Public Bill Committee

HEALTH AND SOCIAL CARE BILL

First Sitting
Tuesday 8 February 2011
(Morning)

CONTENTS
Programme motion agreed to.
Written evidence (Reporting to the House) motion agreed to.
Written evidence reported to the House.
Motion to sit in private agreed to.
Examination of witnesses.
Adjourned till this day at Four o’clock.
Members who wish to have copies of the Official Report of Proceedings in General Committees sent to them are requested to give notice to that effect at the Vote Office.

No proofs can be supplied. Corrigenda slips may be published with Bound Volume editions. Corrigenda that Members suggest should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor’s Room, House of Commons,

not later than

Saturday 12 February 2011

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The Committee consisted of the following Members:

Chairs: † Mr Jim Hood, Mr Mike Hancock

† Abrahams, Debbie (Oldham East and Saddleworth) (Lab)
† Barron, Mr Kevin (Rother Valley) (Lab)
† Blenkinsop, Tom (Middlesbrough South and East Cleveland) (Lab)
† Brine, Mr Steve (Winchester) (Con)
† Burns, Mr Simon (Minister of State, Department of Health)
† Burstow, Paul (Minister of State, Department of Health)
† Byles, Dan (North Warwickshire) (Con)
† Crabb, Stephen (Preseli Pembrokeshire) (Con)
† de Bois, Nick (Enfield North) (Con)
† James, Margot (Stourbridge) (Con)
† Kendall, Liz (Leicester West) (Lab)
† Lefroy, Jeremy (Stafford) (Con)
† Morgan, Nicky (Loughborough) (Con)
† Morris, Grahame M. (Easington) (Lab)
† Poulter, Dr Daniel (Central Suffolk and North Ipswich) (Con)
† Pugh, John (Southport) (LD)
† Shannon, Jim (Strangford) (DUP)
† Smith, Owen (Pontypridd) (Lab)
† Soubry, Anna (Broxtowe) (Con)
† Sturdy, Julian (York Outer) (Con)
† Thornberry, Emily (Islington South and Finsbury) (Lab)
† Turner, Karl (Kingston upon Hull East) (Lab)
† Twigg, Derek (Halton) (Lab)
† Wilson, Phil (Sedgefield) (Lab)

Chris Stanton, Committee Clerk

† attended the Committee

Witnesses

Sir David Nicholson, Chief Executive, National Health Service (and NHS Commissioning Board)

Stephen Thornton, CBE, Chief Executive, the Health Foundation

Dr Jennifer Dixon, Director, the Nuffield Trust

Professor Julian Le Grand, Richard Titmuss Professor of Social Policy, London School of Economics

Tim Gilling, Deputy Executive Director, Centre for Public Scrutiny

Chris Ham, Chief Executive, King’s Fund

Dr Hamish Meldrum, Chairman, BMA Council, British Medical Association
Public Bill Committee

Tuesday 8 February 2011

( Morning)

[MR JIM HOOD in the Chair]

Health and Social Care Bill

10.30 am

The Chair: Before we begin, I have a few preliminary announcements. Members may, if they wish, remove their jackets during Committee meetings—that is a huge concession on my part, but I am sure that it will be appreciated. Would all Members please ensure that their mobile phones and so on are turned off or switched to silent mode during Committee meetings? As a general rule, I and my fellow Chair, Mr Hancock, do not intend to call starred amendments that have not been tabled with adequate notice. There is a money resolution and a ways and means resolution in connection with the Bill. Copies are available.

Not everyone is familiar with the process of taking oral evidence in Public Bill Committees, so it might be helpful if I briefly explain how we will proceed. The Committee will first be asked to consider the programme motion on the amendment paper, for which debate is limited to half an hour. We will then proceed to motions, which I hope we can take formally, to report written evidence and to permit the Committee to deliberate in private in advance of the oral evidence sessions. If the third motion is agreed to, the Committee will move into private session. Once the Committee has deliberated, witnesses and members of the public will be invited back into the room and the oral evidence session will begin.

If the Committee agrees to the programme motion, it will hear oral evidence this morning and this afternoon, as well as Thursday morning and afternoon.

Ordered,

That—

(1) the Committee shall (in addition to its first meeting at 10.30 am on Tuesday 8 February) meet—

(a) at 4.00 pm on Tuesday 8 February;
(b) at 9.00 am and 1.00 pm on Thursday 10 February;
(c) at 10.30 am and 4.00 pm on Tuesday 15 February;
(d) at 9.00 am and 1.00 pm on Thursday 17 February;
(e) at 10.30 am and 4.00 pm on Tuesday 1 March;
(f) at 9.00 am and 1.00 pm on Thursday 3 March;
(g) at 10.30 am and 4.00 pm on Tuesday 8 March;
(h) at 9.00 am and 1.00 pm on Thursday 10 March;
(i) at 10.30 am and 4.00 pm on Tuesday 15 March;
(j) at 9.00 am and 1.00 pm on Thursday 17 March;
(k) at 10.30 am and 4.00 pm on Tuesday 22 March;
(l) at 9.00 am and 1.00 pm on Thursday 24 March;
(m) at 10.30 am and 4.00 pm on Tuesday 29 March;
(n) at 9.00 am and 1.00 pm on Thursday 31 March;

(2) the Committee shall hear oral evidence in accordance with the following Table:

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<tr>
<th>Date</th>
<th>Time</th>
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<td>NHS Alliance; National Association of Primary Care; Royal College of General Practitioners</td>
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<td>MIND; Parkinson’s UK; Cancer Research UK; Target Ovarian Cancer; Rethink</td>
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<td>Until no later than 10 am</td>
<td>Independent Regulator of NHS Foundation Trusts (Monitor); Foundation Trust Network; Association of Chief Executives of Voluntary Organisations</td>
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<td>Until no later than 10.30 am</td>
<td>National Institute for Health and Clinical Excellence; Department of Health</td>
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<td>Royal College of Physicians; Royal College of Nursing; Royal College of Surgeons; RemedyUK</td>
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<td>Tuesday 8 February</td>
<td>Until no later than 4.30 pm</td>
<td>Department of Health</td>
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(3) proceedings on consideration of the Bill in Committee shall be taken in the following order: Clauses 1 to 5; Schedule 1; Clauses 6 to 21; Schedule 2; Clauses 22 to 43; Schedule 3; Clauses 44 and 45; Schedules 4 to 6; Clauses 46 to 50; Clauses 186 to 192; Clauses 166 and 167; Schedule 13; Clauses 168 to 183; Clause 185; Clause 51; Schedule 7; Clauses 52 to 92; Schedule 8; Clauses 93 to 97; Schedule 9; Clauses 98 to 106; Schedule 10; Clauses 107 to 135; Schedule 11; Clauses 136 to 164; Schedule 12; Clause 165; Clause 184; Clauses 193 to 215; Schedule 14; Clauses 216; Schedule 15; Clauses 217 to 233; Schedule 16; Clauses 234 to 236;
Schedule 17; Clauses 237 to 257; Schedule 18; Clauses 258 to 260; Schedule 19; Clauses 261 to 271; Schedule 20; Clauses 272 to 274; Schedules 21 and 22; Clauses 275 to 281; new Clauses; new Schedules; remaining proceedings on the Bill:

(4) the proceedings shall (so far as not previously concluded) be brought to a conclusion at 4.00 pm on Thursday 31 March.—

(Mr Simon Burns.)

Resolved,

That, subject to the discretion of the Chairman, any written evidence received by the Committee shall be reported to the House for publication.—(Mr Simon Burns.)

Written evidence to be reported to the House

HS 01 National Institute of Health and Clinical Excellence (NICE)
HS 02 Royal College of Surgeons
HS 03 Bliss
HS 04 Ken Kirk, Claire Hughes, David Hughes and Mick Barry
HS 05 RNID
HS 06 British Dental Association (BDA)
HS 07 Dr Naomi Elton
HS 08 NHS Confederation
HS 09 Chartered Institute of Environmental Health (CIEH)
HS 10 BASW—The College of Social Work
HS 11 UNISON
HS 12 National Voices
HS 13 Centre for Public Scrutiny
HS 14 London Scrutiny Officer Network
HS 15 Cancer Research UK
HS 16 Foundation Trust Network
HS 17 British Medical Association (BMA)

Resolved,

That, at this and any subsequent meeting at which oral evidence is to be heard, the Committee shall sit in private until the witnesses are admitted.—(Mr Simon Burns.)

10.33 am

The Committee deliberated in private.

10.36 am

On resuming—

The Chair: Sir David, welcome to this evidence session. We are looking forward to asking you some short questions and I would invite brief replies so that we can ask you as many questions in this evidence session as possible. To kick off the evidence session, I call Emily Thornberry.

Q1 Emily Thornberry (Islington South and Finsbury) (Lab): With the Chair’s indulgence, I have three questions for you. First, in your evidence to the Health Committee on 12 October you spoke of the need to make £15 billion to £20 billion of efficiency savings in the next three years, which has been dubbed the Nicholson challenge. You said that half of that change was in better community services. You said that a quarter of hospital beds were full of people with four or more long-term conditions, and they would be better managed in the community. In what way does the Bill help with better integration of health and social care?

Sir David Nicholson: This is a really important part of the reform and the change that we are trying to make in the NHS at the moment. If you look at most developed health care systems in the world, the challenge around people with long-term conditions is increasing. There are over 11 million such people in this country, and that will rise over the next period. So in order both to give those people the best quality service that we can for the future and to create a more productive system, treating these patients and supporting and helping them in the community is a vital part of that.

The people who are primarily responsible for these individuals are general practitioners. A really important part of the Bill, and the way that the proposals are being put forward, is the key role that general practitioners and general practice will play in the shaping of services. What it will mean for supporting people with long-term conditions is the provision of more services closer to them, whether that be diagnostic services, case management, district nurse support or whatever—it needs to be close. To manage that and to change the pattern of service, you need to shift resource from secondary to primary care, which is essentially what the commissioning system is designed to do. So the role of GPs in understanding people with long-term conditions, and being able to move that connection between the resource and the service to the patient, is a vital part of this change.

Q2 Emily Thornberry: But my question was about the integration of social and health care.

Sir David Nicholson: Yes, and as a part of that of course, people with long-term conditions not only get supported by their general practitioner; they also require support from social care. A critical part of the changes is the development of the health and well-being boards. In lots of ways, if you think about the health and well-being boards of the future, and local government being in a sense the integrator of services where they bring all of the bits of the local health, social care, housing and support systems together, to shift power to health and well-being boards from PCTs is a critical part of that.

Q3 Emily Thornberry: I want to ask you about strategic planning. Again, your evidence to the Health Select Committee seemed to suggest that you accepted that the strategic health authorities played a key role in driving productivity and maintaining improvements in the service. In London, of course, we have a great example of that in stroke services. If you have a stroke, you go to certain hospitals and not to others, and many lives have been saved. In the future, under these reforms, how will we get that strategic planning? Do you think there is a role for the NHS commissioning board to have regional boards?

Sir David Nicholson: I think there are two issues there. There is one about how you get consortia to work together for a particular geography to make decisions that affect the totality of health care in that system. There is good evidence, even from talking to the pathfinder consortiums, that they want to work together and understand the need to think about a bigger footprint
than the current consortiums. That is good. On the other side, of course, you have the role of the commissioning board. The commissioning board will have responsibility for directly commissioning a significant amount of specialist services, which are critical when you are talking about these kinds of strategies. For both those reasons, I can see how we can take forward strategic planning.

