



House of Commons
Health Committee

NHS Next Stage Review

First Report of Session 2008–09

Volume I



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Report, together with formal minutes

*Ordered by the House of Commons
to be printed 15 December 2008*

HC 53-I

Published on 13 January 2009
by authority of the House of Commons
London: The Stationery Office Limited
£0.00

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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 53-II, Session 2008-09. Written evidence is cited by reference in the form DZ x for evidence to be published in HC 53-II, Session 2008-09.

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Summary

High Quality Care For All: Next Stage Review Final Report (NSR), which was led by Lord Darzi and published on 30 June 2008, is the latest of many reviews of the NHS. The main difference from its predecessors lies in the extensive consultation undertaken with clinicians and patients.

Its main focus is improving the quality of care provided by the NHS. Variations in quality have been known about for a long time and, as Lord Darzi acknowledged, continue despite the doubling of NHS expenditure in real terms since 1997. The Minister believes that the emphasis of policy in the last decade has rightly been on access; now it is possible to look at improving quality.

We do not accept that it was necessary or sensible to improve access before improving quality. Moreover, many of the NSR's key recommendations have been made in previous reports and White Papers. Nevertheless, we welcome the extensive consultation undertaken as part of the NSR and the emphasis it places on quality.

However, we have concerns about the implementation of the report, which will be the responsibility of PCTs, because we doubt that most PCTs are currently capable of doing the task successfully. As we have noted in a series of inquiries, PCT commissioning is too often poor. In particular, PCTs lack analytical and planning skills and the quality of their management is very variable. This reflects on the whole of the NHS: as one witness told us, "the NHS does not afford PCT commissioning sufficient status". We consider this to be striking and depressing.

The Department to its credit accepts that there are serious weaknesses in PCT commissioning and has launched a 'World Class Commissioning' programme to improve the situation. We are not convinced that this will make the necessary changes. As a result, implementation of the NSR may be slower and more uneven than the Government hopes.

SHAs will have an important role in managing the performance of PCTs, but there are also doubts about their ability to do this.

We are also concerned that the NSR provides little detail about costs; it also contains many priorities without ranking them, as too many reviews of the NHS have in the past.

The NSR proposes to seek improvements in quality through better measurement and the provision of financial incentives for providing a high quality of care. We strongly support the principle of using financial incentives, but we recommend that the Department proceed with caution. Schemes such as Advancing Quality and PROMs which link the measurement of clinical process and patient outcomes must be piloted and evaluated rigorously before they are adopted by the wider NHS.

The NSR reiterates the Department's plans to create 150 GP-led health centres, one for each PCT in England. We welcome the provision of additional primary care services and acknowledge that there are strong arguments for increasing provision in under-doctored areas. However, this expansion in supply needs careful management and evaluation to

determine whether it leads to better evidence-based medical interventions for patients and whether it reduces disparities in health care access and utilisation between different social classes. It should be recognised that the investment in primary care might increase demand for hospital care as deprived people get better access to care and referrals increase with more diagnostic tests.

While some PCTs, particularly those which are “under-doctored” or with a high burden of disease, would undoubtedly benefit from more primary care services, it is less clear how other PCTs would benefit. We are not convinced by the Department’s argument that all PCTs should have a GP-led health centre. Whether PCTs have such a centre should be a matter as a witness stated: “to be decided locally on a case-by-case basis using the best clinical evidence available together with a full assessment of the costs and the impact on patient access”. However, PCTs should not make their decisions on a whim, but national criteria should be set out to ensure that benefits and costs of their decisions are known. We were disappointed that neither the Government nor witnesses representing doctors could tell us what criteria should be used to decide whether a PCT needed a GP-led health centre.

While polyclinics and GP-led health centres can bring benefits, we are disappointed that the Department is introducing them without prior pilots and adequate evaluation.

The NSR also proposes to increase personal choice through the extension of personal care plans and the introduction of personal budgets for health care. The Department’s decision to conduct trials of personal budgets for healthcare is welcome if it is done rigorously and policy makers wait for the results of the trials before any large scale roll out of the programme.

The draft NHS constitution set out in a single document the principles, values, rights and responsibilities of patients and staff in respect of the NHS. We note witnesses’ contradictory concerns, on the one hand, that the constitution should not be a “lawyer’s charter”, on the other, that the Constitution will be regarded as meaningless waffle. We welcome the establishment of a patient’s right to drugs and treatments which have been recommended by NICE for use in the NHS. However, it is important to recognise that the commitment will not by itself end the post code lottery which determines access to drugs and treatments not on the NICE approved list.

The NSR makes a number of proposals for improving workforce planning and the quality of leadership in the NHS. We welcome the Department’s focus on these areas following the severe criticisms in our report on *Workforce Planning*. However, we note concerns that planning will be concentrated in the Department. SHAs have a key role in workforce planning and the Department should take steps to ensure that regional NHS employers are given a role in identifying future workforce requirements.

It is widely recognised that the quality of leadership in the NHS must improve. In seeking to do this, the Department places considerable stress on introducing new institutions and on turning doctors into managers. The emphasis on medical leadership is important; however, we are concerned that at present many doctors are put off becoming senior managers. We therefore recommend that more training and support be given to those who wish to take on senior management responsibilities.

It is also unfortunate that the NSR does not place more emphasis on the importance of recruiting and developing better managers. Over many inquiries this Committee has heard concerns about the quality of management in the NHS which witnesses to this inquiry echoed. Some managers lack the analytical skills or motivation to handle and interpret the wide range of performance and routine administrative data, such as Hospital Episode Statistics, that they have to deal with. With the introduction of PROMs and other quality related measures this issue is becoming ever more important. The Department must address the issue of weak management skills in this area with urgency.

One means of improving management would be through more effective use of the NHS Graduate Management Scheme which has attracted graduates of great ability, but too often not made the best use of them. Graduates on this scheme should be encouraged to take appropriate academic qualifications and be given sustained career support to ensure that their talent is exploited to the full throughout their careers.

1 Introduction

1. On 4 July 2007 the Secretary of State for Health, Rt Hon Alan Johnson MP, announced that he had commissioned a review of the National Health Service.¹ This was to be “A once-in-a-generation opportunity to ensure that a properly resourced NHS is clinically led, patient-centred and locally accountable”. The NHS *Next Stage Review* (NSR) would, he said, engage with patients, staff and the public on addressing what he described as four critical challenges facing the NHS:

- “Ensuring that clinical decision-making is at the heart of the future of the NHS and the pattern of service delivery;
- Improving patient care, including high-quality, joined-up services for those suffering long-term or life-threatening conditions, and ensuring patients are treated with dignity in safe, clean environments;
- Delivering more accessible and more convenient care integrated across primary and secondary providers, reflecting best value for money and offering services in the most appropriate settings for patients; and
- Establishing a vision for the next decade of the health service which is based less on central direction and more on patient control, choice and local accountability and which ensures services are responsive to patients and local communities”.²

2. The NSR was led by Professor the Lord Ara Darzi KBE, the newly appointed Parliamentary Under Secretary of State at the Department of Health, who had recently completed a review of health services in London, *A Framework for Action*.³ From July 2007, Lord Darzi combined leading the NSR with his ministerial duties and his work as a Consultant Surgeon at St Mary’s Hospital, Paddington.

3. Only three months after his appointment, during a period of heightened speculation about the timing of a possible general election, Lord Darzi published an interim report, *Our NHS, our future*.⁴ The Report contained both an early indication of Lord Darzi’s thinking and some policy announcements including plans to establish GP-led Health centres in every PCT and instructions to hospitals about MRSA screening.⁵ On 25 October, the Health Committee held an evidence session with Lord Darzi and his officials to examine the findings of his interim report and to question him in detail about how he planned to conduct the rest of the Review.⁶

1 HC Deb, col 963, 4 July 2007

2 Ibid

3 NHS London, *A Framework for Action*, July 2007

4 Department of Health, *Our NHS, our future*, October 2007

5 It was proposed to introduce MRSA screening for all elective admissions in 2009, and for all emergency admissions as soon as practicable within the next three years.

6 Health Committee, 25 October 2007, HC (2006–07) 1106–i

4. The next significant development occurred in the early summer of 2008 when nine Strategic Health Authorities (SHAs) in England published regional strategies and visions for health services in their region (NHS London had published its strategy in July 2007). On 30 June 2008, on the eve of the sixtieth anniversary of the establishment of the NHS, the Department published what Lord Darzi described as an “enabling document” for the development and application of SHA regional strategies entitled, *High Quality Care For All, Next Stage Review Final Report*.⁷ The Final Report was accompanied by three supporting documents which provided more detail about some of its key proposals, namely:

- *Our vision for primary and community care*,⁸
- *A High Quality Workforce*,⁹ and
- *A consultation on The NHS Constitution*.¹⁰

5. Given the significance of the Next Stage Review to the future of the NHS, we decided to hold an inquiry into the findings and recommendations of the Review and issued a call for written evidence.¹¹ We held three oral evidence sessions between July 2008 and October 2008. We took oral evidence from a wide range of witnesses including academics, representatives of Royal Colleges and NHS managers, the BMA and Chief Executives of Strategic Health Authorities, as well as the author of the NSR, Lord Darzi, David Nicholson CBE, NHS Chief Executive and Dr Jonathan Sheffield, Medical Director, NHS South West, Department of Health.

6. Our Report describes the main proposals contained in the *Next Stage Review* and witnesses’ responses to them. The area covered by the *Next Stage Review* and its supporting documents, as well as the SHA regional reviews, is too wide ranging and covers too much ground, for us to comment on all the proposals in great detail. Chapter 2 describes the process leading up to the publication of the NSR. Chapter 3 then looks in general terms at witnesses’ concerns about some of the proposals, in particular whether they are likely to be implemented successfully. Chapters 4 to 8 then address the most significant proposals in the NSR. We examine in particular the Department’s proposals to:

- improve quality (Chapter 4);
- extend “patient choice” and “personalisation” in primary healthcare (Chapter 5);
- establish an NHS Constitution (Chapter 6); and
- improve workforce planning and leadership in the NHS (Chapter 7).

7 Department of Health, *High Quality Care For All, Next Stage Review Final Report*, Cm 7432, 30 June 2008

8 Department of Health, *NHS Next Stage Review, Our vision for primary and community care*, 3 July 2008

9 Department of Health, *NHS Next Stage Review, A High Quality Workforce*, 30 June 2008

10 Department of Health, *NHS Next Stage Review, A consultation on The NHS Constitution*, 30 June 2008

11 www.parliament.uk/parliamentary_committees/health_committee/hc0708pn18.cfm

7. The Committee would like to thank all who gave evidence. We are particularly grateful for the expert advice which we received from our specialist advisers: Professor Nicholas Bosanquet and Professor Alan Maynard.¹²

12 Professor Bosanquet declared no interests. Professor Maynard declared his interest as Chairman of York NHS Trust.

2 The Next Stage Review

8. In this chapter we describe briefly the process that culminated in the publication of the *Next Stage Review Final Report* (NSR) and its supporting documents. We also identify the main proposals and themes in the NSR which, Lord Darzi argues, will lead to a “service transformation” in the NHS.¹³

9. Following his appointment to lead the NSR, Lord Darzi said that a review of the NHS had been necessary because, owing to a variety of factors, the NHS “needed to adapt to the different challenges in the twenty first century”.¹⁴ He believed that a comprehensive review, which looked at all aspects of the NHS, had been necessary because the “drivers for change in healthcare and society are beyond the control of any single organisation”.¹⁵ According to Lord Darzi the six challenges which the NHS needs to address over the next ten years are

- Rising patient expectations: patients increasingly expect healthcare to be tailored to their own particular needs.
- Demographic change: by 2031, the number of over 75 year olds will increase from 4.7 million to 8.2 million. Older people tend to have significantly greater healthcare needs than younger people.
- The development of the information society: people will increasingly be able to find information about treatment and diseases quickly and conveniently and in a way that was previously impossible.
- Advances in treatment are enabling patients who would once have been hospitalised to live fulfilling lives in the community.
- The changing nature of disease: the NHS in the 21st century increasingly faces a disease burden determined by the choices people make: to smoke, drink excessively, eat poorly, and not take enough exercise.
- The changing expectations of the health workplace: healthcare professionals expect the depth of their expertise to be recognised and rewarded, and their skills to be developed and enhanced.¹⁶

10. Lord Darzi maintained that in the face of these changes in the health service and wider society, the appropriate response for the NHS was for the organisation to focus on improving the quality of all aspects of the healthcare it provides to patients. Over the next ten years, the NHS would have to change both the way it provided services and the manner in which it interacted with patients and the public. The NSR, Lord Darzi argued, provided SHAs, Primary Care Trusts (PCTs) and clinicians, with the guidance and means to provide

13 While our examination focused on the proposals contained in the NSR, we also make reference, where appropriate, to the NSR’s associated documents (Our vision for primary and community care, A High Quality Workforce and The NHS Constitution) and the ten Strategic Health Authority (SHA) regional plans.

14 Cm 7432

15 Ibid

16 Ibid

high quality health services closer to a patient's home in a manner in keeping with their personal choice.¹⁷

The regional reviews

11. In July 2007 Lord Darzi asked nine of the ten Strategic Health Authorities (SHAs) to review existing health services and to formulate strategies for improving health in their region. They were to report to him by the early summer of 2008.¹⁸ SHAs were given this central role because the purpose of the organisations is to provide leadership, co-ordination and support, and management of the performance of PCTs and NHS Trusts.¹⁹ In addition, Lord Darzi told us that by involving them closely in the development of his review, SHAs had developed a “sense of ownership” for their content.²⁰

12. The consultations were to be locally-led, but the Department did provide a framework within which SHAs were to conduct them. In particular, SHAs were asked to make their plans within the context of eight areas of healthcare, referred to as “Clinical Pathways”. These were:

- staying healthy;
- maternity and newborn care;
- children and young people;
- mental health;
- long-term conditions;
- planned care;
- acute care; and
- end of life care²¹

13. SHAs consulted patients, carers and the general public about what NHS services they wanted and how and where they should be delivered. In all, “2,000 clinicians and other staff in health and social care from every NHS region in England” participated in these consultations.²² According to Lord Darzi, these groups “considered the best available clinical evidence, worked in partnership with thousands of patients, listened to the needs

17 Cm 7432

18 The ten Strategic Health Authorities in England are: East of England; East Midlands; London; North East; North West; South East Coast; South Central; South West; West Midlands; and Yorkshire and the Humber. NHS London had published a review of the capital's health service in July 2007.

19 SHAs are also responsible for the recruitment, retention and training of NHS staff.

20 Q 133

21 Cm 7432

22 Ibid

and aspirations of the public and set out comprehensive and coherent visions for the future”.²³

14. In addition to the eight clinical pathways prescribed by Lord Darzi, some SHAs considered how changes could be made in other areas of healthcare. For example, NHS South West formed groups to look at improving health services in the following areas: services for people with a learning disability; improving dental health services; reducing waiting; patient safety; workforce planning; integrating health and social care; and managing the health care system.²⁴

15. SHA witnesses described how they had undertaken their consultations. NHS South West consulted clinicians and representatives of patient groups, staff organisations, voluntary groups and local authorities at a series of “arranged events around the clinical pathways”.²⁵ Proposals drawn from these consultations were then discussed in a variety of fora including Local Government Overview and Scrutiny Committees and Patient and Public Involvement groups.²⁶ Both NHS North West and NHS Yorkshire and the Humber told us that they followed a similar process.

