capital underspends because they do not have a clue what the PCTs are doing because commissioning is not coming together quite as quickly as some people would like. Is this the PCTs’ fault or is this the Foundation Trusts making excuses?

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Mr Flory: Undoubtedly we can see in the numbers that there is a surplus built up in the Foundation Trust sector and I do not think it is proper for us to generalise the reasons why that is generated or what is going to happen next with it. There are a number of instances that we are aware of—because the organisations are talking about it quite publicly—where they are formulating plans to refurbish or to redevelop some aspects of their infrastructure stock and I think that that is less to do with the PCTs declaring their intentions for service change and more about the Foundation Trust looking at its asset base, looking at where it can improve. It is what good businesses do. They generate surpluses and cash from their business, their operation, and reinvest it in the asset base of the organisation. I think there are a number of incidents where that is most clearly going to be the case, therefore. With regard to the primary care trusts—

Q21 Sandra Gidley: I am sorry, you say that is what good businesses do, but I think the public, the taxpayer, the patients would actually expect this money to be spent on health. When Foundation Trusts are sitting on large amounts of money and somebody cannot get their cancer drugs, for example, this does not quite seem fair to the person on the ground.

Mr Flory: Redeveloping or improving hospital or other facilities is crucial.

Q22 Sandra Gidley: But it is not clear that is what is going to happen.

Mr Flory: But there are a whole lot of examples those Foundation Trusts are talking about where that is going to happen.

Q23 Sandra Gidley: And there are others where it is less clear.

Mr Flory: In a number that is what is going to take place. The whole patient experience, what patient surveys tell us, what patients tell us, is that the environment in which the care is delivered is a really important part of quality care. Improving modernising facilities in which health care is delivered I think is a really important part of that, and that is what a number of these organisations are planning to do.

Mr Nicholson: We have been going through the process around the Next Stage Review, which for me was the first time for a long time where we have what I would describe as a process that had delivered us what could be described as a set of compelling clinical visions for what the NHS is going to look like. We have been going through that process. Every region now has its vision, its direction, its strategy. The PCTs have now gone through their planning process to identify that. If there was an issue in the past about a lack of clarity about the future or whatever—and I think it is variable around the country—then there certainly is not now. We have absolute clarity. Whether you are talking about London or the East of England or South Central or wherever, we now have a clear vision, a clear set of directions, about what the NHS of the future might

look like, and the PCTs have now gone through their processes, so there should be no excuse now, if you like, for one part of the system to say, “We are not clear what the other part is trying to do.”

Q24 Dr Taylor: Moving on to productivity and information that we have had from the Office for National Statistics, the quantity of health care provided was 50% higher in 2006 than in 1995, however the volume of resources going into the NHS was 67% higher in 2006 than 1995. Does that mean productivity has fallen?

Mr Nicholson: If you look at the figures from the Office of National Statistics—and I think we have had this discussion before about how realistic they reflect increased productivity in the NHS—and you look at the figures across the developed world, you will see that by those criteria productivity is falling across the whole of the developed world in healthcare terms. That is the first thing. You also see in those figures, interestingly, whether it is the OECD or the Commonwealth Fund, that the NHS happens to be at least either the most productive or the second most productive healthcare system in the world. That aside, it is always difficult to deliver productivity gains when you are building capacity, and that is essentially what we have been doing. You will know better than me, but several years ago if you were a breast surgeon, you would have done your operations; now you have a multidisciplinary team of pathologists, radiologists, cancer nurses and all those sorts of people around you. They do not add to the number of patients that we treat but they significantly add to the quality of the service that we provide. Our view has been with the Office of National Statistics’ results that they do not sufficiently reflect the improvement of quality. We are working with them in order to do it. Whether you will ever get to one number which will adequately reflect efficiency and productivity across the NHS, I doubt, but certainly we are trying to strive for that.

Q25 Dr Taylor: The Office for National Statistics say that “amenable mortality” is not falling faster, it has continued at the same rate of fall for many years. Is that another sign that we have not got any more efficient?

Mr Nicholson: No, I do not think so at all.

Q26 Dr Taylor: You would not agree with that.

Mr Nicholson: No, I would not agree at all. If you look at mortality in relation to cardiovascular disease or cancer or almost all of the areas, we are significantly improving, and in most cases the gaps between ourselves and the rest of the EU are reducing.

Q27 Dr Taylor: Can I come on to Better Care, Better Value Indicators. We talked about these at this same session last year. When they came out, I thought the Department had really hit on something brilliant because the initial indicators that came out implied that if we improved the way people worked to the top 70% of PCTs we would save £2 billion. I cannot

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help being terribly disappointed, possibly because I cannot understand these tables, but it does not seem that we are saving anything.

Mr Nicholson: Which page are you on?

Q28 Dr Taylor: Ev 153, Table 54. “Better Care, Better Value Indicators: overall national opportunity per quarter . . .” This table is pretty similar to most of them, in that you need about ten degrees in statistics to get anywhere. What do the figures mean? If you take the £146 million at the end of the top column in heavy print, is that what might be saved if everybody worked at the efficiency of the best levels? It really leaves me very puzzled, and it is made worse if you go on to Ev 227. We asked if the Department could identify any savings occurring as a direct result, and the answer is, “It cannot be assumed that movement in the productivity opportunity translates directly into savings . . .” The whole idea of this is to make savings. Then: “The Better Care Better Value metrics set out the productivity opportunity . . . It will be as a result of that further action that real financial savings are generated, but these are not monitored centrally.” So we are never going to know. I cannot help remembering when they first came out, when we had 303 primary care trusts, that it was absolutely noticeable with statin prescribing that the PCTs of three of the health ministers at that time were in the 290s out of the 303 for poor performance on generic statin prescribing. It seems absolutely obvious that if these examples of poor performance were publicised, possibly passed to MPs, something might be able to be done about it. With these really revolutionary and very good ideas for the economy, the publicity seems to have been nil. At least the Health Service Journal of 6 November this year did a brief article. It says that these indicators are sent to each hospital and Foundation Trust on a regular basis, but are they doing anything with them? We are questioning whatever have we been doing with these, why have they not raised this vast amount of money that they should do, and how do we make them work better?

Mr Nicholson: I will try to do my best to find my way through all of that.

Q29 Dr Taylor: Maybe somebody could explain the figures to us in the table.

Mr Nicholson: Every health organisation has to deliver a 3% cashable efficiency gain. That is identified and set out in the planning and all the rest of it. If a particular move towards the delivery of a particular Better Care Better Value upper quartile performance adds to that cashable efficiency gain, you can see what it is and it is transparent. But most of them do not. The reason they do not is because if you reduce your length of stay on a particular ward, you can either close the ward, take the three beds out or whatever, get the savings there, or you can put three more patients into them. What happens in those circumstances? The capacity you deliver by improving your performance on the Better Care Better Value, generally speaking, gets taken by capacity of other patients coming in, so you are

improving your efficiency but you are not delivering cashable savings into the system. That, I think, is the heart of what you are saying. If you reduce your length of stay for a particular condition and you save three beds’ worth of patients for that, you cannot close three beds on that ward and then reduce the savings. You will use the capacity to go further on your 18 weeks or whatever to reduce it, so in that way you drive the change, not in a way that necessarily drops out cashable savings. It is opportunity costs, I guess, that you are talking about. As we get better at this and as the measurement gets better and as all the rest of it goes forward, there should be and are more opportunities. As the best get better, where you compare them with the rest of performance, the rest can get even better. I think it is good news because it shows there is more to go at, so that when we get, as we are now, into the real productivity gains that we need to do there are more opportunities for us to take it forward.

Q30 Dr Taylor: I think you have chosen examples that do not raise money but there are other examples that do raise money, particularly the statin prescribing—which is the easiest one to understand. Reducing agency costs, reducing sickness absence rates, reducing staff turnover, all those should produce cash savings.

Mr Nicholson: Yes. They will. They do and are doing. What happens is we do not collect the information in that way that would identify what of the 3% cashable savings you would allocate to each of those Better Care Better Value processes. We do not collect it in that way.

Q31 Dr Taylor: Would it not be helpful to collect those sorts of figures? Would it not be possible, so that one could tell a PCT, “You are improving” or “You are not improving.” And if you are not improving, “Why not?” and you have to do something about it.

Mr Nicholson: These are all inputs, are they not? We are trying to move away from defining the success of PCTs by input. It does not work like that. Why would you do it in those circumstances? It would not deliver the change that you wanted.

Q32 Dr Taylor: I am looking at it probably too simply but it was said that we could save £85 million on statins alone by better generic prescribing.

Mr Nicholson: Yes.

Q33 Dr Taylor: And some PCTs could have saved something like, from memory, £1.5 million.

Mr Nicholson: Yes.

Q34 Dr Taylor: Why have we not persuaded them to do that or pushed them to do it and followed them up and watched if they are doing it?

Mr Nicholson: Of course on statins and generic prescribing we have done.

Q35 Dr Taylor: Can you say that we have saved some of that £85 million?

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Mr Nicholson: Yes.

Q36 Dr Taylor: How much?

Mr Nicholson: On generics we can. We have got the best generic prescribing rates in the world.

Q37 Dr Taylor: Is that in this table somewhere?

Mr Douglas: Yes.

Mr Nicholson: Richard has just said yes, so yes it is.

Q38 Dr Taylor: What we asked was how much savings had been realised because of the Better Care Better Value Indicators.

Mr Nicholson: I think it is quite difficult to do it for the whole of them but there are some of them we can do it for.

Q39 Dr Taylor: Is somebody going to explain this table, which tells me where the savings are?

Mr Nicholson: Richard is much cleverer than me.

Q40 Dr Taylor: I was thinking we might come to him.

Mr Douglas: Thank you. I think the simplest answer you get—and I will follow this up for you as well—is in Ev 227, answer 3. The very last sentence says that when you take into account change in activity the productivity opportunity falls by £188 million. What that should mean, if I have interpreted this correctly, is that—

Q41 Dr Taylor: Did you write it?

Mr Douglas: I did not write every answer personally. My interpretation of that and from when I worked on these before is that productivity opportunity falls by £188 million and effectively means you have realised that opportunity.

Q42 Dr Taylor: So we have saved £188 million.

Mr Douglas: You have realised that saving. I would like to check that with my colleagues, but that is the way it has worked in the past. That is saying that you have realised £188 million of savings in aggregate against these indicators.

Q43 Dr Taylor: Could you next year you put that it is saving, rather than “falling in the productivity opportunity”?

Mr Nicholson: I shall try to write the answer personally.

Mr Taylor: You need to be careful about the use of the word “saving” though because that does not necessarily mean that people have spent less money on drugs.

Q44 Dr Taylor: Absolutely.

Mr Taylor: It tends to be used rather loosely, as though money had actually been taken out of the system, whereas in fact overall the drugs bill has gone up. We can point to the increase in generic prescribing for statins, for example. That will have led to an efficiency saving.

Mr Douglas: In broad terms, if you look at the tables, a reduction in the productivity opportunity means a saving has been realised, so the opportunity

to get the saving has gone down, so we have taken the saving out. An increase in productivity opportunity means it has gone in the other direction.

Q45 Dr Taylor: I am sorry to labour this, but to go back to Table 54 on Ev 153, so many of the figures seem to be absolutely identical in the top half and the bottom half, and yet when you get to the very bottom, the total productivity opportunity in the bottom right-hand corner is minus £188 million and the total productivity opportunity in the summary above is £135 million.

Mr Douglas: The difference is the extent to which you adjust for different activity levels. As activity has gone up, you need to adjust the figure. The bottom table, the bottom half of it, adjusts everything for changes in activity levels, and when you adjust for activity levels that is where you come to this bottom right-hand corner figure of minus £188 million productivity opportunity.

Q46 Dr Taylor: So that minus £188 million—

Mr Douglas: Is the same as the £188 million fall—

Q47 Dr Taylor: As the figure?

Mr Douglas: Yes.

Dr Taylor: Thank you. Was I being rather slow on this?

Dr Stoate: How can we tell?

Q48 Dr Taylor: Moving on, what impact has the NHS Institute for Innovation and Improvement had on some of these things like variations in length of stay, improvements in day-case surgery rates?

Mr Nicholson: They have two roles really in all of this. One of them is the publication of the information, bringing it to people’s attention, the transmission of that information around the system, making sure that people know about it and all of that thing. The second thing is to help people go through the processes that they need to improve, so the service improvement stuff. They do the work with organisations to help them get at this sort of thing. If you need to increase your day case rate in a particular condition, they can help and support organisations who have to go through the change process in order to make that happen. That is their responsibility in relation to that.

Q49 Dr Taylor: Is there any way that you can plug these Better Care Better Value Indicators more to Trusts, to make them to take more notice of them?

Mr Nicholson: One of the central parts of the Next Stage Review is all about transparency of information. We will expect in the future, for example through things like policy accounts, for individual Trusts to both publish where they are in relation to those Better Care Better Value metrics and where their benchmarking group would be, so that they would be able to account to their local communities and their boards as to where they actually were. We think that is a better way of generating change. Having a big stick from the centre and telling them what to do will simply not deliver the kind of change you want. That kind of

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transparency and accountability is seen to us as a much better way of getting it, so publishing it and explaining it to their local populations and to their boards.

Q50 Dr Taylor: Is the Commission for Quality and Innovation (CQUIN) going to do any good?

Mr Nicholson: In terms of the particular things in Better Care Better Value, obviously the incentive is that they get a fixed tariff and if they are able to deliver it for less than the fixed tariff they can generate a surplus to use in whatever way they want. That is a big incentive for them. In terms of CQUIN, we have said this year that 0.5% of the tariff will be available for commissioning for quality and innovation. It is going to be agreed locally between the PCTs and the NHS Trusts. Our expectation is that in most cases that will be in the first year for delivering better data—because one of the issues we really have to get is the data—but there will be some improved service improvements in all of that and then we will build that 0.5% up over the years. I think in the Next Stage Review it talks about between 3% and 4% of the tariff. That will be a significant amount of money available to support those kinds of incentives. We think between 3% and 4% is the figure. Certainly the research that we have looked at internationally is that that is the kind of incentive that people will respond to. Anything bigger than that, it becomes too difficult to manage and people start to act and behave in negative ways. Any less than that, people do not take notice of it.

Q51 Dr Taylor: On the opposite, do you have any ideas for financial penalties for poor quality?

Mr Flory: One of the issues that came out of High Quality Care For All was this issue of not paying for never events. This is the work that is being developed now by the National Patients Safety Agency to define what those never events are. That will then move into contracts, so that where that takes place the provider of care will not be paid by the commissioner of care.

Q52 Dr Taylor: Is a never event something that should not ever happen?

Mr Flory: Yes.

Dr Taylor: Thank you.

Q53 Dr Stoate: What a concept! Reduction in total productivity opportunity. I am amazed that Tesco do not patent it: “This weekend only, come for your last reduction in total productivity opportunity”. It is not surprising that we have difficulty with these papers. What you will have noticed from Richard’s questioning is, first, that he needs to get out more and, second, that we do in this Committee really want information and evidence for information. We find week after week that assertions are made and evidence is lacking. I want to ask a pretty straightforward simple question: What evidence is there to demonstrate the value of money in the GP contract and the consultant contract?

Mr Nicholson: Silence! I am just trying to work out what you would describe as evidence in those circumstances.

Q54 Dr Stoate: What do you describe as evidence?

Mr Nicholson: If you look at the GP contract, for example, we can demonstrate, can we not, through the way in which the Quality and Outcomes Framework has moved and the points that people get, that significantly processed targets have been improved as far as patients are concerned across the whole of general practice? That is not a bad way of describing what value for money was.

Q55 Dr Stoate: It is, but on the other hand is there any evidence to show that doing something different might have produced a similar outcome or even a better outcome? Just because you put some money in and you have demonstrated an improvement does not necessarily amount to very much. Doing something slightly differently may have produced a much greater leverage effect and we simply do not know. What evidence have you collected and what evidence are you currently collecting to ensure that the money that has been invested in the GP contract is getting the best possible outcome?

Mr Nicholson: If you are asking me have I got an alternative to the GP contract which we are costing as to what the alternative benefit might have been, I do not have that. That is not what I am doing or planning to do. What I am doing is looking at how much money we are putting to the GP contract—and over the last three or four years, as you know, the amount that we have been putting in has either levelled out or gone up only slightly—and what we are getting out of it. What we are getting out of it is longer consultation times for patients. We are getting more patients seen, we are getting an improvement in the Quality and Outcomes Framework, and we are now getting better access for patients in terms of extended opening.

Q56 Dr Stoate: That is obviously very positive but what about the consultant contract? What evidence do you have that that has been beneficial?

Mr Nicholson: I think that is more potential than anything. The thing about the consultant contract of course is that before we had it there was no mechanism in which we could manage the time of NHS consultants. There was a whole series of notional arrangements around. The consultant contract put in a much better managed framework, which is one of the reasons, for example, we have been so successful in getting consultants to work on shifts, working out of hours to extend the amount of consultant cover we have in our hospitals in order to reduce junior doctors’ hours, but also to increase the quality of service that we have. We are in a much better place, therefore, to be able to manage consultants and their time and I think that will be increasingly important as we go forward, when we talk about productivity and change. I cannot in the same way as I can with general practitioners point out the benefits that that had to patients in relation to it at the moment.

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Q57 Dr Stoate: The problem is that in the coming squeeze, which obviously is going to affect everyone's budgets in some way or another, will you be able to continue to justify, for example, the consultant contract? If you have no productivity outcomes—

Mr Nicholson: It is an important precondition to be able to manage those productivity improvements, because unless you have a real control over time consultants spend at work and the things you expect them to do through the appraisal process and all the rest of it, you cannot do the sorts of things that you need to in terms of managing the workforce better, so it is an absolute precondition to make it happen and we will have to do it in order to deliver the productivity gains that we need.

Q58 Dr Stoate: We want to pick up on Table 69b, which shows that in 2007 the NHS had approximately 185,000 administrative and clerical staff compared to just under 132,000 in 1997. What is that increase all about and what are the extra people doing?

Mr Nicholson: As I am sure you are well aware, one of the biggest drivers in extending the number of admin and clerical is clinical staff. You will see that there are similar rises in terms of doctors as there are in admin and clerical staff. I know myself, having run hospitals for many years, that every time you appoint a consultant you need to appoint the clerical staff to support them. As we drive forward, getting it so that professional and clinical staff spend more of their time on direct care with patients, often it is the admin and clerical staff supporting them that needs to increase. I think it is a perfectly rational and reasonable way of taking it forward and that has made a big difference in terms of the way in which that clinical staff work.

Q59 Dr Stoate: Certainly the anecdotal evidence is that an awful lot of duplication goes on in NHS clerical work. Is there any evidence for that or do you honestly think that all these people are genuinely necessary and producing improvements in the NHS?

Mr Nicholson: I am absolutely sure. Two things have been going off, of course, since 2005. As you know, we got ourselves into some financial difficulties during that period on the one hand and on the other hand we significantly reduced the number of organisations in the NHS through the merger of PCTs. During that period, you can see, as we have squeezed that, the numbers have started to come down. That reflects both in terms of a drive for efficiency. I am absolutely sure there is scope for efficiency in this area as we go forward, but also the reduction in the number of organisations.

Q60 Dr Stoate: As you have pointed out, there are an extra 29,800 medical graduates and only 14,000 or so leaving the NHS, which means that there is going to be a net increase in medical graduates. That is fine, but have you worked out what they are all going to do and will they all find jobs?

Mr Nicholson: One of the things that came out of the Next Stage Review of course is our need to get our staff planning much better organised. That is why we have set up Medical Education England, that is why we have set up the centre that is going to do lots of exciting manpower planning, staff planning. Anyway, all of that will enable us to get a much better handle on all of this. The issue we have at moment is that we need more doctors not less.