In terms of the commissioning board having a set of regional boards, the legislation certainly does not allow for that, and nor do I think it is a very sensible thing to do, given that the commissioning board gives a national perspective on services generally. There will obviously be times when the national commissioning board needs to think regionally, London being the best example. The national commissioning board will have to find a way of working across London as a whole and working with the institutions around London, but I do not think you need to institutionalise that, in terms of having a board to make it happen.

Q4 Emily Thornberry: Can I move on to what will happen to QIIPP—the quality, innovation, productivity and prevention plan? If the Bill goes through, GPs may well focus their attention and energy on governance, how they will organise themselves and so on. Should they focus primarily on that or on QIIPP? Can they do both at the same time?

Sir David Nicholson: Of course they need to do both, because they need to engage now with the changes that are happening and they need to provide leadership and clinical input to make those happen, but they also need to make their organisations safe. The issue is getting the right balance. As far as the pathfinders are concerned—they are the people who are engaged most in all this—one of the criteria we have used for becoming a pathfinder is that you are engaged in the QIIPP process. Pathfinders are increasingly involved in that and they will need to be involved in it before they become formally established in 2013. If they do not engage and work through these really important issues now, my argument to them is that they will not have budgets to receive in 2013, because we will have spent all the money.

Q5 Emily Thornberry: But do you think that all GP consortiums will be able to behave in the proper way? How will you stop them playing in what you have called the sandpit of redesign?

Sir David Nicholson: That is an issue for not just consortiums but NHS management and leadership generally. Part of my job is to make sure that we focus our attention on the really important issues right in front of us. In a sense, that is why we are putting so much time and effort into the planning process, which is ongoing at the moment. As you know, we have a broad idea about the way in which QIIPP will be developed, but we are now operationalising that. Every primary care trust is now working through with their local providers the implications in 2011-12 and 2012-13 of what that means in practice in terms of services and resources for their patients. That has to be the focus of our attention. If you think about the way you design a consortium, a better measure of the potential success of that consortium is how it engages in this planning process, rather than some of the more esoteric parts of organisational design.

Q6 Nick de Bois (Enfield North) (Con): Sir David, I believe you originally said these reforms were so large you could actually see them from space. In fact, on further examination, and now that the Bill has been presented to Parliament, where there is clearly evidence of its being more evolutionary—building on other pre-existing services, practice-based commissioning and so forth—do you still hold to that view, or do you accept that there is more evolution than revolution?

Sir David Nicholson: There are two issues here, and you will know better than me the potential benefits of being quoted and unquoted at various times. I was referring to the quality, innovation and productivity challenge and the reforms together. It is quite difficult to think about one without the other, and when you add those two things together it is a very, very significant change for the NHS. It is the biggest I have ever seen in my career in the NHS. We have taken advice from people around the world in terms of management of change challenge and it is very, very large.

You are absolutely right, however, to say that we can see most of the change within the service as it is at the moment. If you take the commissioning consortiums, in my career I have worked from GP fundholding through total purchasing, PCGs and PCTs to practice-based commissioning. You can see a 20-year level of experience and knowledge of taking general practitioners and working in this area. If you look at the other area, you have got foundation trusts. We have been working at this now for some years to give independence and freedom to individual institutions to encourage both local accountability and innovation. You can see a mixture of things that are very bold and some that are building on our experience.

Q7 Liz Kendall (Leicester West) (Lab): Thanks for coming. You are giving an awful lot of evidence, Sir David, and I have three brief questions. The first is about the role of Monitor, which, as you know, will stop being the regulator of foundation trusts and start being the economic regulator. At the Public Accounts Committee evidence session on 18 January 2011 you said that ultimately, if a foundation trust is failing,

"The buck stops in the foundation trust.”

Under the new system, how does anyone step in to prevent a hospital from failing?

Sir David Nicholson: One of the issues that I guess will come up throughout the discussion is the new role of the economic regulator, as opposed to the old role of the economic regulator. Those are slightly brought together because they have got the same name, but they are quite different functions. I think the thing about the new economic regulator, as set out in the Bill, is that its prime responsibility is not the integrity of an individual organisation—that was old Monitor’s job—but what the regulatory jargon terms continuity of supply, which for me and you is protecting services to local people. It seems to me that that is a very different way of thinking about the world. We would see the economic regulator intervening to protect services, which, it seems to me, is the most important.

Q8 Liz Kendall: With respect, my question was about

who prevents them from getting to the position where they fail.

Sir David Nicholson: So sorry. Who prevents services from getting to a place where we cannot provide them? Clearly, the commissioner has a major responsibility to
ensure that their local population has access, so I would expect the commissioner to intervene to ensure that services were improving. If there were a threat to the local services—the designated services that the economic regulator looks after—I would expect the economic regulator to intervene to ensure that those services continue, but not necessarily to intervene to deal with the financial position of a particular organisation.

Q9 Liz Kendall: My second question is about Monitor’s role in setting price under the new system. You were very clear in your evidence to the PAC that you thought that services should be allowed to go below the maximum price only if you were able to measure quality but that you had “yet to come across any services that have done that”. I am confused here. You are clear from your position as the chief executive of the national commissioning board that you do not want any services to go below the maximum price if we cannot measure quality, but is it not Monitor that sets price under the new system, not the national commissioning board?

Sir David Nicholson: The new system is that the commissioning board sets the pricing system. It decides on the currency and on the shape of the tariff. For example, the commissioning board could say, “We’ll give this particular organisation £10,000 to look after the total health care of that individual who has diabetes,” or it could decide that we pay people on the basis of the number of patients that are treated. The commissioning board does that, but the economic regulator will set the price—the number—because its prime responsibility is obviously to ensure that we have a provider side that is vibrant and can take the issues. The legislation cleverly locks us together to ensure that you get agreement on that, so it is very much a joint position that we find ourselves in.

Q10 Liz Kendall: So you have to jointly agree the price?

Sir David Nicholson: Yes.

Q11 Liz Kendall: Finally, I would like you to confirm something that you said in the Public Accounts Committee, which is that although your aim is to ensure that no PCT debts are passed on to consortia, you could not guarantee that GPs would not have to take on PCT debts. Is that correct?

Sir David Nicholson: That is my ambition, absolutely, and we are doing everything that we can over the next two years to ensure that that is the case.

Q12 John Pugh (Southport) (LD): Sir David, we have met often in the past in the Public Accounts Committee, when you have been explaining some NHS financial problem—and doing it rather well, I have to say. I think that it would be accepted if you brought NHS accounts under control in a way that they have not been hitherto, so you will excise me if all my questions are on just the financial side of things.

If this legislation had not existed, I think that PCTs would have been under a remit to reduce their administrative costs by 30%—obviously some PCTs will continue to exist for a little while anyway. Would they have met that target, and will they continue to meet the target, given that the legislation is in the offing?

Sir David Nicholson: That is a really important question, and it is one that we have considered in the past. If you had asked me, “Going forward, irrespective of these reforms, could you sustain 151 independent organisations, operating as they do at the moment?” I would have said that we simply could not do that. We would have had to look at how PCTs were configured and organised in order to deliver the scale of change that we need to make as part of the QIPP arrangements.

Q13 John Pugh: Are you saying that you probably would have met that 30% target, but in current circumstances there is an uncertainty there?

Sir David Nicholson: We would have hit our targets; we always do. But I am saying that you would undoubtedly have had to change the configuration and nature of PCTs. You could not sustain that for 151 organisations.

Q14 John Pugh: There are obviously different elements to assessing the administrative costs of PCTs. There is the commissioning, which is being transferred, and there is the administration of various producer organisations—the producer or provider arm of the PCT—which presumably will continue to exist. Are you able to give an average administrative cost of commissioning in a PCT currently, separate from the cost of general administration?

Sir David Nicholson: Yes. The total cost for the strategic health authorities and PCTs’ commissioning is £5.1 billion across the NHS. That is just the PCTs’ commissioning bit and, as part of the financial position of the NHS, we plan to reduce that to £3.4 billion by the end of the process.

Q15 John Pugh: Okay. During most previous reorganisations, there has been a drop in productivity in the NHS, or in whatever organisation was being reorganised.

What are you going to do to measure productivity over the next two to three years?

Sir David Nicholson: A whole set of measures are set out in our QIPP plans. Clearly, the financial position of each individual organisation will be a key part of that, because to deliver their financial targets we will have to deliver an increase in productivity. There are the productivity measures that are currently produced by the Office for National Statistics, which are limited but nevertheless important for us to take that forward, and there are the quality gains that we want to see as part of that, which we would normally set out in terms of number of lives saved.

Q16 John Pugh: A last question about the one-off costs of reorganisation, which I think are £1.4 billion in the impact assessment: can I tease out of you the distinction between the impact assessment as provided by the Department of Health and the impact assessment as offered by the National Audit Office? As I understand it, the NAO gives a figure of £15 million per reorganisation of an organisation. Presumably it is thinking of SHAs, PCTs and so on. The Department has scaled it down by taking out the estimated costs of redundancies and then suggests that the cost of reorganising a large organisation differs from the NAO’s understanding of the costs of reorganisation. The letter I have from the Comptroller and Auditor General says:

“The NAO has not validated the Department’s figures.”
Given that you will eventually appear before the Public Accounts Committee in a few years’ time, are you happy with that? Would you like the validation or are you prepared to stand very robustly by the figure in the impact assessment?

Sir David Nicholson: We believe that the figure in the impact assessment is robust. Based on our evidence from previous reorganisations and our knowledge of this one, we think it is a good figure that we will be able to stand by. The outstanding issue for us though, in terms of that figure, is the redundancies and the decisions that consortia make over whether they buy NHS-commissioning support or they go outside. They have, quite rightly, been given the freedom to decide how they want to organise it themselves, but those decisions are very sensitive to the redundancy figures that we come out with.

Q17 Grahame M. Morris (Easington) (Lab): Sir David, in evidence to the Health Select Committee on 19 October, which is only three months ago, you said:

“If you look at what commissioning is, it is often kind of caricatured as some kind of transaction arrangement, but of course it isn’t that at all. It has a major strategic context in relation to whole population planning”.

If we have a completely open market you can never plan strategically. If Monitor’s job is to enforce competition rules, would not any sort of strategic planning contravene those rules?

Sir David Nicholson: For me and people in the NHS, commissioning is a really important issue. Part of the benefits of the new system is to introduce and develop more integrated services for our patients. There has been an idea that the only way you can do that is by managing it all yourself and we simply have not delivered that to patients. There will be lots of different providers for any individual supporting and providing them with care. The critical thing is how you connect all those things together. Commissioning is the way in which you do that. Your armoury of tools—partnership agreements over many years, close clinical working, the use of protocols, tendering and any willing provider—is for the commissioning system to use to improve services for patients. That is a helpful way of developing the service and taking it forward. The other issue on the other side is that in some places, for too long, essentially, patients have had to put up with sub-optimal services because of too cosy a relationship between commissioners and providers and between individual providers. So in the sense of the economic regulator being there to stop abuse, I think it is absolutely the right thing to do.

Q18 Grahame M. Morris: May I ask a quick supplementary on that? In relation to the risks to destabilising the system and Monitor’s role as an economic regulator looking at price competition, could you comment on what is happening at the moment with the reduction in the tariff of 1.5% that is being passported through to foundation trusts and the impact that has had in terms of the timetable is that the Government have protected NHS expenditures. It is not that the money that we save through the cost reduction programmes goes somewhere else; it can be recycled within the NHS to improve services for patients. What has been happening is that quite a lot of the accent is on cost reduction, and not enough on what we are going to use the money for, now that we have got it, in order to invest in community in other services. It is difficult at the moment to identify—we will know better by the end of March when the planning round is over—what exactly, at the end of the day, the various balance of staffing will be between clinical and non-clinical staff.