16. Lord Darzi told us that the degree of consultation carried out by SHAs was unlike reviews previously undertaken centrally by the Department of Health. He argued further that this approach had resulted in high quality discussions,

The eight pathways... provided a process through which we got clinicians and non-clinicians from all sorts of different backgrounds...sitting around a table and really challenging themselves... to improve the quality of care at a local level.²⁷

The regional priorities

17. In the summer of 2008 SHAs duly published their regional frameworks listing their priorities for the next three to five years. The priorities varied between regions. Tables 1–3 below show the priorities for NHS North West, NHS South West, and NHS Yorkshire and the Humber.

Table 1: The priorities for NHS North West

- Reducing health inequalities.
- Improving choice in maternity services.
- Personalising care for people with long-term conditions.
- Commissioning high quality mental health services.

23 Cm 7432

24 DZ 18

25 Ibid

26 In 2008 these groups were replaced by LINKs.

27 Q 134

Table 2: The priorities of NHS South West

- Access – getting prompt GP appointments and reducing waiting times for hospital treatment.
- Quality – getting the most effective treatment and drugs.
- Safety – providing clean facilities and safer systems.
- Health – tackling the rising level of childhood obesity.²⁸

Table 3: The priorities for NHS Yorkshire and the Humber

- Tackling alcohol consumption and binge drinking.
- Addressing rising levels of obesity.
- Reducing the prevalence of smoking which remains the single biggest cause of premature death in the region.
- Increasing the amount of information on how to keep healthy.²⁹

18. A major benefit of consulting clinicians and patients in clinical pathway groups had been that they had identified unexpected priorities. Mr Mike Farrar, Chief Executive, NHS North West, was surprised that the issue of alcohol misuse was given such emphasis by clinicians, patients and the public.³⁰ Sir Ian Carruthers, Chief Executive, NHS South West had learnt that the support available to carers was a major concern for all groups; and Ms Margaret Edwards, Chief Executive of NHS Yorkshire and Humber, said that the consultations had underlined the growing importance to people in her region of tackling obesity and addressing diabetes.³¹

19. Once priorities had been established, the SHAs devised targets to address them. Table 4 below illustrates the variety of targets formulated by SHAs, including NHS South West's aim to achieve the highest levels of fruit and vegetable consumption in England.

28 NHS South West, *Improving Health: Ambitions for the South West*, May 2008

29 NHS Yorkshire and The Humber, *Healthy Ambitions*, May 2008

30 Q 362

31 Ibid

Table 4: Targets of NHS North West, NHS South West and NHS Yorkshire and Humber regional strategies.

NHS North West	NHS South West	NHS Yorkshire & Humber
Improve life expectancy by 16% for women and 11% for men by 2010	Match the highest life expectancy in Europe by 2013 Match Europe's lowest death rates from cancer, heart disease and stroke. Match Europe's lowest smoking levels by 2013	Improve life expectancy in areas currently recording figures significantly below the national average.
Urgent and out-of-hours elements of primary, secondary and intermediate care to be commissioned in combination with social care. Access and availability outside office hours to be determined locally	Reduce healthcare-associated infections to match Europe's lowest	Halve number of children admitted to hospital with asthma
Every woman to be assigned a named midwife for her pregnancy	Achieve the highest levels of fruit and vegetable consumption in England	Prevent 600 premature deaths each year with improved stroke care
Personalised budgets for people with some long term conditions	Complete 90% of diagnostic tests within two weeks by 2011.	Double the number of people dying at home instead of hospital
		No waiting lists for mental health patients

20. PCTs are responsible for delivering the SHA regional strategies. By the spring of 2009 each PCT is to publish its five year strategic plan setting out how it proposes to improve the "health of people locally". The NSR requires that the PCTs' plans are designed around the eight clinical pathways contained in each SHA "vision document".³² We discuss the role of PCTs further in the following chapter.

The Next Stage Review Final Report

21. On 30 June 2008, following the publication of the regional strategies, the Department published its national strategy *The Next Stage Review Final Report*. The NSR was described by Darzi as an "enabling document" which draws together the themes common to the regional strategies and gives them a national perspective.³³ In general terms it does this by making proposals which, it argues, will "improve the quality of care given to patients and providing it to them closer to their homes in a more personalised, integrated and safer way".³⁴

32 Cm 7432

33 Q 131

34 Cm 7432

22. In the following chapters we have concentrated on what we consider to be the most significant proposals or themes from the NSR and regional strategies. These are:

- Improving the quality of treatment and of clinical outcomes: this is the main theme of the NSR, which makes a number of proposals to achieve it, notably the use of financial incentives.
- Increasing “choice” and “personalisation”: the NSR argues that extending patient choice is another important way of improving clinical quality; choice is to be extended in a number of ways, including the establishment of GP-led health centres in each PCT; in addition, there will be personal care plans and pilots for personal budgets for patients “following the trials in social care in which people had a greater say over how to allocate money for their treatment”.
- Establishing an NHS constitution, which will list patients’ rights and responsibilities, including the right to NICE approved treatments.
- Improving leadership and the workforce: There are to be improvements to workforce planning and new programmes of clinical and board leadership, with “clinicians encouraged to be practitioners, partners and leaders in the NHS”.³⁵

3 Key issues

23. Witnesses had two general concerns about the Next Stage Review. These were:

- Whether a review had been necessary; and
- Whether SHAs, PCTs and clinicians had the necessary capabilities to implement the NSR's proposals successfully.

Was a further review of the NHS necessary?

24. The Secretary of State told the House of Commons that he had ordered a review of the NHS because he was aware that clinicians and the public had lost confidence in the NHS as a result of “top-down instructions and restructuring”.³⁶ The Review was the Government's response to the concerns of these groups of people who, he said, “want a stronger focus on outcomes and patients, and less emphasis on structures and processes”.³⁷ Mr Johnson added that the Review would ensure that the NHS kept abreast with the changing demands and expectations of patients.

25. Following the publication of the NSR, critics argued that many of its proposals are not new and are merely a restatement of previously announced proposals. Professor Steve Field, President of the Royal College of GPs, for example, told us that his initial reaction to the announcement of the NSR was “Why are we doing another review?”.³⁸

26. Since 1997 the Department of Health has published a number of White Papers and pursued a range of initiatives which have proposed significant improvements to NHS services. Indeed, some of the Department's initiatives placed a similar emphasis to the NSR on improving quality. For example, the 1998 consultation document, *A First Class Service—Quality in the new NHS*, argued the case for improving quality in strikingly similar terms to Lord Darzi ten years later:

High quality care should be a right for every patient in the NHS. The Government wants an NHS that is both modern and dependable. Such a National Health Service should guarantee fair access and high quality to patients wherever they live.³⁹

The *NHS Plan*, published in 2000, which made proposals for how the NHS should be funded and “designed around the patient” and the 2002 *Delivering the NHS Plan*, which set out how it should be staffed, both sought to improve the quality of services provided by the NHS. Most recently only one year before Lord Darzi began his work on the NSR, the White Paper *Our Health, our care our say* contained proposals also covered in the NSR including promoting patient choice, shifting medical care from secondary to primary care

36 HC Deb, col 961, 4 July 2007

37 Ibid

38 Q 2

39 Department of Health, *A First Class Service—Quality in the new NHS*, 1998

and setting out the Government’s plans for “a new direction for the whole health and social care system”.⁴⁰

Table 5: Significant White Papers documents published by the Department of Health since 1997

1998: A First Class Service–Quality in the new NHS
2000: NHS Plan: a plan for investment, a plan for reform (Cm 4386)
2002: Delivering the NHS Plan: next steps on investment, next steps on reform (Cm 6268)
2003: Building on the best: choice, responsiveness and equity in the NHS (Cm 6079)
2004: The NHS Improvement Plan: putting people at the heart of public services (Cm 628)
2006: Our health, our care, our say: a new direction for community services (Cm 6737)

27. Professor Nicholas Mays argued that the measures contained in the 2006 *Our health, our care, our say* White Paper had not had sufficient time to bed in and could not therefore reasonably be evaluated.⁴¹ However, he thought that although there was little new in its proposals, three aspects of the NSR gave it significance: it had been led by a practising clinician (Lord Darzi) who understood clinical practice and the challenges facing clinicians; unlike other reviews (such as *Commissioning a patient-led NHS* in 2005), it did not propose any major structural changes to the configuration of organisations within the NHS; and it consulted a wide range of people, including clinicians, patients and the public, about their ideas for improving the NHS.

28. Other witnesses agreed that the NSR had been a worthwhile exercise. It was accepted that Lord Darzi’s personal experience of working in the NHS and the consultative approach he took by involving clinicians, patients and other interested parties in the NSR process had been beneficial. Witnesses believed that this approach resulted in the NSR showing greater understanding than some previous studies undertaken by the Government both of the issues facing the NHS and of the appropriate solutions for tackling them.⁴²

Implementing the Next Stage Review

29. There was less agreement among witnesses, however, about whether NHS institutions and staff were capable of delivering the proposals made in the NSR. We look at Lord Darzi’s plans for improving clinical care later in this Report;⁴³ here we consider PCTs and SHAs.

40 Department of Health, *Our Health, our care, our say*, Cm 6737, January 2006

41 Q 2

42 Qq 429–432

43 See Chapter 4

30. The Department's stated aim for the "transformation of the NHS" through the NSR will largely depend on how well it is implemented in hospitals, hospital trusts, and primary care settings. In its written evidence submitted to this inquiry, the NHS Confederation argued:

We believe that implementation will be the most difficult part. The review is very dependent on high quality local leadership taking responsibility for making change happen. To enable this to happen requires a change in the style of leadership from the Department of Health's performance management system: this has been promised and it will be important that it is delivered.⁴⁴

31. The NSR states that local leadership for implementing the NSR regionally and nationally will be provided primarily by the 152 Primary Care Trusts in England. The performance of PCTs will, in turn, be managed by the ten SHAs which represent the NHS in the regions of England.⁴⁵

Table 6: Primary Care Trusts

Purpose of Primary Care Trusts

PCTs are responsible for commissioning services for the NHS totalling £70 billion per year; over 80% of the 2008–09 NHS budget.

Typically PCTs [commission and] provide healthcare services for a population of 330,000 people.

Their main functions are to: improve the health of their population by reducing health inequalities; promoting health and commissioning services including GP services, hospital care, mental health, dentists, pharmacists and opticians; and developing staff skills.

Source: NHS Confederation

32. Lord Darzi described how SHAs and PCTs would be responsible for implementing the NSR:

There is fairly detailed implementation planning in every regional report and how they are going to make these changes happen based on the eight pathways. At the same time we will be holding the PCTs accountable in...translating the regional report into strategic plans, which will be published in the spring of next year [2009].⁴⁶

PCTs are expected to develop strategies for implementing improvements in health and healthcare in their area in accordance with the priorities set by their SHA. These strategies should be included by PCTs in operational plans for 2009–10 and in their strategic plans covering, as a minimum, the period 2008–09 to 2010–11.⁴⁷ PCTs are expected to produce updated plans for approval by their SHA during the autumn and winter of 2008–09.

44 DZ 05

45 Cm 7432

46 Q 133

47 Cm 7432

33. Table 7 below shows the schedule adopted by NHS South West for implementing the NSR locally through its PCTs.

Table 7: The NHS South West implementation timetable

In NHS South West, by January 2009 PCTs are expected to have updated their strategic plans covering the next five years and their operational plans for 2009/10. They are expected to undertake

- a work programme for each clinical pathway; and
- an annual review of each work programme.

The annual reviews will be supported by staff from the SHA and will be expected to identify the priorities for action for each NHS organisation and to assess any problems in implementing them.

Source: NHS South West, Improving Health Ambitions for the South West

34. The onus on what some witnesses called “local ownership” of the plans, rather than central direction from Whitehall, was welcomed by many of witnesses. Mr Niall Dickson, Chief Executive, King’s Fund, argued that it was a major strength of the NSR that “responsibility for shaping the quality of care is going to be, or should be, led by staff at a local level”.⁴⁸ The Chief Executives of SHAs argued that their PCTs were best placed to understand the healthcare needs of their local communities and how to meet them.⁴⁹

PCTs

35. Several witnesses doubted the ability of PCTs to implement the plans they had drawn up. Indeed, PCTs have attracted a good deal of criticism over a long period, often focussing on their inability to evaluate data and identify cost-effective interventions based on evidence.⁵⁰ This Committee has expressed concerns about PCT commissioning in a series of inquiries from our examination of the Department of Health’s restructuring of PCTs in 2005–06,⁵¹ through our study of *NHS Deficits* in 2006–07, when we commented on the weakness of financial management, to our report into *Dental Services* in 2007–08, in which we concluded that some PCTs did not possess the required knowledge and experience to commission services effectively. Our most recent report, *Foundation trusts*, published in October 2008, highlighted weaknesses in the strategic planning capabilities of PCTs.⁵²

36. Anxieties about PCT commissioning were reinforced during this inquiry. Professor Mays described commissioning as the “weakest link of the NHS”.⁵³ Mr Niall Dickson gave three reasons to explain why PCT commissioning in some areas was poor: the NHS had

48 Q 75

49 Qq 347–352

50 Health Committee, First Report of Session 2006–07, *NHS Deficits*, HC 73–i

51 Health Committee, Second Report of Session 2005–06, *Changes to Primary Care Trusts*, HC 646

52 Health Committee, Sixth Report of Session 2007–08, *Foundation trusts and Monitor*, HC 833

53 Q 69

provided insufficient investment in developing commissioning skills; PCTs lack data on the health needs of their communities; and, remarkably, PCT commissioning has been afforded a lack of status within the NHS.⁵⁴ Mr Dickson's analysis was not disputed by other witnesses. According to Professor Maynard, the weakness of PCTs as commissioners is epitomised by the Department of Health's decision to set PCTs performance targets over recent years.⁵⁵

37. The task of PCT commissioners will become more difficult following the introduction of patient outcome measurements (such as PROMs) which PCTs will have to administer.⁵⁶ In addition PCTs will be expected to meet the regulatory requirements of the new Care Quality Commission.