Q61 Dr Stoate: Yes, but if you look at, for example, what is planned for GP numbers, there is a planned increase of 30% in GP numbers over the next couple of years and yet if you look for GP vacancies in things like the BMA they are simply not there. I am being told by my colleagues who still take part in GP training that they are producing an awful lot of highly qualified and highly trained GPs who are not going to have practices to work in.

Mr Nicholson: We had the other problem some time ago, did we not? We had a shortage and vacancy rates and all the rest of it. It seems to me that for employers it is a good thing to have more choice over who you employ and more competition. That seems to me a good thing. Certainly over the next two years I would expect an expansion both of consultant numbers and general practitioner numbers as we make sure we invest the 5.5% growth over the next two years in the best possible way.

Q62 Dr Stoate: It is quite expensive to train these doctors and, as I say, there is good evidence now that they are finding it increasingly difficult to find practices, so are we doing the right thing?

Mr Nicholson: I do not think that tightening the labour market is necessarily a bad thing. As an employer, we want to get the best doctors we possibly can for our patients, and employers having choice over who they get, so that they get the right staff, seems to me to be a good thing.

Q63 Dr Stoate: Table 75b shows that between 2003–04 and 2007–08 administrators got a 27% pay rise, whereas nurses got 19% and ambulance staff got 18%. Has Agenda for Change not simply put more money towards the pen pushers and less to the clinical frontline staff?

Mr Nicholson: No, I do not think that is true at all. As you know, admin and clerical staff are amongst some of the lowest paid people in the NHS.

Q64 Dr Stoate: So are nurses and ambulance drivers to some extent.

Mr Nicholson: Even lower paid than ambulance drivers and nurses. If you look at the long-term position you can see that there has been much more equity in the way that has worked.

Q65 Dr Stoate: But 27% versus 18% does seem to some people to be pushing money towards bureaucracy and away from frontline staff.

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Mr Nicholson: I do not think that is the case. If you look at the amount of money that we spend on clinical staff as opposed to the background infrastructure of the NHS, you can see that there has been a massive shift over the last few years.

Q66 Dr Stoate: Table 64a shows that management costs in the NHS are only 3% of the budget but a study commissioned from the University of York 2005 showed that total management and administration costs more like 13.5% of NHS spending. Do you agree with the 13.5% as opposed to the 3%?

Mr Nicholson: It was a calculation that the University of York did. It was all very interesting but it is a set of researchers doing—

Q67 Dr Stoate: Could it be wrong?

Mr Nicholson: I am not saying it is wrong. If you are asking me does it reflect the amount of resource that we put into managing the NHS, then, no, it does not. I think it is significantly less than 13% in terms of the resource that we have that manages the NHS on a day-to-day basis.

Q68 Dr Stoate: Where did the University of York go so far wrong as to produce a figure four times the size of yours?

Mr Nicholson: I did not say the University of York have got it wrong, I am just saying that when we have looked at the management overheads for the NHS over the last few years, 3% and 4% has been consistently the number that has come out of that process when you compare one year with another. If you want to invent a brand new definition which covers a whole series of other issues, that is a matter for the University of York. I am sticking with the definitions that we have consistently used, so you compare one year with another.

Q69 Dr Stoate: You are sticking to your 3%.

Mr Nicholson: Yes.

Q70 Dr Stoate: How much money are you spending on external management consultancy at the moment? I could not find that in any of the tables. Do you have any figures?

Mr Nicholson: No. We have not so far collected that information centrally. We have started to think about how we might do it but I think the numbers we have got are so unreliable at the moment that we are not satisfied that we have got that number right.

Q71 Dr Stoate: Is that not a cause for concern, because they are rather expensive.

Mr Nicholson: That is why I think we need to get the numbers right. Absolutely.

Q72 Dr Stoate: If you have not collected them, it is difficult to know if they are right or wrong.

Mr Nicholson: Yes. We think we need to know how much money the NHS is spending on management consultancy and we have started the process of collecting the information. I agree with you, we should have collected it in the past, but we did not.

Dr Stoate: Thank you.

Q73 Dr Taylor: I was rather stung by Howard's comments that I ought to get out and about more because I do get out and about quite a lot, and what bothers me particularly is that in certain hospital wards when the nurses talk to you they are under a tremendous amount of stress and strain from staffing levels. Qualified nursing staff increased dramatically from 1997 to 2005 and then from 2005 onwards they have pretty well stuck. Would you accept that there are particularly some wards that seem to do quite well from the staffing levels—intensive care units, high dependency units—and some of the more mundane wards, particularly geriatrics and some medical assessment wards, are relatively deprived of nursing staff. Is this something that you get a picture of?

Mr Nicholson: I do get out and about quite a lot as well.

Q74 Dr Taylor: I am sure you do.

Mr Nicholson: I do not think that. I would not say that there was that pattern. There is no doubt that there has been significant investment in intensive care and those sorts of areas and numbers of beds and the staffing levels that we have within them. We have always said that particular levels of staffing are a matter for local determination rather than national norms or whatever. We think that is the best way of doing it. What I would say, though—and it comes back to your point on the National Institute—is that there is a fantastic programme being rolled out across the NHS at the moment called Time to Care or The Productive Ward which I think is extraordinary. Every hospital that I go in you see it. It is interesting, it was not mandated nationally to do but suddenly everyone is doing it and it has a massive impact on the kinds of ward particularly that you describe there. By simple organisation and simple management and involving the staff in the way in which the ward is managed, it can increase by up to 15% to 20% more direct patient time for nurses because it takes a whole lot of things off them. It is a very powerful way of doing this. I think the more wards take that on, particularly in the kinds of areas you describe, the better it will be.

Q75 Dr Taylor: Yes. The RCN *Dignity in Care* paper has been a tremendous help.

Mr Nicholson: Absolutely. Yes.

Dr Taylor: Thank you.

Q76 Chairman: My local hospital has a far better choice of doctors than they had ten, 15 or 20 years ago to be quite frank. That is a good thing because they can choose who is going to be the best for that position. If you ended up in surgery and the surgeon said to you, "I'll be doing the operation this morning but I've been unemployed for the last three years," where do we get the balance in relation to that?

Mr Nicholson: I was not suggesting that unemployed doctors are a good thing.

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Q77 Chairman: There is an issue of skills and competencies on an ongoing basis. If we have a market-place of doctors—and this may be my crude analysis—how do we accept that somebody might be bumped out of the market-place for a while and then come back in, potentially lacking in skills? Where would the responsibility be to make sure that that doctor was competent to do something that they had been doing but maybe had not been doing for a short period?

Mr Nicholson: First of all, it is the responsibility of the doctor to keep their skills up to speed and up to the standards that you would require. I am not suggesting that unemployed doctors are a good thing. They are not a good thing. It is very important that we get the workforce planning as right as we can. That is why we have set up our Centre for Excellence as part of the Next Stage Review to get that connection much more closely aligned. It will never be absolutely right, but I think we can get it better. We know there are more doctors coming out of the medical schools over the next few years but we also know that we have to deliver shorter hours for junior doctors; we know we have to provide a much more consultant delivered service in the future. I do not anticipate that in the time horizons we are talking about here we will get to a place where we have unemployed UK graduates. I do think that is what we want to do but we do need to be flexible. At the moment we have to deliver the European Working Time Directive by August on junior doctors' hours and we have a big issue around paediatrics, obstetrics, and anaesthetics, and so we are looking at a whole range of things that we need to do to make sure that we can produce people for those particular areas. Part of that is retraining, skilling people up, giving people new opportunities in our hospitals to refresh their skills, which is exactly what you have said.

Q78 Sandra Gidley: Moving on to the 18-week referral-to-treatment waiting target, what have been the health benefits of introducing targets?

Mr Flory: I think there are a number of ways in which you can look at this. We have been measuring the referral-to-treatment times now since March 2007. For the last two months we have set the level that we set out for patients who unless they choose otherwise where it is absolutely appropriate would receive their treatment within 18 weeks. There is a whole number of dimensions to it, of course. Previously we have measured and recorded separately the time people wait for their operation at hospital. If they are on an inpatient list, that has come down significantly as part of 18 weeks and, likewise, the wait for the outpatient appointment. The piece in the middle of that which we have never measured in quite the same way previously for a diagnostic procedure, where people need that as part of their pathway of care, has fallen significantly. Whereas if we go back two years there were 200,000 people waiting more than six weeks for their diagnostic test, their scan or whatever, now it is a very small number of people waiting more than six weeks and the median time for wait for the

diagnostic procedure is significantly less than six weeks. I think that is one part of the patient experience that has improved unrecognisably by the 18-week drive. Clearly the reduced waiting at all those stages reduces the period in which people are in pain, reduces the period of anxiety. It speeds up for many people the time taken and they can get back to work and resume their lives.

Q79 Sandra Gidley: Has there been no attempt to quantify the health benefits? When NICE looks at a drug, there is always a financial case made for giving this drug. What was the financial case with regard to health benefit for introducing this particular target? I am sure patients love it, but what is the financial benefit and the health benefit?

Mr Flory: We have not done a structured cost-benefit evaluation yet of the 18 week programme. Clearly the concentration of effort across the National Health Service as been to achieve this and it has required genuine transformational change in the way that services are delivered, in the way that support systems for booking and so on behind it work. The date that was set for the achievement of this was the end of this calendar year. It has been achieved in aggregate early. We are now concentrating effort on those places that have not yet achieved it to get them up to the standards of the best. Once we get past there into the next calendar year and it embeds in the system in the way it works, then we need to consider how we would do the more formal evaluation that you have described.

Q80 Sandra Gidley: How are you about to do that if you did not baseline what was happening before?

Mr Flory: At the very start of the 18-week programme, when the policy came into place, the overwhelming and overriding concern of the public, of patients, and prospective patients, was the length of time that they were waiting for treatment. There was an absolutely compelling case, we would have to say, for us to deal with reducing waits in the way that we had not before, so the need to do it was there and obvious. The pull to do it from patients was obvious. It was not a case of a cost-benefit analysis looking at fine margins, "Should we or shouldn't we?"

Q81 Sandra Gidley: Effectively this was a political imperative rather than an evidence-based health intervention. I am just trying to clarify. I am not saying it is good or bad.

Mr Nicholson: One of the things that the 18-week programme has done is to increase significantly the amount of diagnostic capacity in the system. One of the things that is very marked about our system is the lack of diagnostic capacity: the number of MRI scans per head of population and all the rest of it. It has brought us much better into a place around the rest of Europe and there is good evidence to show that access to diagnostics has an impact on health gain generally. I think that is a really positive thing and it has been a big part of the 18 weeks. One of the things about the Next Stage Review is that it talked about quality as the organising principle and it talked about a definition of quality and it talked

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about quality as being safety, effectiveness, and patient experience. One of the things about the NHS has sometimes been that the experience has been traded out, in a sense. I think a big, powerful benefit of this is the improvement in patient experience. We can show that by the way in which patient satisfaction has gone up and we can see that particularly by the way in which public support for what we are doing and satisfaction in the NHS has gone up over the last couple of years or so. I think they are really important things for us in the NHS.

Q82 Sandra Gidley: You mentioned Darzi, and some SHA areas have set even lower targets.

Mr Nicholson: Yes.

Q83 Sandra Gidley: So that is a patient experience benefit rather than an evidence-based health impact.

Mr Nicholson: Patient experience is part of it, is it not? You cannot say that there is a health benefit if the patients have a miserable experience.

Q84 Sandra Gidley: No, there is the outcome and there is how you get to that outcome. They are two completely different things.

Mr Nicholson: Yes.

Q85 Sandra Gidley: Everybody wants a good experience in hospital but given that some work by York University—

Mr Nicholson: Them again.

Q86 Sandra Gidley: Yes -- has shown that the health impacts of reducing waiting times are very small, is that where we should be focusing?

Mr Nicholson: It is a very narrow definition about what is a health benefit, is it not? Bruce Keogh, the Medical Director of the NHS, tells a very interesting story. Seven or eight years ago, when he was in Birmingham, he was a cardiac surgeon. The patient, normally a man, would come and sit in front of him and their partner would be there. He would say, "Yes, you need cardiac surgery. These are the risks of having the treatment and these are the big risks of not having it," and the patient would say, "Yes, okay, I'll have it," and then normally the partner would ask, "Okay, so when can it be done?" and he would say "18 months." That would have a massive impact on somebody, would it not? When he was at UCLH, before he came to work for us, after the same conversation his answer was "When would you like to come in?" That may not have been picked up in your research project on this—it may not have been—but that seems to me a massive step forward in health and patient satisfaction and quality of service.

Q87 Sandra Gidley: I will accept that from a quality of service point of view patients will be happy. What about those patients who are disadvantaged by this target? I am talking about those for whom the gap between repeat, routine appointments is being lengthened and there are now some health consequences being picked up. I have constituency casework on this; my own mother has suffered from

this. There is a whole cohort of patients out there who are not getting a better experience if they do not have an acute problem. How are you going to tackle that? Is tackling that next not more important than reducing from 18 weeks to 17 or 16 weeks?

Mr Nicholson: I cannot comment on the individual cases that you make but one of the issues that comes out of the Better Care Better Value initiatives is that the amount of repeat attendances people have in this country is way beyond what other health systems might have had and generally there is an issue about whether they add much value at all. You might come back every six months or three months or whatever and see a different junior doctor and have a different arrangement and that does not add much to anyone at all. I have not picked up this issue that you have just described.

Q88 Sandra Gidley: I thought it had been fairly well documented. I have read about it in some of the medical press.

Mr Nicholson: Okay.

Sandra Gidley: Thank you.

Q89 Dr Stoate: The latest PCT allocations give PCTs an average of 5.5% per annum cash increase in 2009–10 and 2010–11 and yet the overall NHS budget is going up by 6.7% in each of those years. Why is there the discrepancy?

Mr Taylor: In practice, for 2009–10 we still have to make the central budgets. The total allocation, of course, is composed of allocations from central budgets and other things and we have yet to make the central budget allocations for 2009–10, although we expect to do that shortly. At the moment a certain amount of money has been held back which will get out to the system on a non recurrent basis. We have got the full amount of money for 2009–10, we expect to play it out to the NHS in due course, but it has not all gone out in the form of allocations. Between central budgets and a certain amount of potential for targeting investment, there remains money to be put out which will go out to the NHS over the next period.

Q90 Dr Stoate: That will go the PCTs. Where will it go? Will it be extra funding for PCTs or capital projects?

Mr Taylor: That is for decision, but it would effectively go down through the PCTs. It is quite a complex picture this, because you have the central budgets as well, some of which have been going up at a slightly higher rate of growth than others. On dentistry, for example, which is one of the budgets at the moment, we continue to manage their budgets through a central fund. So it is not a like-for-like comparison but the potential is there within the 2009–10 allocation for some extra investment going out to the NHS and the form in which we do that has yet to be decided.

Q91 Dr Stoate: So you have got your money but you are not sure how to spend it. That is unusual.

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Mr Douglas: I would just add that the overall growth for revenue is not 6.7% over those years, it is 6.3% and 6.4% in those two years.

Mr Nicholson: I do not think that it is we are not sure what to spend it on. There are lots and lots of things to spend it on. Perhaps I could give you an example. The big central budgets that are held are research and development, of which most is already committed and in fact is ring-fenced as part of it and which is a massive, massive amount; dental, which is several billion pounds and which needs to go out as well; ophthalmology; and pharmacy. There are still some big budgets to go out.

Mr Flory: The total money we have which is allocated to primary care trusts is now over 80% of the total, which is higher than at any stage before in these allocations, so there is more and more going into the baseline allocations and less proportionately being kept back.

Q92 Chairman: Some PCTs are over target—and I understand that, it is historical—and some are under target and have been traditionally for a long time—including my own—and we are not there with the baseline we said they should have. Are we likely to see that in 2010–11?

Mr Flory: No. It is unlikely. The decision that we make of course is within the total amount available for primary care trusts, the extent to which those primary care trusts who are below their fair-share target can have more than those who are at or above the target, and that effectively is what we have done in the allocation formula and policy for 2009–10 and for 2010–11. It is a fine balance this.

Chairman: When do we get there, then? This has been ongoing for years now.

Q93 Dr Stoate: About 20 years.

Mr Flory: The answer to that, I am afraid, is that there is no definite date when we do, because of course it depends on levels of growth in future years and the extent to which we can therefore have space to make sure that every PCT, irrespective of where they are vis-à-vis target, gets more money to deal with some of the known cost increases and pressure it has to face, so that every part of the country can do that, but at the same time those that are below target get an even bigger share.

Q94 Dr Stoate: Whilst we are looking at percentages, the hospital tariff is going up by 1.7%, how are hospitals going to cope with that small increase in tariff, particularly given the extra pressure that you are bringing to bear on them, such as screening for MRSA and introducing NICE recommendations and so on, all of which will significantly add to their cost pressures, and yet you are expecting them to do it on a 1.7% uplift on their tariff.

Mr Flory: Yes. The numbers of course are a net uplift after taking into account a 3% efficiency requirement that is there across all parts of the service, so the gross uplift is 4.7%. that builds in with what we now know about the agreed pay awards, it builds in an uplift in line with GDP for non pay pressures. It does recognise the increase in costs that will be borne

because of drug costs and through NICE and so on. It recognises various other particular cost increases that the service will face. For example, David referred earlier to the European Working time Directive, so there is now some money that is being put into tariff to enable providers of care to meet some of those increased costs.

Q95 Dr Stoate: Is it realistic or practical to expect a 3% efficiency saving whilst they also have significant pressures, as I have said, on some new initiatives they have to introduce?

Mr Flory: Yes.

Q96 Dr Stoate: You think they can still do that.

Mr Flory: Yes. The 3% per year for each year of the CSR, they have all known about it right from the beginning, we have worked through it with them, it is perfectly possible for them to make.

Dr Stoate: I will have another go at my GP and hospital doctor contracts. Are there measurable health gains in paying doctors more money?

Sandra Gidley: Declare your interest.

Q97 Dr Stoate: I declare an interest on this, of course.

Mr Nicholson: To the doctors?

Q98 Dr Stoate: To the NHS. It is a very simple question. You have told me that that the GP contract is producing good results, and I accept that. You are telling me that the consultant contract is potentially going to produce good results.

Mr Nicholson: Yes.

Q99 Dr Stoate: But much of the money has in fact gone into increased wages. I am asking where is the health gain from simply putting more money into increased wages?

Mr Nicholson: I am sure the University of York will do a research project on this, but it seems to me that there is a whole range of issues here. If you take the GP contract, to go back to that, when we launched the GP contract we could not recruit GPs. There were big vacancies around GPs, so the health disbenefit of not being able to get a GP was quite big, particularly in those areas which are under-doctored. I think there are health gains in relation to the amount of time a GP can spend with their patient—which has, as you know, gone up significantly—and by improving access. I think there are health gains in all of those things, as well as the process things in the Quality and Outcomes Framework.

Q100 Dr Stoate: The programme budgeting table on Table 24 tells us an awful lot about expenditure on services and individual services but it does not tell us anything about the relative benefits of those expenditures, which was another point I was trying to raise earlier, but this phrases it rather better. What I want to know is when we are going to get data which shows actual outcomes achieved by particular services so that we can in some way compare services to see if we are getting best value?

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Mr Douglas: All the programme budget information tells you in this form is how much you have spent—you are absolutely right; that is all there is—but at a local level as well people can access information linking outcomes. So they can look at the outcomes of each those disease areas, they can look at those against the level of spend, they can look at them against the level of spend and the outcomes in other areas. The whole idea of having programme budgeting is to produce both the cost base that is there and then at a local level people can use the outcome data and compare costs with outcomes, look at what the balance with investment is, but that is done very much at a local level. This is something for PCTs to do themselves.

Q101 Dr Stoate: It is also something I believe the Government should be doing, or certainly departments should be doing, to make sure that the money you are allocating to particular services does show a benefit that might possibly be a greater benefit elsewhere if the money was allocated differently. If you do not collect that data, we cannot know the answer.