Q19 Mr Steve Brine (Winchester) (Con): Hello, Sir David. Thank you for coming. May I press you a little with regard to the commissioning board, of which you are, obviously, the head? I appreciate that you are chief executive designate at the moment. You mentioned that there would not be a regional structure, which I completely endorse. There is no point in taking one apart to recreate one, if we are looking for savings and to eliminate bureaucracy. However, dental services commissioning, for instance, will sit with the board. Can you take us in more detail through how that will work? How will you commission dental services in Winchester and in the north-east of England, for instance?

Sir David Nicholson: We are at quite early stages in developing all this at the moment, as you might expect—I was only identified just before Christmas—so we are trying to think it all through. You highlight the dilemma. On one hand, you have a national body, but on the other hand, it will be commissioning very local services, so you will need more people working for the board operating on a more local level. Dental is a good example of teasing that out in a constructive way. We have not teased it out. I think that there are things that we could centralise far more in dental commissioning, such as a lot of the activities around back-office support and all that sort of thing, but you will not get away from requiring some local presence in order to have the kind of thing that you described, because the local dental market in Winchester is different from the one in Durham.

Q20 Mr Brine: May I ask you one more general question in your role as chief executive of the NHS? I think that what health care professionals—I am married to one—and front-line staff would say to Governments over the years, because this certainly did not begin in 1997, is that when something goes right in the NHS, it is a triumph of Government policy and the Health Secretary wants to tell everybody about it, but when something goes wrong in the NHS, it is the fault of NHS trusts and front-line professionals. How do you see that changing under the proposals?

Sir David Nicholson: Umm—[Laughter] If you think about it, most of the coverage and the plaudits that go out are local anyway. Most local newspapers’ relationship
with the local trust and local organisations is very clear, and I think that they do get plaudits locally when they do things well. That is true.

I think that what will be clearer is the accountability. At the moment, it is too easy to say that the Government are to blame in all of this. It is a real problem for us in terms of accountability. One thing about foundation trusts and having local accountability to a local membership is that it should hone that sense of local accountability in a way that perhaps we have not seen before. Of course the health and well-being boards will give us the opportunity, in a very public way, to demonstrate that accountability. Sometimes Ministers have said to me that it’s the opposite: they get blamed for everything that goes wrong and the NHS gets all the plaudits. But I think you will see a much more local NHS and feel it is much more of a local NHS, through these arrangements.

Mr Brine: I hope so. Thank you.

Q21 Phil Wilson (Sedgefield) (Lab): One of the main tenets of the Bill is ultimately to hand over to GPs a budget equivalent to the GDP of Hungary. Is that evolutionary or revolutionary?

Sir David Nicholson: If you think at the moment that almost every PCT has some kind of practice-based commissioning arrangement set in it, where GPs have got real control over resource utilisation, you can see how you can build on that to get us somewhere; but of course the point I would make is that the consortia do not get their budgets until 2013. It is not as if they get them tomorrow. We have got some time now to work through and understand better what works and what doesn’t work; to hone the arrangements that we have and build capacity in consortia, so that by the time we get to 2013 we are in a position to authorise them. We are not just going to give them the money as a matter of right; they are going to have to demonstrate to the commissioning board that they can fulfil their responsibilities, through the authorisation process.

Q22 Phil Wilson: So is it revolutionary or evolutionary?

Sir David Nicholson: I think it is neither. I think it is bold and imaginative.

Q23 Phil Wilson: Bold and imaginative; a very nice way of putting it. So we are essentially going from first gear to fifth gear, missing out second, third and fourth, really. You have said yourself it is the largest reorganisation ever—you can see it from space.

Sir David Nicholson: I am not going to underestimate how large it is. It is a significant change. I was in Tipton on Friday, where the consortium has been working through practice-based commissioning for some time. It is taking full responsibility for the budget from 1 April 2011 and is geared up and well capable of doing that. It has the experience. In some parts of the country they are a long way from doing that. Part of my job is to get them to a place, by 2013, where they are capable of doing it.

Q24 Phil Wilson: The perception that is given with the Bill and what we read about in the press and hear in speeches is that it is like devolving the NHS to GPs and making it more globalised, essentially. Obviously the GPs know what is going on in their area—but you have a national commissioning board at the same time. You have said yourself in answer to a previous question that you will end up employing local people to administer all this. Does that mean you will end up re-employing people who have been made redundant from PCTs?

Sir David Nicholson: There is a whole load of questions in all of that. The thing about the changes is—you are right—that they involve significant devolution and more local accountability; however, they involve some centralisation, in a way that will give patients more consistency and a clearer set of quality standards about the service that they provide. So with national quality standards all that sort of thing will provide consistency across the country for delivery. The point that you made is right: we will have local people administering parts of the system, but they will do so as part of a corporate whole—a national service that will deliver locally.

Will we ever employ people who have been made redundant by PCTs? Part of the process that we are going through and the HR system that we are trying to put in place is to keep that at an absolute minimum. We have had a series of schemes. We had the mutually agreed resignation scheme, and will have a second one. We are to have a scheme that keeps people who could take redundancy, making them stay another couple of years. That is what we need to do, because the last thing we need to do is spend money on redundancy and then re-employ people. We want to avoid that as far as we can.

Q25 Phil Wilson: So what you are saying is that it is the PCT structure by another name.

Sir David Nicholson: No, because what we are doing is quite different. Most of the commissioning functions of the PCTs will be carried out by the consortia, but there are specific responsibilities around primary care commissioning, dental commissioning and specialised commissioning, which the commissioning board will do, and which it will have to have mechanisms for. For most of it we will be able to achieve great economies of scale by doing a lot of the back-office stuff nationally. Even in a big organisation such as the national commissioning board there needs to be local flexibility and local understanding, because that is the way services are delivered.

Q26 Jeremy Lefroy (Stafford) (Con): Good Morning, Sir David. I would like to raise three questions that come out of the evidence being given at the Mid Staffordshire inquiry at the moment. The first is on local government and the health and well-being boards being critical, which you mentioned earlier. One thing that has come out is that the expertise available to, for instance, the oversight and scrutiny committees, or even the health and well-being boards, might not be sufficient to enable them to do their very important job. How do you envisage that being addressed?

Sir David Nicholson: I perfectly understand why that might appear to be the case. First, if you think about it, the health and well-being boards will have the expertise, knowledge and understanding of the public health service at their disposal with the changes on the public health side of the NHS and the appointment of a director of public health for every local authority. That brings with
it big capacity, understanding and knowledge of health care and the way it is delivered, as well as the public health stuff.

The second issue is the engagement of general practice with local government. One of the things that I have found with the pathfinders and with the work that local government is doing is that, in some places, GPs and local authorities are invisible to each other because of the way in which the bureaucracies operate. In terms of understanding how local government works on the ground, GPs have quite a lot to offer. So engagement of the consortia in health and well-being boards will give them more capacity to understand it. The third thing is that the national commissioning board has the opportunity to engage with the health and well-being boards, which will bring expertise, knowledge and understanding. Those three things together will significantly enhance the ability of the health and well-being boards to play a proper role in health care in the future.

Q27 Jeremy Lefroy: My second question is on the approval of foundation trusts. It was clearly a problem with Mid Staffordshire that it was approved at a time when it should not have been. My concern is that, according to the legislation, all trusts have to become foundation trusts by 2014. How would you ensure that there is no repeat because of a trust being rushed into foundation trust status? As a supplement to that, we are aware that some of the private finance initiative contracts that are going through at the moment mean that some of those private finance initiative contracts that are going through at the moment mean that some of those trusts will not be able to meet their financial return of 8%, or whatever it is, because of the payments.

Sir David Nicholson: I have two things to say about that. First, Mid Staffordshire was a dreadful experience both for the patients and for the service as a whole. People were absolutely horrified by what happened. We moved very quickly and learned a lot of lessons. If you look at the foundation trust process at the moment, quality is written through it in a way it never has been before. Every foundation trust has to be signed off by the NHS medical director and has to go through a rigorous process. So we have learned some really important lessons, but we need to continue to do so. The national quality board, which I chair, will issue a report in February that will give individual boards, patients and staff some clear tools and techniques to ensure that we are alerted earlier when such things happen.

The second thing is the foundation trust pipeline, which is going through all the organisations that are not currently foundation trusts and is categorising them into groups that we can take forward. For the biggest group, which contains more than 70 of the organisations that need to become foundation trusts in the next four years, it is relatively straightforward. It is about developing a plan and a model for each organisation that is robust and clinically and financially stable. I have little doubt that that big group of organisations will go forward.

Then there are some other organisations that are either in difficulty at the moment or that have, as in the example that you used, some PFI schemes, which are making it very difficult for them to achieve due diligence and the arrangements about finance. We will have to deal with each of those organisations individually, and we are starting to work through, case by case, what the process means for each of those organisations. When we have done that, I think that I will be in a much better position to say to you, “Yes, we can deliver the 2014 programme”. However, it seems to me that the most important priority is to get the right fit and the right response for patients.

Q28 Jeremy Lefroy: Thank you very much for that. You referred to the issue of accountability briefly in your answer. However, judging from the Mid Staffordshire experience it still seems to me that we are not quite sure who will pick these things up in future and who will aggregate the evidence that is out there that a trust is failing. Where does accountability for blowing the whistle on that lie, because it really has to lie in one place?

Sir David Nicholson: It does lie in one place and that is with the board of the organisation involved. That is the accountable bit of the system and strengthening that bit, with the powers of local governors and members, is an important part of future developments.

However, organisations go wrong and although it would be nice to say that one organisation in those circumstances will be responsible for dealing with everything that comes out of it, because of the nature of health care it is very difficult to do that. Nevertheless, we have a very clear set-up now, where the Care Quality Commission is responsible for co-ordinating the various organisations. It uses a technique of “risk summits” to enable it to do that. So the CQC will ensure that the commissioners, the other providers, the clinicians and the commissioning board are all brought together to solve these problems when they occur.

Q29 Owen Smith (Pontypool) (Lab): It is very interesting to hear about the local strata that you are now talking about for the commissioning board, which I do not think are included in the Bill in any form. How many of these sorts of local people do you anticipate you will need, how local will they be and what sort of costs are associated with them?

Sir David Nicholson: I think it is quite early for us to get a complete picture of that, because it partly depends on what we can centralise and what back-office work we can do nationally. We simply have not done the work to make it happen. However, I have been given an indicative amount of money to work with for the commissioning board at the end of the process and if you think, for example, that at the moment there are more than 5,000 people working in PCTs on primary care commissioning, clearly we will have to work with at least a third less of that number. However, I think that it gives you an indication of the amount of local work that is done.

We have to work through it, service by service and issue by issue. I do not believe that out of that you will have regions, districts and all of that, because that is only one place where everything comes together. I think that you will have different mechanisms for different services that we commission.

Q30 Owen Smith: Continuing on that theme of regional variation, do you think it is inevitable that at the end of this process we will have a less homogenous and perhaps less equitable NHS across England?

Sir David Nicholson: No. In fact, I think that the opposite is true. When we developed the NHS through a document called “High Quality Care For All”, which was a very important document for the NHS and one
that established quality as the organising principle, one of the things that we did was to say, “How would the system know, how would people know, what ‘really good’ looked like?” We wondered how you could do it in a way that ensured that everyone who was involved in commissioning and provision, as well as the public, could say, “What does a really good stroke service look like?” because there are myriad views about all of that.