Department of Health measures to improve commissioning

Practice based commissioning

38. Lord Darzi accepted that commissioning capabilities of some PCTs was poor but he also argued that the Department had taken measures to improve the situation. The Department was promoting stronger clinical engagement in the commissioning process by reinvigorating its "practise based commissioning" initiative. Practice Based Commissioning (PBC) is a scheme intended to give commissioning powers to healthcare professionals working in primary care (general practitioners [GPs], nurses and others), based on the belief that these staff are best placed to make decisions about their patients' needs. GP practices have been allocated "indicative" budgets with which to "buy" health services for their population (these are "virtual" budgets and PCTs continue to hold the actual money). According to a recent King's Fund report on PBC, the scheme was intended to:

- encourage clinical engagement in service redesign and development
- to bring about better, more convenient, services for patients
- to enable better use of resources.⁵⁷

39. The NSR did not provide much detail about how PBC would be reinvigorated but, according to Lord Darzi, it would be done by involving "all clinician groups in strategic planning and service development to drive improvements in health outcomes".⁵⁸ More specifically, the NSR proposed improvements to PBC that would "ensure that primary care trusts are held fully to account for the quality of their support for practice based commissioning".⁵⁹

54 Q 103

55 DZ 20A

56 See Chapter 4

57 The King's Fund, *Practice-based commissioning: Reinvigorate, replace or abandon?*, November 2008

58 Cm 7432

59 Ibid

40. Witnesses were critical of the Department's initial attempts at Practice Based Commissioning (PBC) and doubted whether the situation would improve. The submission from the Company Chemists' Association was particularly scathing, describing PBC as a "costly failure" which had failed to deliver any significant patient benefits.⁶⁰ Professor Steve Field, Chief Executive, RCGP, argued that GPs had not often chosen to take part in PBC because they "do not understand what it is...and PCTs think they are losing their influence if they hand over commissioning to groups of healthcare professionals".⁶¹ According to Mr Niall Dickson:

PCTs are either not really encouraging them to do it or are not interested in doing it and are not promoting it. On the other side, some PCTs are saying that a lot of GPs are really much more interested in the provision side than the commissioning side.⁶²

The BMA thought that it was important for the Department to provide a clearer explanation of what practice based commissioning is and what it is expected to achieve. The organisation considered that clarifying the goals of PBC was more important than the Department's proposals to employ business consultants to help GPs and PCTs "work better together on commissioning".⁶³

World Class Commissioning programme

41. The Department's main means of improving the performance of PCT commissioning is its World Class Commissioning (WCC) programme which began in July 2007. Like practice based commissioning, many of our witnesses were uncertain about what WCC was and what it was intended to achieve. However, the Department subsequently provided us with its description in Table 8 below.

60 DZ 14

61 Q 67

62 Q 100

63 Health Service Journal, "Bradshaw to bring in firms to boost GP commissioning", 24 July 2008

Table 8: World Class Commissioning

World Class Commissioning has four components:

- (i) A vision for world class commissioning setting out how the programme raises ambitions and strengthens PCTs as commissioners on behalf of their patients and populations;
- (ii) Eleven organisational competencies that a world class commissioning organisation will need to demonstrate;⁶⁴
- (iii) A commissioning assurance system to hold commissioners to account and to reward performance and development; and
- (iv) Support and development tools and resources to help commissioners achieve world class commissioning.⁶⁵

Source: Department of Health

42. The Department argued that its evaluation of commissioning capabilities under the WCC programme would help achieve greater consistency among PCTs. According to the Department this “Assurance Scheme” due to be completed by the end of 2009, will be the first time that evidence, rather than anecdotes, has been used to assess PCT performance in this area.⁶⁶ The evaluation, which will be carried out by SHAs, will review a “PCT’s status and current direction of travel, and development needs, [as well as] focusing on organisational health issues”.⁶⁷ According to the Department, the system has three elements by which PCTs will be measured: “outcomes, competencies and governance”.⁶⁸ The Department will reward those PCTs displaying high levels of performance or improvement with “certain freedoms from monitoring or regulation” while those performing least well and not improving will have “interventions applied in line with the NHS Performance regime”.⁶⁹

43. Until the evaluation has been completed, Mr Mike Farrar, Chief Executive of NHS North West, maintained that it would not be fair to assess the commissioning capabilities of PCTs. He stated that:

We are about to get the best evidence-base that we have ever had about their competences in the key elements of commissioning—their procurement, their needs

64 These are: “locally lead the NHS; work with community partners; engage with public and patients; collaborate with clinicians; manage knowledge and assess needs; prioritise investment; stimulate the market; promote improvement and innovation; secure procurement skills; manage the local health system; and make sound financial investments”.

65 For more information about World Class Commission can be found at: www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Vision/index.htm

66 DZ 19

67 Ibid

68 Ibid

69 Department of Health, *Commissioning Assurance Handbook*, June 2008

assessment, their engagement with the public, the way in which they use a variety of providers.⁷⁰

Previous criticisms of PCT commissioning have centred on their inability to evaluate data and identify cost effective interventions based on evidence. Neither the Department nor Mr Farrar elaborated on the criteria which should be used to evaluate PCT commissioning. Neither did they tell us how they would identify the actions that would be taken to address poor performance.

44. When we asked him to describe the progress made by PCTs since the introduction of WCC, Mr Dickson informed us that “PCTs were only in the foothills of world class commissioning”.⁷¹ Although the Chief Executives of three SHAs who gave evidence to us argued that PCTs had been successful at commissioning some services, for example Accident and Emergency Services, they also accepted that WCC had yet to fully deliver the hoped for benefits and that PCT performance in this area had been patchy.⁷² Sir Ian Carruthers recognised that the record of some PCTs with regard to tackling Healthcare Associated Infections (HCAIs) was sub-standard. Mr David Nicholson, NHS Chief Executive, was of the same opinion, acknowledging that there had to be greater consistency in PCT commissioning across the country, but also claiming that there were “islands of excellence” although he did not name them.⁷³

SHAs

45. Although the Department hopes that its WCC programme might well over time bring about improvements to PCT commissioning capabilities, in the meantime it will be the responsibility of SHAs to make sure that commissioning staff in PCTs follow guidelines set by the Department and to manage their performance effectively.

46. This will not be easy. Mr Nigel Edwards, Director of Policy, NHS Confederation, explained the difficulty facing SHAs:

Most of these strategic health authorities are about the size of Denmark... “Local” is not really a word that you would use to describe them...The difficult challenge for them is how to do the often incompatible tasks of development and improvement with performance management.⁷⁴

47. However, Mike Farrar told us that he saw his role of performance managing PCTs in NHS North West as vital. He then explained the consequences of not doing so:

It would be unacceptable in my case with 24 primary care trusts for 16 of them to deliver what we are talking about in the north west—improving lives, improving health, but eight, a third of the region, not doing so.⁷⁵

70 Q 348

71 Q 103

72 Qq 348–352

73 Q 249

74 Q 75

75 Ibid

48. SHAs told us that they would manage variations in PCT performance through a combination of initially providing support to and then, failing that, showing less toleration of, poorer performers. Ms Margaret Edwards told us that she saw the role of NHS Yorkshire and the Humber with regard to its PCTs as:

Holding people to account for delivering what they promise to do on behalf of their local populations and making sure that they assess what their population needs and they communicate with them. I would make no apology for holding organisations to account in that way.⁷⁶

She added, and other witnesses agreed, that her role was not to order top-down orders without any evidence to justify them. Rather, the role of an SHA was to ensure that PCTs had carried out appropriate procedures and holding them to account on behalf of the NHS for spending taxpayers' money.⁷⁷ In response to questioning from Members about the role of SHAs, SHA Chief Executives argued that it was important to have a tier between the Department and PCTs, responsible for managing PCTs.

Priorities and Costs

Priorities

49. The NSR and the SHA strategies contain many proposals that are described as a "priority" but do not rank them. We questioned SHA Chief Executives about this "shopping list" approach. Mike Farrar argued that PCTs would ultimately be responsible for deciding which of their priorities they would give greatest importance to,

Because clearly they are the people who are spending the money and resourcing this change. What then happens is that you get this immediate prioritisation, not against areas that you should be involved in but what are you going to go for first, what is the most immediate aspect...and that, I think, is emerging from our PCT plans as we speak about their key priority areas.⁷⁸

The cost of implementation

50. The NSR also contains little detail about how much the NSR will cost to implement. In fact, the NSR devotes only eight paragraphs of the report to implementation, of which nothing is said about the cost of implementation at all. Professor Adrian Newland, Vice President, Academy of Medical Royal Colleges (AoMRC), told us that the NSR was "strong on aspiration but fairly light on the detail of how it will be achieved".⁷⁹ In addition it was argued that some of the incentive systems that were designed to increase productivity in the NHS had not been tried in any other health system. There was therefore no evidence on which to estimate costs or to evaluate them.⁸⁰

76 Q 350

77 Ibid

78 Q 362

79 Q 75

80 DZ 20

51. In responding to these concerns, Lord Darzi argued that the NSR specifically requires PCTs to take on responsibility for implementing the NSR locally and that further detail about costs would become apparent when the PCT strategies were published in 2009; but it is not clear how much information there will be. The Minister claimed that improving quality would over time result in lower costs for the NHS. Improved clinical processes would eradicate waste and duplication and other inefficiencies as well as enabling patients to pass through the system more quickly.

52. The importance of the lack of detail about costs has been heightened since the advent of the present credit crunch. Witnesses told us that the wider economic situation would affect the Department's proposals. According to Professor Mays, although improvements to quality would ultimately lead to cost savings, some quality improvements might require significant initial outlays of resources which might prove difficult to gain from the Treasury in the changed economic environment. Improving quality would require significant initial expenditure such as the costs of establishing systems to measure the quality of patient treatment and outcomes (which we discuss in the next chapter).⁸¹

53. In addition it was argued that although the Secretary of State had pledged that NHS expenditure would not be affected by either the credit crunch or the associated general economic downturn, this now looks unlikely since the Pre-Budget Report of November 2008 which announced a smaller real terms increase to the NHS budget than it had experienced for the last ten years.⁸² The impact of the economic situation on the NHS will, it was argued, make it even more important that the NSR delivers the savings that the Minister hopes will be achieved by improving quality.

Conclusions

54. **The significance of the Next Stage Review owes more to the manner in which it was conducted than to the proposals it makes. Many of its key recommendations, such as the need to improve quality of care, have been made before. However, the involvement of the Strategic Health Authorities is new, as is the extent of consultation with clinicians and patients, which we welcome.**

55. **There is much to commend in the Review, in particular the emphasis on quality and leadership. However, we are concerned about its implementation. This will largely be done by PCTs, but we doubt that most PCTs are currently capable of doing this task successfully. We have noted on numerous occasions, and the Government has accepted, that PCT commissioning is poor. In particular, PCTs lack analytical and planning skills and the quality of their management is very variable. This reflects on the whole of the NHS: as one witness told us, "the NHS does not afford PCT commissioning sufficient status". We consider this to be striking and depressing. We look at ways of improving management below.**

56. **The Department argued that its World Class Commissioning programme will transform PCTs. While the programme has only been in place since July 2007, there are**

81 Q 29

82 HC Deb, col 489, 24 November 2008

few signs yet that variations between PCTs in their commissioning capability have been addressed. The NHS purchasing/commissioning function was introduced nearly 20 years ago and its management continues to be largely passive when active evidence-based contracting is required to improve the quality of patient care. Given the failure of successive reforms to enhance commissioning, implementation of the NSR may be slower and more uneven than the Government hopes. The Government must publish milestones for implementation of the NSR and monitor them rigorously.

57. The Department's other main proposal to improve commissioning is through better use of practice based commissioning. We heard that practice based commissioning had failed to engage doctors and PCTs in the commissioning of services. We are not convinced that the Next Stage Review will succeed in reinvigorating the scheme. Moreover, the role of practice based commissioning in relation to the planned World Class Commissioning by PCTs remains opaque and needs greater clarification.

58. SHAs have an important role in managing the performance of PCTs. However, in recent inquiries we have heard evidence that the performance of SHAs in this area has been inadequate and we doubt SHAs' ability to manage effectively the performance of PCTs. We recommend that their work in this area be evaluated independently and rigorously. If SHAs are to manage performance effectively, they must improve their ability to gather and analyse data and to assess the strategic needs of their region.

59. Department of Health documents have too often provided a long list of priorities without ranking them. It is unfortunate that the NSR repeats this bad habit.

60. The NSR provides little detail about how much it will cost to implement its proposals. Lord Darzi argues that PCTs will produce local strategies with details of costs by spring 2009, but it is unclear how much information about associated costs there will be. He also asserts that, by improving quality, costs will be saved over the long term. However, we are concerned that neither SHAs nor the Department have made clear where and how much will be saved. We recommend that the Department publish, as soon as possible, figures for each SHA region and for each PCT, identifying the cost of implementing the NSR. We also recommend that the Department quantify the savings that it expects to make from improving quality and indicate when the money will be saved.

4 Improving quality in the NHS

“We must have an unwavering, unrelenting, unprecedented focus on quality”.⁸³

Secretary of State, Rt Hon Alan Johnson, 30 June 2008.

61. The Next Stage Review stresses that improving quality must be “the basis of everything we do in the NHS”.⁸⁴ This chapter considers Lord Darzi’s proposals to improve the quality of clinical care provided to patients and then some of the concerns that witnesses expressed about them. First we look at the definition of quality and why the NSR focuses on it.

The definition of quality

62. ‘Quality’ is a term used with different meaning within the NHS and covers many aspects of service provision, including waiting times for treatment, convenience and accessibility, cleanliness of facilities, and patient involvement, as well as the quality and effectiveness of clinical care. In the NSR, quality is defined by Lord Darzi as care which is “clinically effective, personal and safe”.⁸⁵ Sir Ian Carruthers, Chairman of NHS South West, expanded on this theme:

I would define quality as being safety, the experience of the individual, evidence-based best practice, access and taxpayer value, all of which string together to say: how do we improve treatment and the quality of life of individuals?⁸⁶

Addressing variations in quality

63. Variations in quality have been known about by NHS researchers and practitioners since the 1970s. Thirty years later they still remain.⁸⁷ The NSR claims that in 1997 the first priority of the Government had been to increase capacity in the NHS and to shorten waiting times for patients.⁸⁸ Now, Lord Darzi argued

We have fixed the structure—in other words the ratio of doctors and nurses to the number of patients we are treating. We have also dealt with processes—waiting times. It was a free-for-all back in 1994... Intermittently you had to check your waiting list to see how many patients had dropped out from the waiting list. We now have a process metrics which says in 18 weeks that is the treatment plan that you should have. I think what we have missed out on is the qualitative outcome based patient-related metrics, and that is what this report is all about.⁸⁹

83 HC Deb, col 595, 30 June 2008

84 Cm 7432

85 Ibid

86 Q 347

87 DZ 20

88 Cm 7432

89 Q 147

64. There is much recent evidence about variations in quality. They have been highlighted in a number of reviews and audits carried out by a range of organisations including the Healthcare Commission.⁹⁰ Witnesses also provided us with examples. The NHS East of England report, *Towards the best, together*, noted the important “huge variation” in Caesarean section rates between its hospitals (from 15% to 27%) and the wide variation in the numbers of consultant level psychology staff across the region.⁹¹ The NHS North West report, *Healthier Horizons*, drew attention to wide variations in the quality of stroke care within its region. Best clinical practice is not always followed. Mr Nigel Edwards of the NHS Confederation told us that there had been:

A lack of willingness to challenge, including by the professionals themselves. [For example] The Royal College of Physicians has introduced excellence guidance on strokes and yet many of the people who have fellowships with it still operate services which completely fail to the standard that their own college sets.⁹²

Ms Margaret Edwards, Chief Executive, NHS Yorkshire and Humber informed us that:

About 600 people a year [die] in Yorkshire and Humber because we do not provide the best stroke care, not because we do not know what to do. We know what to do, but we do not actually do it, and that is what we really need to address.⁹³

65. Lord Darzi argued that improving quality in the NHS would bring three core benefits:

- 1) A less wasteful use of resources and more cost-effectiveness. Lord Darzi cites the increasingly common practice of patients attending day surgery to remove cataracts, which delivers the highest quality of care without the need to be admitted to hospital and therefore saves costs.
- 2) Improved patient safety. Fewer avoidable healthcare associated infections, which has obvious benefits for patients and reduces the need for costly post-infection recovery in hospital.
- 3) More patient control over their care, including information to make healthy choices, which will reduce their chances of poor health and dependency on the NHS.