Mr Nicholson: No. In a sense that is what the revolution underneath the Next Stage Review is all about, and that is why myself, the Medical Director and the Nurse Director have recently written the whole system around metrics about collecting information that reflects properly the quality of care that clinicians and front-line staff produce. One of the dangers in the past that we have had is that if at the centre decide what are the important things to measure, we have got no ownership. You know, the NHS collects more data than almost any other health system around, but it is not owned by people, it is often not accurate, people do not think it that really reflects the quality of service they provide: so what we have started to do, as you know, is to go out to the system and say to people what are the things that truly reflect the quality of service that you provide, and out of that process will come a whole set of things that we need to collect across the system. So we will get to a place where we have a really good set of metrics which do reflect the quality of service to our patients so that we can then benchmark it and describe it, but what we have decided to do is to do that from the bottom up, which will take longer, I know, but I think will give us a much better idea about the quality of service, and people will produce those as part of the quality accounts and all the rest of it.

Q102 Dr Stoate: If you are going to do that at local level, is there not a case to base PCT allocations on public debate and public discussion at individual PCT level? Should not the public effectively decide what allocation their PCT gets?

Mr Nicholson: How would that work?

Q103 Dr Stoate: Because if you are suggesting that people have got access to all of these outcome data, they can see for themselves what they are getting, should they not then have a say in whether they think their money is being spent in the best way?

Mr Nicholson: No, that is a different thing. I think the allocations should be based on a formula, it should be based on need as far as possible, rather than clamour of individuals in a local area, but how money should be spent within the particular local area, I think the public should have much more of a say in all of that. PCTs should be much more accountable in the way that they work with their local population; absolutely.

Q104 Dr Taylor: We are coming on to the private finance initiative, please. First, a general question. How has financing for planned PFI project been affected by the credit crunch? We gather that the Government is bailing out three of the banks that are major funders of PFI schemes. Does this not give a risk that the Treasury might be lending itself the money?

Mr Taylor: Quite possibly.

Mr Flory: In the current climate, currently the capital for PFI projects is less available and is, indeed, more expensive, and it does raise questions and issues about how—

Q105 Dr Taylor: That means for further new PFI projects?

Mr Flory: Yes.

Q106 Dr Taylor: But the existing ones: is the cost of those not going up?

Mr Flory: The cost of those, in terms of the existing schemes and the new unitary payment target, is fixed.

Q107 Dr Taylor: It is the proposed ones that are going up?

Mr Flory: Yes.

Q108 Dr Taylor: So how is that going to be coped with? Does that mean the numbers of beds will be cut?

Mr Flory: For the forthcoming period within the next year, there is only one scheme that we expect to come to financial close. It is the scheme in North Bristol, South Gloucester. We cannot say how the credit markets will be at the time that that comes to financial close, we will have to simply deal with that when we get there, but that is the only scheme in the next year.

Q109 Dr Taylor: Going back to the tables, these are 9A to 9E, evidence 17 to 19, the first one, 9A, which is the regional summary, I can understand that, but if we move on to the one for the West Midlands, which I thought I understood, if you look at the Worcestershire acute (this is 9F) payment apparently stopped in 2001?

Mr Flory: I presume that is when the scheme opened.

Q110 Dr Taylor: Yes, but we are going on paying, so why does the figure—

Mr Flory: These are the capital spend profiles. When the scheme completes the period of capital spend ends. Clearly, the unitary payment goes on beyond that.

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Q111 Dr Taylor: That is the mortgage and the service charge?

Mr Flory: But that is not classified as capital spend.

Q112 Dr Taylor: Right. So why on the SHA scheme, which is the 9A, do the things go on increasing all the time? That, again, is just capital spend?

Mr Flory: Yes, it is. Obviously, for the years ahead, it is projected spend on schemes that are not yet at close.

Q113 Dr Taylor: So do we have somewhere the total cost including the unitary charges?

Mr Flory: We have got the—

Q114 Dr Taylor: Have I just not found those in this huge tome?

Mr Flory: I think Table 12 and 13 deal with unitary payments. On that table what we see for schemes that are now operational is what the unitary payment is in year eight or nine. They are now quite separate things, of course, but the term of the contracts on each of these will be slightly different and, therefore, we cannot include in here a total. We do not include in here a total estimated unitary payment for the remaining term of that contract; we highlight it as one year.

Q115 Dr Taylor: Taking, again, evidence 37, the Worcestershire group, the unitary fee at the completion was 19,399—that is millions—going up to 24 million. Is that fairly typical of the increases across the board?

Mr Flory: I do not think that it is possible to say what is typical across the board on these. There are different reasons in different schemes for changes in the unitary payment. One of the benefits that we have experienced in these PFI schemes is a flexibility to adjust specification or to adjust component parts, and different schemes have taken that forward in different ways.

Q116 Dr Taylor: Going on to keeping NHS capital stock up-to-date, are we going to be able to manage that for the next five years or so? That is not talking about just PFI; that is talking about all the NHS capital stock. There must be a vast amount that needs spending just to keep things up-to-date.

Mr Flory: Yes, the regime now that applies for NHS trusts, where the majority of the asset base will sit, is one whereby, according to the strength of the trust's balance sheet, it will be able to raise cash through loans to be able to refurbish its capital stock. Clearly, the acid test in that is that the revenue that the trust can generate is able to service those loans, and as long as it can do that and keeps its borrowing within its borrowing limit, then it is free for the trust to make those decisions.

Q117 Dr Taylor: So you are reasonably confident that the stock will be able to be kept up-to-date?

Mr Flory: Yes.

Q118 Dr Taylor: We understand from April next year PFI can no longer hide debt off balance sheet. What difference will that make?

Mr Flory: It will make a difference for the trusts that have PFIs, and we are clear in the *Operating Framework* that we have just published for next year that whilst the capital costs of that, the value coming onto the balance sheet, in itself will not impact upon the trust, it will not need to raise capital resource to cover it, that will be dealt with by us, but then for the trust when it comes onto the balance sheet, of course, there are revenue consequences in terms of you need to depreciate for replacement and the trust will need to build that into their own funds.

Q119 Dr Taylor: Was there any truth in the Heath Service Journal or report that some NHS organisations are setting up charities to take over their PFI contracts?

Mr Flory: I am not aware of any specific instances where that is the case.

Mr Douglas: Let us be clear on the PFI. We have an agreement with Treasury that Treasury cover the impact of any classification changes of PFI schemes coming onto our balance sheets. So that does not affect either the department's capital resources in this spending period or the NHS.

Q120 Dr Taylor: So you think things are fairly safe from that point of view?

Mr Douglas: We have an agreement with Treasury that the impact of that will be neutral in our budget in terms; so any change in classification is treated as neutral during the spending review.

Q121 Dr Taylor: Are there changes coming up in NHS capital charges? Are PFI buildings going to be regarded as capital assets on which capital charges have to be paid?

Mr Douglas: Effectively you are create an assets, there will be a capital charge, but the way the accountant will work, you will effectively be offsetting that against the unitary charge you are already paying to the private sector. So you are not doubling up and suddenly paying a double charge.

Q122 Dr Taylor: So it will not be charge on top of the unitary charge?

Mr Douglas: It will not be a charge on top of it; the two of them have to effectively work together. It may lead to some slight increase in the early years of the scheme and some slight reduction in the charge in the later years of the scheme based on almost how the mortgage effect of it works, but you do not get hit twice. You do not get: here is a unitary charge payment and here is a massive capital charges as well.

Q123 Dr Taylor: That it not just an accounting dodge to obscure it?

Mr Douglas: We do not do accounting dodges.

Q124 Dr Taylor: You do not.

Mr Douglas: No.

Chairman: Not any more!

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Q125 Dr Naysmith: Can I, first of all, apologise for being late. I was at a meeting elsewhere and I underestimated the time that I needed get here. It was in Senegal! This is one of the most interesting meetings of the year for me. It has been very productive in the past, as Mr Douglas will know, so could I just continue with something along the lines that often come up here. You mentioned, Mr Flory, the North Bristol and South Gloucestershire PFI, the North Bristol Trust. Last year in the 2007 Memorandum it was valued at 382 million and in 2006, Table 9K, it shows it as now valued at 475 million. What could be the reason for that increase? Is that to do with the credit crunch?

Mr Flory: As the scheme goes through the later stages of its planning phase, and so on, then these numbers can move.

Q126 Dr Naysmith: It is at the outline business case stage at the moment. So the figures are still going up, are they?

Mr Flory: I do not know the detail of exactly where those figures are now and what might happen in the short term, but the change that you refer to year to year simply reflects the updated planning position on the scheme.

Q127 Dr Naysmith: I really want to talk about independent sector treatment centres. I apologise if some questions have already been asked on that while I have been away. It is a subject that comes up regularly in this committee when we have you before us, and the Secretary of State, but the data in Table 17A of the first wave of ISTC's performance shows that most of them are still failing to do a large part of the work for which they were guaranteed payment when the contracts were agreed. It varies from 9%, 25%, up to 110% in one instance, and one of the best performing ones, of course, is the one at Shepton Mallett, so Sir Ian will be very pleased about that. Why is there such a variation and why are so many of them still failing to do the work that they are still being contracted to do?

Mr Nicholson: The reason the independent sector treatment centres were set up was not just one of capacity—it was not just that we needed more capacity, it was that we needed a different kind of capacity as well—and they are all absolutely dependent on patients making choices and GPs advising and helping them to make those kind of choices. That is absolutely what they are dependent on. We took a judgment, as you know, in order to increase the variety of organisations that were providing these kinds of services, that we would provide some certainty in all of that. Hence the extra tariff and hence the arrangements that are in place to make sure that they get guaranteed income. In some places, you are absolutely right, they have not delivered in the way that we would have hoped that they would deliver, and we are absolutely, with the strategic health authorities and the PCTs, working with them to see how we can best make sure we maximise the benefits of those systems, but it is often difficult. The people that are expressing choices, individual patients, are saying they would rather go

to their local hospital, or they would rather go to hospital X. It is very difficult in those circumstances, I think, for us to override that choice. There are general practitioners who have particular connections with other hospitals that they want to continue with, and, again, it is very difficult to override all of that.

Q128 Dr Naysmith: Could not some of this have been foreseen when these contracts were made. You mention flexibility for the inflow recently.

Mr Nicholson: Yes.

Q129 Dr Naysmith: But there was no flexibility in some of these areas.

Mr Nicholson: No, I am sure it was foreseen and the judgment was taken. How do you both, on the one hand, increase the choice and plurality in the system and, on the other hand, get the best value for taxpayers? The judgment was taken that it was worth spending some money in order to create that market. That is essentially the judgment that was made.

Q130 Dr Naysmith: Some people say that these contracts have given the taxpayer a very bad deal. You would say that is purely in financial terms. If you look at it purely in financial terms, there may be case for that, but you are saying there were other the reasons for doing it: choice, competition?

Mr Nicholson: Yes, choice and competition.

Q131 Dr Naysmith: That is the real underlying one.

Mr Nicholson: The idea behind it, of course, was that by providing more choice and competition in the system, not only would you give individual patients that choice but that the NHS would respond to improve the quality and access of the services that it provides as well, and that demonstrably has happened around those places.

Q132 Dr Naysmith: Everyone is very confident over that.

Mr Nicholson: Absolutely not. I want those independent treatment centres to be working all the time—all of those patients, all those slots to be filled and us to get the maximum benefit out of the money that we are spending—and that is why we are working with PCTs and strategic health authorities to see how we can boost the use of the independent treatment centres.

Q133 Dr Naysmith: The Healthcare Commission said in July that the quality of the data provided by ISTCs on what they are doing continues to be poor. Do you agree with that and, if so, what are you doing about it?

Mr Nicholson: There undoubtedly has been an issue about all of that. We are working with both the independent treatment centres, the organisations that run them and the PCTs to make sure that we significantly improve the quality of data that they are getting, and it is already improving; I think you can see that. The other thing is that the introduction of quality accounts, which will be absolutely crucial,

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I think, over the next year, is equally applicable to independent treatment centres as it is to NHS organisations as well. So they will have to produce annually a report on the quality of service that they provide.

Q134 Chairman: How long is this going to take? This committee pointed this out, I think, in 2006. It was one of the earliest reports we did following the last General Election. How long does it take before we are able to look in a quantifiable way at what is happening inside these health centres?

Mr Nicholson: We have got a quantifiable way of doing it at the moment. The issue is whether the data is comparative to what we collect in the rest of the system. We will have to do this for 2009 in order to deliver the quality accounts in the way that we need to do.

Q135 Dr Naysmith: We have also mentioned before that by their nature ISTCs take the easier cases and leave the difficult ones for the National Health Service. In general that is true. They are set up to do, as you know, lots and lots of similar procedures and that sort of thing. How is this going to be taken into account in determining the payments that you have just been talking about under quality incentive schemes like CQUIN and the Payment by Results tariff?

Mr Nicholson: Because the first wave of the independent treatment centres are not on tariff, CQUIN, as it stands at the moment, would not be applicable to that. We would expect them to deliver the highest possible quality through the existing payment arrangements. However, as we develop independent treatment centres—and, of course, as you know, over the last 12 months or so we have implemented what is described as free choice, so there are now another 127 different private hospitals around the country that are offering NHS services at tariff—like all the rest of the NHS, 0.5% of the uplifted tariff will be available to them if they can get an agreement with their local PCT about how they can demonstrate the improvement of quality of service and get the data right.

Q136 Dr Naysmith: So it is going to happen, is it?

Mr Nicholson: Yes.

Q137 Dr Naysmith: Okay. Let us turn to the future role of the private sector in the National Health Service. There are all sorts of other “for profit” healthcare providers in the NHS—ISTCs, APMS contracts, walk-in centres, the extended choice network and the free choice network, and there are one or two others as well. What do you think the impact of the credit crunch will be on this experiment with its increasing volume of “for profit”?

Mr Nicholson: There are some really big issues for us, I think, as we go forward in relation to this, not least of all because, if you take the first wave ISTC contacts, they will all come up for renewal in the next couple of years or so, right at the time when we have delivered 18 weeks and right at the time when, as you say, the economic circumstances will change

significantly. What we have consistently said is that once those contracts have ended, essentially they get their money driven through patient choice, there will be no extra arrangements put around them, which I think is obviously going to create for them some difficulties; and we will have to think about how we can manage those difficulties going forward if we want to keep choice and contestability in the system, which I think we do, and it is certainly something that our patients tell us that they want.

Mr Taylor: We are also looking at the impact of the downturn on third sector organisations, which are key providers of many services to the NHS. So it is not right to just think of it in terms of the impact on the private sector, but we need to look at the third sector as well.

Q138 Dr Naysmith: What is the evidence that any of these initiatives have been really good value for money? We have just been talking about it with ISTCs but a lot of these organisations are not really rigorously tested against NHS provision. They might provide the competition, but how do you know that they are providing good value for money?

Mr Nicholson: If you take the second wave of ISTCs, of course, they all have to provide a tariff. In fact, some of them are providing it below tariff, so we can demonstrate better value for money on a considerable number of the second wave ones. As far as the first wave ones are concerned, you are absolutely right, an element of the money that we are spending is in a sense a payment for providing choice and contestability.

Q139 Chairman: The first phase of ISTC contracts is going to end. What happens if they are not renewed? You have got this building there, the potential to do work for NHS patients. Could you foresee a situation where maybe a foundation trust or two or three foundation trusts would say, “We will buy it and use it”?

Mr Nicholson: There is a whole variety of deals that were dumped on us, there is a whole variety of agreements that were made at the time around the capital. Some of them revert to the NHS, some of them revert to the private sector, for some of them there are special arrangements in relation to them, but I can absolutely see a case where a foundation trust or another health organisation might take one over.

Q140 Dr Taylor: Dentistry. You will be aware that we did a fairly scathing report on the dental contract, and we have now got some up-to-date figures since the big green book, and the figures we have been given are that in the two years ending 31 March 2006, 28.1 million patients were seen by dentists, in the two years ending 31 March 2008 it had dropped 26.9. What does that tell us about the effect of the contract?

Mr Nicholson: It is taking time to see the benefits of it. I think that is what it says. That is what it tells you.

Q141 Dr Taylor: That is the most optimistic statement I think I have ever heard!

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Mr Nicholson: Thank you. I take that as a compliment. I am not going to sit here and say everything is absolutely fantastic as far as dentistry is concerned, but I have no doubt that we will see the benefits in the next two quarters in relation to those figures and we will see an improvement, but there is no doubt that we need to do something in order to improve it and we have taken note of the conclusion you came to. All I can say about that is the Secretary of State is going to make an announcement tomorrow about dentistry, so I would leave it to him.

Q142 Dr Taylor: Tomorrow?

Mr Nicholson: It is tomorrow, is it not? Tell me it is tomorrow.

Q143 Chairman: Could you just clarify that, because normally they make statements when we debate our reports, which is due next Tuesday.

Mr Nicholson: Oh, well, it might be next Tuesday. The Secretary of State is about to make an announcement on dentistry, and so I would like to leave it to the Secretary of State to tell you.

Q144 Dr Taylor: But you are confident that in the two years from now on we will see that figures are picking up?

Mr Nicholson: Yes; absolutely.

Q145 Dr Taylor: If we are still here in two years we will hold you to that?

Mr Nicholson: And if I am! I thought it would say that before anybody else does.

Q146 Dr Taylor: Have we any idea of the number of people in each area who still cannot find an NHS dentist? I am aware that many PCTs have set up new services, but are there still appreciable numbers who really cannot find an NHS dentist?

Mr Nicholson: Yes, in 30% of our PCTs it is getting much better and they are opening new capacity and it is working well. In about 60–70% of our PCTs we have not seen that level of progress, and that is one of the reasons that the Secretary of State will be making the announcements that he will be over the next couple of days to improve that position across the board.

Q147 Dr Taylor: So there is going to be pressure on PCTs to improve it?

Mr Nicholson: Yes.

Q148 Dr Stoaite: I want to move on to the National Programme for IT. The NAO, as you know, of course, found that the Care Records Service is now four years behind schedule?

Mr Nicholson: Yes.

Q149 Dr Stoaite: Are you confident is not going to slip any further and we will actually have a workable system by 2015?

Mr Nicholson: Yes, I am confident that we will have a workable system by 2015. The thing about the National Programme for IT, I am sure you will be aware, is that it has had some difficulties delivering

part of it but there have been significant improvements as well. The PAX systems, the CUMAS systems, the Spine, the electronic prescribing which is starting to be rolled out, the GP systems of choice. All of these things are either moving forward or have moved forward, some of them ahead of time, but there this bit you have just described where we have had some difficulties, and part of the difficulty has been that there are not the products available to do the things that we want them to do. Nowhere else in the world do they provide services quite in the way that we do. If you take, for example, the Cerner system, which is being deployed in London and the South, functionality is fantastic clinically but it is also based on billing, it has been developed in America and is based on billing and does not take into account a whole series of issues around 18 weeks and patient tracking that we need, so we are having to change all of those. That has been part of the issue, getting the product absolutely right, and we are still not absolutely there.

Q150 Dr Stoaite: Should we not have been more realistic in the first place then? Surely these things should have been foreseeable. To have slipped by four years so far is not a very good result, is it?

Mr Nicholson: It is not a good result. I would have hoped that we would have removed it even before that. On the other side, of course, is that the benefits of the way in which we contracted for the National Programme for IT did save several billion pounds in procurement costs, and that has been independently evaluated, but we do not pay until we get—it is based on Payment by Results. So, as you will know, in the past when there have been IT problems, scandals in government and all the rest of it, government have ended up paying a lot of money for something they have not delivered, we do not pay for it. We have only spent, I think, about 28% of the money available to us for the National Programme for IT. I wish we had spent more, but it has proved a very effective way of taking things forward. We have got to think about how we take it forward because, you are absolutely right, we cannot go on and on for this. There is good evidence now that the Lorenzo system, which will be available for the North Midlands and East of England, is just very tentatively being tested in Morcambe Bay and good results are coming out of that, but we need to be very careful about that. We have got some serious issues around the Cerner system, particularly in London at the Royal Free, and what we have said to Cerner and BT is they have got to solve that problem at the Royal Free before we will think about rolling it out across the rest of the NHS. So I think we are at a quite pivotal position in terms of the programme for IT. If we do not make progress relatively soon on this, I think we are going to have to rethink it through.