NICE was given the responsibility for developing quality standards and that is what it has started to do. It has done stroke, it has done a few—it has 150 quality standards to develop across all of the major services. In those quality standards, the NHS will set out for the first time for commissioners, providers and the public what a really good neonatal intensive care service or a really good diabetes service looks like and all of those things. That will then be translated by the commissioning board into local commissioning guidelines. It will all be translated into a national framework contract for providers. In that way, I think that you can get the potential for local innovation and change on how you deliver a service but you can be really clear about what a good service is for the first time. In that way, you can give much more consistency across the country, both for patients and providers.

Q31 Owen Smith: My final question goes back to strategic planning. Under the new dispensation, who at local level will make the key decisions about reconfiguration of, for example, secondary care services? Who will decide whether a maternity ward needs to close due to, for example, secondary care services? Who will make the key decisions about reconfiguration?

Sir David Nicholson: Clearly, the people who will set out the outcomes expected and what the service shape would look like, would be the commissioners. They would set that out. You would expect the consortium to set out what it required and the quality standards. The commissioners are responsible for responding to it. If they needed to respond by changing the configuration of what they did, they would have to do that. Both of them would have to account to the health and well-being board, to explain what they were doing and whatever scrutiny arrangements the local authority put in place. In that way, you would get a clearer view about local responsibility for change. In terms of designated services, there is still the right of the local authority, whatever scrutiny arrangements are put in place, to refer the matter to the Secretary of State.

The Chair: Five Members still want to ask questions and the clock is ticking.

Q32 Mr Kevin Barron (Rother Valley) (Lab): Can I go back to the issue of the national commissioning board’s role in direct commissioning locally? You said earlier that you simply had not done the work in relation to dentistry. We have a brief from the British Dental Association that says that, while it supports the NHS dental services, it does not say that you simply had not done the work in relation to dentistry. We have a brief from the British Dental Association that says that, while it supports the NHS dental services, it is “anxious to ensure that mechanisms are in place to strengthen the ability of commissioners and providers to develop services that are responsive to local needs, and to ensure that they are fully integrated with other NHS services.” Given the history of NHS dental services in the past 10 years, are you sure that a national commissioning board is the right and proper way to do this?

Sir David Nicholson: It is what has been set out in the legislation. That connection between local and national is going to be critical to its success. There are different ways to define national and local. There will be a national contract of sorts, I guess, quite different from the one we have at the moment. There will be a local interpretation of that in individual circumstances. How is that to be done? It could be through PCTs, through the national commissioning body, through a whole set of things, but that principle about national and local applies. The potential benefits of a national commissioning board approach are that you are more likely to align the negotiation and discussion of the contract with the delivery of the service.

Q33 Mr Barron: Would not some people just say it would be better if the GP consortia had responsibility for commissioning dental care?

Sir David Nicholson: The important thing is about the way in which the GP consortia developed and commoditised, that the way in which general practices have engaged in the consortia. The argument for general practice commissioning is that GPs have power and influence over the outcome. You will have seen the stuff the National Association of Primary Care has said: if every GP referred one less patient for diagnosis a week—and I am not suggesting they should do that—it would make £500 million-worth of difference to costs in the NHS. Relatively small micro-changes in general practice affect the service. They simply do not have the same effect on dentistry; that connection is not there.

Q34 Mr Barron: I have just one more question, on a related matter. I ought to declare that I chair the all-party group on pharmacy. My local PCT has a number of contacts with local pharmacies. In some pharmacies, it delivers smoking cessation measures; in others, it delivers daily doses of methadone. A minor ailments treatment scheme runs throughout the PCT, which means that the pharmacists can do it and there is no need to clutter the doctors’ surgeries. Are we saying that the way forward is for national commissioning of those things? The PCT commissions those things effectively on a pharmacy-by-pharmacy basis at the moment. What are we going to end up with if it is commissioned at a national level?

Sir David Nicholson: Again, you get consistency.

Q35 Mr Barron: Of what?

Sir David Nicholson: Service to patients. I have been in front of several Committees where I have been berated for the fact that we have this service in locality x, and we have a completely different service in locality y. One of the things that the NHS commissioning board will enable you to do is to be consistent across the whole country in what you provide, which seems to be a strong argument for national commissioning. I also think that the benefits that you get from back-office arrangements are significant. You can see perfectly well how you can get benefits out of that system. I agree with you. The NHS commissioning board is not going to sit in Leeds and decide what happens in Rotherham, Burnley or Birmingham. We need people on the ground to make it happen.

Q36 Mr Barron: So why do the GP consortia not do it?
Sir David Nicholson: For the very same reason. It is the impact that they have on it as general practitioners. I am sure that they will be engaged and have a view about pharmacy commissioning, but it seems to us as logical at present, given the state of commissioning in pharmacy and how we need to enhance and improve it, to do that on a national basis.

Q37 Dan Byles (North Warwickshire) (Con): I am conscious of the time, so I will stick to one quick question.

Many GP practices are providers through practice-based commissioning and non-general medical services work. Do you see a potential conflict of interests there, and how can that be managed?

Sir David Nicholson: There is a potential conflict of interests there. I think we should be really clear about that, and that is one of the reasons why we are going for national commissioning of primary care, as opposed to leaving it to the consortia.

The real issue here is one of transparency. There is no doubt that one of the benefits of the changes is an expansion in the quality and nature of primary care. It seems to us that you cannot connect the commissioning of primary care with consortia commissioning, because of the thing that you described. Doing it separately seems to be sensible, and the best way of encouraging that and making it work is through transparency, which means the identification of how much we are paying, what the quality standards are and whether other organisations have had the opportunity to compete for suitable work. All of those things will be part of the way that we should do it.

Q38 Debbie Abrahams (Oldham East and Saddleworth) (Lab): Good morning, Sir David. My question relates to health inequalities and follows on from one of my colleague’s earlier remarks about how the proposals might contribute to less equitable access to care. Can you tell me what evidence there is to support what you were saying about this actually increasing access to care? An inverse care law exists at the moment. Those were saying about this actually increasing access to healthcare? An inverse care law exists at the moment. Are we likely to see an increase in access to care?

Sir David Nicholson: As I said, first, the resources will be allocated to consortia on the basis of a formula that we derive around access to care. Secondly, the identification of a set of national standards is a really important mechanism to take the service forward. At the moment, it is up to individual organisations to decide what standards they have, and, because of that, you have different ways of measuring and so on. Getting clear, evidence-based standards, which are based on NICE standards, and getting the commissioning guidance and a mechanism for holding the consortia to account in place are more likely to deliver a more equitable service than a less equitable one.

Q39 Debbie Abrahams: So you are saying that there is no tangible evidence at the moment, but you estimate that that might happen.

Within the existing primary care trust boundaries, there may be several GP consortia, and there is no requirement for them to communicate together. How might that pan out if they come to different decisions on the services that they want to provide?

Sir David Nicholson: First, the consortia cannot just pluck priorities out of the air. What the legislation sets out very clearly is that all this is based on the joint strategic needs assessment, which is done on a local authority footprint. In a sense, that is the driver—

The Chair: Order. I am afraid that that brings us to the end of the time allotted for the Committee to ask questions of this witness. I thank Sir David on behalf of the Committee for his attendance.

11.30 am

The Chair: We will now hear evidence from the Health Foundation, the Nuffield Trust and Professor Julian Le Grand. Welcome to the Committee. I am sure that you will be well received. We have a number of questions. I suspect that, as in the last evidence session, the questions will need more time than is allotted to the Committee.

Q40 Emily Thornberry: May I begin with a question for the whole panel? What risks do the witnesses feel may be associated with the changes that will be introduced by the Bill, if it is passed?

Stephen Thornton: I think there are two types of transitional risk. Having just listened to Sir David’s evidence, I think he was very clear about the need to manage the transition during a period when the finances of the NHS will be, let us say, troubled, as the new arrangements are brought in. That set of risks has been well rehearsed and dealt with.

I have a concern that there is a longer-term risk, which is that we forget what the fundamental plan is—what the fundamental idea is that we are trying to achieve—and become too obsessed with the pros and cons of introducing a market in health care, and with whether GPs, PCNs or managers make the local commissioning decisions, and actually forget that the fundamental reason for bringing about this change is that really important sentence in the White Paper, “no decisions about me without me.”

We must remember that this is trying to put the patient at the forefront of decision making.

I went to a meeting last week where hundreds of people in the audience were debating the White Paper. Julian spoke at that meeting, and there were a lot of different views. At one point, a very senior and well-respected clinician who is critical of the changes stood up and said, “Soon, the only people able to make a choice in our new NHS will be the patients.” What an arrogant viewpoint for him to adopt. Fundamentally, these changes are about putting patients in the driving seat and empowering and enabling them. If we do not achieve that, that will be the biggest risk of the changes.

Q41 Emily Thornberry: The Health Foundation did a review of evidence in 2004 about the effectiveness of primary care-led commissioning. I believe you came to the conclusion that such commissioning struggled to engage patients and the public in a significant way. Do you still stand by that, and do you feel that changes ought to be made in the Bill to address the tendency of primary care to struggle with engagement?

Stephen Thornton: I do think that is true. At another meeting I went to recently, I listened to several new GPs who will take the pathfinder roles and some others. I was enthused by their desire to improve the quality of
local services, but I was disappointed by their overall attitude in general to engaging patients in an effective way.

There could be a change in the Bill. In clause 19, proposed new section 13F talks about "promoting patient involvement". It is in a batch of other things that talk about health inequalities, and there is an "etc." thrown in as well. That needs to be pulled out, and a duty needs to be placed on the national commissioning board and the consortia to embed shared decision making in all care and treatment, and to promote supported self-management.

We have got to get absolutely real about this, and we have to align all the different bits of the system, whether it is the CQC, Monitor, or the national commissioning board, so that all and sundry are focusing on what they need to do to enable the patient to be the decision maker. That is not only about patients choosing which hospital they go to, but at every step along the journey that they are involved in. If they have a long-term condition, that journey is for life.

**Dr Dixon:** The short-term risk is loss of financial control, because too much is going on and there is too much to manage. The clusters are new and the consortia will be green, which is the short-term issue. As a result of that short-term risk, loss of financial control could lead to panic and therefore, blunt cuts.

In the longer term, I tend to agree with Stephen. The Bill's impetus on competition could be played out in a number of ways, because the measure is very wide-ranging and there are clauses to suit every eventuality. The possible fragmentation as a result of competition not allowing collaboration—which is needed to make efficiency gains—could be a problem. That will be all about who runs the economic regulator and how accountable they are—it is not clear to whom they are accountable, or who will adjudicate on decisions. How the competitive regulator views competition and how it views collaboration will be absolutely critical.

**Q42 Emily Thornberry:** Do you agree that the promotion of competition, which, in my view, is at the heart of the Bill, threatens the integration between primary and secondary care and the integration of social and health care?

**Dr Dixon:** I think it can, if it is viewed through a narrow economic lens. If it is viewed as it is in the United States, where vertical mergers and vertical integration are allowed because the promise of efficiency gains is greater than the danger of consolidation on prices, there could be some sense in it. That all depends on how integration is viewed by the economic regulator.

**Q43 Emily Thornberry:** Will it be within the Bill's parameters to allow GP consortia to give efficiency bonuses to GPs?