Proposals for improving the quality of care

66. Professor Maynard informed us that the Department’s traditional policy to address quality was either to increase the NHS budget or to reorganise the structures of the NHS. Neither approach in his opinion has been systematically evaluated in terms of whether they had delivered a more efficient and equitable service for patients.⁹⁴

90 For example, the 2007/08 Healthcare Commission Annual Health identified two areas where quality of care was inconsistent between NHS organisations: infection control and access to GP services.

91 NHS East of England, *Towards the best, together*, May 2008

92 Q 85

93 Q 347

94 DZ 20

67. Significantly, the NSR does not follow this traditional approach. Instead, the Government makes the case for a new approach: improving quality by measuring both the way that treatment is provided (clinical process) and the effectiveness of the treatment (patient outcomes). According to the NSR, once data has been collated and analysed, those hospitals and organisations which are judged to have provided the highest quality of care will be rewarded financially through the Department's reinvigorated payment by results programme.⁹⁵

Patient outcomes

68. Some measurements of patient outcomes have already been published. Since July 2008 the Healthcare Commission has published data on mortality rates against certain surgical procedures in hospital trusts.⁹⁶ Lord Darzi described the publication of such data as a useful, though blunt, tool.⁹⁷ Because the vast majority of procedures carried out by the NHS were for non-life threatening conditions, a wider set of patient outcome measures, in addition to mortality rates, was required.⁹⁸

69. To that end, the NSR proposes using a combination of measures of patient outcomes covering the collation and analysis of data on clinical outcomes, patient experience and patients' views about the success of their treatment.⁹⁹ The outcome measure to which Lord Darzi gave particular emphasis was PROMs (patient-reported outcome measures) which will be based on a questionnaire designed to measure patients' "experience of four elective procedures: hips and knees, varicose veins and hernia procedures".¹⁰⁰ From April 2009, hospitals will be obliged to measure patients' physical and psychological well being before and after hernia repairs, hip and knee replacements and varicose vein repairs.¹⁰¹ Comparative data about the standard of care provided by clinical teams and hospitals, from the patient perspective, will be published on the Department's *NHS Choices* website.

70. In addition to being published on the *NHS Choices* website, data concerning both the clinical process and patient outcome will be published by hospitals and other NHS organisations alongside their annual financial returns in newly established Quality Accounts. Lord Darzi argued that Quality Accounts would, in time, be seen to be as important to hospitals and trusts as meeting financial targets.¹⁰²

71. Financial incentives will also be used to improve quality. Lord Darzi, told us that funding will be made available, through reductions to the tariff uplift,¹⁰³ so that commissioners can reward trusts for providing improved outcomes. From no later than

95 Cm 7432

96 www.healthcarecommission.org.uk/homepage.cfm

97 Q137

98 Ibid

99 Cm 7432

100 Q 154

101 The Department's intention is that over the next three years PROMs will be extended to other procedures

102 Cm 7432

103 Tariff uplift represents a broad assessment of the overall cost pressures facing the NHS. When it is set the NHS makes use of a range of estimates and forecasts and about its appropriate level.

2010, payments will reward outcomes under the scheme.¹⁰⁴ However, incentives would only form a small proportion of an average hospital's income. Reports following the publication of the NSR suggested that an average district hospital with a turnover of £250 million could expect to receive up to £9 million through the quality payments system.¹⁰⁵ We asked the Department to respond to these reports. The Department told us that:

The comments reported in some media stories at the time of the publication of High Quality Care for All seem to have been based on the suggestion that the CQUIN framework may apply to a larger proportion of income. Whilst the proportion may increase in future years, the decision to set the proportion of income at 0.5% in year one was intended to recognise that using the CQUIN framework will be a developmental journey. It is important to allow organisations a chance to get used to developing local schemes and agreeing the right indicators. Therefore we are setting a reasonably modest proportion of money in year one, and suggesting that organisations may link this to data collection on quality.¹⁰⁶

Clinical processes

72. The NSR does not provide much detail about how clinical processes will in future be measured other than that the NHS “will expand the number and reach of national quality standards, either by selecting the best available standards (including the adoption of the relevant parts of National Service Frameworks) or by filling in gaps”.¹⁰⁷ However, NHS North West region has introduced an innovative scheme for measuring the quality of clinical process. This is *Advancing Quality*, which is currently being trialled in forty hospitals in the North west region. It is part of the Department's commissioning for quality and innovation (CQUIN) scheme, itself based on the incentive scheme run by the healthcare organisation *Premier* in the United States.¹⁰⁸ We were told that *Advancing Quality*, builds on the NHS National Service Framework (NSF) which sets standards designed to measure whether the appropriate clinical guidelines and processes have been followed in the treatment of patients. The *Advancing Quality* scheme will measure the treatment for five conditions.¹⁰⁹ For each condition clinical standards have been established and data will be collected for evaluation after the first year of operation. NHS North West describes this process as “a clinically led, evidence-based approach to improving the reliability of care processes”.¹¹⁰

104 Cm 7432

105 The Times, NHS Review: hospitals that provide poor care to be fined, 1 July 2008

106 DZ 19A

107 Cm 7432

108 Serving more than 2,000 hospitals in the United States, “Premier collects and analyzes clinical and financial data from its member hospitals to determine the best practices and products that drive the best patient outcomes”.

109 It is intended that additional treatments will be measured in the future.

110 DZ 16

Table 9: Advancing Quality**Advancing Quality: key points**

The system will focus on improving the quality of healthcare in NHS North West in 5 areas: acute myocardial infarction, congestive heart failure, coronary artery bypass graft, hip and knee replacements and community-acquired pneumonia.

Within each of the 5 conditions there are 34 standards against which clinical process is measured.¹¹¹

NHS North West predicts that the scheme will save approximately 150 lives a year and about £17 million annually.¹¹²

The SHA predicts that the scheme will save lives, reduce re-admissions, reduce complications and decrease the length of stay in hospital for patients. It will also help hospitals significantly reduce costs.

73. A significant difference from the existing NSF programme is that under *Advancing Quality* NHS North West will amend the existing payment by results system so that hospitals receive a percentage of their payment (tariff) according to the effectiveness with which procedures have been carried out.¹¹³ Mike Farrar argued that, based on the evidence from the incentive system run by *Premier* in the United States, he expected *Advancing Quality* to result in significant improvements in the quality of treatment provided within NHS North West.¹¹⁴

You will have better outcomes clinically, so lower mortality. You will have fewer medical re-admissions, you will have fewer medical errors, you will have a lower length of stay and you will have a lower overall costs of care.¹¹⁵

Concerns about Lord Darzi's proposals to improve quality

74. Witnesses strongly supported Lord Darzi's emphasis on improving quality. It was agreed that two main benefits arose from measuring how treatment is provided: clinicians will adopt more efficient and effective treatment practices and clinical teams and hospitals will be encouraged to perform better by the publication of data about their performance.

111 For example, aspirin on arrival after myocardial infarction, prophylactic prescribed antibiotics an hour before surgery for hip and knee replacements, which we know has a consequence in terms of improving outcomes.

112 DZ 16

113 In the United States scheme, payment is graduated according to performance. For example, those hospitals in the top 10% of performers annually get an uplift of 2% in their PbR income. Those in the second best ten per cent get a 1% uplift. The hospitals in the worst ten per cent of performers lose 2% of the tariff and the second worst ten per cent lose 1% of their tariff.

114 NHS North West claims that "Premier Inc has a proven track record in improving patient care in the not-for-profit health sector and pioneered a similar programme in the US. This had amazing results—saving the lives of 1,300 heart attack patients, reducing heart bypass surgery death rates to 1.6% and improving patient care quality by an average of 11.8% in its first two years."

115 Q 383

75. However, a number of witnesses expressed concerns about some of the proposals. These were: whether incentives would work in the NHS; the possible perverse consequences of linking measurements to incentives; and the lack of detail about the availability and cost of PROMs data.

Can incentives work in the NHS?

76. Mr Nigel Edwards, Director of Policy of the NHS Confederation, accepted the Department's position that incentives can lead to improved care, but cautioned about the Department's new found enthusiasm:

I think the Department of Health have discovered incentives in the last few years, and it has come almost to the point where they believe it is the only answer. I think it has to be part of the package, and if you only rely on these incentives to drive up quality you will be disappointed. There was enough evidence to make it worth trying these out and piloting them. There is probably not yet enough evidence to adopt them.¹¹⁶

Applying the US Premier system to the NHS

77. Sir Ian Carruthers, Chairman of NHS South West, had doubts about whether the system pioneered by *Premier* in the United States would be similarly successful at raising quality in the NHS.¹¹⁷ Professor Maynard informed us that the Premier System had been successful in the US, but he noted a number of potential problems in particular that for the majority of medical interventions the clinical evidence base is absent.¹¹⁸

Penalising poor quality care

78. There was some disagreement among witnesses about whether, in addition to the provision of incentives, hospitals should be penalised for providing sub-standard care. Although he acknowledged that hospitals had been fined for poor patient safety and having high rates of HCAs, Lord Darzi argued that penalising poor quality, for example through fines, was not appropriate:

I think what we are trying to do is to really reward quality of care based on the patient experience and also the outcomes, and that is a completely different phenomena of what we are really talking about when it comes to safety.¹¹⁹

79. However, Professor Mays argued that the Department should penalise poor performing hospitals with a reduction in their tariff:

If we really are serious about using quality measures as a way of influencing payment, why do you not do as some American payers do and say: "30% of your patients

116 Q 89

117 Q 391

118 R.Fleetcroft and R.Cookson, Do the incentive payments in the new NHS contract for primary care reflect likely population gains? *Journal of Health Services Research and Policy*, 11 January 2006

119 Q 160

received a quality of care or an outcome that we thought was suboptimal. We are not paying for that 30%. We will pay for the other 70%”? It would be quite a tough discussion, but if you really are paying for results, given that we know that better care is not always more costly, you have to think carefully about the incentive effect of paying for quality and how you do it best.¹²⁰

Possible perverse consequences of linking measurements to incentives

80. A further concern was expressed by witnesses who warned that focusing on improving certain services might be at the cost of others. For example, Nigel Edwards questioned whether under the US Premier system:

Did all the effort that was put into improving the pathway for myocardial infarct¹²¹ mean that the chronic obstructive airways disease, which was not part of the incentive scheme, suffer from that? There is no evidence on that, but obviously it would be a danger.¹²²

Others agreed and argued that performance should be monitored in areas of care where incentives were not in place so that the effect on other areas could be evaluated.¹²³

Availability and cost of PROMs data

81. Witnesses expressed some uncertainty about when PROMs would be ready and how much PROMs would cost to run. Lord Darzi told us that PROMs, which had been piloted in a trial conducted jointly by the London School of Hygiene and Tropical Medicine and the Royal College of Surgeons, would be introduced and applied initially to four clinical conditions by April 2009.¹²⁴ However, he was less certain about how much it would cost to administer PROMs. Recognising that the proposals for implementing PROMS were not fully formed, David Nicholson, NHS Chief Executive, told us that PROMs would be implemented gradually. This gradual introduction, he argued, would enable the Department and SHAs to address any outstanding issues including how to ensure that groups such as the very elderly, and people who do not speak English very well, receive appropriate assistance to complete their questionnaires.

82. Despite this assurance, other witnesses expressed doubts about whether the April 2009 deadline would be met. Mr Niall Dickson described the timetable for implementing PROMs as “very challenging”.¹²⁵ At the time of this report’s publication, the procurement process involving SHAs and companies to support the administration of PROMs questionnaires and the processing and analysis of data, had not yet been concluded.

120 Q 28

121 Heart attack

122 Q 89

123 DZ 20

124 Q 154

125 Q 90

83. Lord Darzi told us that the Department's working assumption was that the processing of PROMs questionnaire forms would cost about £6.50 per form.¹²⁶ Other witnesses put the likely cost at between £2.50 and £10 per completed questionnaire. It should be noted that none of these figures includes processing and management costs. The Minister was uncertain whether all, or a sample of, patients would be expected to complete the questionnaire forms and recognised that the sample size would have a direct bearing on the cost of the scheme.

84. Professor Maynard argued that more detail on the cost of implementing PROMs was needed. In particular he pointed out that significant costs would be accrued from collecting data from patients before and after their operations. In addition, he thought that effort and expense would be incurred from achieving a high response rate to ensure a statistical significance in the results.¹²⁷

Conclusions

85. **Variations in the quality of care provided by the NHS have existed for a long time. Lord Darzi accepted that despite the doubling of NHS expenditure in real terms since 1997 and a number of reorganisations of NHS structures during that time, wide variations continue. The emphasis of policy for the last decade has been on access rather than improving the quality of care. We do not accept that this emphasis was sensible or that it was necessary to improve access before improving quality. We welcome the change to give more emphasis to quality.**

86. **In principle, like our witnesses, we also welcome the emphasis given in the NSR to seeking improvements in quality through better measurement and the provision of financial incentives for providing a high quality of care. However, we have some concerns:**

- **The Department should not rely solely on the use of incentives to achieve improvements in quality; they should be part of a wider package of measures.**
- **There is a danger that by focusing incentives on a narrow range of clinical services, performance elsewhere might decline.**
- **The incentive scheme on which *Advancing Quality* is based is used in the United States, a very different health system to the NHS. Its effectiveness may not be replicable in the NHS and should be demonstrated by rigorous evaluation.**
- **There is a lack of information about how extensive the PROMs incentive scheme will be; how much it will cost to implement; when it will be fully implemented; and whether it will provide value for money.**
- **The timetable for implementing the initial set of PROMs by April 2009 is challenging. There is a lack of detail about how the PROMs results will be used by**

126 Q 164

127 DZ 20

PCTs and SHAs to provide incentives to improve patient care. Furthermore the implications for the governance of clinicians need careful clarification.

For these reasons, while we strongly support the principle of using financial incentives to improve the quality of care, we recommend that the Department proceed with caution. Schemes such as Advancing Quality and PROMs which link the measurement of clinical process and patient outcomes must be piloted and evaluated rigorously before they are adopted by the wider NHS.

5 Extending “choice” and “personalisation” in primary care

87. Providing patients with greater choice about where and how they access NHS services has been a running theme of the Department’s health policy in recent years. In 2006, for example, *Our health, our care, our say* restated the Government’s commitment to provide more choice for patients about where they access services and to allow commercial providers to provide services. The NSR and its accompanying document, *Our vision for primary and community care*, claimed to take the application of “choice” and “personalisation” further than previous initiatives. The documents describe a “vision” for primary care where care is “shaped by and around individuals”.¹²⁸ According to the Next Stage Review, this vision will be realised by giving patients “more rights and control over their own health and care” and by the NHS providing them with “more information and choice to make the system more responsive to their personal needs”.¹²⁹

88. The NSR made the following significant proposals which were aimed at extending “patient choice” and greater “personalisation”:

- additional resources for areas with the greatest health needs;
- the introduction of GP-led health centres; and
- the introduction of personalised care plans and the piloting of personal budgets.