Q151 Dr Stoaite: You have now introduced, apparently, an information management technology survey, in which you are going to introduce firmer measures. When are we going to see some results

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from that and when are we going to be confident that costs are not simply to going on escalating in the next five years?

Mr Nicholson: They are not escalating. That is the whole point.

Q152 Dr Stoate: That is what you said before. We keep hearing of slippage; we keep hearing of cost overruns. Are you now saying you have not a guaranteed figure that you are not going to exceed?

Mr Nicholson: First of all, I do not know where you have heard about these cost overruns, because we have not had cost overruns in terms of the National Programme for IT. Where we have spent more money it is because we have asked for more functionality or wanted new things. The basic contracts with the local service providers are fixed for the whole period, and so we are confident we can hold on to that as we take it forward. At the end of the day, as you know, Wanless in his work talks about 4% of the revenue of the NHS being spent on IT as a waste. We have still to get there. But, as I say, we have got some really difficult issues to tackle in the National Programme right at this very moment.

Q153 Dr Stoate: One of which is to replace Fujitsu. Have you got any plans to replace Fujitsu, particularly for the southern cluster?

Mr Nicholson: I was involved in the discussions with Fujitsu around all of that, and we terminated the contract because we did not believe that they would be able to deliver what they said they would, and it is now subject to a whole set of legal discussions at the moment. There are a number of options available to us as far as the south is concerned, and we are working our way through them. The first option is that one of the existing LSPs take them over, so BT or CSC or a combination of both, and we are working through that with them, or there is an alternative in going for another local service provider outside of those, and we are currently working through that. We will be making a decision in February, I think, around what to do with that.

Q154 Dr Stoate: Finally, what plans are there to have workable connectivity for pharmacy with the NHS? At the moment pharmacists are pretty much out on a limb and it makes it extremely difficult for them to provide the care which we are asking them to deliver? How can we get connectivity with them?

Mr Nicholson: We are working through that at the moment. As part of the electronic prescribing, we are working with the pharmacists at the moment to find out what the best—. We have got the technological solutions to it, it is how we finance that arrangement we are getting in place, but I would hope we have made progress over the last 12 months in relation to that.

Q155 Dr Taylor: I am going to test your optimism a little bit more. Coming to back to the *European Working Time Directive*, you have already touched on it and you have told us that paediatrics, obstetrics and anaesthetics are going to be the difficult ones.

The Royal College of Surgeons, I gather, recently has suggested that over half the trusts are not really ready to do this. Does that mean they have not got down to the 56 hours, if that was the previous requirement?

Mr Nicholson: No, it is the requirements for August of this year.

Q156 Dr Taylor: It is to get down to the 48?

Mr Nicholson: Yes.

Q157 Dr Taylor: What is going to be the cost of this?

Mr Nicholson: First of all, it is perfectly possible to do. The North West region of the country has delivered the 48 hours 12 months early for 97% of their doctors, so it is perfectly possible, with planning and organisation, to make it happen. We have an issue at the moment about how we are doing. Our figures show us that over 60% of organisations have got plans in place and have got a process in place to deliver everything by August. Both the Royal College of Surgeons and the Royal College of Physicians are worried about those figures—they think they are overstated—so what we have agreed to do, jointly with the Royal College of Physicians, is do a proper analysis and survey, a quick one, over the next few weeks to see where we actually are in practice. We have got until the end of January if anyone needs, I think, derogation is the right word, for them to talk to the department about it to see whether they simply cannot deliver it so we need to go to the European Commission to ask for derogation. I would expect there to be none, or very few, that we would let through, because our expectation is it can be done given what the North West have said. Our calculation of the cost of it all is just over 300 million. We put 100 million in the tariff for last year to enable them to take it forward, we put 150 million in the tariff uplift for next year, to put it in place and we are allocating 50 million across the strategic health authorities. We have done that in conjunction with the Royal College of Paediatrics, Obstetrics and Anaesthetics, so that we have a 50 million pot particularly to help in paediatrics, obstetrics and anaesthetics. So it comes to just over £300 million altogether.

Q158 Dr Taylor: What have you said to the criticisms, particularly coming from some of the junior surgeons, that although they approve of certainly a cut in hours, this cut to 48 is going too far and really reducing their actual experience and the actual training that they get?

Mr Nicholson: That is part of a discussion that we are having with the surgeons at the moment. There, are as you know, all sorts of ideas about perhaps extending training or doing it in slightly different ways. All we do know is that 80% of surgeons say that the training is excellent.

Q159 Dr Taylor: As the Government have shown that it can tell Europe where to go over the Post Office card account, where it actually pulled out of the tendering exercise completely unilaterally, you

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do not think we should be a bit like some of other continental countries that are taking less notice of the 48-hour absolutely strict directive?

Mr Nicholson: I start on the premise: do we really want our junior doctors to be working more than 48 hours a week?

Dr Stoate: We did, did we not, Richard? It did not do us any harm?

Q160 Dr Taylor: We certainly did far too much, but do you not think from the training purposes that 48 hours is going just a bit too far?

Mr Nicholson: No, we do not believe that is the case at all. As I say, whilst we have opened the door, the door is ajar for people to say they need derogation because some things are so complicated therefore they cannot be done in time, I would be reluctant to take any of those forward. We needed an expectation that our junior doctors work reasonable hours.

Q161 Dr Taylor: But if you absolutely had to, you would tell Europe to get lost?

Mr Nicholson: We would not tell them to get lost, no, somebody else would. We would seek derogation.

Q162 Dr Naysmith: Before you leave that topic, I wonder if I can quickly ask: do we have any reliable figures as to how much it is going to cost the NHS to introduce the *Working Time Directive* in full?

Mr Nicholson: Right back from when we first did it.

Q163 Dr Naysmith: How much a year is it costing to do it?

Mr Nicholson: I have not got those figures to hand. I am happy to give them to you if I can find them.¹

¹ The European Working Time Directive introduces a commitment to reduce the number of hours worked per week from the current 56 hours, to a 48-hour week from August 2009–10. The Department has estimated that the full cost of implementation could be around £300 million per year.

This calculation is based on an analysis of the difference in doctors being 100% compliant at 56 hours and 100% compliant at 48 hours, so includes a valuation of:

- the difference in pay to existing doctors; and
- an assessment of the value of hours lost.

There are a number of complicating factors that mean the calculation can only be approximate, for example:

- different applications of “banding”; a form of job intensity payment;
- extent to which additional training will be necessary to make up for the lost hours; and
- extent to which more effective design of rotas has mitigated the need to cover for the hours lost.

Set against this cost are significant benefits to patients: reduction in errors; better outcomes; and an improved patient experience. The commitment in 2009–10 continues a trend to limit the hours worked per week. The commitment to limit working to 56 hours per week was introduced as part of SiMAP/Jaeger in 2004. This followed the New Deal, introduced in the NHS in 1990 to limit the hours worked by junior doctors to 72 hours.

The Department’s assessment is that it would not be appropriate to calculate an historic annual time series of the costs of implementation. Accuracy would be highly dependent on detailed knowledge of changes to particular working practices adopted by local organisations over a number of years. This level of detail information is not held centrally.

Q164 Dr Taylor: Coming back to foundation trusts. Can you give us any idea of the number of trusts that really do not have much hope of making foundation trust status?

Mr Flory: Clearly, there are 112 foundation trusts now. We are trying to bring a bit more discipline into the process by which potential foundation trusts are assessed and the time-line in which it might be happen, with a view to completing the programme during calendar year 2011, and we will know in 2010 how everybody was going to go forward. There are clearly some organisations over which there is a doubt as to whether they could progress to foundation trust status, particularly in that timescale, because of some longstanding financial problems that they have experienced in the past. So we have not taken the view, and certainly SHAs have not taken the view yet, that there are some that definitely are not going to make it, but over the course of the next six to 12 months I think we are going to have to bring certainty to that one way or another so that we can begin to develop alternative ways forward for any trusts that are not going to make it.

Q165 Dr Taylor: So in the next 12 months you will have a better idea?

Mr Flory: Yes.

Q166 Dr Taylor: I think Monitor have told us that they only take two things into consideration: one is finances and the other is the state of governance, as those are the really crucial things. So if there are some that are just not going to make it, they are obviously not going to be attractive to other foundation trusts to take over because they could drag them down, so what is going to happen?

Mr Flory: One of the things that we have developed in the course of the past six months is proposals round a performance and failure regime which we have done some consultation on; and our expectation in bringing this regime into place is that in itself it will be a lever to improved performance and that it will be a disincentive for people to fall into this situation. We have recently completed a consultation on a specific piece of that, which we call the “unsustainable provider regime”, and a trust which is clinically and financially unviable and we just cannot see a way forward for it—and those two things, clinical viability and financial viability, ultimately tend to sit pretty close together—then options in there that we spell out would be to look for an option to franchise the management to see if things could be improved, to look at whether some of the services could be taken over by other organisations, such as foundation trusts (they would have to be a next-door neighbour foundation trust) could be undertaken; but if, ultimately, a trust is not viable, then the question of whether it should be dissolved in a way in which the assets are looked after first and foremost to protect services for patients and the staff would be looked after to transition into a different organisational model. We have consulted on the principle; we are still reflecting on what the next steps to take are.

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Q167 Dr Taylor: Is failure always going to be due to poor management?

Mr Flory: Not always.

Mr Nicholson: No, a good example: an organisation which has declared that it does not believe it can become a foundation trusts was the Nuffield Orthopaedic Centre in Oxford. The tariff does not work for it. The way in which they do the specialist work, the way they can spread their costs and the clinical connections they need to make with other hospitals, it seems to them that they will be never be in the place where they can take that forward, so they are looking at alternatives of different partners they might work with to make that happen.

Q168 Dr Taylor: Certainly tariffs do not help the specialists hospitals, do they? So they have got a real reason. Are there enough really good managers to move around to take on others that do not have that sort of reason for failing?

Mr Nicholson: In a sense it is one of the reasons that we are doing the work we are as part of the Next Stage Review on leadership, because there are not either the quality or the quantity of people across the system as a whole to do everything that we need to do. So we need to bring more people in from outside; we need to get more clinicians engaged in management and leadership; we need to really up our game as far as management is concerned, because simply staying as we are will not be able to deliver the quality people that we need to do this sort of work.

Q169 Dr Stoate: I want to move on to Payment by Results. Is there any evidence (and again I come back to evidence because we are very, very keen on evidence) that Payment by Results is actually changing behaviour at a local level?

Mr Flory: Yes, there is, and there has been some evaluation work undertaken. You are probably familiar with the work that was undertaken by the Audit Commission and also the work that has been independently commissioned from a collection of universities, led by the University of Aberdeen, which recognises that the introduction of Payment by Results is changing behaviour, is having organisations and service managers within it more focused on the costs of the service they provide and more thinking about the way in which they can be more efficient.

Q170 Dr Stoate: That is obviously a change of behaviour, but is there any evidence that it is reducing costs or improving efficiency?

Mr Flory: I think, as we have observed over time, the reference costs system, which is the foundation upon which the Payment by Results system works and tariffs are set, shows that in a number of areas we can see improving efficiency on a year-on-year basis. As we have said earlier, the requirement to generate efficiency savings is very much part of the spending review period. There is 3% required to be achieved

this year, another 3% required to be achieved next year. So in the way that we uplift the tariff, which is central to the Payment by Results system each year, builds in that efficiency requirement.

Q171 Dr Stoate: We hear a lot of evidence, anecdotally I have to admit, from many GP colleagues of mine who feel that what Payment by Results actually does is to Hoover money up into large hospitals, leaving PCTs and, therefore, GP budgets picking up the bill. That might be very good news from the hospital point of view, might even be quite good news in some ways for efficiency, but certainly is not good news for a primary care led NHS?

Mr Flory: I think that where we tend to hear some of those anecdotes, and in some cases we would have to treat the conclusions that we draw from them with caution, is that the increasing bill to the primary care trust is more about increasing volume and less about increasing price. What we have observed in some places is that as the discipline of payment by results has got in, trusts have become much smarter at the way in which they count and record activity. That, to be fair, has always been there but has not always been counted in the past, and under the Payment by Results system that then triggers additional payments.

Q172 Dr Stoate: Except, of course, that the incentive for hospitals is effectively to do more and more rather than handing a patient back to the primary care, which might actually be in the patient's best interests?

Mr Flory: Absolutely. This is not just for the hospital trust to decide in those instances. The strength of commissioning, the strength of the contract between the PCT and the trust is important in making sure that that potential unintended consequence, which could work against the patient's best interests, does not happen. It needs to be managed by the primary care trust.

Q173 Dr Stoate: Have you any research going on that does look at that? Because, as I say, if a patient goes to A&E, there is a very strong incentive for the hospital to do as much as possible for that patient rather than simply saying: "You should be seeing your GP or your pharmacist tomorrow"?

Mr Flory: Yes, and one of the things that we have done in developing the tariff system, particularly around A&E emergency, is to break down the component parts of that so it reduces the way in which hospitals could potentially make more money than was due to them having patients presenting in that way.

Q174 Dr Stoate: The problem is, because the information takes such a long time to get back to the GP, it is far too late for any meaningful change in behaviour on anybody's part.

Mr Flory: There are timing issues in that, but I do think we are getting much better now, and there are some really good examples that we can see across the

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country in the ways in which hospital and primary care trust commissioners are sharing information and agreeing information and projecting what that means for the future and building it into the contract.

Q175 Dr Stoate: Yet what the Healthcare Commission's report yesterday showed was that there is something like a 30% increase in A&E attendances. Now that cannot be seen seriously as an efficiency measure.

Mr Flory: No, the evidence is there of what is happening to people presenting at A&E. Certainly I would agree with you. You cannot just tick that off as an efficiency gain; there is a whole factor of reasons which come together to determine why the numbers of people turning up at A&E is going up.

Chairman: Gentlemen, could I thank you all very much indeed for coming. We have had just over two hours for what is our annual marathon session in relation to where money goes within the system. Thank you very much indeed for coming along and helping with this inquiry.

Wednesday 11 March 2009

Members present:

Mr Kevin Barron, in the Chair

Mr Peter Bone
Sandra Gidley
Stephen Hesford
Dr Doug Naysmith

Mr Lee Scott
Dr Howard Stoate
Dr Richard Taylor

Witnesses: **Alan Johnson MP**, Secretary of State, **Mr David Nicholson CBE**, NHS Chief Executive and **Mr Hugh Taylor CB**, Permanent Secretary, Department of Health, gave evidence.

Q1 Chairman: Good morning, gentlemen. Could I welcome you to the evidence session that we are taking in relation to the NHS Operating Framework, and there are one or two other questions we would like to catch up on, given that we have you here in front of us this morning. For the record could I ask you to introduce ourselves and the position that you hold?

Alan Johnson: This is David Nicholson, who is Chief Executive of the NHS and Hugh Taylor, Permanent Secretary, and myself Secretary of State.

Q2 Chairman: Welcome. I want to ask a few questions about the future of the National Health Service budget in view of the current climate that we read about. The Institute for Fiscal Studies says that the Pre-Budget Report effectively cut £37 billion from planned public spending in the next spending round, 2011–12 to 2013–14. Do you agree with this figure? Or if you agree with that figure or a lesser figure what are the implications for the National Health Service?

Alan Johnson: What I saw was an envelope from 2011 to 2014 with a real term growth of around 1.1%. There was no departmental breakdown of that, so it was just a very broad envelope. As David has been saying constantly when we put the allocations out last year, people should not be thinking of the next two years—because we did a one-year allocation last year and a two-year allocation just in December—they should be thinking five years because undoubtedly with the spending growth that we have been used to it would be completely irresponsible to think that that level of growth is going to continue into the future. So people should start to think about that. But could I just point out, Chairman, in 1997 we spent on health £426 per head; from next year, 2010–11, we will be spending £1,612 per head of population, and all of that is locked in. If we are talking about 1.1% real term growth across the public sector—of course I do not know how that is going to pan out for health, that depends on the next Spending Review—if we lock in everything we have we start from the best platform that health has ever had in its 61-year history. On efficiencies we have a terrific record. If you look at Gershon we extended—I think we were supposed to make about £6.5 billion and we actually saved £7.9 billion by March of last year under the Gershon Review. So a good level of funding to start from; a good record of efficiencies and then we will see what the future holds. Certainly

not the levels of increase we have had—I do not think anyone expects that—but if I am still Secretary of State for Health, as I hope I am, I will be arguing for real term growth of some sort on the back of the enormous increases we have seen over the last 12 years.

Q3 Chairman: In *The Times* newspaper last month the Chief Executive of the Audit Commission said that growing public debt meant that “the Armageddon scenario” for government finances “begins to look a distinct possibility . . . any managers of a public service who are not planning now on the basis that they will have substantially less money to spend in two years’ time are living in cloud-cuckoo land.” If we were to say that the envelope that you have seen suggests that there will still be real growth with health expenditure in this country, is the Chief Executive of the Audit Commission living in “cloud cuckoo-land” as far as health is concerned?

Alan Johnson: I do not know what land he is living in but what the Treasury set out was 1.1% real term growth across the public sector. We are not talking about people being in an “Armageddon” situation. Since we have put the allocations out in December, 5.5, 5.5 drawing down £800 million of surplus over that two-year period. People out there have been absolutely delighted with that; they are getting on with the job and they feel that that is a reasonable settlement for this year. In terms of into the future, it is inconceivable to me that—and health is the priority of this government—people will have to cope with real term cuts. What they will be coping with, I very much hope, is real term growth, albeit not on the levels of the real term growth we have had over the last 12 years.

Q4 Chairman: So if we have low growth as opposed to no growth or negative growth, what is the issue even on a low growth situation? What is the issue about demographics, changes and public expectations of health? As you say, we expect to get a lot more from the National Health Service now than we did a decade ago, and the figures you have quoted to us, quite rightly too, in terms of what taxpayers are putting in. Technological changes as well are happening inside the Health Service, so what is going to happen there if we are a low growth scenario?

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Alan Johnson: My view is that if we get to where we were aiming to get to, which is roughly the European average of proportion of GDP spent on health, which is around 9%, I think that is a good place to be and I think it is the right place to be. I think then that you need to ensure that you are examining every penny you spend; you have to ensure that you are catering for the undoubted pressures that will come from an ageing population, but you have to plan for that. Darzi makes this point, which I think is shared by clinicians across the country, that actually quality costs less. If you reduce the number of errors and you improve the quality you actually make a financial saving as well. We have to plan, not for a continual rise in GDP share—if it is 9% now then it must be 12% in a few years' time and eventually it will be 20%, I do not think that is a value for money Health Service—and I think what people look for is the proportion of our wealth to be spent on health to be roughly the level that it should have been for many years. The scandal in the past has been the under investment in health—and then they expect us to ensure that we live within that basic budget, and I think we can. Yes, there are the effects of an ageing population but there are numerous ways, including new technology that you have mentioned, to deal with that in a cost effective way without taking a bigger share of national wealth into health.

Q5 Dr Naysmith: Good morning, Secretary of State, it is good to have you before us again. Can I ask you what estimates have the Department of Health and the National Health Service and maybe even some others made of the possible impact of a recession with things like growing unemployment, falling incomes and house repossession? What effect do you think that will have on the demand for healthcare, given that all of these things I have mentioned have been shown in various studies over many years to impact on people's health?