**Dr Dixon:** Yes. There is provision in the Bill for the commissioning board to give a performance bonus to consortia—if that is the question you are asking. Again, that will need to be carefully policed and the details have not yet been sorted out.

**The Chair:** Margot James?

**Q44 Emily Thornberry:** Sorry, may I just ask Professor Le Grand what he thinks the dangers are, if there are any?

**Professor Le Grand:** Price competition is one; so much evidence now shows that price competition is likely to lead to a lowering of quality. It will lead to a lowering of costs, but it will probably also lead to a lowering of quality, which I do not think the system can take. Although that provision in the Bill has been carried over from the previous Government's operating framework, none the less, it is probably one that carries a significant risk.

The consortia will be too big. There are lots of arguments in favour of small consortia, such as GPs talking to each other better. The evidence from the so-called total purchasing pilots of the late 90s suggested that the bigger the consortium, the likelier the wheels were to come off. Smaller consortia will be better able to shift to play the market, so to speak—to shift commissioning without destabilising providers, which can happen—and they will be closer to patients. There is a kind of minimum size that you need for a risk pool—in my judgment, it is probably about 100,000—but there is a danger that the consortia will be too big.

**Q45 Emily Thornberry:** Are GPs able to make strategic decisions on a regional basis?

**Professor Le Grand:** I do not see why not. On the whole, the experience of total purchasing pilots was that they seemed capable of doing that, so I have no particular objection there.

May I make a comment about vertical integration? It is worth distinguishing between two kinds of integration: there is organisational integration between primary and secondary care, and there is budgetary integration. There are dangers about organisational integration between primary and secondary care, and particularly, the dominance of secondary care swamping primary care. Acute hospital trusts can absorb any amount of resources and energy that is thrown at them. The experience of acute sector organisations running community services is that the acute sector tends to dominate. On the other hand, budgetary integration, which is what, in some sense, the consortium offers, with the GP holding the budget, makes much more sense.

**Q46 Margot James (Stourbridge) (Con):** I would like to move the discussion to clinical practice. There has been so much discussion about the Bill's proposed changes to structures, but one of the main drivers in relation to differences in both cost overruns and quality variance is the different standards of clinical practice throughout the country, even within the same hospital. In general, what do you think the Bill's reforms will do to iron some of those changes out in a positive direction? Specifically, what are your thoughts about the changes to NICE, which is going to be renamed the National Institute for Health and Care Excellence, and the new pathways with which it will be charged in addition to those of its prior role? How do you think those care pathways will impact on the variance of clinical standards in practice?

**Stephen Thornton:** I am a member of the National Quality Board, to which Sir David has referred. That is the mechanism through which we have been encouraging NICE to produce the national quality standards and then to look to have the rest of the service and system aligned in order to deliver them. That includes making
sure that it is built into the way in which doctors, nurses and other clinical professionals are trained. I am pretty upbeat about all that. That will be built into the way in which, under the Bill, the transparent commissioning board would—the words in the Bill are not quite the ones that I would use—hold to account the delivery of the commissioning that the consortia engage in. I think that is really important.

I am sorry to come back to the point that I always make, but it is also about activated patients. The patients are not passive; they need to know about these things and we need to promote them. People need access to them through websites, and we need to inform them about what the current best practice and standards are, so that people can challenge them locally, feel that they are activated to do so and that it is not embarrassing to ask your GP whether he or she is part of a consortium that is promoting that kind of best practice.

One other really important thing is that we need to think about the nature of clinical professionalism. Right at the heart of this is a consultation that the Government have out at the moment about the future of medical and other clinical education. It is really important that, if you are a doctor of the future, it is not just about the patient in front of you, but about having a leadership responsibility for the whole of the journey that your patient is on, and about being open and transparent about your data, your performance and that of your colleagues. It is about being open about the bad apples in your community and not turning your back on all that. We want a new professionalism. No amount of controls or market can facilitate some of it. It is going to be right at the heart of what it means to be a clinical professional in the future.

Dr Dixon: I think that the measures strengthen peer review of clinician-to-clinician performance in a way that we have never had before, by the mere fact of holding a budget. The consortia will have to review the referral patterns, for example, and their quality. They will soon realise that primary care provision has a deep impact on the secondary care spend of their budget. Therefore, this will really concentrate minds, I believe, in a way that it simply has not before.

It would be even better if specialists were in the mix, which takes us back to this idea of integration—budgetary or real. One of the problems at the moment is that primary care is still very separated from hospitals. Clinicians are still very separated—they do not talk to one another particularly; they do not budget together; and they do not have aligned incentives. That kind of peer review performance would be much better if specialists were in the mix and doing this together in relation to a pathway. That is failing in the Bill, but it will definitely encourage it in primary care, and it is coupled with, as you say, the quality standards and evidence base that have come down from NICE. That can only reinforce this peer review.

The Chair: I call Kevin Barron. Sorry. You have to jump in there. [Laughter.]

Professor Le Grand: I will not be long, anyway.

There is always a problem in the public sector about how to spread good practice. So many times I have sat in my office and heard, when I was working in government, someone come through the door and say that they had a great idea for improving the NHS in a variety of ways, including clinical practice and so on. Although everyone nodded their heads and said, “That is very interesting; that is great”, nothing ever happened. My judgment is that that is because the incentives are not present. The incentives really are not present to adopt good practice. It is much easier just to carry on doing what you were doing. To return to my mantra, quality competition is the driver for that. That does actually drive incentives to improve it. It provides resource incentives and reputation incentives for people to improve and to bring up standards of clinical practice that are below the best to the best. That is where I would put my faith, rather than in reorganisation of NICE or national standards.

Q47 Mr Barron: This is in relation to quality. Outside the pilot schemes that have been run by North West strategic health authority, which has been looking at quality, what evidence do we have from the NHS in the past six years that quality is something that can be measured, something we can put faith in, as opposed to a target, and something that is going to improve services? I do not know who would like to start. Stephen, you are on the National Quality Board.

Stephen Thornton: As everyone knows, quality in health service delivery is notoriously difficult to get your head around and to define. People say, well surely you can define mortality—it is pretty clear; you are either dead or alive. But we know from the debate about hospital standardised mortality ratios of late just how difficult even that is to get a clear understanding of whether the case mix in your particular hospital is more complicated than others and so on.

It is important to remember that the best way of achieving an overall improvement in the quality of service in the health care system is to have a whole mix of the different arrangements and levers at our disposal. There is a danger, in the conversation on the Bill, of asking is it markets, or is it not markets, as if that is either bad or good or the panacea. They have an important role to play in some bits of health care delivery, but I have to say that I am slightly anxious about losing the targets—the small handful of top-down targets that, frankly, worked. Setting an 18-week waiting time and targets about hospital-acquired infection have produced results. When we had 173 of them at the turn of the century it was hopeless, but with four or five, it is different. So you need a mixture of all those things to bring about an overall improvement in quality. It then is possible to have an overview of quality across different bits of the health care system, and that is really what the Care Quality Commission is in business to do.

Dr Dixon: The premise behind the question that quality is not very observable, as the economists say, is absolutely right and it probably never will be. So even though the measures in the Bill, or at least in the White Paper, are good, with respect to the outcomes framework, they are never going to take us all the way. We are never going to be totally confident, at a national level, that things are improving, so there has to be a mix of levers, exactly as Stephen says. But also we have to rely on
softer measures, including what the public think of local services, that need to be hard-wired into any assessment of quality in a way that they are not at the moment. Who knows what Mid Staffordshire is going to show up, but what we do know is that our measures of quality did not show in a timely way what the issues were, but the public were saying something.

Professor Le Grand: The trouble is, as members of the panel have said, that it is so difficult to measure quality. To some extent, we have to rely upon inferring improvements in quality from changes in other areas. There was quite an interesting study that looked at a set of English hospitals and a set of Welsh hospitals across the border with similar case loads. The English one was subject to targets and a performance management regime and the Welsh one was not. It was interesting that the English hospital performed much better in terms of the targeted areas, which was not altogether surprising, but the researchers found that it seemed to perform better in a whole range of other, softer areas as well—more conventional things. The inference was that the targets regime led to a kind of tightening up of management all round, from which one could infer, perhaps, a general improvement in quality. I am afraid that is the game we are in: trying to infer improvements in quality from other areas, improvements, inputs and processes that we think will deliver.

Q48 Nick de Bois: Dr Dixon, I noticed the Nuffield Trust made a suggestion to de-risk the legislation in one area—that, in the event of service reconfiguration, ward downgrading or whatever, it would be better left to SHAs and PCTs by effectively allowing them to run longer, because, you argue, GP consortia are not well placed or are too overburdened to do this. My concern is that that runs against something else I think you believe in, in terms of local accountability, transparency and engagement, which have all been lacking in just about every service reconfiguration that has taken place under PCTs and SHAs. I am not sure that is a price worth paying. Is not the assumption that GP consortia cannot do this really just speculation or worry?

Dr Dixon: The point we are trying to make is that some consortia are ahead of the game—they are already functioning well and are quite well developed, even though they are in shadow form—so some can take the lead in making the leadership decisions on reconfigurations that were discussed with David Nicholson earlier. Some, however, simply will not: they are just too green, too small and too undeveloped. To abolish PCT clusters at a time when they are still in such a state could be very dangerous. The point we make is that PCT clusters could be given a longer guarantee of existence, simply to get the less developed ones up and ready.

We also say that there ought to be an explicit authorisation process—I noticed that David Nicholson used that word today—aakin to that for foundation trust status, so consortia would have to clear a high jump to be able to take on a fully fledged budget and the associated risk. There would be several waves, and that would give a role to the PCT clusters to develop the consortia which were not ready to get over the high jump. We think that would de-risk the process in fundholding, where there were first, second and third waves, and it would mean that there would be more obvious successes first, with the go-ahead, developed ones achieving successes, and fewer failures. We think that would be a really good way of de-risking, even, in the short term, still having some PCT clusters or regional presence. That is pragmatic under the circumstances.

Q49 Nick de Bois: On that basis, I think you are saying that some would be fit to do it and some would not. Are you recommending that we differentiate between the two? Is it reasonable to think that that could be done, or would we end up with a one size fits all?

Dr Dixon: Yes, there is no reason why it cannot be done. Indeed, it might happen by default. The NHS commissioning board has to decide upon which applications it accepts; there are criteria that it itself has set out, and there will be further criteria. I was interested that David Nicholson used the word “authorisation”—that in fact a process like that may happen. That was the process used in fundholding, with great effect.

Q50 Liz Kendall: Some 90% of patient contact with the NHS, as you know, is in primary care. We know that if we want to provide better care for patients with long-term chronic conditions, developing primary and community services to keep people out of hospital is vital. In my area, poor provision of GP services in the past is one reason why we have some very high emergency admission rates in Leicester’s hospitals. What does the Bill do to improve primary care? I would like to ask Dr Dixon first, if that is okay.

Dr Dixon: We have already mentioned the provisions in the Bill and the fact that consortia will scrutinise greater peer review by clinicians on the quality of care, and that includes primary care.

Q51 Liz Kendall: Does that mean that GPs will manage their fellow GPs?

Dr Dixon: They will not hold the budgets for primary care, as we heard, but they will have greater reason than ever before to scrutinise and ask questions about why patients from one practice are going to hospital many times more than patients from another practice. That is one way. I guess that the standard contracts also, if they define an evidence-based care pathway, may have something in them about the quality of primary care that needs to be offered in order to provide world-class care across a pathway. However, the Bill is silent on how else the quality of care may be improved, for example through the contract.