Additional resources for areas with greatest health needs

89. Lord Darzi’s interim report, *Our NHS, our future* announced that £100 million would be made available to fund 100 additional GP surgeries in “areas with the fewest GPs and greatest health needs”.¹³⁰ The document did not make clear how it would be decided which PCTs would receive this money. Some witnesses thought this would be a difficult decision. Professor Field, Chairman of the Royal College of GPs told us:

In my own practice area, if you can survive crossing the busy road in two halves of the area, life expectancy is ten years longer in one part than the other, and so you can look at that. The workforce distribution is a health inequality issue, the make-up of the local population, the deprivation, is another issue, and these are the sorts of things that public health departments look at.

On the other hand, the Department assesses need as part of the formulae used for PCTs budget allocation and it should be possible to allocate the additional money to areas with high Standardised Mortality Rates.

¹²⁸ Department of Health, Next Stage Review, *Our vision for primary and community care*, July 2008

¹²⁹ Cm 7432

¹³⁰ Department of Health, *Our NHS, our future*, October 2007

A GP-led health centre in each PCT

90. In October 2007 *Our NHS, our future* announced that the NHS had been given £150 million to build a new GP-led health centre in every PCT by 2010–11.¹³¹ By November 2008, ten contracts had been signed with organisations to build GP-led health centres. On 28 November the first centre was opened in Bradford, Yorkshire. The Department expects about twenty centres to have been opened by March 2009.¹³²

91. Lord Darzi claimed that GP-led health centres were a response to two developments in primary care: changing patient expectations and the desire where possible to move services out of hospitals closer to where patients live. The centres have several objectives:

- to increase the capacity of primary community services and thereby improve access;
- to provide more choice for patients;
- to tackle some of the inequalities in healthcare; and
- to encourage team working between a range of health care professionals located in one building.

92. Patients, the Minister claimed, increasingly wanted to visit their doctor outside the traditional 9 a.m.–5 p.m. working day, perhaps on their way to or from work. GP-led health centres, he argued, would provide GP services for patients at a time that is convenient to them. In addition he argued that patients wanted increasingly to receive a range of treatments either close to their home or work and that in some areas single-handed general practitioners may struggle to meet these requirements.¹³³ The centres would not just treat patients when they were ill, they would also manage long-term conditions proactively and offer a range of preventive services to keep the population as healthy as possible. In addition, if PCTs so determined, the new centres could provide a range of routine diagnostic procedures such as blood testing and scanning which were traditionally carried out by hospitals. This would, it was claimed, aid patients because their treatment could be carried out at the same facility without requiring referral to hospital.

A polyclinic for each London PCT

93. The plan for the GP-led health centres was a development of the recommendation Lord Darzi made in *A Framework for London* that polyclinics should be established in each PCT in NHS London.¹³⁴ In NHS London, plans for five polyclinics had been announced by November 2008. The new facilities are expected to open by March 2009.¹³⁵

94. The plans for London polyclinics differ from GP-led health centres in a number of ways set out in the table below.

131 Department of Health, *Our NHS, our future*, October 2007

132 DZ 19A

133 Cm 7432

134 NHS London, *A Framework for London*, July 2997

135 The first five polyclinics will open in Harrow, Hounslow, Lambeth, Redbridge and Waltham Forest PCTs.

Table 10: Attributes of GP-led health centres and London polyclinics

GP-led health centres will: ¹³⁶	London Polyclinics will provide access to services such as:
<ul style="list-style-type: none"> • be open 8a.m.–8p.m., 7 days a week; • offer GP appointments and walk-in services; • provide services for both registered and non-registered patients. • potentially provide a wide range of diagnostic services as decided by PCTs. In addition, they will • be located in an easily accessible location. 	<ul style="list-style-type: none"> • Antenatal and postnatal care; • community mental health services, community care, • social care and specialist advice; • diagnostics and consulting services for outpatients (to allow a shift of services out of hospital settings). In addition, • they will be located where the majority of urgent care centres are based.

95. Polyclinics were expected to provide a wide range of services, including GP and pharmacy services and, like the plans for GP-led health centres, some diagnostic services traditionally carried out in hospitals. *A Framework for London* also envisaged that polyclinics could house other services such as dentistry, physiotherapy, family planning and mental health services, although it was vague about the extent of the services that would be provided and at what cost. Lord Darzi argued that the capital was suited to such a concentration of services owing to the ready availability of public transport that enabled patients to travel easily to the polyclinics. The absence of these advantages meant that the London polyclinic model was not applicable to PCTs outside of the capital especially in rural areas, where concentrating GPs in one place could create serious problems of access.

The model for GP-led health centres

96. Initially, it was emphasised that the funding for the new centres was for new capacity—not the expansion or replacement of existing surgeries or health centres. Commercial providers of healthcare would be able to bid to run the centres under the Alternative Provider of Medical Services (APMS) contract.

97. Subsequently a “federated model” as proposed by the Royal College of GPs, became an accepted alternative means of delivering the centres. In a federated model a network of GP practices would remain in their existing buildings but would be linked to what the Royal College of GPs called a local referral centre, which would provide diagnostic tests and

outpatient clinics, and would be housed either in a separate building or in a GP practice.¹³⁷ The Department told us that it was up to PCTs to decide which model they chose:

Every PCT has been asked to undertake an open and transparent procurement to identify providers for these new services, to ensure they consider the full range of innovative service models from all potential providers including existing GPs, social enterprises, and independent, third sector and secondary care providers.¹³⁸

98. The Department confirmed that PCTs would decide which services GP-led health centres provided over and above the core requirements listed in the table above. At the time of our report it was unclear how PCTs intended to staff the centres including for example what the mix between doctors, nurses and other clinicians will be, or even how large or small GP-led health centres might be.

Witnesses' opinions about GP-led health centres

99. Of all the proposals contained in the NSR, those for GP-led health centres have been the most contentious. Several witnesses supported the introduction of these centres. The Royal Pharmaceutical Society told us that the centres could deliver real benefits for patients through the closer integration of services provided by pharmacists, GPs and other primary and community care providers.¹³⁹ Assura, a commercial health provider, claimed that the centres would benefit patients because they would be able to exercise more choice about where they received treatment. According to the organisation, the NHS would benefit from making savings as a result of increased competition.¹⁴⁰

100. On the other hand, there were many criticisms of the GP-led health centres:

- they have been imposed by the Department regardless of whether a PCT needs one or not;
- they will adversely affect existing GP services; and
- there is a lack of evidence that they improve quality or provide value for money

A "One-size fits all" approach

101. Each PCT will be obliged to create a GP-led health centre. Lord Darzi argued that PCTs would welcome this because all areas of the country would benefit. His argument seemed to be reinforced by the October 2008 Healthcare Commission report on GP access which highlighted the difficulty experienced by some patients in every part of the country in obtaining an appointment with their GP within 48 hours.¹⁴¹

137 DZ 03

138 DZ 19 A

139 DZ 03

140 DZ 12

141 www.healthcarecommission.org.uk/homepage.cfm

102. However, a number of witnesses argued that GP-led health centres were not needed by all PCTs. It was argued that PCTs varied greatly in terms of geographical size, demography and disease burden and therefore had different requirements for health services. Dr Meldrum of the British Medical Association (BMA), told us that it had:

been misconstrued in many areas that the BMA was totally against any change, totally against GP-led health centres—that was not the case.¹⁴²

He added that whereas some PCTs might well require additional primary care services, others did not and he objected strongly to the Department's insistence that every PCT must have a GP-led health centre.¹⁴³ In addition, Dr Meldrum argued that some PCTs were planning to create GP-led health centres without prior consultation and sufficient forethought in areas where they were not needed and without prior consultation:

I work in East Yorkshire, a fairly rural PCT, a PCT which was told that it must have a new GP-led health centre. There is a problem as to where you put it; so they decided to put it in Bridlington, where actually, though I say so myself, GP services are reasonably good and it is not going to help probably about 80% of the population in East Yorkshire, whereas Hull, down the road, could perhaps do with two or three.¹⁴⁴

Although the BMA accepted that access to GP surgeries was poor in some areas, the organisation argued that in rural areas with poor transport links, new GP-led health centres would not benefit most people, only those who lived close to them. It would be more cost-effective to invest in improving existing GP surgeries.

103. Evidence from the Better Local Healthcare Campaign, Haringey, claimed that there could be problems in urban areas too.¹⁴⁵ Access to polyclinics in some areas of London would also be difficult for some patients. The organisation argued that in large PCTs in the capital, people with mobility problems, the elderly, and people with low incomes would find it difficult to travel a significant distance to access services in a polyclinic which might previously have been provided much closer to home in hospitals. We followed up Dr Meldrum's views by asking him how to decide whether a PCT area needed a GP-led health centre or not. We did not receive a very clear answer. Dr Meldrum told us:

We have our local structures, our local medical committees, where we get information about what they feel about GP services, what the public opinion is of access and the quality of their present services...Rather than parachuting in a new surgery, why not develop the existing ones and build on the good practices already taking place.¹⁴⁶

104. Other witnesses agreed that not all PCTs would benefit from a GP-led health centre or polyclinic. Niall Dickson, argued that the Department's requirement that all PCTs should

142 Q 292

143 A petition with over 1.2 million signatures supporting the BMA's Support our surgeries campaign was presented to Downing Street in June 2008.

144 Q 292

145 DZ 07

146 Q 304

establish a centre represented what he called “classic top-downism”. The King’s Fund thought that the location of GP-led health centres should be a matter “to be decided locally on a case-by-case basis using the best clinical evidence available together with a full assessment of the costs and the impact on patient access”.¹⁴⁷

The effect on local health economies

105. Lord Darzi insisted that GP-led health centres should be seen as complementary to existing primary care provision, not a threat to it. Ms Margaret Edwards, Chief Executive of NHS Yorkshire and the Humber, agreed with this assessment and argued that the impact on existing GP practices would be minor because they would be introduced in such a limited scale. The effect on policy would be trivial too:

We have got over 800 GP practices and we are being asked to increase by 14. It is a drop in the ocean, it is less than...a 2% increase. If it had been a 30% increase imposed [by the Department], I think that would have been a different debate.¹⁴⁸

106. There was particular concern about the impact of commercial providers. The BMA claimed that Lord Darzi’s proposals were designed to increase commercial provision of primary care services at the expense of existing GPs. The organisation had run a “Support your surgery” campaign throughout 2008 against the Department’s plans which was designed to gain support from patients against the Department’s plans for primary care. In particular, the campaign was against what the BMA called the “Department’s central directive to SHAs to use the APMS (Alternative Provider of Medical Services) contract, in a process which is geared towards the commercial sector and thus, the implied disregard for the ‘traditional’ independent contractor model”.¹⁴⁹ Dr Meldrum thought that,

There is a possibility—in the main, initially, a lot of the contracts were very much geared to the commercial sector—that if commercial GP premises are set up, in effect in opposition to existing ones, then it could put the existing ones under threat good or bad or both.¹⁵⁰

107. During our inquiry we became concerned that under the umbrella of the BMA’s national campaign, efforts were made to unsettle patients by issuing misleading literature about the Department’s plans for health centres and encouraging patients to vote against their Member of Parliament if they had expressed support for the centres. When we asked Dr Meldrum whether the BMA supported these tactics, he told us:

No, and I would not support that at all. Actually we put out with all the documentation something that talked about the law and political neutrality and defamation, and, therefore, I think, hinting at how people should vote in an election we would not support at all and I would condemn that.¹⁵¹

147 DZ 01

148 Q 423

149 DZ 03

150 Q 295

151 Q 294

108. Mike Farrar, NHS North West argued that critics of GP-led health centres, including the BMA, should welcome the proposals because they were boosting the provision of primary care. He argued that opposition to the new facilities was more concerned with protecting GPs' professional interests from commercial providers,

I think it is much more, from the BMA's perspective, about who is involved in providing that primary care...in this case, interestingly, [the Department] brought in some alternative potential providers, subject to their winning contracts because they are the best providers of course and they can deal with the quality of care, and I think it is that that the BMA is concerned about.¹⁵²

109. Recent developments suggest that Dr Meldrum's fears might be misplaced. A combination of the "credit crunch" and suggestions that PCTs are favouring the terms of their contracts towards GP federations over commercial bidders had led to reports that commercial organisations are having second thoughts about pursuing GP-led contracts.¹⁵³

110. In addition to these concerns witnesses, including Professor Field, expressed the view that competition from the new centres could draw patients away from smaller existing local GP practices, forcing them to close. It was argued that some GP practices were at the heart of communities and the services they provided were greatly valued by patients they served. The introduction of GP-led health centres would destabilise these practices unnecessarily and harm the continuity of care provided particularly to vulnerable patients.¹⁵⁴

111. Nigel Edwards argued that the impact on the local health economy would depend on the particular PCT:

There will be parts of the country, where it has been very difficult to get practices to open late and at weekends, where maybe they are not as responsive to the needs of improved quality as you would like. In those cases, it might be that a certain amount of destabilisation is precisely what you do want to achieve. In other areas, where you have very good general practice... why would you want to destabilise that? You would want to develop that?¹⁵⁵

112. There remain a number of unanswered questions about the effect that the centres will have on local health economies. The BMA has stated that GP-led health centres might not undermine existing practices, but instead would not treat as many patients as expected. This could lead to over-supply of GP-services in some areas, raising costs by creating services which are not needed.¹⁵⁶ There was a possibility that GP-led health centres might create additional demand for hospital care because they will increase the number of patient referrals to hospital.¹⁵⁷

152 Q 427

153 Financial Times, "Private bidders find GP contracts too risky", 13 November 2008

154 Q 11

155 Q 96

156 DZ 02

157 DZ 20 A

The lack of evidence that GP-led health centres improve quality of care, promote closer working or provide value for money

113. The NSR emphasised the importance of basing decision-making in healthcare on evidence. As we have discussed earlier, many of Lord Darzi's proposals including those for measuring quality will be the subject of pilot studies and evaluation before they are introduced more widely. In contrast, however, GP-led health centre programme appears to have been introduced without any prior pilot testing.

114. However, health centres similar to the model adopted by the NSR do exist overseas and the King's Fund has published a report, *Under One Roof*, examining polyclinics in Germany and the United States.¹⁵⁸ We questioned Niall Dickson, Chief Executive of the King's Fund, about its findings. The Report concluded that, although polyclinics appeared to have had some success at providing a wider range of services closer to patients' homes, there was no evidence that they had improved care to patients or provided care more cost effectively.¹⁵⁹

115. Proponents of GP-led health centres argue that they facilitate the closer working of healthcare professionals, thereby benefiting patients through the provision of more integrated care. Niall Dickson argued that the study of polyclinics in Germany and the United States had shown that getting different clinicians to work together effectively took a great deal of effort and time. He told us:

Simply bringing them in under the same roof does not necessarily mean that they will work better or that they will start working together. That is not an argument for not doing it but it is an argument, if you do it, to really think it through. It is not a question of saying, "X just open your office there and Y have your office there, and then it will all be fine". You have to really change the pathway of care and integrate the way in which those services are offered if they are going to be effective.¹⁶⁰

116. Some witnesses told us that the NHS would benefit from making savings as a result of increased competition provided by commercial providers.¹⁶¹ However, other witnesses, including Professor Mays, doubted whether there was any evidence for this view and argued that the Department had not addressed the issue of whether GP-led health centres would provide value for money. Professor Field told us that that the Royal College had tried to find some evidence the centres would be cost-effective, but "had not found any".¹⁶²

117. The Department informed us that the evaluation of the first five polyclinics in London (which are expected to open in March 2009) had not yet been designed:

Healthcare for London are currently drafting an invitation to tender for the evaluation of the polyclinic model across London. There is no firm timescale for this at present.