Alan Johnson: We have looked at what happened in previous recessions, in the 1990s and the 1980s and we have looked at how government responded to those recessions and we are not going down that same route. What happened in the 1980s and the 1990s, waiting lists grew longer—they just stopped operating and stuck them on to longer waiting lists; restricted the flow of new drugs on to the market and got rid of staff. We are not going to do that. That is point number one. The effects are if you look at them that people go to the GP more often if they are unemployed is effect number one. Mental health services: if it is long term unemployed it is a serious mental health problem—the suicide rate is 30 times higher than people who are in work. The whole effort of the government is that we do not get into that long term unemployed situation. So if we are talking about short term unemployment there are mild levels of mental health problems associated with that—a different level to those of the long term unemployed, which is why James Purnell and myself announced that we are bringing forward the Psychological Therapies Programme, the IAPT Programme, so that we are doing more this year to roll that out, and actually ensuring that the

psychological therapists are engaged in those places where people will come looking for employment, having lost their jobs. So, all the evidence from the pilots on psychological therapies in Doncaster and Newham shows that particular effect for people who have been unemployed, people on incapacity benefit for years. So I think that is an important contribution we can make as well.

Q6 Dr Naysmith: Clearly we are not going to let what happened last time there was a recession happen again, but I think, Mr Taylor, the last time you were here you told us that you were going to look into this and look into some sort of study of the whole situation. Did that happen? Is there something concrete on paper that you have produced?

Mr Taylor: We have produced an analysis which, broadly speaking, is what the Secretary of State is referring to. This is not an exact science because a lot depends on, for example, for how long a recession goes on. But we are looking at it from a number of points of view. One is any potential increase on demand. That is not hugely significant in our anticipation at the moment but that is one of the things we want to keep under review. Second, there is the expected increased potential demand for mental health services to which the Secretary of State has referred and our response to that has been to accelerate the programme on cognitive therapy. Then through our Audit Committee and associated structures we are scanning the whole time for impacts of the recession on, for example, contractors, on the market in residential care, for example, and social care to keep an eye on whether that is impacting on delivery of services to people at the frontline.

Q7 Dr Naysmith: I do not want to go back over what has been said already in answer to the Chairman's questions, but with a small budget you are anticipating increased demand. How are you going to handle that? Does it mean cuts elsewhere? You mentioned mental health and we know that in some parts of the country mental health services are not nearly as good as they should be, even though we have been trying to get them there. But it is going to get worse in some areas, is it not, and you have at the most probably a 1.1% increase in your budget?

Mr Taylor: Obviously to some extent the response to this has to be localised. PCTs have to look at what is happening on their local patch. One of the objectives of what we have done in terms of accelerating the IAPT Programme is to ensure that all PCTs are able to offer at least transitional services for that programme this year. We brought money forward in this year, so we are actually planning an increase in expenditure this year to cope with that level of expected demand. We are providing employment support coordinators to have a better link between people both in work and out of work with the sort of counselling and therapy services associated with that. So we are taking some immediate action but I would be misleading you if I was able to say that

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there is some exact science in which we could correlate increased demand over the period, for example on GP services.

Alan Johnson: Could I just make a point, Doug? When I said in the 1990s and the 1980s that the way the Health Service dealt with this is by getting rid of staff, restricting drugs, extending waiting lists, that was not because there was evidence of a huge extra cost to the NHS from the recession; that was because the government then chose to deal with it by cutting public services. So there actually is not any evidence I have seen that says, “People go to the GP more is about the best we can come up with; and if it is long term employment serious effects for mental health.” Actually there is nothing that leaps off the page that says your costs suddenly dramatically rise as unemployment rises. That does not follow; what happens is that savings were made because of cuts in public services. The mental health stuff, of course we are putting this huge amount of money into psychological therapies. Richard Layard says it is the biggest development in mental health services, the most important development since the NHS was created—3,600 psychological therapists. So that was there and the funding was there and what we are doing is bringing it forward and putting it in much earlier because it will be particularly beneficial as unemployment rises.

Q8 Dr Naysmith: I am personally very pleased to see that because I have been arguing for more psychology services for a very long time and I am glad it is happening now. The other point I want to put to you, Secretary of State, before we move on is that we still have a backlog of repair and maintenance and building works in the National Health Service. What effect is this going to have on the capital budget in the financial climate, which means that probably we will have to cut back on some of the planned maintenance, will we not?

Alan Johnson: I do not think so. From memory, we are heading towards 110 new hospitals and 750 new primary care facilities since 1997. A lot of the cost of maintenance was for old buildings—over half of the NHS estate in 1997 was built before the NHS was created—so the very high maintenance costs associated with those have now disappeared because there are new buildings, and that is even without the GP-led centres and the new centres we are putting into under-doctored areas. So this is a matter for local Trusts to deal with but I would be very surprised if there is a serious problem with maintenance out there.

Q9 Dr Stoate: Good morning, Secretary of State. I want to raise the always contentious issue of efficiency savings. The Pre-Budget Report announced a £5 billion allowance for Additional Value for Money Savings 2010–11, and the Health Service Journal estimated that the NHS’ share of that could be between 1.35 and 2.5 billion. Do you recognise that figure and, if so, how do you anticipate the NHS meeting that target?

Alan Johnson: We are going to have to make our contribution to the £5 billion and it is right that we do; it is right that every penny of taxpayers’ money being spent in the public services is examined and scrutinised—I think that is a very sound way to deal with the current situation we are in. So we will make a contribution to that. The Treasury also at the same time talked about the Operational Efficiency Programme—the savings we can make from back office. We have a great track record in the NHS and already there are a large number of Trusts who are part of this back office service—around 100, probably more. So there are issues around how we procure; there are issues around how we use the NHS estate. This is a vast organisation with 1.3 million employees. There are always possibilities to move that a bit further to find savings, but where it will not come from is patient care. So I am confident that we can actually meet that and I think it is the right thing for us to make our contribution that will be a significant contribution because we are a significant spending department—we will not be putting in tuppence ha’penny to this—but the HSJ figures are speculation. I think we can do that and carry on with the excellent improvements to patient care that we have seen.

Q10 Dr Stoate: It is always a bit of a soft target to say we will just improve efficiency and therefore produce what you could call real term growth because of savings. However, the question is: if it had been that easy to produce back office savings why has it taken this long, why are we still doing it? Why have we not effectively driven out all those inefficiencies years ago?

Alan Johnson: We have driven out lots of them. As I say, we have a good track record; we have a good track record under Gershon, but there is always more that you can do. The things we will be doing now are things we will find pretty painful—I am not saying this is going to be easy. It is not taking out huge amounts of slack; it is things that perhaps seemed like a good idea to do that we now will not do. There are issues around our central budgets; how closely have we looked at central budgets—not the money that is going out to the PCTs but the money we keep at the centre? How rigorously have we looked at that in the past? I think we have looked at it rigorously but there is always more you can do. I do not want to give the impression that the contribution here will just be because we are laying around peeling grapes, it is easy for us to do that. It will be tough but it will be doable and that is the way to deal with a recession—not getting rid of staff, not restricting drugs, not expanding waiting times; it is looking remorselessly at the internal savings you can make, excluding from that the very important developments in patient care.

Q11 Dr Stoate: The Department often says that improved quality is cheaper. Is that the case and, if so, is there any evidence for it?

Alan Johnson: As I said, Ara talks about this all the time—it was in his review—and everyone who worked with Ara, all the clinicians, made the point

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that quality is better. I can think of an example, just dealing with healthcare acquired infections and getting them down now 57%, 60% reduction is estimated to have saved us £75 million. I am sure there are lots of other examples of how quality saves money that you can invest elsewhere.

Q12 Mr Scott: Secretary of State, one of my pet subjects, as you know, is both the negligence payments that have been made, which total a quarter of a billion in London alone, and also the amount of money that is paid to former Chief Executives. I know that you have very kindly said that this is being looked into, but obviously this is one large area where savings can be made because the money is not achieving anything other than making certain people richer for failure.

Alan Johnson: It has been something that you have raised on many occasions and I admire you for doing that because I feel very strongly about this—so does David and so does Hugh—which is why last year or the year before last David sent out to all Trusts the very firm message that people should not be getting more than their contractual obligations. It is quite right to give people six months' notice if that is part of their contract but six months' notice plus is not acceptable. So I think this is an area where you are quite right to keep a hawkish eye on what we are doing. It is not a case of talking about what we might be doing; we have already sent out the guidance and advice and there are a couple of high profile tribunals going on at the moment because of what we have done. Most managers out there, if not all managers, will recognise the importance of this. They do a really valuable job; they cannot say that that is not reflected in any more in their pay and their conditions—it may not have been in the past but it is now. We do not want to pay for failure and it is as important in the NHS not to pay for failure as it is in the banking sector.

Q13 Chairman: Secretary of State could I ask you about the efficiency savings? Howard posed a question about why is there still inefficiency inside the National Health Service. What strikes me about it is that we have efficiency savings in the National Health Service year on year—it is targeted centrally and each different organisation has to meet it. And at the same time we have had this colossal increase in expenditure that you mentioned earlier going into the system as well. Is not really the answer to Howard's question no matter what money goes in, if the centre is saying, "Next year you have to be efficient by 3% or 5%" or whatever, it is not in their interests to be efficient because they know that the Grim Reaper in terms of the efficiency, the e-factor, is going to come along the following year. Is that not the true story about efficiency or do I completely misread this?

Alan Johnson: I would not like to say that you completely misread it. I think that is a bit of a philosophy that I hope is out of date. What do we do now? We build in the 3% efficiency savings; the tariff builds in a 3% efficiency savings. It is not a case of if we do not spend this money the Grim Reaper will

come along, or whatever; it is built into everything we do. Of course that efficiency saving is money for us to spend elsewhere; it does not go into the Treasury. Everyone is now focused on you make these savings on efficiency so you concentrate putting that money where it is best used. So it is actually par for the course; it what we do in the NHS now, we make these efficiencies. We have exceeded Gershon; we are top of the class, and probably to some other departments we are sickeningly popular with the Treasury for the kind of regime that David has put in place. We do not have PCTs now that are in deficit, that sell off bits of land and use it to employ staff, which is the kind of thing that was going on before. There is a very rigorous process out there now and we are not going away from that. The old way where you build up the end of year surplus stuff and all the games that people used to play, because of the systems now out there it does not work like that any more. The difference between the efficiency savings that we are used to, i.e. we spend elsewhere, and the money that Howard was referring to, that money is a contribution going back to the centre; that is £5 billion across all departments that we need to put back into the centre to deal with the economic difficulties we are in. So it is in a different category.

Chairman: I may come back to that at some stage in the future, but let us move on.

Q14 Dr Taylor: Good morning, Secretary of State. That brings us on to really talk about surpluses. I think we have been told that the surplus at the end of this year is going to be something like £1.8 billion. Could you look into the future and what sort of surplus do you think that the NHS will carry forward from its very good position now, right on in to 2011–12? Will there be any surplus to carry forward then?

Alan Johnson: Actually the figure is 1.73, so almost 1.8; there is about 1.73 surplus.

Q15 Dr Taylor: The end of this year?

Alan Johnson: Yes, in the system at the moment?

Q16 Dr Taylor: Yes.

Alan Johnson: We have said as part of the allocations last year that £800 million of that could be drawn down by those Trusts that have the surplus of course—not all Trusts have the surplus. That leaves, by my calculation, about £970 million; so at the end of this SCR period if they spend all that £800 million there will be £970 million surplus still there carried into the next Spending Review.

Q17 Dr Taylor: The crucial question is how safe is that? Do you think that that is under threat from other departments—the Treasury?

Alan Johnson: No, it is their surplus. It is not in a safe in Whitehall, it is out there; it is their surplus money. I actually think that £970 million is quite a nice cushion to have actually; I think that sounds just about right for an organisation the size of the NHS to keep there as a bit of fat.

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Q18 Dr Taylor: So you are saying that it is entirely safe within the NHS; the Treasury are not going to suddenly turn around and say, “You have a billion spare; can we have it back?”

Alan Johnson: The Treasury might well turn round and say all kinds of things; but, no, that is the surplus that is out there in the system.

Q19 Dr Taylor: Turning to capital underspend, is there not a history here? Has the Treasury not clawed back some of the capital underspend in 2007–08?

Alan Johnson: I think you might be referring to 2010–11; they talk about . . .

Q20 Dr Taylor: 2007–08.

Alan Johnson: Probably they did, yes.

Q21 Dr Taylor: So we did lose some back to the Treasury then?

Alan Johnson: But this is different from the money—

Q22 Dr Taylor: That is capital?

Alan Johnson: Yes, capital, and is in a different box.

Q23 Dr Taylor: Yes, but it still belongs to the NHS and has been taken away.

Alan Johnson: I am not sure about the 2007–08; do you know about that, David?

Q24 Dr Taylor: We have been told—and I am quoting—“Hasn’t the Treasury already ‘got form’ in this respect, having plundered your Department’s £4.2 billion cumulative capital underspend in 2007–08?” I do not say that they have taken 4.2 but they have perhaps taken a bit of it.

Mr Nicholson: It was unallocated and it had not been put out to the NHS, it was with us in the Department. We were not going to spend it.

Q25 Dr Taylor: So you gave it back?

Mr Nicholson: Yes.

Alan Johnson: Which is what we have done in 2010–11, which is what I thought you were referring to—1.3 billion unallocated capital. So in the negotiations on CSR I look for every penny I can get and then at the last knockings I managed to get £1.3 billion on capital for 2010–11. We did not know where on earth we were going to spend it for but seemed like a good idea at the time; I am a trade union leader, that is what I do! When the Treasury came and said, “That money in 2010–11 is unallocated; we are in serious economic difficulties here, we would very much like to take it back”—I wish they had said it that way, but it was not quite said that way—we would have like to have kept it but it was totally unallocated; and I think the 2007–08—and I am sorry I am not completely *au fait* with that is in the same category. It is not the surplus that is out there with the Trusts that they have built up.

Q26 Dr Taylor: Can we be sure that other departments are being as generous to the Treasury as you are?

Alan Johnson: I think you can rest assured that this is a government initiative.

Q27 Dr Taylor: Foundation Trusts’ cash surpluses, can you give us an idea of the latest estimate of Foundation Trusts’ cash surpluses?

Alan Johnson: From memory the quarter two figure was about £300 million—quarter two in 2008–09.

Mr Nicholson: £303 million.

Alan Johnson: £303 million.

Q28 Dr Taylor: Do you know if they have plans to spend these, to use these in the next couple of years or so?

Alan Johnson: It is a matter for the Foundation Trusts. I do know that they are putting aside a lot of money to implement Darzi, the outcome of the next stage review.

Q29 Dr Taylor: So you really are keeping out of what they are doing and letting them have a free hand?

Alan Johnson: Interfere? Moi! Certainly not.

Dr Taylor: Very good; excellent.

Q30 Sandra Gidley: Moving on to consultancy costs. I had to wonder when you were talking so proudly about the Gershon whether the decrease in staff had been mirrored by an increase in consultancy costs but there may be a different reason for the high use of them. The National Audit Office estimated that the NHS spent £0.6 billion on consultancy services in 2005–06, and that is about a fifth of the public sector consultancy spend for that year. They also estimated that a third of the increase in public sector consultancy expenditure between 2003–04 and 2005–06 was largely due to what was being spent in the NHS. Actually Mr Nicholson was before us in December and said that the Department had never had never tried to keep track of how much the NHS is spending on consultancy services. Why not?

Alan Johnson: The Audit Commission keep a very careful eye on this, but I think Hugh is probably the best person to answer this.

Mr Nicholson: I am happy to say again why we did not do it. From the centre we desperately try not to micromanage what the NHS does and consultancy can be literally from a very small amount of money to help a particular part of an organisation get better, whether it is environmental health or all sorts of things for which we use consultancy, right the way through to using the big firms. We believe that with the responsibility of individual boards to make sure that they get value for money, with the responsibility of the Audit Commission to monitor this and to make sure that through their scoring systems they have every year that they make sure that the individual organisation is getting value for money. We think that is a better way of doing it than of collecting pennies from every single organisation in the country to bring up to a complete national whole.

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Q31 Sandra Gidley: But a huge proportion of this is in the Department itself, so you are telling me that with modern computer systems there is not a budget line?

Mr Nicholson: Centralising organisations all over the world start off by collecting detailed information in this way and then they start to use it to micromanage organisations; we do not think that is the right thing to do. There is absolutely no doubt that significant amounts of money are being spent across the NHS and we need to make sure that we are getting value for money. I will give you three examples where, both in the Department and the NHS, we have spent significant amounts of money in the past. We have spent significant amounts of consultancy money in Connecting for Health, in the Commercial Directorate and in the turnaround teams. All three of those have a substantial amount of consultancy. Particularly in Connecting for Health and in the Commercial Directorate at the time we were developing these things there simply were not the people out there for us to recruit, so it was not an issue that we could get a lot of people to do these really very complicated technical things, so we had to use consultancy significantly. Now, of course, the circumstances have changed dramatically and we have a programme both in terms of the Commercial Directorate and in Connecting for Health to significantly reduce the amount of consultancy we use across the board, and you will see that come down significantly over the next six months or so. In terms of the turnaround we spent in excess of £50 million on the turnaround, and I have to say that turnaround moved us from half a billion deficit to one and a half billion surplus, but, nevertheless, we spent significant amounts. What we discovered from that, of course, when we looked at it, that that is what the consultancies were saying to us, or what we found was that there virtually none of the schemes that came up around getting ourselves back into financial balance came out of the brains of the consultants—most of the ideas came out of the NHS itself. What the consultancies gave us was the ability to execute some of these much better, and what we did in response to that was to set up a thing called IMAS, which you may or may not have come across, which is an internal consultancy. So we have developed an internal consultancy where we use our own people across the NHS now to do this kind of work and they are currently working in 23 organisations. So we are looking at the way in which we use consultancy across the board and we do think we could reduce it and get better value for money at the centre, and those are the three areas I would identify.

Q32 Sandra Gidley: Connecting for Health is probably not the best example to use for money well spent.

Mr Nicholson: It is a very good example to use for money well spent; it is probably one of the best managed, in financial terms, computer systems that the government has ever had.

Q33 Sandra Gidley: It is shame we are not seeing much of it in the NHS but there are some separate questions about that later, so I will not steal somebody else's thunder. In December 2006 my understanding is that the Treasury issued guidance for the Spring 2007 departmental reports, placing a requirement on departments to include information on consultancy spending. So I assume the information is now collected—

Mr Nicholson: We do in the Department.

Q34 Sandra Gidley: How difficult can it be to add it up?

Mr Nicholson: We do in the Department.

Q35 Sandra Gidley: You do it in the Department?

Mr Taylor: We do collect spend for the Department, yes. It depends where the spend occurs. If the money is spent in the Department, either on programmes or on admin then the expenditure is monitored and we publish the spend figures. As David was saying, one of the things we are trying to do is wherever we can we want to reduce the spend on consultancy not least because we want to get value; and where we have had to use consultancy for skill substitution and so on, what we will then look to do is to see if we can then follow that through by building in expertise inside the Department.

Q36 Sandra Gidley: You have just made a very interesting comment. You said “we want to reduce the use of consultancy because we want to get value”. So does this not mean that there should be some sort of external peer review of consultants' reports or some way of ensuring that the taxpayer is getting value for money?

Mr Taylor: As far as the NHS is concerned, of course, the Audit Commission is there to look at the way that NHS organisations spend their money and in the Department we have our own internal function that certainly looks at use of consultancy within the Department and we are obviously subject to NAO review. And we have our own internal protocols to ensure that if a consultancy contract is let it is let with strict adherence to procurement rules, and we do look to try and evaluate internally within our finance and other directorates whether we are getting good use of the money we are paying to consultancy organisations. But this is, as David said, a very broad range of organisations that are classified as consultancy for this purpose. So that would range from using the Big Four; for example, we use Ernst & Young; we have had a consultancy contract with Ernst & Young to support our internal audit function within the Department. That was because we felt we had a skill deficit in that area so we purchased some expertise from Ernst & Young and we have been gradually reducing the cost of that contract with Ernst & Young to us as we have built up our own internal audit function. That is characteristic of the way we do this. On the other hand, for example, for the NHS investing in a new scheme for accrediting educational supervisors. We have brought in an expert external body—one of the NHS Academies effectively—to support us in doing

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that work because we do not have the expertise internally. That would classify as consultancy costs on our spend but it is not quite what people imagine when they think consultancy because they tend to think of the big firms. We would at any one time have a range of consultants working for us from really quite small firms, some highly specialised people in areas such as education and training and then we do have recourse to the Big Four from time to time when we think we need them.