Stephen Thornton: May I come in? Your colleague mentioned, in the first question, some Health Foundation research that we did some years ago about GPs’ involvement in commissioning. At that time, the most important thing that they felt that they could get to grips with was the quality of out-of-hospital care—community health services and so on—rather than what was going on inside the hospital. For a long time there has been a GP desire and willingness to get to grips with some of the issues.

I referred earlier to a meeting that I went to with some pathfinders and other leading GPs who want to be part of that process. It was fascinating that when we were talking about quality and where there were quality deficiencies, the most important thing collectively that they wanted to do was deal with the poor quality of
general practice in their midst. The one criticism that I have of the Bill is placing that responsibility with the national commissioning board.

Listening to Sir David’s answer to your questions on all of this, I thought, “I am not convinced here.” These are essentially local services. Local GP consortia know where the issues are and want to get to grips with them. Notwithstanding issues to do with conflict of interest, which would need to be worked through, these are essentially local services that should be commissioned locally—just as dental services should be: it is nonsense to think that they should be commissioned on some kind of national basis. The services are essentially local, they are on your street corner, and they should be done by the consortia.

Professor Le Grand: I have very little to add, other than to say that that is another argument for small consortia. One mechanism for trying to lever up quality in primary care is through patient choice. If you have very large consortia, patients are not going to be able to move from consortium to consortium with any ease. However, I would not put enormous faith in it—patient choice as a lever for driving up quality in primary care is a problem because people are loyal to their GPs.

Q52 Liz Kendall: May I come back to that point, as you have raised it several times? If GP consortia are very small, if they get a couple of expensive patients—perhaps two, three, four or five—they could run out of money. David Nicholson, in his response to the Public Accounts Committee last week, said that, in the end, it is the GPs’ responsibility, so they could end up going into debt.

Professor Le Grand: There has been quite a bit of research on the size of the risk pool, and you are absolutely right: that is a key issue, and an important question. I have looked at the evidence, and I think it suggests, as I said, a figure of 100,000. There is a tension here: 100,000 will give just about the right level of risk pooling, so you will not get one or two expensive patients busting a budget, but at the same time it is small enough to allow for some of the other advantages of small size.

Q54 John Pugh: I wonder if Professor Le Grand could comment on the London situation, because, obviously, there the reconfiguration problems are at their most acute. Will they go away, remain the same or be adequately addressed through the legislation?

Professor Le Grand: The honest answer is that we do not know. There is an argument for saying that PCTs were, in some sense, in the pocket of their local acute trusts. It was the old business of, “If you owe £100 to the bank and can’t pay it back you’re in trouble, but if you owe £100 million to the bank and can’t pay it back, the bank’s in trouble.” There was too close a relationship between the PCTs, particularly in London, and that made it difficult to engage in reconfiguration.

There is another argument that says that GPs, who in some senses have more of a tradition of independence, would be less respectful of their acute colleagues and likely to be more robust in making reconfiguration decisions, or at least switching their commissioning, which in turn will have as a knock-on consequence the need for reconfiguration. My guess, for what it is worth, is the latter is closer to the truth, and I suppose I believe that there will be more reconfigurations. The relationship with MPs will be interesting, and I suspect that, as Jennifer was saying, a lot of it will be shuffled off to Monitor to carry the can for the responsibility.

Stephen Thornton: GPs will be more independent over this issue. There is a need for these reconfigurations. That is a politically tough thing to accept, and it is really difficult if you are the local sitting MP where that happens, but in pure health care terms, this is the future. David Nicholson spoke about QIPP being underpinned and about a transfer of services from hospital into the community. If they transfer, it is pointless keeping the facilities in the hospital open. For many years, there has been a direction of travel. Whether this Bill gets passed or not, that is where we are headed, and collectively we must face up to that.

Q55 Owen Smith: We heard from Sir David about what might be thought of as a counter-intuitive suggestion that this more market-driven, less planned world that
we are moving into will provide a more homogenous, just as equitable provision of health care across the UK. Do you agree with him about that conclusion?

Professor Le Grand: Evidence from other sectors is that competition tends to lead to homogeneity under certain conditions. Lapping into economists’ jargon, if you have an homogenous commodity, such as cataracts or hernia removal for example, I suspect that you will get a greater homogeneity of service and, hopefully, at the higher level of service. When you have highly specialised services, competition can—this is a reservation one has about competition—lead to the growth of monopolies of various kinds, and hence a variation in the standard of service and the types of service offered. On balance, I think the arguments favour competition, but it is something we have to bear in mind.

Dr Dixon: David Nicholson spoke about resource allocation and standard contracts being the way to achieve equity. As he was speaking, I was worried not so much about the quality standard differences across the country but about geographical access. I feel that there is less threat from competition and new entrants than there is from consolidation, which means that there will be fewer hospitals, which will mean longer travelling times for people. We know what happens from literature on that: some demand just stays in the woodwork and does not come out any longer. The geographical component is not really discussed on the standard contract idea, and that is the one to watch. It really should be the CQC and the commissioning board that take seriously the duty of equitable access, which is in the Bill. In its annual report, the commissioning board should explicitly have a section on equity of access.

Stephen Thornton: My take on that is if we simply believe that giving patients more information will be the thing that will drive them to be activated to make choices, then we run a serious risk that it will be the articulate middle classes that will find that information on the web and then use it. That is why, at the opening of this session, I spoke about getting really activated patients who can engage and about designing and shaping the system in such a way that they are given those opportunities. Unless we do that, poorer people, people from minority ethnic communities, people whose first language is not English, and so on, will inevitably find it more difficult. We really must get that bit right first.

Q56 Grahame M. Morris: May I ask Dr Dixon a question in relation to the work that the Nuffield Trust has carried out, which looks at evidence from the United States? In response to an earlier question, you mentioned that you felt the failing of the Bill was a separation of primary and secondary clinical expertise in terms of commissioning. Will you say a little more about that and what the evidence base is for the system that we are considering at the moment? Will you also say something about the capacity of GPs in the United Kingdom based on your experience? In the evidence you submitted, you say:

“many English GP consortia will really struggle unless there is a relentless focus on securing and sustaining high-quality leadership and substantial investment in management”.

Given that the Government’s principal driver for reform is drastically to cut management and admin costs, is there a tension there?

Dr Dixon: Yes, those are good questions. We did some work and we commissioned another piece of work which looked at the experience in the United States of physician groups that formed in order to hold budgets. In the early 1990s and late 1980s, 3,000 of these groups formed; there are now 300 left. Broadly, there are two reasons why many of them went belly up in that period. One was that they were unable to take on appropriate financial risk and were therefore torpedoed. They were too small to take on the risk that was given to them. The second thing is that they invested badly in management—they did not see the need for management; they were clinicians who felt a pound spent on management was a pound down the drain. Those are the ones that failed. Those are the main lessons from the US.

Q57 Grahame M. Morris: What were the numbers? What was the percentage of failures in the study?

Dr Dixon: From 3,000 in the early ’90s to 300 now, so a significant failure.

Professor Le Grand: It is worth looking at the GP fundholding experience, too. The total purchasing pilots tended to show, as I said earlier, that the smaller groups tended to be more efficient than the larger groups. Some of the GP fundholders, who admittedly had a much smaller brief than the total purchasing pilots or the consortia, also turned out, on average, to be rather better managers of their budgets than the health authorities, which were the principal bodies at the time. Again, that might be something to do with size, but that is what the evidence tends to suggest.

Q58 Mr Barron: Not that many years ago now, we saw the reorganisation that brought in primary care trusts, followed three years later by the reorganisation that made PCTs bigger. That seems to be contrary to what you have just said about size, Professor Le Grand. Would smaller bodies not have a major problem with administration?

Professor Le Grand: All I can say is that I do not think so. I do think it was one of the great mistakes of the Labour Government to abolish GP fundholding in the first place, and I argued quite strongly at the time that it should not have been abolished. Of course there were inefficient, wasteful and not properly managed GP fundholders. Of course there will be, and one has to accept that that there will be, some GP consortia that will not do a good job. My contention would be that the average GP consortium will probably be better managed that the average PCT; and, on average, the smaller consortia are likely to be better managed than the bigger ones.

Q59 Mr Barron: Do you think the GP consortia that are not that good will take kindly to being told by the national commissioning board that they have to improve in certain areas?

Professor Le Grand: I think they will have to because, at the end of the day, the national commissioning board holds the funding.

Q60 Mr Barron: We have had 60 years of this now. I just wondered whether you think things will change in the next few years.

Dr Dixon: Probably not.
**Professor Le Grand:** I will leave my colleagues to answer that.

**Dr Dixon:** Can I just come back on this question of size? I was one of the researchers who wrote this report and evaluated total purchasing. We found that the total purchasers and the fundholders, which were forerunners of the consortia, made absolutely no headway in reconfiguring hospitals; they made very little headway on anything to do with the inside of hospitals. They did lots of things outside hospitals because they were small and able to do that, but they could not take on the hospitals, because they did not have enough purchasing clout, the information or the leadership. Bigger would be better with respect to having that kind of leadership, particularly if there is nothing between the consortia and the commissioning board. That is quite apart from the considerations about taking on financial risk, having the management expertise that they need and the critical mass of skills that leads to higher things. Those things push me towards a larger size.

We at the Nuffield Trust are in the process of doing the risk calculations for the Department, so I cannot say yet whether 100,000 is the right size. Any size is fine, but if consortia are smaller, they just cannot take on the commissioning for certain services—if they are limited, they cannot have much clout with the hospital. The big issue here is service reconfiguration. We are going to see masses of that over the next few years.

**Dan Byles:** That is really interesting, but what about the idea that smaller consortia can still band together with neighbouring consortia to commission some of these services? Is it not automatically the case that the size of the minimum consortium will be a constraint on commissioning some services, because my understanding of the Bill is that we are expecting strategic partnerships, possibly different strategic partnerships with—

**The Chair:** Order.

Dan Byles: It would have been a fantastic question.

**Emily Thornberry:** I think my hon. Friend the Member for Leicester West will ask you more questions about that. Doctor Meldrum?

**Dr Meldrum:** I would agree with Chris Ham in terms of the timing and size of the reorganisation, given the financial problems facing the NHS and the country in general. I think the other risk that we see is the possibility of destabilisation and fragmentation of services at a time when you need integration and co-operation. We do not feel that widening or increasing market forces within the NHS in the way in which this Bill seems to want to do is going to be helpful. For instance, giving the economic regulator, Monitor, a prime function of encouraging competition will not be helpful when I think its prime function should be to ensure good, cost-effective, comprehensive provision of services.

There are other side effects of the reorganisation, particularly getting rid of PCTs and strategic health authorities and the effect that will have on—for instance—education, training and the work force, and as your previous speakers were saying, on the accountability of the provider side of general practice as well.

**Emily Thornberry:** May I just ask a couple of questions of Tim Gilling, if that is alright? But first of all I will give you an opportunity to answer the first question, then I have a couple more questions for you.

**Tim Gilling:** A quick answer to the first question is that the parts of the Bill that talk about greater local autonomy and freedom from burdens run the risk that public accountability will be missed out in that move forward. Our second major concern is the governance culture of some of the new organisations. We think that the Bill could be strengthened somewhat in terms of the way some of the new organisations will structure themselves and the way they will involve patients and the wider public in decision making, assessing quality and things like that.