158 King's Fund, *Under One Roof: Will polyclinics deliver integrated care?* June 2008

159 Ibid

160 Q 95

161 DZ 12

162 Q 10

The consequence of this is that the collection of baseline data will be difficult if not impossible and “before and after” comparison of performance even more difficult. It is also unclear how the results of the evaluation will be used to inform the roll out of the programme.

Personalisation

118. Linked with proposals to extend choice through GP-led health centres are the NSR’s proposals to increasingly shape services around patients through personal care plans and personal budgets.

Personal care plans

119. The NSR describes care plans as:

Packages of care that are personal to the patient. It involves working with professionals who really understand their needs, to agree goals, the services chosen, and how and where to access them.¹⁶³

Personal care plans are not new in the NHS. The NSR state that according to the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians:

International best practice suggests that control by a patient is best achieved through the agreement of a personal care plan. In Germany, nearly two-thirds of people with long-term conditions have a personal care plan, whereas the same is true for only a fifth of people in this country.¹⁶⁴

The NSR proposes extending the provision of the care plans over the next two years: fifteen million people with one or more long-term conditions such as asthma or diabetes will be offered “a personalised care plan, developed, agreed and regularly reviewed with a named lead professional from among the team of staff who help manage their care”.¹⁶⁵

120. The limited evidence we received on personal care plans was favourable to the extension of the scheme,¹⁶⁶ although some concern was expressed by *Help The Aged* that while developments in the care of individual conditions such as heart disease, stroke and cancer are welcome, the wider health and care needs of frail, older people should not be overlooked.¹⁶⁷

Personal budgets

121. The announcement in the NSR that the Department will conduct trials of personal budgets represents a fundamental shift in the Department’s policy. In the White Paper *Our health, our care, our say* (January 2006) the Government stated as follows:

163 Cm 7432

164 Cm 6737

165 Cm 7432

166 DZ 15

167 DZ 08

It has been suggested that we should extend the principle of individual budgets and direct payments to the NHS. We do not propose to do so, since we believe this would compromise the founding principle of the NHS that care should be free at the point of need. Social care operates on a different basis and has always included means testing and the principles of self and co-payment for services.¹⁶⁸

122. However, two years later the Department's position had changed. It now argued in the NSR that personal budgets will have the potential to:

Empower patients. We will explore the potential of personal budgets, to give individual patients greater control over the services they receive and the providers from which they receive services.

123. Personal budgets (sometimes called individual budgets or direct payments) have been trialled by approximately 6,000 patients in social care, a figure expected to reach 1.7 million people by 2011.¹⁶⁹ The Department of Health set up pilots in 13 English local authorities, running from November 2005 to December 2007, and commissioned an evaluation by academics from the Universities of York, Kent, Manchester and the London School of Economics.¹⁷⁰ According to the evaluation, people receiving a personal budget were significantly more likely to report feeling in control of their daily lives, welcoming the support obtained and how it was delivered, compared to those receiving conventional social care services.

124. The generally positive experience of pilot studies of personal budgets in social care has encouraged Lord Darzi to pilot a similar scheme in health care. Lord Darzi told us that pilots of personal health budgets will begin in early 2009. The pilots will test three models:

- Notional budgets, where patients know what the cost of their treatment is;
- Hard budgets, possibly with a clinician or a nurse to assist the patient in making choices; and
- Cash budgets where patients are able to choose the treatment that they want.

The pilots, which are likely to involve only patients with long term conditions will, according to Lord Darzi, be evaluated rigorously before a decision is made on whether they will be introduced more widely.¹⁷¹

125. A number of witnesses were cautious about how quickly to proceed. For example, Mr Niall Dickson cautioned that there might be difficulties in transferring the experience of social care to health care. He also noted that there had been resistance to personal budgets by some practitioners of social care and warned us that that might be replicated during trials in health care.¹⁷²

168 Cm 6737

169 Cm 7432

170 <http://www.kcl.ac.uk/research/>

171 Q 192

172 Q 115

126. However, other witnesses welcomed the decision to pilot the alternative schemes. For example, Professor Mays described the plans as, “Spot on. It seems to me it is robust innovation and, if they wait until the pilots have been evaluated, that would be a welcome innovation”.¹⁷³ This view was reinforced by Professor Newland (AoMRC) and Niall Dickson of the King’s Fund who described the pilots as “commendable”.¹⁷⁴

127. The *Diabetes Society* and *Help the Aged* argued that for personalised budgets to work in health care patients will need support in making informed choices about how to plan their own care. They also argued that clarity was needed about what exactly patients will be allowed to spend their allotted money on.¹⁷⁵ For example, whether patients will be able to spend their budget on alternative therapies and treatments that have not been approved by NICE. Mr Niall Dickson told us that difficult decisions would have to be made,

At the most extreme case, you might say that if somebody was an alcoholic you would not hand them over some money and say, “That’s fine, just head off to the pub.” There are other, for example, unproven therapies which somebody might say, “That’s what I want to use my budget for.”¹⁷⁶

He also raised the issue of whether personal budgets could lead to inequity between patients.

[If the NHS was to say] “There is £1,000 to manage your long-term condition,” then if I have additional resources I could say, “Yes, I’ll take that £1,000 and I’ll top it up with my £500” and now I have £1,500. That would fundamentally undermine a basic principle of the NHS, which is equity of care. Just the same as now then?”¹⁷⁷

Conclusions

128. We welcome the provision of additional primary care services. There are strong arguments for increasing provision in under-doctored areas. However, this expansion in supply needs careful management and evaluation to determine whether it leads to better evidence-based medical interventions for patients and whether it reduces disparities in health care access and utilisation between different social classes. It should be recognised that the investment in primary care might increase demand for hospital care as deprived people get better access to care and referrals increase with more diagnostic tests.

129. £100 million has been provided for extra capacity in areas of need. The allocation of this money should be determined by national criteria measuring deprivation. PCTs and SHAs should be required to use these criteria and locate facilities where access and utilisation is poorest.

173 Q 36

174 Q 115

175 DZ 08, DZ 15

176 Q 115

177 Ibid

130. The Government has proposed that there should be a GP-led health centre in each PCT. While some PCTs, particularly those which are “under-doctored” or with a high burden of disease, would undoubtedly benefit from providing more primary care services it is less clear how other PCTs would benefit. We are not convinced by the Department’s argument that all PCTs should have a GP-led health centre. Whether PCTs have such a centre should be a matter as a witness stated: “to be decided locally on a case-by-case basis using the best clinical evidence available together with a full assessment of the costs and the impact on patient access”. PCTs should not make their decisions on a whim, but national criteria should be set out for them to follow to ensure that benefits and costs of their decisions are known. We were disappointed that neither the Government nor witnesses representing doctors could tell us what criteria should be used to decide whether a PCT needed a GP-led health centre.

131. While polyclinics and GP-led health centres can bring benefits, we are disappointed that the Department is introducing them without prior pilots and evaluation. The evaluation of the first 5 polyclinics in London is yet to be designed making the collection of baseline data difficult if not impossible and “before and after” comparison of performance even more difficult. It is unclear how this evaluation, which will be commissioned in early 2009, will be used to inform the roll out of the programme. There is a risk that roll out will precede the results of the evaluation, which has the potential to waste taxpayers’ money and be grossly inefficient. The evidence that similar centres in Germany and the United States improve the quality of patient care and provide value for money is mixed.

132. GP-led health centres offer the potential for closer collaborative working between GPs, pharmacists and other clinicians. This should benefit patients by providing them with more integrated care. However, simply bringing health professionals under the same roof does not necessarily mean that they will work better or that they will start working together. The Department should give consideration to how closer integration will be achieved in practice.

133. The Department’s decision to conduct trials of personal budgets is welcome if it is done rigorously and policy makers wait for the results before large scale roll out of the programme.

6 The draft NHS Constitution

134. A *consultation on The NHS Constitution* was published on 30 June 2008 alongside the NSR. The document set out a number of principles and values which were drawn up following the Department's consultation with lawyers, think tanks, experts and other "stakeholders". In addition, it sets out the NHS commitment to patients, public and staff in the form of rights to which they are entitled and the responsibilities which the Department argued patients and the public owe to the NHS. Following its publication, the public was asked to comment on the content of the draft Constitution by 17 October 2008.

135. The Department argued that a consultation on a constitution was necessary because 60 years on from the establishment of the NHS it was time to "renew and secure our commitment to the enduring principles of the NHS, making sure that it continues to be relevant to the needs of patients, the public and staff in the 21st century".¹⁷⁸ According to Lord Darzi, an NHS Constitution will:

- Secure the NHS for the future.
- Empower all patients and the public.
- Empower and value staff.
- Create a shared purpose, values and principles.
- Strengthen accountability through national standards for patients and local freedoms to deliver.

136. Proposals to establish the NHS constitution were contained in the Queen's Speech which opened the 2008–09 parliamentary session.¹⁷⁹ The Speech indicated the introduction of an NHS Bill which proposes the establishment of an NHS constitution requiring all NHS bodies (including Foundation Trusts) and private and third sector providers of NHS services "to take account of the Constitution in their decisions and actions". In addition, the proposed legislation will require the Government of the day to "renew the NHS Constitution every 10 years, with the involvement of the patients who use it, the public who fund it and the staff who work in it".¹⁸⁰

137. We took evidence on the draft constitution before the end of the consultation period and the Queen's Speech. Because at the time of this report the NHS Bill has not been published, it is uncertain how different the final constitution will be from the draft that was subject to public consultation; however, the novelty of the document and the potential impact claimed for it by Lord Darzi merited our attention. In this section we describe briefly some of the content of the document before discussing further the proposals affecting patients' rights to treatment and its implication for NICE.

178 Department of Health, *A consultation on The NHS Constitution*, July 2008

179 HC Deb, col 8, 3 Dec 2008

180 Department of Health, *A consultation on The NHS Constitution*, July 2008

138. The draft constitution contained three main parts. Part one sets out the seven principles by which the NHS should operate, while part two describes what patients and staff could expect from the NHS in terms of legal rights and pledges made by the Department. Finally the document sets out what the Department sees as the responsibilities of patients and staff to the NHS.

Principles

139. According to the NSR, the principles of the NHS are “intended to be the enduring high-level rules that govern the way that the NHS operates, and define how it seeks to achieve its purpose”. The principles identified are:

- The NHS provides a comprehensive service, available to all;
- Access based on clinical need not an individual’s ability to pay;
- High standards of excellence and professionalism;
- NHS services must reflect the needs and preferences of patients, their families and their carers;
- The NHS works across organisational boundaries and in partnership with other organisations;
- The NHS is committed to providing best value for taxpayers’ money and the most effective and fair use of finite resources; and
- The NHS is accountable to the public, communities and patients that it serves.

The document then encouraged readers to comment on the principles and make suggestions for any others that should be added.

Legal rights and pledges

140. The draft constitution is the first time that NHS patients’ existing legal rights have been written down in a single document. Lord Darzi claimed that this was a worthwhile exercise:

As a clinician working in the NHS for 18 years a lot of this was foreign news to me. I knew about consenting patients, I knew about dignity and respect, and I could not agree more with that, but some of the rights in there certainly were not familiar to me.¹⁸¹

141. The patient rights covered were wide ranging, including access, the quality of care, respect and confidentiality, informed choice, complaint and redress if things go wrong. The document also explains who is accountable if mistakes are made and how patients can make complaints. In addition to what the Department described as existing patient rights, The draft NHS Constitution proposed the creation of two new rights: the right to

“universal patient choice” and “to drugs and treatments that have been recommended by NICE”.

142. According to *A consultation on The NHS Constitution*, the pledges it listed are commitments that the Department will strive to achieve a particular outcome or standard, but which it could not guarantee that it will meet each time. Accordingly they will not be subject to legal action if they are not met. It could be argued that the pledges are somewhat vague, for example the pledge that “The NHS will strive to make decisions in a clear and transparent way”. Despite this, David Nicholson, NHS Chief Executive, argued that the pledges should be considered as important as the rights identified in the document but that they had been expressed as commitments rather than legally enforceable rights because, what “we did not want to do was to create something that became a lawyers’ charter”.¹⁸²

Responsibilities

143. The draft constitution also lists patients’ and the public’s responsibilities to the NHS organisation and the staff who work in it. These range from requiring a patient’s commitment to register with a GP practice and to follow any treatment prescribed by a clinician, to a commitment to give feedback about treatment. Only one responsibility is legally enforceable: the duty not to cause a nuisance to NHS staff on hospital premises. The constitution rules out the option of linking any responsibility to a sanction, for example denying them treatment.

Witnesses’ concerns about the draft constitution

144. We did not receive a great deal of evidence about the draft constitution, but the evidence we did receive was largely favourable. For example, The King’s Fund welcomed the draft NHS constitution as “a positive statement of patients’ rights and how they can exercise them, as well as what services the public can expect to receive”.¹⁸³ The NHS Confederation thought that an NHS Constitution “could be a driver for change”.¹⁸⁴ Two broad concerns however were identified by witnesses: whether the draft constitution adequately reflected the balance between rights and responsibilities; and whether the public would engage with it. In addition, some doubt was expressed about whether the right to NICE approved treatments would end the “postcode lottery” for patients.

Too many rights, too few responsibilities?

145. A number of witnesses expressed concern that in its attempts to avoid creating what David Nicholson called a “lawyers’ charter”,¹⁸⁵ the draft Constitution was lop-sided and had given insufficient weight to the importance of patients’ responsibilities towards the NHS. For example, Niall Dickson, Chief Executive of the King’s Fund, argued that:

182 Q 258

183 DZ 01

184 DZ 05

185 Q 258

There are an awful lot of rights and very few responsibilities...I understand why that is, because the responsibility side is difficult, because enforcing the sanctions is more difficult. But having some responsibilities there is good in itself, just as a recognition that we, as the people using the service, do have a responsibility to look after our own health but also a responsibility in how we use and handle the service.¹⁸⁶

Professor Newland, President of the Academy of Medical Royal Colleges reinforced Niall Dickson's argument:

The balance between rights and responsibilities needs to be looked at in more detail: at the moment patients have rights but no responsibilities, and it seems that the staff in the NHS have responsibilities but few rights. I think we need to balance those.¹⁸⁷

Relevance of the Constitution

146. If the constitution is to realise the Department's objective "to renew and secure the public's commitment to the NHS", then it follows that patients and the public must engage with the constitution and make active use of the rights and pledges contained in the document as well as discharging their responsibilities. The test of the Constitution in practice will be the extent to which it helps patients to make choices about their care. Niall Dickson was hopeful that:

[The Constitution] will be something that people can identify genuinely where the service should be giving them service and where it is falling short and enable them to challenge in a sensible way. If it does that, that is a good thing. It keeps the service on its toes.¹⁸⁸

However, Mr Dickson also cautioned that there was no guarantee that patients and the public would view the Constitution in this positive light. There were, he argued, two potentially less attractive outcomes:

One is that nobody takes a blind bit of notice of it and it is just a lot of waffle. The other is that it is somehow misused.¹⁸⁹

The right to approved treatments

147. As we noted earlier, one of two new rights identified in the draft constitution was the right "to drugs and treatments that have been recommended by NICE for use in the NHS, if your doctor says they are clinically appropriate for you".¹⁹⁰ In addition to the establishment of "patients' rights" to treatment, the NSR makes two other significant proposals regarding NICE:

186 Q 129

187 Ibid

188 Ibid

189 Ibid

190 National Institute for Health and Clinical Excellence (NICE), the body responsible for providing guidance on public health, health technologies, and clinical practice (the use of new and existing medicines, treatments and procedures)

- The NICE budget will be increased threefold to £90 million per annum from 2009.
- NICE will no longer wait until a drug has been licensed before starting its assessments.