Q37 Sandra Gidley: So the firms you are currently employing, that is Ernst & Young—

Mr Taylor: I can let you have a list but we have a range of consultants. We use the Big Four a bit but then we have sometimes really quite small consultancy organisations doing very niche pieces of work.

Q38 Sandra Gidley: So with the Big Four, what is the daily rate of a senior partner?

Mr Taylor: It would be a six-figure.

Q39 Sandra Gidley: A six-figure daily rate?

Mr Taylor: Typically. But just bear in mind—

Q40 Sandra Gidley: Six-figure?

Mr Taylor: No! Four—thousands! Probably from £1000 up.

Alan Johnson: You see, it has come down in the last couple of minutes—you have seen the savings we are making!

Mr Taylor: One of the advantages of people like me working in the Department of Health is that you work in billions mainly! Seriously, the point is that the daily rate would be from £1000 up from a senior partner but it differs between organisations. Of course, in any one contract you may or may not purchase senior partner time; you would not purchase very much of it.

Q41 Sandra Gidley: So how much would a junior consultant be paid?

Mr Taylor: It would depend on the firm but it could be £400 to £500 a day.

Q42 Sandra Gidley: We have estimates of £700 a day and given that their salaries are only about £30,000 a year it seems like somebody is milking somebody; would you like to comment on that?

Mr Taylor: When you let a contract you have to look at the total value of the contract, so the daily rates which are given by firms are indicative and then it is a matter of negotiating the total value of the contract, and that is a negotiation. There will be a procurement and you have to negotiate the total value of the contract. So the daily rate is an indicative figure; it may not reflect the actual rate which you then pay for an individual, and it will vary across all these contracts.

Q43 Sandra Gidley: I think we are going to find out of work bankers working in consultancy; it seems to be the only place where they can earn the same sort of money. Last question: is it true that the

Department has recently hired a consultancy firm to find an additional £2 billion in efficiency savings by the end of 2010–11?

Alan Johnson: No.

Mr Taylor: No.

Sandra Gidley: That was a simple one.

Q44 Mr Scott: Before moving on to IT can I just ask are the mechanisms now in place to make sure that somebody who has been an employee of the National Health Service and perhaps received a six-figure sum—not for the day but for a longer period of time—as a pay-off can no longer then come back as a consultant who has actually lost their job or resigned because of failure. Is there a mechanism in place now to stop that happening?

Alan Johnson: No, there is not a mechanism in place to stop it happening; it depends on the Trust and who they are employing and what kind of consultancy work is going on there. I am just as concerned with your major point, which is that people do not get paid for failure. I am not looking to persecute them for the rest of their lives but what they can go and do and what they can present to be a good case to be a consultant to an NHS Trust, I am not going to have a police force out there spending money looking at all that. So there are no strict rules out there. I expect a bit of commonsense.

Q45 Mr Scott: Secretary of State, are you confident that we will have a usable Electronic Patient Record, both the Summary Care Record and the Detailed Care Record, by 2014–15?

Alan Johnson: I am confident that it is deliverable.

Q46 Mr Scott: Is that yes or no!

Alan Johnson: There have been issues with that contract but it might be good to clarify them because there is so much utter drivel talked about this such as we underestimated the cost of the contract. No, we did not, in 2006 we estimated that it would cost £12.4 billion and the latest estimate is that it will cost £12.7 billion. That is the kind of margin that anyone would expect and in fact is much lower than most people would expect; so we did not underestimate the cost. We have spent billions of taxpayers' money on this; we have wasted billions of taxpayers' money. No, we have not; we have spent £3.2 billion. Part of the problem is that we have not spent enough money. As David was alluding to, I challenge you to find a more robust contract anywhere in the public sector or the private sector because it is the deliverer of this service that has to pay for any delays and our problem has been not an overestimate of the cost, not wasting billions of pounds of taxpayers' money; our problem has been the delay in getting this in place. It is a huge programme; it is, to semi-answer a point that was not made earlier, delivering huge benefits to the NHS. We were talking about this the other week, that no Health Service has had this level of ambition or this prospect for what it can do for health services. Most health services set up a computer system to get people to pay into the system, to get the insurance money in—that is where they set up their systems. We are putting this purely

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aimed at improving patient care and it is going to have a really exciting effect, and I hope that is by 2014–15. I certainly have no reason to think that that figure should be changed or it is undeliverable. I think it is eminently doable.

Q47 Sandra Gidley: I am sorry, Mr Nicholson, to keep reminding you of things that you said in December when you were before us, but then you said, referring to the National Programme for IT: “If we do not make progress relatively soon on this I think we are going to have to rethink it through.”

Mr Nicholson: Yes.

Q48 Sandra Gidley: And in January the Public Accounts Committee said: “If there is no improvement to this situation in six months, then the Department should consider allowing Trusts to apply for funding for alternative systems.” Are you now ready to go back to the drawing board or do you have a plan B?

Mr Nicholson: I do not think there is any need to go back to the drawing board. We are at a particularly important time in the development of the programme. One of the issues we have been dealing with all along is that there is nowhere else in the world that quite does things in the way that we do, and this idea of looking after patients across the whole system and connecting all your organisations up together in that way, there is nowhere else that does it quite like this. So there was no system off the shelf that we could get. There are some organisations that have literally been scouring the world looking for them and they have not found them. The two that are most likely are Cerner and Lorenzo. Both of those are at a particularly delicate stage in their development. You may, I am sure, be aware of the issues around the development of the Cerner Millennium product at the Royal Free and the difficulties that we have had there. It looks now as if we have got over that and we really do have a product that then can be rolled out across London. The Lorenzo product is currently being developed in Morecombe Bay; so we are really optimistic that something will come out of that, but it is not inevitable. I think we will know over the next few months whether these products will actually be able to deliver the things that they promised to do. So it is a particularly important time for the development of the service, but the potential is absolutely enormous. The issue that we have also been dealing with is how do you get to a situation where we can deploy these more quickly? That is obviously something we are thinking about quite carefully: how can we give individual organisations a bit more flexibility about what kind of product they take and when they take it, and that is certainly part of our considerations at the moment. I think we will know in the next period whether Cerner and Lorenzo will deliver a fantastic produce for us and we are pretty confident that it will.

Q49 Sandra Gidley: So if one fails will you go with the system that works throughout the NHS?

Mr Nicholson: There is that possibility. What we are also doing in parallel to all of this is going out again to tender to a variety of other organisations to see whether now there are other organisations who could also provide this service. It is always helpful, I think, for us to have reserves if one of them fails.

Q50 Sandra Gidley: But would they not be starting from scratch again with all the consequent problems?

Mr Nicholson: There is that issue but since we went out to tender originally of course technology has moved on significantly as well and some organisations who felt that they did not want to be engaged in the programme might want to be engaged in the future so we are keeping our options opened as far as that is concerned.

Q51 Dr Taylor: On the same thing, the Summary Care Record has such potential and is so absolutely crucial, is there any way of decoupling it and getting it out earlier than the rest? In Canada we saw a superb Summary Care Record, a single screen that gave you everything that you needed to know in the middle of the night in an A & E Department. Are we trying to make the Summary Care Record much too complicated? We visited the department and saw people adding this, that and the other to it, and all that is wanted is a summary—one sheet. Is there any way of decoupling and getting that out quickly?

Mr Nicholson: It is perfectly possible to do that. We have piloted in Bolton in the Northwest, as you know, and we need to handle this very carefully because there are all sorts of issues about patient confidentiality wrapped up in all of this that you will know very well. We are looking at a programme of rollout of the Summary Care Record across a whole series of other PCTs after April and if we can do that properly I think there is a rapid rollout that we could do with the Summary Care Record.

Q52 Dr Taylor: So long before 2014–15 for the Summary?

Mr Nicholson: Yes.

Q53 Dr Taylor: Brilliant; thank you.

Alan Johnson: Chairman, before you move on. Richard has pointed out one of the huge benefits of this, the Summary Care Record, but can I just mention the picture archiving and communications, which is up and running successfully.

Dr Taylor: We know about that.

Q54 Sandra Gidley: That was not part of the original spec though, was it?

Alan Johnson: It is part of the computerisation.

Q55 Sandra Gidley: It was not part of the original vision; it is the only thing that has worked and it was not part of the original vision.

Alan Johnson: It is not the only thing that has worked; Choose and Book has worked as well.

Q56 Sandra Gidley: It has gone down in my area, with GPs getting so fed up with it.

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Alan Johnson: I merely draw attention to something that is revolutionary.

Sandra Gidley: But not part of the original spec.

Q57 Chairman: We have seen that, Secretary of State, in situ and it is working but I think Sandra is right to say it was not in the original plans, but it just shows you what IT has to offer the National Health Service

Mr Nicholson: It is part of the national programme for IT; it is part of the 12 billion.

Q58 Sandra Gidley: It is now.

Mr Nicholson: You would not expect us to set up a programme four years ago and not change it.

Chairman: You can read our report on this Electronic Patient Record that puts all this into perspective, but let us move on. We are going to move on to the Operating Framework now, which you are here to give evidence on this morning.

Q59 Dr Naysmith: How do the recommendations from Lord Darzi's Review fit in with the Operating Framework for 2009–10?

Alan Johnson: It is intertwined in the Operating Framework; the Operating Framework's priorities are the priorities that Darzi saw—safety, quality, patient involvement. The five priorities that were in the Operating Framework this year, the same priorities as last year, reflect all of that; so it is integral, I would say.

Q60 Dr Naysmith: The Operating Framework contains additional national priorities for local delivery and there are still more than 400 National Health Service quality targets defined centrally. So how can the Department claim that the NHS is moving into a new era of devolution, devolving things out to the regions?

Alan Johnson: There are not 400 central quality targets—there are 400 holes in Blackburn, Lancashire, I think the Beatles said. I think you are getting two things mixed up.

Q61 Dr Naysmith: Are there 400 quality targets or not?

Alan Johnson: No, no. What we are doing is consulting on quality indicators. So to get quality right and for people to be able to measure it properly, lots of clinicians have been working as part of the Darzi Review to say what are the best indicators to use and we are out there consulting at the moment on 400 of those that clinicians have drawn up to say which are the best ones to use. They are not quality targets from the centre.

Q62 Dr Naysmith: They are indicators rather than quality targets.

Alan Johnson: It is a consultation on quality indicators.

Q63 Dr Naysmith: So these two approaches in your view intertwine perfectly and they are not in any sort of competition or conflict?

Alan Johnson: That is absolutely right, and of course the big part of Darzi was the Strategic Health Authorities' visions for their local regions and that is all being reflected in what they are doing in implementing the Operating Framework as well.

Q64 Dr Naysmith: One of the areas that is coming up when people are asked about the National Health Service into the future is dementia care and the integration of local authorities, social services and National Health Service dementia care and it is moving rapidly up the agenda. How is that treated in these two different documents?

Alan Johnson: The Darzi Review with its focus on quality, its focus on safety, its focus on ensuring that we listen to patients and that it is the patient experience that governs what we do is a large part of the dementia strategy, of course. We published the dementia strategy four weeks ago. The Alzheimer's Society, all of the charities that helped us with that were extremely welcoming. We have the money behind it to implement the projects. As you rightly say, it means the integration with adult social care; it means having memory clinics in every town. The things that are happening—I saw it in Middlesbrough the other week—the best practice spread everywhere, and there is absolutely no difference or tension between the Operating Framework and Darzi.

Q65 Dr Naysmith: Getting the most from limited funding is especially important in the current situation as we were talking about earlier on, so why is improvement of financial management not a "must do", ie a Tier 1 target in the Operating Framework, and only mentioned in very subordinate and vague terms in Lord Darzi's recommendations?

Alan Johnson: First of all on the Darzi Review, you have to look at what Darzi was focused on. This was all about improving care in the NHS and they are very clearly portrayed. We have been through the stage of putting in the extra investment and the resources; we have been through the consistent reform like payment by results. We are putting aside all the structural changes now for the foreseeable future. How do we get everyone engaged in improving patient care? So, yes, Darzi was not focused on financial management, there have been other ways to do that and it would have been less effective if he had tried to do it. The benefit of having a clinician working with other clinicians is to look at patient care remorselessly.

Q66 Dr Naysmith: We are talking about the Operating Framework as well.

Alan Johnson: I know, but you mentioned it was not part of Darzi. On the Operating Framework, I would say it is a Tier 1 principle in the Operating Framework, good financial management. It will not be in Tier 1 because Tier 1, Tier 2, Tier 3 you separate out the actual issues there, but overriding it all is financial management; it is an absolute number one priority. We were talking earlier about PCTs moving from deficit to surplus and we never want to go back

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to those days again. So it is central to everything the Operating Framework is around—it is just one message. It does not have to be broken down into tiers—good financial management is an absolute priority.

Mr Nicholson: Financial balance for PCTs is a national requirement.

Q67 Dr Naysmith: And how do you police that?

Mr Nicholson: Very vigorously.

Q68 Dr Naysmith: Vigorously. Is that through Strategic Health Authorities?

Mr Nicholson: Yes.

Q69 Dr Naysmith: There have been improvements in Strategic Health Authorities but there have been very severe failures in areas of Strategic Health Authorities scrutinising budgets in the past.

Mr Nicholson: I agree but this year we have an absolutely tiny number of organisations across the NHS who are not in financial surplus or balance. The Audit Commission has said that we have significantly improved our ability to manage the financing of the NHS and it continues to be a national absolute priority.

Q70 Dr Stoate: Lord Darzi told us that there is going to be a new scheme called Commissioning for Quality and Innovation, or CQUIN, involving financial incentives to improve quality. How is that going to work?

Alan Johnson: Basically because a proportion of the provider income will depend on it, about 0.5%. So there is actually a financial imperative here. This is really difficult stuff—you will appreciate this more than anyone—because when I go around and talk about what was in the Darzi Review, clinical dashboards, quality accounts, this issue of CQUIN—it sounds more like *Strictly Come Dancing!*—it is not the sort of issue that sets the blood pulsing through your veins amongst your average punter at a political meeting. But it is crucial to everything that Darzi was talking about. It is all right saying, “We are going to make quality the organising principle of the NHS”; it is all right saying, “We are going to put everything around quality” but how do you actually do it? The way you do it is these kind of esoteric mechanics, the metrics of all this. So it is a very important step forward, innovation being a part of it. So every local area—we are not going to dictate this from the centre—will have to have their plan, part of which they will have to have one element of these four bits of quality, which is effectiveness, safety, patient experience and innovation. It is really crucial that we are focusing more on innovation in everything we do. So once of those elements will have to be in their plan and their plan will be judged and a proportion of the money for providers will be judged on how well they work against it. That is what those quality measures, the 400, were about how we actually put all this together to make it work.

Q71 Dr Stoate: I entirely agree it is a great thing to do, but what is the logic in that case in making it local determination; is there not just a risk that that Trust will concentrate on what they are already good at, tick the boxes and effectively get paid for what they are already doing?

Alan Johnson: No, I do not think so. It is 0.5% dependent on this and they would have to come up with one element from all of those four bits. The alternative to doing it locally is for us to dictate it centrally and that would be a ridiculous reversal of what we have been trying to do and I know you want to do, of having a Health Service that is locally led and clinically driven. So we are going to have to make this work. Yes, there will be a few dangers in it but I do not think they are anything like the dangers of trying to make it a centrally driven project.

Q72 Dr Stoate: You made QOF centrally driven and actually that has been, arguably, one of the great successes of the new GP contract and that is nationally negotiated, most GPs are on side for it and it is transparent and comparable across different areas of the country. So why have you not gone down the same route?

Alan Johnson: There will be people who would not take the same view. I am pleased you have said what you said Howard, but that would not be a universal view. Do not forget that Darzi was all about how we focus on patient care, make the NHS clinically led and locally driven—I got it the other way around! So locally driven means that you give them the metrics there; you have the system to appraise it, you have the system to see how it is going and they have their goals to reach, etcetera, and then you give them the ability and the freedom to actually get on with it. David?

Mr Nicholson: I think we are only at the beginning of this and, to be fair, the whole issue about CQUIN came from the Service itself rather than the pointy heads in Richmond House. The Service was saying, “If you are really serious about this put some money behind these things.” If you look around all the places in the world that have done this—and the United States is the place where they do it most—first of all they say that there is a limit to the impact you can have, so no more than 3% or 4% or a budget of any organisation, if you get bigger than that it becomes very difficult; the behaviours become opposite to what you want. And the first thing you need to do is to pay for really good information, and that is essentially the focus of the first year. Most of the payments are related to providing information, really good data. Then after that, of course, the Commissioners can then start to say how they want that data to improve, how they want particular conditions to improve. We are driving it locally, that is absolutely right, we think that is the right thing to do, but there is the possibility at some stage in the future, if we felt it was appropriate, to have a national element to it; if there was a particular condition or a particular service that we were particularly concerned about we could do it. But we are starting locally and building it up to build confidence and understanding in it.

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Q73 Dr Stoate: I want to finish with the rather murky area of Clinical Excellence Awards which basically nobody really seems to understand inside or outside the Health Service. Why do you not simply tie Clinical Excellence Awards to CQUIN and say to consultants, “If you hit your CQUIN targets you get your Clinical Excellence Award because that is transparent and it is easily measurable”?

Alan Johnson: You might be right about few people understanding it but all I know is that there is a great appetite out there for them. I was being urged on Friday by clinicians in my local patch, “When are we going to get these Clinical Excellence Awards?”

Q74 Dr Stoate: Surprise, surprise! It is called cash money; of course there is an incentive for it. But what I want to do is to tie it to outcomes.

Alan Johnson: You are a cynic, Dr Stoate! Can we tie it in with CQUIN?

Mr Nicholson: We could tie it in with CQUIN and what we have said is that as another part of the next stage review we are currently setting up a National Quality Board, which brings together experts in the field, lay people, the regulators and the Department together in a sense to drive quality from the centre, and one of the issues that we are dealing with is how we link Clinical Excellence Awards to the overall development of the policy around quality. CQUIN could be one example and there could be all sorts of other ways we might connect them together, but to do it in a transparent way is very important.

Q75 Mr Bone: Just for Mr Nicholson there. I was very interested to hear you to say, “We are going to devolve it down to local decision-making; we are going to get quality improved that way. And, by the way, if they do not do it we will take it back under central control,” which was the second bit. It does not seem that the idea of the commitment to devolving is really there in that statement or was that a slip of the tongue.

Mr Nicholson: I do not think my tongue slipped at all. What I was saying is that there is always the possibility, if we need it, for a national push on something.

Q76 Mr Bone: I think that is my point, is it not?

Mr Nicholson: For example, if we thought that dementia was a particular national priority that for a whole variety of reasons had fallen back then we might want to think about it. I am not saying we would do it, but they are the sorts of things.

Q77 Mr Bone: I was not talking about specifics, Chairman; I am just saying that you cannot have the commitment to devolving and then saying, “By the way, we might want to do it nationally.” I am not saying that one is right or wrong but you cannot have the commitment to devolve if you are saying, “By the way, if we do not get what we seek we are going to go back to national targets.”

Alan Johnson: No, you misunderstood. The point that Howard was making was about QOF and QOF has been very successful and it is centrally driven,

why not have an element of that in CQUIN. What David was saying in response is that this is a very new area to build up CQUINs and we want it to be locally determined but there is the opportunity there to have an element of it, if we decide it is best to do nationally—and it would be a consensus, everyone would say, “That one is best to be done nationally”, once we have got this underway—but it would not be taking the whole thing and making it national. You can have one element of it. Just as QOF is lots of different elements you can have an element of CQUIN that would be national; that is a long way from saying that one minute we are devolving and the next minute we are centralising.