**Emily Thornberry:** I want to ask some questions about public accountability and to use a fairly graphic example. I could use my local hospital, but I will use Chase Farm instead. If a decision was made to close Chase Farm, or, indeed, the A and E at the Whittington, who would be making that decision, how would they be accountable and how would the public and patients have a voice in order to try to stop that? Could you help us with the different levels and how someone living in north-east London could try to stop a reconfiguration?
**Tim Gilling:** Perhaps I should describe how I see the provisions in the Bill working in the best way to make that a constructive process.

**Emily Thornberry:** If you would explain how it works now, you are very welcome to say then how you think it should change. We need to understand how the Bill stands at the moment to begin with.

**Tim Gilling:** Okay. How it works now is that commissioners and providers have a duty to involve patients and the public under Section 242 of the National Health Service Act 2006. They are duty-bound to involve patients and the public not only in decisions on their own care, but in developing proposals for service changes. Proposals for service changes quite often become very controversial. In our experience of supporting the local authority in its scrutiny and review function, that is very often because conversations about change do not start early enough in the process. When providers and primary care trusts are talking about making service changes, we do not think that patients and the public are involved at an early enough stage. There is considerable scope for the new arrangements in the Bill to improve that, if they work in a certain way.

**Q63 Emily Thornberry:** Perhaps I am not making my question clear enough. What I would like to know is who will be making the decision, at what level, when it comes to reconfiguration of services? Where are the pressure points that the public could take advantage of in order to make sure that their voice is heard, as the Bill stands? Where is the “no decision about me without me” in the Bill?

**Tim Gilling:** As the Bill stands, decisions will be taken about service reconfiguration by consortia. A key part of the process, though, will be the strength of the joint strategic needs assessment and the health and well-being strategy that flows from that assessment. In an ideal world, decisions about reconfiguration would be driven by needs and by the health and well-being strategy. I see the health and well-being board as a crucial place where some democratic legitimacy can be brought to bear on those decisions.

**Q64 Emily Thornberry:** Does it have legitimacy at the moment, as the Bill is currently drafted?

**Tim Gilling:** It has legitimacy in the sense that the Bill talks about a requirement for a de minimis number of elected councillors to be on the board and there is scope for local authorities and boards to add to their membership, but perhaps it does not go far enough at the moment.

**Q65 Emily Thornberry:** Could the health and well-being board stop a reconfiguration?

**Tim Gilling:** I am not sure.

**Q66 Emily Thornberry:** Could anybody else stop a reconfiguration, where the patients might have a voice?

**Tim Gilling:** Currently, there is a power for local authority scrutiny committees to refer. That is quite an important power, quite a strong power, a power that does not really exist anywhere else in relation to public services. We think that that is a strong lever for local people, local accountability.

**Q67 Emily Thornberry:** Is it right that the public cannot require GP consortia to do anything and do you agree, if you have seen it, with the letter that is in The Times today, signed by eight major charities, in which they say that there is a gap between the rhetoric and reality in relation to patient involvement and democratic accountability?

**Tim Gilling:** The Bill currently provides local authorities with flexibility and freedom in how they carry out what is currently known as health scrutiny—health scrutiny functions. It remains to be seen how local authorities choose to carry out that function if the Bill goes through as it is. I would expect any new arrangement carried out by local authorities to be founded on elected councillors, because it would seem to make sense for local authorities to do that.

**Q68 Jeremy Lefroy:** I have three questions. The first relates specifically to public scrutiny, and is addressed mainly to Mr Gilling. I am talking about the matter in the context of Mid Staffordshire NHS Foundation Trust in my constituency. What provisions of the Bill do you think would make public scrutiny more effective than it was in the case of mid-Staffordshire?

**Tim Gilling:** What would have made it more effective in that particular scenario would have been for all the different players in the field of accountability, assessment and scrutiny to have had a closer relationship with each other and to have had a forum for a dialogue.

**Q69 Jeremy Lefroy:** Do you think that the Bill does that? Does it provide for a closer relationship or does it just leave it up to individual organisations to make that relationship for themselves?

**Tim Gilling:** I think that the Bill tends to leave them to make it up for themselves.

**Q70 Liz Kendall:** I am sorry but I could not hear the answer to that question. Could you say that again?

**Tim Gilling:** Sorry. I said that I think the Bill leaves it up to them to create that stronger relationship.

**Q71 Liz Kendall:** So it does not clarify that?

**Tim Gilling:** No.

**Q72 Jeremy Lefroy:** My second question is directed to all three gentlemen. Do you think that there would be a case for, for instance, Monitor having a responsibility to consider the stability of the provision of acute services in a particular area when deciding which providers to authorise in that area?

**Dr Meldrum:** That was partly behind my first comment about the idea that seems to be around at the moment: that Monitor’s prime duty was to encourage competition. It seems to me that if you want to try to ensure good quality long-term services, the first duty is to consider the stability of services. I have used an analogy. It would be easy to find that you could have any willing provider who might tender for certain elected services that a hospital provides—for example, cold orthopaedic—but if that is going to affect the trauma provision in that hospital and destabilise the rest of the services, it would seem perverse to say to a consortium that they have to go to that particular provider.
I shall just comment briefly on public accountability. I share the concerns expressed. I do not think there is much in the Bill that would necessarily prevent another mid-Staffs from happening elsewhere. We all want to learn about how something as dreadful as that could happen without people at all levels responding. But, I think that might be more about the culture that pertains at the moment, rather than the various structures. Unless we change the culture, I do not think changing the structures, as the Bill proposes, will necessarily prevent what happened in mid-Staffs from happening elsewhere.

Chris Ham: May I respond on the stability point because there is a fairly fundamental question here about whether you think stability is a good or bad thing? There is a respectable view that we probably need a bit more instability in our system in the sense that if we are really going to deliver world-class outcomes and quality of care, freezing our existing pattern of specialists to keep services in current district general hospitals is not the best way of delivering that. We need to take some tough decisions about what has happened, for example, in London. We are beginning to see some really good results around better outcomes for stroke patients because decisions have been taken by the strategic health authority to concentrate specialist stroke services in fewer hospitals, therefore delivering better results.

The question for me coming out of your challenge to us is whether will the dynamic for instability—positive instability—to deliver better outcomes come from? One argument would be that GP commissioning consortia will, quite rightly, be attached to their local services and less minded to do what the SHA did in London, which was to stand above local communities and say, “Actually, there’s a case for change here, and change means some services moving away from local hospitals to specialist centres, because that’s good for patients.”

Q73 Liz Kendall: This is a question for Dr Meldrum. In the evidence that you provided for this session, there is quite a lot about your concerns about introducing competition, including on price. There are two quotes in particular that I want to ask you to expand on. In the first, you say that it could make it impossible for commissioners and providers to operate in the best interests of their patient population and in the confidence that they will not be exposed to frequent and potentially costly challenge. The second point that you raise is that FTs will become private entities rather than NHS entities, and as such will be subject to the same rules and regulations that apply to other private companies, including UK and EU competition law. Have you received any legal advice about how the Bill subjects the NHS to the competition law of this country and of the EU?

Dr Meldrum: We have, obviously, taken legal advice. On the first point about price competition, we hear the rhetoric that the Government do not want price competition—and quite rightly so, because all the evidence shows that that tends to lead to a downward spiral in quality. Yet it seems absolutely obvious that if a maximum price can be stipulated, you can go below that. It would seem to us to be much better to say that a price should be set.

There may be circumstances in which a consortium, because of local circumstances, will have to argue that it needs a price above that level. That would be a constant price, and there would not then be competition there. Or there might be circumstances in which the price could be below the level. That would be consortium-wide, and you would have people tendering on not price, but quality.

In terms of taking legal advice, it is quite difficult to get legal advice about the things that might or might not happen to bodies when we do not quite know what they are going to look like, but the legal advice that we have is that the more the body looks like, behaves like and is governed like a private enterprise body, the more it will be open to the Europe-wide competition laws.

As somebody said, if a foundation trust looks like a duck and quacks like a duck, it will be a duck, and it will be treated as a private duck. If we want to avoid that sort of destabilisation and interminable challenge, and the uncertainty that it would give those in consortia, I think that there is a very good argument for making sure that NHS bodies such as foundation trusts are clearly distinct from private enterprise bodies.

Q74 Liz Kendall: May I confirm this? You think that the Bill raises at least the possibility that foundation trusts could be treated as private companies under EU competition law?

Dr Meldrum: There are certain measures to allow them to compete, in a way, with private bodies—giving them greater autonomy, getting rid of the private income cap and various other things—that would, by their very nature, mean that you would be moving them much further in that direction. Therefore, the uncertainty about how they would be treated is that much greater—even to the extent that many lawyers might say that they should be treated as private bodies.

Q75 Nick de Bois: Mr Gilling, I will take you back, if I may, to an earlier conversation. Can you confirm whether, in your opinion, the Bill gives more public and democratic accountability than before?

Tim Gilling: The Bill puts more responsibility and focus on local government to play a co-ordinating role right across health care, social care and health improvement activity in its area, driven by a requirement to carry out a needs assessment and a requirement to produce a health and well-being strategy. If that is becoming the responsibility of a local authority made up of elected councillors, it would mean a higher degree of democratic legitimacy in the process than currently.

Q76 Nick de Bois: Thank you. May I pick up the point made by the hon. Member for Islington South? If there is a scenario of potential reconfiguration, and the GP consortium that would be principally affected by that made it clear that if reconfiguration was to happen, it would not be inclined to procure those services, is it not realistic to assume that that would significantly influence the decision about reconfiguration?

Tim Gilling: Yes, I would expect that to have some influence.

Q77 Nick de Bois: One final question, if I may. It is brief. Dr Meldrum, in respect of the BMA, I am slightly confused about something. The BMA wants hospital specialists to be involved in GP consortia. I understand that; you want that written into the Bill. What I do not understand is why you want it written into the Bill when the Bill allows it in the first place.
Dr Meldrum: It is one of those difficult areas. The Bill is very unclear. It does not even say that you have to have a GP on your consortium, which is a little strange considering that it is a GP consortium. The message that we are getting loud and clear is that hospital colleagues feel pretty alienated by this whole business. Therefore we feel that unless there is something in the Bill giving consortia a duty to consult with both their public health colleagues and their secondary care colleagues, there will not be the reassurance for them that we would seek.

Nick de Bois: Okay. Thank you.

Q78 Mr Barron: What evidence is there that GPs want to take on responsibility for commissioning, and are they actually capable of doing so?

Dr Meldrum: The evidence is mixed. Before this happened there were quite a lot of practice-based commissioning groups, many of whom have now been renamed pathfinders. We are conducting a large survey of about 20,000—not just GPs—and the evidence emerging is what we picked up generally at meetings and other times.

There are some enthusiasts and some total rejectionists. There is also a very large group—probably about 70% or so—who are pretty sceptical and pretty pragmatic. They have now been through three or four NHS changes and realise that it is probably best to try and do what they can, rather than be left behind. But I would reject the idea that there is an overwhelming enthusiasm for this just because a lot of people have put themselves forward as pathfinders.

I heard a little of your previous evidence. You need good leaders to take this forward. You need the majority of practices and GPs to co-operate, but not necessarily to have the ability. And you need commissioning consortia to be able to employ the right people to help them in the work that they will have to do. I differ slightly from Professor Le Grand’s idea that small is best. Small is best in terms of getting local buy-in, but if you want to employ the right sort of people, then you need to be larger. That is why I would probably favour a more federated model, with smaller groups feeding in to a larger consortium, and even cross-consortia working for certain of the bigger commissioning decisions.

Q79 Mr Barron: How reasonable are the fears of some GPs that their relationship with their patients will be damaged by suspicions that they are making referring and prescribing decisions for financial rather than clinical reasons?