148. Lord Darzi argued that the effect of the proposals is that PCTs will no longer be able to deny patients potentially life-saving treatments on the grounds of cost only. This is intended to end the so-called "postcode lottery" of drug treatments, which has seen patients in some areas denied funding for drugs that are freely prescribed by other PCTs.

149. The purpose of the proposal to speed-up the NICE decision-making process is that NICE will issue appraisal guidance on or around the drug's launch, as we recommended in our 2007 report on NICE.¹⁹¹ The Department hoped that this would reduce the time from a drug's approval by NICE to being available for prescription by doctors, to a maximum of six months, a process which we found in our 2007 inquiry into NICE can take up to two years.¹⁹²

150. Witnesses generally welcomed the commitment made in the draft constitution that patients would receive clinically appropriate drugs and treatment, regardless of where they lived. Ms Margaret Edwards, Chief Executive, NHS Yorkshire and the Humber claimed that:

It will dramatically help. It will be a help to speed up because obviously one of the difficulties at the moment in terms of consistency is when PCTs have to make decisions about drugs that are awaiting NICE approval, so the sooner we can get that, obviously the less of those there will be.¹⁹³

151. However, witnesses also argued that the post code lottery determining access to drugs and treatments not on the NICE approved list would not end. PCTs would continue to make different decisions about whether to approve payment for "non-clinically approved drugs and treatments".

152. The proposal to speed up the NICE approval process was also welcomed by witnesses including David Pruce, Director of Policy, Royal Pharmaceutical Society. However Mr Pruce warned that there would be significant cost implications:

We have to think carefully about the balance between highly expensive innovative medicines and, if you like, the bread and butter medicines that are used for the majority of patients. You do get a potential skewing towards the highly innovative new medicines. I have worked in the Health Service for many years and had to manage complex, strict drugs budgets that could be skewed as soon as a new medicine came out. The NHS needs to come to some decisions over what it is going to fund and what it is not. It is a very difficult area to make decisions on.¹⁹⁴

153. In November 2008, following the conclusion of our evidence-taking for this inquiry, the Government made a significant announcement which would have potentially

¹⁹¹ Health Committee, First Report Session 2007–08, *National Institute for Health and Clinical Excellence*, HC 550

¹⁹² Ibid

¹⁹³ Q 440

¹⁹⁴ Q 28

significant consequences for PCTs and NICE. Following his inquiry, Professor Mike Richards, the Government's "Cancer Czar", published *Improving access to medicines for NHS patients: a report for the Secretary of State for Health*.¹⁹⁵ The Report announced a series of recommendations aimed at improving access to medicines for NHS patients and made observations on the consequences for NHS patients of seeking additional private care. Following the publication of the report, we announced that we would hold an inquiry into his report's findings beginning in January 2009.¹⁹⁶

Conclusions

154. The draft NHS constitution is, according to the Department, the first time that the principles, values, rights and responsibilities of patients and staff in respect of the NHS have been set out in a single document. We have heard a number of concerns about the Constitution, in particular, that it should not include too many legal rights; we note the NHS Chief Executive's view that the constitution should not be a "lawyers' charter".

155. We also heard concerns that the draft NHS Constitution included "an awful lot of rights and very few responsibilities". We recommend that the Department ensure that the Constitution gives sufficient emphasis to the responsibilities of patients and staff to the NHS.

156. On the other hand, there is a concern that the Constitution will fail to engage the public in a meaningful way because people will view it as "a lot of waffle" without rights to care and treatment that are legally enforceable.

157. We welcome the establishment of a patient's right to drugs and treatments that have been recommended by NICE for use in the NHS. However, it is important that it is recognised that the commitment will not by itself end the post code lottery which determines access to drugs and treatments not on the NICE approved list.

195 Department of Health, *Improving access to medicines for NHS patients: a report for the Secretary of State for Health*, 4 November 2008

196 www.parliament.uk/parliamentary_committees/health_committee/hc0708pn27.cfm

7 Measures to improve the leadership and workforce of the NHS

158. The key to implementing the Next Stage Review and improving the quality of care delivered to patients in the NHS is the skill and motivation of staff: clinicians, managers and others in supporting roles. The training and development of both clinical and non-clinical staff forms an important part of the NSR and its accompanying document, *A High Quality Workforce, NHS Next Stage Review*. In this chapter we examine the main proposals for:

- Improving workforce planning in the NHS, and
- Improving the quality of leadership.

Workforce planning

159. Workforce planning in the health service is challenging and complex. The future workforce is difficult to predict: social and technological changes mean that some skills will become redundant while demand for others will suddenly increase. Basic staff numbers are hard to forecast and problems are exacerbated by the length of time required to train staff: at least three years for most health professions and up to twenty years for some senior doctors. In recent years the NHS has failed to meet these challenges, as identified in two major inquiries by this Committee.¹⁹⁷

160. The NSR recognised the validity of our criticisms and acknowledged that the Department’s performance in this area must improve. In addition to describing its “vision” of staff “empowering themselves” to take charge of their careers, the document stated that the Department will ensure that planning will encompass all staff in the NHS, an approach which “required a stronger and more constructive partnership with all professions”.¹⁹⁸ The NSR made two proposals which it claimed would bring about “a single coherent professional voice to advise on how best to achieve our vision of the high quality education and training that underpins high quality care for patients”.¹⁹⁹ These were:

- An independent advisory non-Departmental public body, Medical Education England (MEE), to advise the Department of Health on the education and training of doctors, dentists, pharmacists and healthcare scientists. MEE will be supported by similar advisory bodies in every SHA region. In addition,
- A Centre of Excellence, which, from April 2009, will provide “objective long-term horizon scanning, capability and capacity development for workforce planning

¹⁹⁷ In 2007 our report, *Workforce Planning*, identified serious failings in the way that the NHS planned its policies on recruitment and retention of staff. Our 2008 report, *Modernising Medical Careers (MMC)*, inquired into the debacle which affected medical training in the summer of 2007 and made criticisms of the Department of Health and pinpointed failings of the Medical Royal Colleges.

¹⁹⁸ Cm 7432

¹⁹⁹ Ibid

functions”.²⁰⁰ The Centre will provide this function for the entire workforce, not only medical practitioners.²⁰¹

161. Witnesses welcomed the recognition of past failings but they warned that the process of predicting the staffing requirements of an organisation as large as the NHS, was fraught with difficulties. In written evidence, Professor Maynard claimed:

Workforce planning nationally and internationally has traditionally been focused on medical practitioners and has usually been wrong!²⁰²

162. Other witnesses cautioned that new organisations might make matters worse. The NHS Confederation claimed that the MEE and the Centre of Excellence would concentrate workforce planning in Whitehall.²⁰³ The organisation favoured a system “which placed greater reliance on the role of local NHS employers in identifying future workforce requirements”.²⁰⁴

Leadership

163. The NSR states that the key to implementing its proposals to improve quality is effective leadership from clinicians and managers. Leadership, however, is a quality that has been neglected in recent years by previous reviews of the NHS.²⁰⁵ David Nicholson told us:

It seems to me it is the issue that got missed out when three or four years ago people talked about reforming the NHS, they talked about the technical aspects of reform, payment by results and all that sort of stuff, but the real issue is leadership.²⁰⁶

The NSR made a great number of proposals which it hoped will strengthen clinical and managerial leadership in the NHS, although the main focus is on encouraging clinicians to become managers. The NSR proposes measures that will take effect over the short and long terms:

Long term

- The Department will establish an NHS Leadership Council, chaired by the NHS Chief Executive, responsible for “overseeing all matters of leadership across healthcare”. The Council will be concerned with both clinical and managerial leadership;
- A National Quality Board will provide strategic oversight and leadership on quality; and

200 Department of Health, *NHS Next Stage Review: A High Quality Workforce*, July 2008

201 The proposed Centre of Excellence (CE) is the subject of a King’s Fund study. Following consultation this will lead to a report on which a tender will be issued.

202 DZ 20A

203 DZ 05

204 Ibid

205 Although it was given some prominence during the 1980s for example, The Griffiths Report, 1983

206 Q 224

- Training for leadership roles will be given to all undergraduate medical and nursing students and for people already working in the NHS.

Short term

- By April 2009, all Strategic Health Authorities will appoint a newly established post of SHA Medical Director; and
- The Department will identify and support the top 250 leaders in the NHS. This group will include both clinical and non-clinical leaders and will receive support in their personal development, mentoring, and active career management.

Witnesses' concerns

164. Three broad concerns were raised by witnesses about these proposals: the proposals favour central initiatives over local action; they do not address the traditional difficulty of persuading clinicians to become managers; and they do not address the weak skills of some clinical and non-clinical managers working in the NHS.

A centralised approach?

165. A number of witnesses criticised the Review's proposals for placing responsibility for training and recruitment of leaders under central control of the Department. That approach, it was argued, had undermined the important role that SHAs should play in this area.

166. The King's Fund claimed that the work of the proposed Leadership Council, which would be led by David Nicholson, NHS Chief Executive, was an example of unnecessary centralisation by the Department:

Confidence in the NHS to deliver high quality services for its populations is undermined if the message on identifying and developing the very best leaders is that this work remains the responsibility of the Centre. The welcome move to realising local control and autonomy over the development of services, and the move away from top down imposed targets could well be seen as a model for leadership development. Many of the SHAs have now established, or are on their way to establishing, creative and intelligent approaches to locally developing talent.²⁰⁷

The NHS Confederation agreed:

We had hoped that the changes to the workforce planning and education commissioning system published in the NSR would establish a system in which local employers had a more central role in identifying future workforce requirements...We were disappointed to find that this is not what is proposed and that the new system lacks sufficient clarity of roles and how employers fit into the system.²⁰⁸

207 DZ 01

208 DZ 05

Turning doctors into managers

167. The NSR recognises that “in parts of the NHS, competing interests between clinicians and managers has, on occasion, been against the best interests of the patient”. At the heart of Lord Darzi’s proposals for improving leadership is his aspiration to bridge the gap between the two groups and to encourage doctors to become managers. Mr David Nicholson claimed that:

We are quite unusual as a health system in this country of having relatively few clinicians in the most senior posts and I think it shows in terms of the focus of our work.²⁰⁹

According to the NSR, the new Leadership Council will identify and train talented and suitable doctors who will become senior SHA managers of the future. According to Mr Nicholson this could be achieved fairly speedily:

Our aspirations are that within three years on every shortlist for a chief executive job in the country there will be at least one appointable clinician who will be available for appointment.²¹⁰

Doctors who become managers will be required to keep their clinical skills if they wish to re-enter medical practice. Although some may abandon medical practice, others will wish to remain clinicians first and managers second. This will mean both time and funding will have to be made available so that clinicians can maintain their skills.

168. Witnesses agreed that it was desirable that more doctors should become managers in the NHS. However some had concerns about certain obstacles in the way of achieving the proposal. Dr Hamish Meldrum, of the BMA, argued that:

Unfortunately, and I think it probably happened because of successive changes and reorganisations and everything else, there is a feeling that in some areas the quality of management is not very good and that clinicians who get involved in that—I hear expressions like they have gone over to the dark side or they have sold out or they could not hack the day job.²¹¹

Dr Meldrum also claimed that the debate sometimes overlooked the point that “The main reason we went into medicine [was] to be doctors and clinicians, not to be managers”.²¹²

169. The reluctance of doctors to take on managerial roles might help explain why previous attempts to increase the number of clinician-managers had been unsuccessful. The King’s Fund for example told us that:

The last three attempts to secure a national approach to developing the most senior leaders has been marked by less than impressive outcomes.²¹³

209 Q 224

210 Ibid

211 Q 344

212 Ibid

213 DZ 01

We were informed that there was little reason to be optimistic that the NSR would succeed where other initiatives had failed:

This policy is ironic as during the Blair years it was proposed to create a NHS University to meet these problems. This was abandoned expensively. Will these proposals thrive where the NHS University failed? The need is obvious but the policy drive has failed in the past!²¹⁴

The quality of management in the NHS

170. The King's Fund claimed that in the drive to encourage more clinicians, particularly doctors, to become leaders, the Department must not overlook the importance of management, regardless of whether it is done by clinicians or non-clinicians.

Caution needs to be taken to ensure the management task is not neglected and that managers are not undermined, overlooked or vilified. Equally clinicians cannot have all their time diverted to tasks which could be done as well, or better by professional managers—these too are skilled and “values driven” individuals whose work in the NHS should be recognised.²¹⁵

171. We discussed earlier in this report concerns about the ability of PCT managers to implement aspects of the NSR. Similar concerns were raised about the weakness in the skills of managers working in both primary and secondary care. Given the importance of this subject we sought a memorandum from Professor Maynard. He argued that leadership and management in the NHS would be enhanced if managers made better use of data before they made decisions. He argued that there is

A considerable amount of evidence concerning clinical and cost effectiveness as well as routine administrative data that has been available and underused for decades.²¹⁶

Professor Maynard maintained that Hospital Episode Statistics (HES), which had been available since 1989, contained a wide variety of data that could be used to examine the comparative performance of doctors and managers. However he argued that this data was not used effectively because:

Managers generally have neither the skills, the motivation nor the time to tackle the problems of clinical practice variations which if benchmarked and performance controlled vigorously would free resources to enable their organisation to meet national targets.²¹⁷

172. The need for analytical “business” skills in the management of the NHS will be increasingly important in the light of the Department's plans to measure clinical quality and patient outcomes through measurement systems such as PROMs. However, if the analytical skills of managers and leaders are not improved, “the risk is that without the

214 DZ 20A

215 DZ 01

216 DZ 20A

217 Ibid

skilled workforce the NHS will once again collect but not use these vital sources of information to improve patient care”.²¹⁸

173. The NSR does not place much emphasis on the importance of recruiting and developing better managers. Although the NHS National Training Programme has attracted graduates of great ability, the system has had difficulty keeping hold of its graduates. Over many years this Committee has heard many concerns about the quality of management in the NHS which witnesses to this inquiry echoed. Some managers lack the analytical skills or motivation to handle and interpret the wide range of performance and routine administrative data, such as HES, that they have to deal with. With the introduction of PROMs and other quality related measures this issue is becoming ever more important.