Q78 Dr Taylor: Can we come on to PROMs and can I welcome them because it has long been known that to know how the Health Service is doing you just have to ask the patients. I think it is one of our experts who reminds us that Florence Nightingale had three questions—relieved, unrelieved or dead. So it has taken us 150 years to come to actually ask the patients what the quality is like. My specific is: are PROMs going to be linked to CQUIN and how will they be linked to CQUIN?

Alan Johnson: Yes, is the answer, they will be linked to CQUIN because it is one of the elements—quality measured by effectiveness, safety, patient experience, the patient experience bit being crucial, although with PROMs of course we are measuring the actual outcomes. There is a different bit of work going on about how you can actually gauge and measure those things like compassion, the things that nurses have been saying for a long time—“A lot of what we do is not measured”—and we are looking at how we can do that. PROMs will be the absolute basic experience. Your hip operation, how did it work? Has it been successful clinically? As well as the other bits of the patient experience. So it will be a crucial element in CQUIN.

Q79 Dr Taylor: Is there any estimate of the costs of PROMs?

Alan Johnson: There is an estimate of about £70 million, £75 million; that is the cost of actually putting out the questionnaire—one questionnaire before the operation, another questionnaire afterwards—actually assimilating the data. So around about £75.

Q80 Dr Taylor: We believe there is a plan to put PROMs on the NHS Choices website. Is that so and roughly when do you think that might happen?

Mr Nicholson: We are not rolling it out until April so we need to get some data in the bank.

Q81 Dr Taylor: Before you can pull it off.

Mr Nicholson: We need to get all of that settled before we can make the results of that public.

Alan Johnson: Sorry, Richard, can I correct that? I misread it—it is £7.5 million!

Dr Taylor: Thank you very much, that is much better!

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Q82 Dr Naysmith: Are you confident that the PROMs deadline will be met in April?

Alan Johnson: Yes.

Q83 Dr Naysmith: And it will be of usable quality by April?

Mr Nicholson: We think so.

Q84 Dr Naysmith: We were told that from April PROMs will apply to treatment of hips, knees, hernias and varicose veins. Is there an intention to extend it to any other condition?

Mr Nicholson: I am sure we will but in the past we have been, I think, sometimes unfairly and sometimes fairly criticised for rolling things out before we have worked out whether they actually work or not. This is such an important issue that we want to take our time with it to get it as absolutely right as we can. There is a whole series of other conditions that they could apply to, but we want to get these right first.

Q85 Dr Naysmith: Do we have any other frontrunners on any others?

Mr Nicholson: I think there is a whole series that we are talking about; I would not like to say who the frontrunners were at the moment.

Q86 Dr Naysmith: How soon after being treated will the patient actually be asked how much better they feel? This is probably quite an important point because if someone has just come out of hospital they might be so glad to be out of hospital that they say they feel really great and then six weeks' later, if they have had a hip operation, they might say, "It is not that much better than it was when I went in." So it is really quite an important question.

Alan Johnson: It is six months for hip and knee replacements; three months for hernia and varicose veins. So it is linked in with the time when a patient can be expected to have a proper view of what the outcome has been.

Q87 Chairman: When you publish what is the potential to being reported or potentially misreported in the local media it could have some serious consequences for hospitals, could it not?

Mr Nicholson: This is important information that we think patients should have. You are absolutely right. Our experience of these things is that once you start publishing information you get a lot of excitement to begin with, but over time people understand it better. We certainly do not want to keep this a secret from the patients; patients really do need to see it and people will want to make choices on the basis of what they see and I think that is perfectly reasonable and perfectly right.

Q88 Stephen Hesford: Something slightly different—day case surgery. We are told that the day case surgery rates between Trusts and within specialities vary. How are you addressing this?

Mr Nicholson: There is a whole range of ways in which we address it, but I would say that in lots of ways the kind of inpatient day case controversy, if

you like, or discussion is really slightly yesterday's conversation. The real issue now I think is day case to outpatient procedure, which is where the real drive for change is going. But on the first one obviously we produced the Better Care Better Value information, so people can benchmark themselves against it. We are considering whether that benchmarking should be as part of the quality account that an individual organisational system might want to use. So we have transparency about all of that and we would expect boards to take notes of that. We are publishing the information on the Choices website, so patients can see whether a particular organisation that they choose do conditions on a day case or inpatient basis, and we think they are the kinds of things that are much more likely to get the results that we need. In terms of the day cases to outpatient procedure is the real important and cutting edge in this. We have organised the pricing system in such that a hospital gets paid the same amount whether it is done on a day case basis or outpatient procedure basis, and we think that will give a financial incentive to drive organisations to provide better services closer to the patient and outpatient procedures.

Q89 Stephen Hesford: So if somebody, man or woman on the Clapham omnibus is just listening to this and they said that there was an element of complacency in the way that you first started to answer me, would they be right, would they be wrong?

Mr Nicholson: There have been massive improvements in day case rates over the last few years and continue to do so because generally speaking the kinds of conditions that are suitable for day cases provide better services for patients and safer services for patients. I think there has been significant improvement.

Q90 Dr Stoate: The NHS is fairly laboured down with acronyms and jargons and we have already quite a few this morning, but I have found a new one, "normative pricing"; what on earth is that?

Alan Johnson: Let me have a stab at it. It is basing pricing on standards rather than basing prices on what they used to be in the past. This is another Darzi point.

Q91 Dr Stoate: How about difference in the tariff? What is the tariff and what is it to do with normative pricing?

Mr Nicholson: If you take the tariff for a cataract the tariff price is the reference cost, which is virtually the average of what a cataract costs across the whole country and we recalculate it every year. So as the unit price goes down the average goes down. So currently the tariff is an average. What normative pricing says is that average may not be the right circumstances; average may not be right. What we need to do is look at from the bottom up what are the actual costs of providing best practice service for cataracts, and then when you have worked that out

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you can calculate what a tariff is based on what your best practice is. So it is moving away from an average into what best practice is and a reflection of that.

Q92 Dr Stoate: I thought the tariff was originally calculated on roughly what it costs for a hospital to provide a similar standard of service across the country.

Mr Nicholson: It is an average. For example, on cataracts the vast majority of cataracts are on a day case basis at the moment, but there are still some hospitals where they do them on an inpatient basis. The average cost for a cataract will have all of those costs in.

Q93 Dr Stoate: So what practical differences will be there for a hospital either to go for the tariff or the normative price? What is the difference?

Mr Nicholson: I do not think we will give hospitals a choice as to whether they go for one or the other; we will decide in which conditions we think that normative pricing would work.

Q94 Dr Stoate: But how do you get round the fact then that some Trusts are going to be faced with a more expensive case mix, or some local circumstances which effectively mean that they will not be able to do it at the normative price?

Mr Nicholson: You mean they will not be able to do best practice?

Q95 Dr Stoate: They might be able to do best practice but it might cost them more to do best practice?

Mr Nicholson: Then they will have to reduce their costs then, will they not?

Q96 Dr Stoate: I am still not happy with that because, for example, if a hospital is taking a complex mix of patients due to their demographic position it is not about best practice. They might be offering best practice but best practice might cost more in their area.

Mr Nicholson: But the case mix would be reflected in the normative pricing, would it not? You would not do a best practice calculation of a particular condition and then apply it to more complex cases, would you?

Q97 Dr Stoate: I do not know, that is what I am asking you.

Mr Nicholson: It may be that more complex conditions are where you do use normative pricing, where the tariff at the moment of averages does not work. I think it has the opposite effect; I think it is a benefit.

Q98 Dr Stoate: You are quite happy then for a hospital to come back to you and say that “The normative price does not work in Margate, I want a different one”?

Mr Nicholson: No. We will expect them to deliver on the national tariff.

Alan Johnson: What Darzi said is that there should be a best practice tariff. We are looking to increase quality; we should be looking at who does the best work, what the best practice is. I doubt it was Darzi who said that, it was all the clinicians who were engaged in this big debate. We are going to introduce this from 2010–11 in some specific areas and I think cataracts will be one of them and stroke will probably be another one, and some other areas, to see whether we can make this more than just an idea in the Darzi Report and actually put this into practice. But it is all about improving quality and, yes, there will be elements, Howard—and they are very important elements—that we will have to take into account, but the principle of it I think had a wide buy-in; that instead of the average let us look at what the best practice tariff should be not the average tariff.

Q99 Sandra Gidley: Before we move on I just wanted to pick up on Howard’s point because I do not think his question was answered. My local hospital is Southampton, which is a tertiary centre, and certainly they have raised with me in the past the idea that they have all the difficult cases which are inevitably a little bit more expensive to treat. So what I am not clear about is how they will be treated fairly under this because I am sure they are best practice but inevitably the case mix they have is more complex and would inevitably, I would have thought, be more expensive.

Mr Nicholson: I am sorry; I am obviously not explaining this very well. The first thing is that they should be in better circumstances now since the implementation of HRG4 because, as you probably know, in HRG3—

Q100 Sandra Gidley: We are coming on to HRG4 in a minute.

Mr Nicholson: I will not go into that.

Alan Johnson: That is something to look forward to!

Mr Nicholson: Normative pricing should be able to take account of complexity.

Q101 Sandra Gidley: It should?

Mr Nicholson: It absolutely should be able to; that is precisely what is there to do. It is not an average; it looks at a particular condition with a particular complexity and says what the best practice is and then builds up from the bottom up what the cost of that will be.

Q102 Sandra Gidley: So could you then end up with having a number of different prices for hip replacement?

Mr Nicholson: Depending on the complexity. You have now—you have not got different prices because they are all put together in the same HRG but you can have different kinds of hip replacements, that is absolutely true.

Q103 Sandra Gidley: So tertiary centres need not worry that they will be subsidising the more complex procedures?

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Mr Nicholson: Not through normative pricing; that will not affect them at all, in fact it will benefit them.

Q104 Sandra Gidley: So they will be doing it through some other means?

Mr Nicholson: No, they will always complain, it is the nature of these organisations to complain. But as we get the—

Q105 Sandra Gidley: Sometimes justifiably.

Mr Nicholson: Yes, occasionally, that is absolutely true; and we do respond and in fact HRG4 was a response to that because HRG4 is a much more granular way of dealing with pricing.

Q106 Sandra Gidley: Granular—what does that mean in English?

Mr Nicholson: I thought it was good English. For example—

Q107 Sandra Gidley: Not the English that your man in the Dog and Duck can understand.

Alan Johnson: You are not the man in the Dog and Duck!

Q108 Sandra Gidley: No, we are a Health Select Committee, it is not that different!

Mr Nicholson: If you take the HRG3 point, whatever it was—I cannot remember what it was—there were over 600 different groupings, so everything that happened in a hospital went to the one of 600 groupings and we had a price for each of them. HRG4 there are 1400 groupings, so your ability to distinguish between different conditions now is much greater than it was under the old regime.

Q109 Sandra Gidley: So it is more precise?

Mr Nicholson: It is more precise.

Q110 Sandra Gidley: I think that is a much better word than granular actually.

Mr Nicholson: I am sorry; I will never use it again!

Q111 Sandra Gidley: The question was going to be why are you introducing the HRG4. Clearly it provides a much more precise system. What difference do you think it will make?

Mr Nicholson: We have had huge amounts of clinical buy-in to this particular process. We have had 30 different subgroups of clinicians—we have had over 300 clinicians working with us to get a better, more clinically relevant grouping. So that is the first thing, it should have and has more clinical buy-in. Secondly, it enables us to be more precise in our pricing arrangements—it makes it much more transparent. What we think is that the conclusion of that will be that it will be fairer for organisations, which will better reflect the case mixing complexity of the services that they currently provide.

Q112 Sandra Gidley: But will it lead to more code switching? How is it going to be monitored so that hospitals and Trusts always use the right code for the right operation and do not sneak something up into the next category?

Mr Nicholson: In anywhere in the world where these kinds of coding systems are implemented there is always something that is described as code drift. Some of that is positive because it is better coding and part of the problem we have in the country actually is that some of our coding is not as good as it should be; so it is better coding and more directly related to the financial benefits of the organisation. So it seems to me that that is a good thing. The way in which we do this of course is through the Healthcare Commission and their arrangements for their assessments; they look at coding in individual organisations. And the Audit Commission expects every organisation to have a way of auditing their coding, and as part of the report that was done into the future of PBR we expect PCTs to have access to the auditing and coding in individual organisations as well.

Q113 Sandra Gidley: That is good. Have you done any assessment as to which Trusts will gain and which will lose from the new tariff? Is there a league table?

Alan Johnson: No.

Q114 Sandra Gidley: You have not, so you do not know how that will pan out in the end?

Alan Johnson: No because the only way we could do that would be by using historical data.

Q115 Sandra Gidley: Obviously any change creates a period of instability. How is the Department planning to manage that, particularly given the late publication of the new Payment by Results tariff?

Alan Johnson: We are being careful about this. We are not introducing the new, more sophisticated tariff in A & E because it is not robust enough yet. We are putting a cap on the market forces factor—it cannot go more than plus or minus 2%, just to see how this settles down. There are some safety measures in there, so I do not accept that it will be as disruptive as perhaps you are predicting.

Mr Nicholson: There are three things going off at the moment in terms of the funding. There is the changing in the allocation formula; there is the market forces factor changes; and there is HRG4. So you have three things interacting together. It is quite difficult when organisations look at what it means to them to separate out what the various impacts are. What we have said is that because of the technical changes we expect no Trust to be put in financial difficulty because of that and we have asked Strategic Health Authorities and PCTs to work with individual organisations to make sure that we have a smoothing mechanism, so that those when they do the calculation . . . You do not like smoothing, either?

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Q116 Sandra Gidley: No, I do not like jargon; sorry!

Mr Nicholson: Sorry. What is the word I want?

Alan Johnson: Granular!

Mr Nicholson: I need to be more precise, I am sorry! I will give up; I will not speak any more!

Q117 Stephen Hesford: Payment by Results, has it reduced costs and/or improved outcomes?

Alan Johnson: It has reduced unit costs. We funded a very important study by Aberdeen University and others that said that. I think the Audit Commission has done something on this, saying something similar.

Mr Nicholson: Yes, they did.

Alan Johnson: So, yes, I think it is a proven benefit.

Q118 Stephen Hesford: That was costs. Outcomes.

Alan Johnson: Outcomes in terms of what is happening out there—premature deaths by cardiovascular disease down by 40%; cancer premature deaths down by 2% a year; and improvements in other areas. I think Payment by Results has played its part.

Q119 Stephen Hesford: Has such a system been proved to improve efficiency in any other healthcare system?

Alan Johnson: I do not know about prove it; it is used in other healthcare systems. I think this idea of the mixed basket of measures that you would use has been used widely—it is certainly used in Germany and it was used in other European countries after us, I think. We have kind of been in the vanguard of this.

Q120 Stephen Hesford: So we kind of led the way, did we?

Alan Johnson: I think we were in the vanguard.

Q121 Stephen Hesford: Leading the way?

Alan Johnson: Maybe!

Q122 Stephen Hesford: Tariff-splitting—a bit of jargon, I think. Has the issue of tariff-splitting been resolved so that the money really does follow the patient if there care is split between acute and primary sectors?

Mr Nicholson: Yes. The thing about Payment by Results is that it tends to focus on institutions rather than care pathways. So it tends to focus around hospital stays rather than the complete pathway that a patient might go in.

Q123 Stephen Hesford: You mean the beginning and end of the journey?

Mr Nicholson: Absolutely, yes; so it tends to do that. As we move more services or parts of services out of hospital into the community it can become a disincentive; so it can stop hospitals wanting to, if you like, give up their patients too early or too late. So tariff-splitting was a mechanism by which you can start to share the money across the different organisations and the approach that we took was permissive rather than mandatory. And we gave some examples of places—stroke care is one, some rehabilitation service is another. Where there would

be a benefit to patients to split the tariff in that way you should be allowed to do it. The benefits of HRG4 it makes that much easier because of the precise way in which the HRG is constructed. So we think there is more of it; we think it is a good thing as long as it benefits patients.

Q124 Dr Naysmith: Moving swiftly on to personal health budgets.

Alan Johnson: Back to politics at last!

Q125 Dr Naysmith: Some of us here remember fondly the Department's 2006 White Paper, *Our Health, Our Care, Our Say*, in which personal budgets for healthcare were ruled out on the grounds that that would be contrary to the founding principles of the National Health Service. So why have you changed your mind now?

Alan Johnson: That was also said, of course, about withdrawing NHS care from people who buy drugs that are not available on the NHS, and I hope, subject to your report as well, that we have cracked that problem. I think this is raw politics actually; we are back to raw politics. We listened to what people said and actually the benefit of the fact that this is now being debated in the House of Lords is that you should go and look at the transcript in Hansard and see what Baroness Campbell of Surbiton, who is a long term care sufferer and Equality and Disability Commissioner said about this. Read her saga of the ripple mattress; she has to have a ripple mattress to prevent bedsores, and the saga she went through to change her ripple mattress and the bureaucracy and the money that was spent unnecessarily. It is just one little episode. So why are we doing it? We have ten years' experience in adult social care of direct payments in individual budgets.

Q126 Dr Naysmith: 2006 is not a very long time ago; it is only just over two and a half years.

Alan Johnson: Yes. I can elaborate on that.

Q127 Dr Naysmith: What I am asking you, Alan, is why has this come on the agenda now? You have said it is raw politics.

Alan Johnson: In 2006 we said that this would interfere with the principles of the NHS. We now think, given the success in adult social care, given ten years' experience in adult social care, given that people with long term conditions, like Baroness Campbell and many others, are saying, "We believe that this issue of choice and us having some control over this is as important in the NHS for people with long term conditions as it is in adult social care." So we listened to that and we are going to be very, very careful about how we introduce this. We are talking about pilots.

Q128 Dr Naysmith: I was going to ask you about the pilots. Are you really going to carefully evaluate them and what is it you are going to look at in the pilots to enable you to say that this is something that needs to be rolled out or not? One of the failures of a number of things in the NHS—no, it is unfair to say it is just the NHS, it is government policy—is

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that they start piloting things and then before they have been properly evaluated they are rolled out all over the country and then nobody knows whether they work or not.

Alan Johnson: I think David was referring earlier to criticisms from this Committee and others about the failure to pilot things adequately in the past. We need the legislation to pilot; we cannot even pilot without the legislation. So the legislation is to get the pilots underway, and, subject to the House, of course, we will close the deadline for PCTs to say, "We want to take part in this pilot; it is at the end of this month." So subject to the legislation we will then see what PCTs are proposing.

Q129 Dr Naysmith: You are going to take proposals from PCTs?

Alan Johnson: We will take proposals from PCTs as to how they think this can help and what they can do to pilot this and then we will very carefully . . . Because there are different problems here and I understand the gist of your question and I understand why *Our Health, Our Care, Our Say* put it in the too much trouble box. This is very, very difficult, not least of all because we will have to ensure that we do make sure that the principles of the NHS recently enshrined in the Constitution are not undermined by this.

Q130 Dr Naysmith: Have the initial guidelines gone out to PCTs then?

Alan Johnson: No. They are clever enough to see what the score is here. This will very much depend on individuals. You have seen people in adult social care, whose lives have been transformed and you cannot actually—

Q131 Dr Naysmith: I have a constituent whose life has been transformed.

Alan Johnson: You cannot actually put this down in Whitehall or Richmond House or anywhere; you have to go out and see—like the famous ripple mattress with Baroness Campbell—how you can introduce the structure here.

Q132 Dr Naysmith: But there are dangers because it may not be for everyone and it may be very easy to lump people and give them—

Alan Johnson: It has to be voluntary.

Q133 Dr Naysmith: . . . a bit of money to go away and not bother the NHS any more. I am sure that is not what is envisaged but it is one of the dangers in this individual payment system.