Dr Meldrum: It is a genuine and legitimate fear. It has been there ever since the introduction of fundholding, for instance. The principal objection to fundholding was that it would create these tensions. We have seen it a bit already with target payments for immunisations. Particularly at the time of the MMR crisis, a lot of parents or patients worried that GPs were giving their advice only because they knew they were going to reach their target payments.

Particularly at a time of financial difficulty in the NHS, there will be worries that “you are not referring me, you are not investigating me because you want to save money”. That is why the BMA has made it absolutely clear that we do not think there should be any financial link or benefit for GPs that is dependent on the success or otherwise of their consortium. The idea of giving GPs bonuses if their consortium do well is complete anathema to us, and would worsen the tensions that you suggest.

Q80 Mr Barron: Finally, funds for commissioning will be calculated at practice-budget level, and allocated directly to consortia. The Government say that practice-level budgets must reflect the needs of both registered and unregistered patients. How can that be achieved, given that the practice boundaries will be abolished and practices will no longer relate to defined catchment populations?

Dr Meldrum: I do not think that that is the only problem with calculating budgets; it is a hugely inexact science. I, for my troubles, sat for a while on the Advisory Committee on Resource Allocation—ACRA—and heard as many different theories on how fairly to allocate budgets as I saw experts.

You can throw into the mix, as you say, the possibility of unregistered patients and the flexibility of boundaries. We proposed the idea of dual registration about 10 years ago, but the Department of Health threw it out, saying that resource allocation would be impossible. You now have not only dual registration but potentially almost infinite registration, if you get rid of practice boundaries. I think that that is just going to add to the problem, but perhaps I should defer to experts greater than myself when it comes to health economics.

Chris Ham: I cannot add any further enlightenment to that. It is much more complex under the system that we are moving to than it has been with allocations to PCTs based on defined populations. It is not impossible, but it requires a different approach.

Q81 John Pugh: I am sure you could help me with this, Chris Ham. One of the arguments sometimes given for this legislation is that there is a differential between the survival rates for diseases such as cancer and heart attacks in the UK and other countries. Clearly, the causal connection between those sorts of health outcomes and the management and commissioning structures is slightly opaque, but can you clarify your view? Do you think that structural reorganisation is possibly a necessary, if not a sufficient, condition for improvement? If not, what is?

Chris Ham: That is a really important and complex question. Is it about the mechanisms for improving population health outcomes, such as premature deaths from cancers, heart disease and strokes? Is whether structural change will help or hinder in that process the essence of what you are getting at? Is that the core question?

John Pugh: Yes.

Chris Ham: Structural change in itself will not help. The key issue is to understand where we stand vis-à-vis other countries that we aspire to be like, in Europe or further afield, and why there are differences with us not doing as well as them.

My colleague John Appleby recently contributed to this debate. He said that if you look at the long-term trends in premature deaths from heart attacks, we are moving very rapidly to a comparable position with France, Germany and the Netherlands—countries that have been doing well for some time.
We do not do so well when it comes to five-year cancer survival rates, and at the King’s Fund we have been doing an analysis of what lies behind that. It will not surprise you to hear that there are many factors that probably explain that, including late presentation by patients to their general practitioner, even when they experience symptoms, sometimes late or delayed referral by GPs to specialists, and the fact that sometimes we do not deliver best-practice specialist treatment when patients end up in hospital.

Q82 John Pugh: On that point, do you think that the GP consortia are perhaps better set up to deliver best practice than the PCTs were to spread best practice?

Chris Ham: The way in which GP consortia will go forward, with greater GP and wider clinical involvement in commissioning decisions about how to use the budget and about what issues to focus on, ought to be a step forward compared with the previous commissioning arrangements. However, they are, of course, just general practice consortia, and we have argued consistently the need to get hospital specialists, nurses and allied health professionals working hand in hand with GPs. It is not simply a primary care challenge to deliver those world-class outcomes in cancer care; much of it rests on primary care working more effectively with hospital specialists in a more integrated approach, which we have strongly advocated.

Dr Meldrum: I should add very briefly that, as John Appleby also pointed out, there are problems with many of the statistics; you are not always comparing like with like. Overall, the UK has life expectancies not too dissimilar from those in most of Europe, so if we are doing worse in cancer and heart attacks, we must be doing better elsewhere.

Certainly, in some countries, the way you measure cancer and cancer outcomes is completely different. If you look at the Commonwealth Fund evidence, which compares us with places such as the United States, Canada and others, you see that the UK does pretty well. What I would say in relation to cancer care is that the biggest improvement we have seen in recent years is happening in the rest of the country financially, in terms of the pressures that there will be. As somebody about its population and how its population accesses health care. Therefore, when looking at proposals for changes, it can make a judgment as to whether or not those changes are significant or substantial.

The extent to which changes are significant or substantial has always been a matter for local conversation and dialogue between scrutiny committees, commissioners and providers. In terms of setting a distinction between the circumstances in which patients and the public need to be involved, the phrase is unhelpful.

Q86 Debbie Abrahams: May I follow that briefly with a question I have asked before about inequitable access to care? There seem to be different views in the evidence we have had so far about the Bill’s impact on equitable access to care. What do you think? That is to the whole panel.

Chris Ham: Can you define what you mean by equitable access to care?

Q87 Debbie Abrahams: For example, there may be a differential in terms of people who need care actually being able to access it. A different level of service may be provided in different areas. If there is an increase in private providers, how might they define the type of patient who may be able to access their care? What do you think the impact will be?

Chris Ham: The general direction of the reforms is towards much more localised decision making by handing over 80% of the budget to GP commissioning consortia. The logic would be that you would expect to see greater variability than we have at the moment. We are not starting from total equity.

The whole purpose is to say to GPs and their colleagues, “You are better placed to assess the needs of the populations you’re serving”, and those needs will vary from place to place. On the other hand, it is clear from what has been said in the White Paper and the various other documents that the NHS commissioning board and NICE will both have a significant role in publishing guidance on best practice, standards and how GP commissioning consortia should commission services.

I think that makes sense, because whatever the number of consortia that we have, you do not want them reinventing the wheel every time it comes to commissioning any kind of specialist service. Until these arrangements are up and running, we frankly do not know what the balance will be between localisation and national direction.

Q88 Debbie Abrahams: Okay. So do you think it will improve equitable access to care?

Chris Ham: I do not think that anybody can say, hand on heart, whether it will make a difference one way or another.

Dr Meldrum: I would agree with that. The good ones will do it well, the bad ones will not do it so well. That comes back to some of the accountability and governance issues that we talked about earlier, but I agree with Chris that there is potentially more scope for differentials. Of course, perhaps the biggest factor that is going to affect access and some of the health inequalities is what is happening in the rest of the country financially, in terms of the pressures that there will be.
said earlier, it will still tend to be the articulate, the new-media savvy, who will do well. Those who are less like that will not.

It is not so much what is in the Bill or not in the Bill, but what is happening elsewhere and how much the Bill will help to address that—and I do not think it will be very much.

**Q90 Nicky Morgan (Loughborough) (Con):** But purely on terms of price, do you accept that those commissioning services—it is the PCTs at the moment—will be looking to get best value for the NHS budget, for the taxpayer, as well as the right level of quality?

**Dr Meldrum:** Absolutely, but to get that best value involves more than just looking at the cost of each individual tender.

**Q91 Nicky Morgan:** Can I move on to GPs and commissioning? One of the issues that has come up a lot with specialist commissioning, in particular for mental health—the panel might have views on this as well—is whether GPs need additional advice and assistance. Do you have any thoughts on that?

**Dr Meldrum:** GPs will need additional advice in a huge number of areas. I am a GP and a generalist, and very proud of it; I do not have specialist expertise, and I refer to specialists when I need to. In developing clinical pathways and commissioning services, of course you are going to have to involve both the clinical and the patient experts in these areas—and financial expertise and suchlike, as well.

The idea that GPs themselves will be physically writing down these care pathways without reference to anyone else is just nonsense. Whether it be in mental health or in many other areas, they will have to involve their specialist clinical colleagues. I am not talking only about medical clinical services, but others such as midwifery or whatever it happens to be.

**Q92 Nicky Morgan:** You feel you would know where to turn to get that advice. It is not a barrier to providing good patient care.

**Dr Meldrum:** Absolutely.

**Chris Ham:** May I add something briefly? The big question is not whether GP commissioners need expert advice or patient input or other sources of information. The big problem that we have had over the past 20 years, in successive attempts to apply market principles in the NHS, has been the fundamental weakness of commissioning, whether done by managers or GPs, and whether it has been fundholding or total purchasing.

Quite simply, commissioning health care well is really hard to do. You need as much management support as you can get, as much expert advice, as much patient and public involvement. The hypothesis behind the Bill is that GP commissioning, without PCTs and SHAs, will succeed where previous models of commissioning over the past 20 years have all failed to varying degrees.

**Tim Gilling:** I want to say something about that. It is about the balance of power and where it lies in that conversation. It seems to me that obviously a lot of the decisions and things that we are talking about are a balance between professional judgment on the one hand and public input and views on the other. It is where the balance of power lies in that relationship. That is why I think the patient and public involvement and accountability aspects of the Bill could be strengthened. It is not clear at the moment exactly where that power balance lies.

**Q93 Grahame M. Morris:** The BMA is on record and has submitted evidence that it is against the increasing commercialisation of patient care, and that it wants to see the NHS restored as a public service, working co-operatively for patients. A recent big BMA campaign, “Look After Our NHS”, publicly funded and provided, focused on money lost to the NHS when it is spent in the private sector.

What do you think the impact of more and more public money going into the private sector will be over the longer term? I would like to draw your attention to the impact assessment, page 42, paragraph B55, where it identifies that the private sector health care companies are 14% higher in cost terms than the in-house NHS provider.
Dr Meldrum: There are a lot of questions there. We are not ideologically opposed to private sector involvement. We have made it clear that if the NHS cannot deliver, you have to look elsewhere. However, the evidence, as we have seen so far in a lot of areas—whether it be from PFI, to some of the experiences of the independent sector treatment centres, to various other things—is that they have not done what a lot of people hoped in terms of driving up quality and driving down cost.

We have seen, certainly in the initial contracts for ISTCs, how they were given guaranteed levels of income, how they tended—not surprisingly—to cherry-pick cases by taking the less complicated and leaving the more complex ones for the NHS. It also particularly tends to lead to fragmentation at a time when you are seeking integration. It is never going to be a true market in health care, because there are so many differences. One fundamental difference is that most markets want to increase volume and turnover and, therefore, increase profit. If you do that in the NHS, it costs the taxpayer more. There are a lot of other differences that I could highlight.

Our worry is that with the increased emphasis on competition, first of all it will be more bureaucratic. Consortia will spend a lot more time trying to ensure that they have got rid of any risk of challenge, because they have not been seen to be looking at all the various options. Again, as I said, it will lead to further fragmentation at a time when you want to see integration and co-operation.

Chris Ham: May I add a brief comment? General practice since 1948 has been essentially a privately run, profit-making activity. That has never been seen to be incompatible with the principles of the health service. These issues are manageable if we have the right system of regulation in place.

Dr Meldrum: I would like to come back on that. General practice has been a very integral part of the NHS since 1948. Contrary to popular belief, the BMA did not oppose the NHS. It did oppose all NHS people being state employees.

The Chair: I am afraid that brings us to the end of the questions.

1 pm

The Chairman adjourned the Committee without Question put (Standing Order No. 88).

Adjourned till this day at Four o’clock.