174. The National Training Programme has attracted graduates of great ability. They should be encouraged to take appropriate academic qualifications and be given sustained career support to ensure that their talent is exploited to the full throughout their careers.

Conclusions

175. We welcome the Department’s increased focus on improving its workforce planning in the NHS. However, we note concerns that planning will be concentrated in the Department. In our recent report on Workforce Planning we recommended that SHAs have a key role in this area. The Department should ensure that regional NHS employers are given a role in identifying future workforce requirements.

176. It is widely recognised that the quality of leadership in the NHS must improve and we welcome the Department’s ambition to do this. However, we note the following concerns about its proposals:

- **There is undue reliance on new institutions such as the Leadership Council; we note that previous attempts to improve the quality of management and leadership in the NHS by introducing new institutions such as the NHS University have failed;**
- **The Department’s approach is over-centralised; and**
- **The emphasis on medical leadership is important; however, we are concerned that at present many doctors are put off becoming senior managers. We therefore recommend that more training and support be given to those who wish to take on senior management responsibilities.**

177. It is unfortunate that the NSR does not place more emphasis on the importance of recruiting and developing better managers. Over many years this Committee has heard concerns about the quality of management in the NHS which witnesses to this inquiry echoed. Some managers lack the analytical skills or motivation to handle and interpret the wide range of performance and routine administrative data, such as HES, that they have to deal with. With the introduction of PROMs and other quality related measures this issue is becoming ever more important. We therefore recommend that the

218 Ibid

Department address the issue of weak management skills in this area with urgency. Senior NHS management, clinical and non-clinical, should acquire analytical skills which will enable them to understand the products of expensive and increased investment in clinical and cost effectiveness data. This should be a central component of their annual appraisals, and in the case of clinicians, linked to their systems of performance related pay (Clinical Excellence Awards). The pay and promotion prospects of managers should be linked to their skills, in particular their ability to analyse and use data.

178. The National Training Programme has attracted graduates of great ability. They should be encouraged to take appropriate academic qualifications and be given sustained career support to ensure that their talent is exploited to the full throughout their careers.

Conclusions and recommendations

Key issues

1. The significance of the Next Stage Review owes more to the manner in which it was conducted than to the proposals it makes. Many of its key recommendations, such as the need to improve quality of care, have been made before. However, the involvement of the Strategic Health Authorities is new, as is the extent of consultation with clinicians and patients, which we welcome. (Paragraph 54)
2. There is much to commend in the Review, in particular the emphasis on quality and leadership. However, we are concerned about its implementation. This will largely be done by PCTs, but we doubt that most PCTs are currently capable of doing this task successfully. We have noted on numerous occasions, and the Government has accepted, that PCT commissioning is poor. In particular, PCTs lack analytical and planning skills and the quality of their management is very variable. This reflects on the whole of the NHS: as one witness told us, “the NHS does not afford PCT commissioning sufficient status”. We consider this to be striking and depressing. (Paragraph 55)
3. The Department argued that its World Class Commissioning programme will transform PCTs. While the programme has only been in place since July 2007, there are few signs yet that variations between PCTs in their commissioning capability have been addressed. The NHS purchasing/commissioning function was introduced nearly 20 years ago and its management continues to be largely passive when active evidence-based contracting is required to improve the quality of patient care. Given the failure of successive reforms to enhance commissioning, implementation of the NSR may be slower and more uneven than the Government hopes. The Government must publish milestones for implementation of the NSR and monitor them rigorously. (Paragraph 56)
4. The Department’s other main proposal to improve commissioning is through better use of practice based commissioning. We heard that practice based commissioning had failed to engage doctors and PCTs in the commissioning of services. We are not convinced that the Next Stage Review will succeed in reinvigorating the scheme. Moreover, the role of practice based commissioning in relation to the planned World Class Commissioning by PCTs remains opaque and needs greater clarification. (Paragraph 57)
5. SHAs have an important role in managing the performance of PCTs. However, in recent inquiries we have heard evidence that the performance of SHAs in this area has been inadequate and we doubt SHAs’ ability to manage effectively the performance of PCTs. We recommend that their work in this area be evaluated independently and rigorously. If SHAs are to manage performance effectively, they must improve their ability to gather and analyse data and to assess the strategic needs of their region. (Paragraph 58)

6. Department of Health documents have too often provided a long list of priorities without ranking them. It is unfortunate that the NSR repeats this bad habit. (Paragraph 59)
7. The NSR provides little detail about how much it will cost to implement its proposals. Lord Darzi argues that PCTs will produce local strategies with details of costs by spring 2009, but it is unclear how much information about associated costs there will be. He also asserts that, by improving quality, costs will be saved over the long term. However, we are concerned that neither SHAs nor the Department have made clear where and how much will be saved. We recommend that the Department publish, as soon as possible, figures for each SHA region and for each PCT, identifying the cost of implementing the NSR. We also recommend that the Department quantify the savings that it expects to make from improving quality and indicate when the money will be saved. (Paragraph 60)

Improving Quality in the NHS

8. Variations in the quality of care provided by the NHS have existed for a long time. Lord Darzi accepted that despite the doubling of NHS expenditure in real terms since 1997 and a number of reorganisations of NHS structures during that time, wide variations continue. The emphasis of policy for the last decade has been on access rather than improving the quality of care. We do not accept that this emphasis was sensible or that it was necessary to improve access before improving quality. We welcome the change to give more emphasis to quality. (Paragraph 85)
9. In principle, like our witnesses, we also welcome the emphasis given in the NSR to seeking improvements in quality through better measurement and the provision of financial incentives for providing a high quality of care. However, we have some concerns:
 - The Department should not rely solely on the use of incentives to achieve improvements in quality; they should be part of a wider package of measures.
 - There is a danger that by focusing incentives on a narrow range of clinical services, performance elsewhere might decline.
 - The incentive scheme on which Advancing Quality is based is used in the United States, a very different health system to the NHS. Its effectiveness may not be replicable in the NHS and should be demonstrated by rigorous evaluation.
 - There is a lack of information about how extensive the PROMs incentive scheme will be; how much it will cost to implement; when it will be fully implemented; and whether it will provide value for money.
 - The timetable for implementing the initial set of PROMs by April 2009 is challenging. There is a lack of detail about how the PROMs results will be used by PCTs and SHAs to provide incentives to improve patient care.

Furthermore the implications for the governance of clinicians need careful clarification.

For these reasons, while we strongly support the principle of using financial incentives to improve the quality of care, we recommend that the Department proceed with caution. Schemes such as Advancing Quality and PROMs which link the measurement of clinical process and patient outcomes must be piloted and evaluated rigorously before they are adopted by the wider NHS. (Paragraph 86)

Extending “choice” and “personalisation” in primary care

10. We welcome the provision of additional primary care services. There are strong arguments for increasing provision in under-doctored areas. However, this expansion in supply needs careful management and evaluation to determine whether it leads to better evidence-based medical interventions for patients and whether it reduces disparities in health care access and utilisation between different social classes. It should be recognised that the investment in primary care might increase demand for hospital care as deprived people get better access to care and referrals increase with more diagnostic tests. (Paragraph 128)
11. £100 million has been provided for extra capacity in areas of need. The allocation of this money should be determined by national criteria measuring deprivation. PCTs and SHAs should be required to use these criteria and locate facilities where access and utilisation is poorest. (Paragraph 129)
12. The Government has proposed that there should be a GP-led health centre in each PCT. While some PCTs, particularly those which are “under-doctored” or with a high burden of disease, would undoubtedly benefit from providing more primary care services it is less clear how other PCTs would benefit. We are not convinced by the Department’s argument that all PCTs should have a GP-led health centre. Whether PCTs have such a centre should be a matter as a witness stated: “to be decided locally on a case-by-case basis using the best clinical evidence available together with a full assessment of the costs and the impact on patient access”. PCTs should not make their decisions on a whim, but national criteria should be set out for them to follow to ensure that benefits and costs of their decisions are known. (Paragraph 130)
13. We were disappointed that neither the Government nor witnesses representing doctors could tell us what criteria should be used to decide whether a PCT needed a GP-led health centre. (Paragraph 130)
14. While polyclinics and GP-led health centres can bring benefits, we are disappointed that the Department is introducing them without prior pilots and evaluation. The evaluation of the first 5 polyclinics in London is yet to be designed making the collection of baseline data difficult if not impossible and “before and after” comparison of performance even more difficult. It is unclear how this evaluation, which will be commissioned in early 2009, will be used to inform the roll out of the programme. There is a risk that roll out will precede the results of the evaluation, which has the potential to waste taxpayers’ money and be grossly inefficient. The

evidence that similar centres in Germany and the United States improve the quality of patient care and provide value for money is mixed. (Paragraph 131)

15. GP-led health centres offer the potential for closer collaborative working between GPs, pharmacists and other clinicians. This should benefit patients by providing them with more integrated care. However, simply bringing health professionals under the same roof does not necessarily mean that they will work better or that they will start working together. The Department should give consideration to how closer integration will be achieved in practice. (Paragraph 132)
16. The Department's decision to conduct trials of personal budgets is welcome if it is done rigorously and policy makers wait for the results before large scale roll out of the programme. (Paragraph 133)

The draft NHS Constitution

17. The draft NHS constitution is, according to the Department, the first time that the principles, values, rights and responsibilities of patients and staff in respect of the NHS have been set out in a single document. We have heard a number of concerns about the Constitution, in particular, that it should not include too many legal rights; we note the NHS Chief Executive's view that the constitution should not be a "lawyers' charter". (Paragraph 154)
18. We also heard concerns that the draft NHS Constitution included "an awful lot of rights and very few responsibilities". We recommend that the Department ensure that the Constitution gives sufficient emphasis to the responsibilities of patients and staff to the NHS. (Paragraph 155)
19. On the other hand, there is a concern that the Constitution will fail to engage the public in a meaningful way because people will view it as "a lot of waffle" without rights to care and treatment that are legally enforceable. (Paragraph 156)
20. We welcome the establishment of a patient's right to drugs and treatments that have been recommended by NICE for use in the NHS. However, it is important that it is recognised that the commitment will not by itself end the post code lottery which determines access to drugs and treatments not on the NICE approved list. (Paragraph 157)

Measures to improve the leadership and workforce of the NHS

21. We welcome the Department's increased focus on improving its workforce planning in the NHS. However, we note concerns that planning will be concentrated in the Department. In our recent report on Workforce Planning we recommended that SHAs have a key role in this area. The Department should ensure that regional NHS employers are given a role in identifying future workforce requirements. (Paragraph 175)
22. It is widely recognised that the quality of leadership in the NHS must improve and we welcome the Department's ambition to do this. However, we note the following concerns about its proposals:

- There is undue reliance on new institutions such as the Leadership Council; we note that previous attempts to improve the quality of management and leadership in the NHS by introducing new institutions such as the NHS University have failed;
 - The Department's approach is over-centralised; and
 - The emphasis on medical leadership is important; however, we are concerned that at present many doctors are put off becoming senior managers. We therefore recommend that more training and support be given to those who wish to take on senior management responsibilities. (Paragraph 176)
23. It is unfortunate that the NSR does not place more emphasis on the importance of recruiting and developing better managers. Over many years this Committee has heard concerns about the quality of management in the NHS which witnesses to this inquiry echoed. Some managers lack the analytical skills or motivation to handle and interpret the wide range of performance and routine administrative data, such as HES, that they have to deal with. With the introduction of PROMs and other quality related measures this issue is becoming ever more important. We therefore recommend that the Department address the issue of weak management skills in this area with urgency. Senior NHS management, clinical and non-clinical, should acquire analytical skills which will enable them to understand the products of expensive and increased investment in clinical and cost effectiveness data. This should be a central component of their annual appraisals, and in the case of clinicians, linked to their systems of performance related pay (Clinical Excellence Awards). The pay and promotion prospects of managers should be linked to their skills, in particular their ability to analyse and use data. (Paragraph 177)
24. The National Training Programme has attracted graduates of great ability. They should be encouraged to take appropriate academic qualifications and be given sustained career support to ensure that their talent is exploited to the full throughout their careers. (Paragraph 178)

Glossary

AoMRC	Academy of Medical Royal Colleges
APMS	Alternative Provider of Medical Services
BMA	British Medical Association
CQUIN	Commissioning for Quality and Innovation
HCAI	Healthcare Acquired Infection
HES	Hospital Episode Statistics
MEE	Medical Education England
MRSA	Methicillin-Resistant Staphylococcus Aureus
NICE	National Institute for Health and Clinical Excellence
NSF	National Service Framework
NSR	Next Stage Review
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PROMs	Patient Recoded Outcome Measures
RCGP	Royal College of General Practitioners
SHA	Strategic Health Authority
WCC	World Class Commissioning

Formal Minutes

Monday 15 December 2008

Members present:

Mr Kevin Barron, in the Chair

Charlotte Atkins
Sandra Gidley
Dr Doug Naysmith

Dr Howard Stoate
Dr Richard Taylor

Draft Report (NHS Next Stage Review), 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 178 read and agreed to.

Summary agreed to.

Resolved, That the Report be the First 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.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Thursday 15 January 2009 at 9.30 am

Witnesses

Thursday 10 July 2008

Professor Steve Field, Chairman, Royal College of General Practitioners, **Professor Nicholas Mays**, London School of Hygiene and Tropical Medicine, and **David Pruce**, Director of Policy and Communications, Royal Pharmaceutical Society of Great Britain

Professor Adrian Newland, Vice-Chairman, Academy of Medical Royal Colleges, **Niall Dickson**, Chief Executive, King's Fund, and **Nigel Edwards**, Director of Policy, NHS Confederation

Thursday 17 July 2008

Professor the Lord Darzi of Denham KBE, Parliamentary Under Secretary of State, Department of Health, **David Nicholson CBE**, Chief Executive, NHS, and **Dr Jonathan Sheffield**, Medical Director, NHS South West

Thursday 16 October 2008

Dr Hamish Meldrum, Chairman, Council of the British Medical Association

Sir Ian Carruthers, Chief Executive, NHS South West, **Margaret Edwards**, Chief Executive, NHS Yorkshire and the Humber, **Mike Farrar CBE**, Chief Executive, NHS North West

List of written evidence

The following memoranda are published as *NHS Next Stage Review: Oral and written evidence*, HC 53–II, Session 2008–09

DZ

- 1 King's Fund
- 2 British Medical Association
- 3 Royal Pharmaceutical Society of Great Britain
- 4 Academy of Medical Royal Colleges
- 5 The NHS Confederation
- 6 The Royal College of Surgeons of England
- 7 Better Local Healthcare Campaign, Haringey
- 8 Help the Aged (developed in close collaboration with the British Geriatrics Society)
- 9 Royal College of Midwives
- 10 Royal College of Nursing
- 11 Association of British Healthcare Industries
- 12 Assura Group
- 13 British Geriatrics Society
- 14 The Company Chemists' Association Ltd
- 15 Diabetes UK
- 16 NHS North West
- 17 NHS Yorkshire and the Humber
- 18 NHS South West
- 19 Department of Health
- 20 Professor Alan Maynard

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 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

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)