Alan Johnson: Let us be clear, what we do know about this in terms of how we pilot this, the individual budget will have to be associated with the care plan, worked out with clinicians and with the National Health Service. It will be about meeting the whole of the costs of that care plan—not part of it, so there is a top-up from the private sector—meeting the whole of that cost. So that is a very important prerequisite for the pilots taking place.

Q134 Dr Naysmith: The final question is some people have suggested that this might lead to the NHS subsidising private care. Is that in any sense a danger? It is probably related to what we were talking about a few minutes ago and the principles of the NHS.

Alan Johnson: That is part of the need for a careful pilot. No, it is the total costs and not part of the costs that will be part of the plan, so we are very aware of that danger and that problem and the pilots will see whether we can overcome it.

Dr Naysmith: This Committee functions on evidence-based politics, evidence-based National Health Service, so I am glad to hear that you are going to implement this by piloting and evaluating carefully the outcomes. Thank you.

Q135 Sandra Gidley: I have some more jargon, I am afraid, or acronyms. We are told that some PCTs are piloting something called P4P4P, which is apparently "pay for performance for patients", which involves incentivising patients to stop smoking, lose weight, probably by means of money and it works with GPs. How is that being evaluated?

Alan Johnson: The PCTs have been responsible for evaluating it. They are responsible for commissioning and evaluating it. That is the first time I have heard of P4P4P, so I must look up who is doing this. But I can understand why they are doing it because it is about stopping smoking, obesity, etcetera. One of our healthy towns pilots is Manchester, where their idea is that people earn points for proper diet and plenty of exercise and they redeem those points at health centres, gyms, swimming baths, etcetera. It is a great idea and that is why it is part of healthy towns. So it is up to the PCTs to justify this. It is a very important part of health inequalities and the PCTs are doing all kinds of imaginative things. It is also crucial to innovation as well; we want people to think innovatively about how they tackle these problems.

Q136 Sandra Gidley: So it is the PCTs we have to hold to account about this?

Alan Johnson: Yes.

Q137 Mr Bone: Secretary of State, I want to ask you some questions about the National Capitation formula. It only seems a few weeks ago you were here and telling me that Northamptonshire was the worst funded Primary Care Trust in the whole country according to the National Capitation Formula. Little did I know that you would be back here and it would all be changed. Of course, what you have done is you have changed the measurements, so we are now not officially the worst funded Primary Care Trust in the country. You have spent great sums of money revising the formula but in reality nothing changes. More or less the same amount of money is given to each Primary Care Trust, there is a slight marginal difference, but you are never going to take money from a PCT that you think is over-funded and give it to somewhere like Northamptonshire

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that is under-funded. So is it worth all the money and expense of actually doing this Capitation Formula; is it not just complete spin really?

Alan Johnson: It has been done since 1976 but the difference of course under this government is that we are looking to tackle health inequalities, which were two words that never went together under the previous government. Let us get this in context: it is not about under-funding Northamptonshire or anywhere in else; this increase in funding from about £400 per head of the population to £1,600 has meant that everyone has seen a huge increase in their funding, including Northamptonshire. What we do to tackle health inequalities—because the basis of one element of this is that people with the highest health needs, which is mainly deprived areas, where there are these terrible disparities and between Hull in my constituency and Beverley, which is seven miles away, there is seven years' difference in life expectancy so one year for every mile—as politicians I would suggest that we need to tackle that problem. I would suggest that as politicians we need to tackle that problem. If we are going to tackle that problem, one element of it—and only one element because health cannot do this by itself—is the amount of funding we allocate. What has happened is that ACRA, the Advisory Committee on Resource Allocation, which consists of clinicians, academics, et cetera, has to up-rate the data because populations shift, things happen in constituencies that mean that areas that were deprived are no longer deprived and things happen with unemployment. They have just revised them. That does not mean that you are now more under-funded. Northamptonshire was previously—

Q138 Mr Bone: — the worst funded, yes.

Alan Johnson: It was not the worst funded. What we do is set a target based on all these different elements and then calculate your distance from the target. You were furthest away from your target. Your funding had gone up to levels never dreamt of in Northamptonshire under previous decades or previous governments, but your distance from target, which is what we are talking about, has changed because the formula has changed. I was in a room near here with a crowd of colleagues that Kevin will know from deprived communities, Members of Parliament, saying that what we should do is take money away from areas which are overfunded, like Kensington and Westminster, et cetera, which do not have these problems of deprivation, and give it to poorer areas. It would solve your problem, for instance. That is not how we are going to do this. We want everyone to have an increase in funding. We want us gradually to move towards the target. Under the previous formula we moved everyone from 20% off target to no more than 3%. Now we will have to start the process over again because the figures have changed, but no one is more than 6% off the target. The last time we did this in 2006 people were 14, 15 and 16% off the target. It is quite a complex issue. You cannot allow it to be

expressed on this very august Select Committee as people being under-funded; that is a distortion of what we are talking about here.

Q139 Chairman: The new table says that Rotherham, which was 1.2% under the target, is now 6.2% under the target. Some people are not going to feel happy about that. I understand why that is the case, it is the deprivation figures and everything else. How long is it going to be? Are you setting a timetable to equal this out? Kensington and Westminster is about 50 million to the good, something like that.

Alan Johnson: The fact you are 6.2% off the target is great news for Rotherham.

Q140 Chairman: It is 6.2% as opposed to 1.2% a few months ago.

Alan Johnson: It is because ACRA has decided that Rotherham should get more money in their health system. They have decided that Hull should get more money in their health system. If they had said you are 1.2% that would mean you are going to get less money eventually into Rotherham. It is difficult to explain but it is good news.

Q141 Chairman: We are going to get more than we received two months ago. When?

Alan Johnson: By the end of this spending review period you will not be 6.2% away from your target, you will be closer to your target and then we will have to see what happens in future spending reviews. When we started to introduce health inequalities into it people were 20% off the target. Now 6.2% is the furthest anyone would be off the target. We are gradually getting there. Surely that is a better system than taking money away from areas. Everyone's health is improving no matter what their social class and that is great and they should all have an uplift in their funding. This is the classic Fabian principle of gradualism that you will appreciate to get to that target. It is an element of health inequalities and a very interesting one.

Q142 Mr Bone: The question I want to ask is about the building of hospitals in the future. My constituency does not have a hospital and we would like to have one in the future. We think we deserve one. I have in front of me a report from a meeting you had a few weeks ago where you alleged that something along the lines of PFIs, which are the preferred system of building hospitals, is plan A and we do not have a plan B, and now that none of the banks have got any money or are likely to have any for a few years the absence of a plan B is going to cause a real problem in taking new hospitals to conclusion. I think you went on to say that 2010–11 and forward is going to be really tight. Is that an accurate reflection of your views?

Alan Johnson: I am aware that 2010–11 is going to be a really tight year, let us not hold the front page stuff. There is going to be a lot of capital investment in 2009–10. We are bringing forward capital investment from 2010–11 to 2009–10. The whole basis of this recovery plan is that 2010–11 becomes a

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difficult year. 2010–11 being tight is common knowledge. On PFI and plan As and plan Bs, I do not know where that comes from.

Q143 Mr Bone: I think it was a meeting you were at.
Alan Johnson: Was this the report from a confidential meeting that someone put an email out about? Excuse me if I do not recognise that. On the issue of PFI, I do not think we need a plan B on it because, apart from North Bristol, which Doug will be extremely pleased about, which is a £425 million PFI—

Q144 Dr Naysmith: Thank you, Secretary of State!
Alan Johnson: —that has just got its consent to proceed, there is nothing on the horizon for 18 months. After 18 months we will be in a completely different economic position and, I hope, through the downturn.

Q145 Mr Bone: So there are no major PFIs going forward. Presumably that means there are no major hospital programmes going forward. It is alleged that the Chief Secretary to the Treasury, despite the fact that there are not going to be any PFI projects in the future going forward, is going to give money to PFI companies, because they cannot get them commercially from banks which are owned by the government, which we then pay a premium for to be lent back to the NHS at no risk to the private sector. I am pretty pleased in that sense that there are no PFI projects going forward because it would be a bit of a nonsense, would it not?

Alan Johnson: There are lots of PFI projects going forward. The important thing is about the pipeline. The PFI projects are up and running. We will have built 110 new hospitals by 2010. We said we were going to build 100; we have actually built 110. No previous government has ever got anywhere near that level of capital investment. The PFIs that are going through are not a problem. What are the PFIs in the pipeline that have not got their funding rates? It is only North Bristol and everything looks really optimistic about that. So there will be hospitals built during that period. What the Chief Secretary to the Treasury announced was perfectly sensible. She said that government can be a part-funder as well as everybody else in this field for PFIs. That strikes me as absolutely sensible to get through the current difficulties. The difficulty is not the expense of borrowing the money, it is the actual difficulty in getting the money. It is not expensive to borrow. So the Treasury stepping in to do that is absolutely right. We certainly would never have been at this level of being able to have 750 new primary care centres and 110 hospitals without PFI making a contribution.

Q146 Mr Bone: I understand PFI stands for Private Finance Initiative. If it is a Private Finance Initiative where does the government money come into it?

Alan Johnson: The whole point about PFI is it is a partnership between the public and the private sector.

Q147 Mr Bone: Do you think it was unfortunate that the £1.3 billion that the trade union leader who, Secretary of State, could not find anything to spend it on, gave it back to the Treasury earlier on? If that £1.3 billion was still available you might be able to build some new hospitals instead of not being able to build any in the future.

Alan Johnson: We will have 110 new hospitals. 2010 is, on my calendar, the future.

Q148 Mr Bone: One new hospital. That is all we are hearing, is it not? For the next couple of years you are just going to have one new hospital, are you not?

Alan Johnson: No. Over the next couple of years we are going to have loads of new hospitals, but there is only one in the pipeline and that is a £425 million new hospital, it is state of the art. We have got Birmingham coming along and that is an extraordinary new hospital. Her Majesty the Queen opened the £75 million new oncology centre in Castle Hill. I will open the new heart centre in Castle Hill just outside my constituency. Surely, Mr Bone, you are not complaining about a lack of new hospitals. It would be the first time I have heard any such extraordinary complaint.

Q149 Mr Bone: Come to Wellingborough. This is really stretching my brain and, with all due respect, I am a chartered accountant.

Alan Johnson: Good. You must have a big brain!

Q150 Mr Bone: Let us talk about the capital cost. The PFI was designed to get these hospitals off balance sheet. From April I understand you have got to bring them on balance sheet, pay a charge in capital costs as well as the PFI charges. Is there some “double whammy” here or have I missed something? Is that not what is going to happen?

Alan Johnson: No, it is not what is going to happen. I think you would be best talking to a Treasury minister about how they organise PFIs. As far as the Health Service is concerned, we have one in the pipeline, which is Bristol, that is going ahead and nothing else for 18 months. When we get to the end of the 18 months we will look at the terrain around us under this Government and see what money is available in terms of our future investment. Of course, not all of our new hospitals have been through PFI. A large number of them and a large number planned are pure Treasury purchases.

Q151 Mr Bone: So we are not diverting money from healthcare to pay capital charges because of a change in accounting rules?

Alan Johnson: No, we are not.

Q152 Dr Taylor: I want to ask about Independent Sector Treatment Centres. We are coming to the end of the contracts for the first-wave ones. Have they been value for money? Figures collected by the *Health Service Journal* suggest that they are only delivering about 85% of the contracted value. Is this value for money?

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Alan Johnson: I think it is. All of the contracts have to meet Treasury guidelines. You have to look at the fact that the people setting up Independent Sector Treatment Centres have to have cases referred to them as well. Reaching an 85% utilisation rate I think is reasonable. We certainly would not have reduced waiting times, we would not have improved the patient experience and we would not have done all the things we have done without the contribution of Independent Sector Treatment Centres.

Q153 Dr Taylor: Is there a widespread resistance from NHS commissioners to using these or is that a local impression I have got?

Alan Johnson: You have to give them time. I was before this Committee talking about other waves, some that have been stopped, some that have gone forward, because you have to be absolutely sure that you are meeting the capacity problem, and it is good value for money. You have to allow time for the utilisation to build up. There was an issue initially, in London in particular, of an absence of patients being referred to the Independent Sector Treatment Centres.

Q154 Dr Taylor: This table came from the *Health Service Journal*. It does not actually show a consistent build up. Some of them have built up over the years but it does not seem to be consistent. Another thing we picked up when we did the inquiry in 2006 was we got lots of anecdotal stories about a poor quality of service and complications. Has there been any extra, hard evidence on standards of care since 2006? Can we be confident that they are not having more complications from their hip and knee replacements?

Alan Johnson: There is lots of anecdotal evidence about how it has improved the performance throughout the whole area. Indeed, I hear this practically everywhere I go. I do not think we have done the analysis yet. I think the analysis is still to be done about the whole issue of ISTCs.

Q155 Dr Taylor: Did you commission the Royal College of Surgeons to do a survey of this?

Alan Johnson: I do not think so. Mr Nicholson?

Mr Nicholson: To do a survey of?

Q156 Dr Taylor: A survey of the comparative quality of care between ISTCs and the NHS. I am absolutely sure there is a study going on.

Alan Johnson: I hope there is, but it does not spring to mind!

Q157 Dr Taylor: I think this is information that has come from the Department of Health. It says, "... the Department estimates that across the whole period of wave 1 contracts, the average cost above the NHS equivalent cost of all wave 1 ISTCs is approximately 12.2%. The Department estimates that across the full period of currently signed phase 2 contracts, the average cost below the NHS equivalent cost of all phase 2 ISTCs is 7.3%." Am I

right in saying that the first wave costs us a lot more than the NHS and the second wave is actually a bargain, it is going to cost us less than the NHS?

Mr Nicholson: I would not say it is a bargain. A number of the second wave ISTCs are providing services below tariff, that is true.

Q158 Dr Taylor: When it comes to the new contracts for phase 1, will they be forced to give this same saving?

Mr Nicholson: Since we set up the wave 1 we have introduced free choice for patients, so patients can choose any NHS hospital to go to plus about 127 different private and voluntary sector organisations to be treated at the taxpayers' expense. The deal there is that if you provide NHS quality services—and CQC will be responsible for both registering and monitoring that—then you are entitled to the tariffs. When we renew the contractual arrangements we would expect them to go on to tariffs.

Q159 Dr Taylor: So all ISTCs, as far as you know, are on choose and book, are they?

Mr Nicholson: As far as I know.

Q160 Dr Taylor: Coming back to what you said earlier, Secretary of State, about *The Spectator*, I think you said that the centres had produced a zoom in performance in local NHS hospitals. Is that anecdotal or is there any evidence of that?

Alan Johnson: It is anecdotal, but it is consistently anecdotal. I would be very surprised if there was not any evidence once we do the analysis.

Q161 Chairman: When you say that is anecdotal, do we measure outputs from NHS hospitals? Do we count the number of hip operations or knee operations in a hospital in orthopedic surgery?

Mr Nicholson: Yes.

Q162 Chairman: So you should be able to look at South Yorkshire and see whether or not there is more taking place in the local hospitals now than there was five years ago before the introduction of the ISTC.

Alan Johnson: You would have to look at what the factors were that led to that. In some cases it is extra capacity, we employ more consultants, more doctors or we build a new wing to the NHS hospital. There is a new hospital. There is more space. So in analysing whether that improvement was caused by the presence of an ISTC, which anecdotally people say has lifted performance in the NHS, you would have to be a bit more rigorous. I fully admit that it is only anecdotal evidence.

Chairman: Our ISTC report did pass comment on the lack of evaluation in the public and the independent sector. We could have measured what the likely effect was going to be.

Dr Taylor: Do you not remember that an inquiry was commissioned to look at quality and outcomes from ISTCs?

Q163 Chairman: Maybe we will go back and look at the Government's response to our report.

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Mr Taylor: My recollection is that there was a survey done of quality output from ISTCs. I cannot remember whether it was the Royal College of Surgeons. I do remember that being done. It is not right in the front of my mind.

Chairman: It may have been in response to our report. It would be useful if you could find some information on that.

Dr Taylor: It has not reported yet, I am quite sure, but it should do soon.

Q164 Dr Naysmith: A recent *Health Service Journal* article listed 20 trusts that are not expected to achieve Foundation Trust status by the current deadline, which is 2010. What do you expect to happen to these trusts?

Alan Johnson: The *Health Service Journal* has cropped up a lot today and they seem to be remarkably accurate. We asked SHAs to assess where they thought these hospitals would be by 2010 and 19 were identified. We will not quibble about the difference in figures. As part of that exercise now strategic health authorities are working with those hospitals to get them to have all the characteristics of being a Foundation Trust by 2010. There are no cruel and unusual punishments planned as far as I know, but Mr Nicholson may have a few up his sleeve.

Q165 Dr Naysmith: Some of these trusts have been trying for some time to get themselves into shape for Foundation Status.

Mr Nicholson: We have been going through the process with the strategic health authorities to identify a pipeline of Foundation Trusts so we can make sure we get the maximum number through as rapidly as we can. When the strategic health authorities did that—and obviously this is very much dependent on a whole series of actions being taken and going through the monitoring process and all the rest of it, because it is not guaranteed you can deliver all of these in time—we came up with 19 that would not. There is a whole variety of reasons why some organisations simply do not look able at this stage to go forward. It could be that their configuration is wrong or it could be that the tariff is particularly difficult for them. There is a whole series of things that need to be put right. We have not given up on any of that 19. We still want to think of ways in which we can do it. At some stage there needs to become an end to this process because we did say that every organisation would be able to apply at some stage. There are alternatives to becoming a Foundation Trust. We could merge them with other organisations. There are some examples around south-east London at the moment where they are going through a process of consulting around the merger of organisations. So a bigger organisation that may be much more capable of dealing with the regime in the future might be created. There will be

some where they are taken over by existing Foundation Trusts. The one I remember best is Good Hope where the Heart of England Foundation Trust took it over and completely transformed it as an organisation. That is another option. There is the possibility of Foundation Trusts taking management contracts for franchising to run other organisations. There are several alternatives. We are working through at the moment what the significance of that is because we expect all NHS organisations in that sense to become Foundation Trusts as rapidly as we can make them.

Q166 Dr Taylor: This is really a very definite sort of request. Four years ago now this Committee did a report on the prevention of Venous Thromboembolism in hospitals and we learnt that there were something like 25,000–32,000 deaths a year, a large number of which were preventable. We had every hope that this would be a tier 1 vital thing coming up under the operations framework, with healthcare infections causing something like 5,000 deaths, a fifth as many is tier 1. Mr Nicholson has already explained that financial matters are not on the tier because it is already a definite “must do”. We gather that on VTE all that is needed is a mandatory risk assessment, which is very easy to do, it takes very little time and is a part of the automatic history when somebody goes into hospital with a surgical or a medical condition, but this is not yet being mandated and inspected by the Care Quality Commission. Baroness Young was very clear that it was not her fault when she told us, “We have under the Act that establishes requirements for the periodic review to seek the Secretary of State’s approval and we did not get that for this line.” Is there any way that this could be moved up to tier 1 because it is absolutely crucial?

Alan Johnson: I agree that it is a crucial issue. My colleague John Smith is the chair of this. The issue about the operating framework is that we were very clear—and I think the Committee would support this—that if you prioritise everything you prioritise nothing. We have been very careful about what is a tier 1 priority. Indeed, what we have tried to do is, instead of overloading and burdening the business, to have some consistency. So the five priorities last year are the five priorities this year and they do include safety. I will look at how we can actually move this issue along and how we can get the assessments you talked about. I will look into this personally to see what we can do, but if it is a tier 2 or a tier 3 issue that does not mean the NHS is concentrating on tier 1 priorities. Let me look to see what more we can do.

Dr Taylor: Thank you very much.

Chairman: May I thank all three of you for coming along and helping us with this session. Where we said we would like some further feedback from you, I would really appreciate it if we could get that. Thank you very much indeed.

Supplementary note to Question 37 (HC 340-i)

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