Public Bill Committee

HEALTH AND SOCIAL CARE BILL

Second Sitting
Tuesday 8 February 2011
(Afternoon)

CONTENTS

Examination of witnesses.
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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

Michael Sobanja, Chief Executive, NHS Alliance

Dr James Kingsland, President, National Association of Primary Care

Dr Clare Gerada, Chair, Royal College of General Practitioners

Councillor Mike Roberts, Rushmoor Borough Council and a member of the Community Wellbeing Board, Local Government Association

Andrew Cozens, Strategic Director of Children, Health and Adult Services, Local Government Association

Nigel Edwards, Acting Chief Executive, NHS Confederation

Karen Jennings, Assistant General Secretary, Unison

Nick Parrott, Health Policy Specialist, Unite

Rehana Azam, National Officer, GMB
Public Bill Committee

Tuesday 8 February 2011

(Afternoon)

[Mr Jim Hood in the Chair]

Health and Social Care Bill

4 pm

The Chair: We will now hear oral evidence from the NHS Alliance, the National Association of Primary Care and the Royal College of General Practitioners. I welcome our guests to the Committee. So that we can get on with the evidence session, I advise them to introduce themselves when they answer their first question, if that is acceptable.

Q94 Emily Thornberry (Islington South and Finsbury) (Lab): A large number of people want to ask questions, so to be fair I will ask everyone one general question, and then I will back off and let my colleagues put their questions. The Bill has been criticised by many as risky. Do you think there are risks associated with it and with the reorganisation that it attempts to marshal? If so, what do you see as the main risks? If possible, perhaps you could each answer that question in turn.

Dr Gerada: I am Clare Gerada from the Royal College of General Practitioners. First, we welcome putting GPs at the centre of planning the health service for the local population. We are very keen on that. However, we have a number of concerns about the Bill. One is about the duplication of care and fragmentation; we are also concerned about the under-provision of care once competition starts kicking in, the pace and extent of change, and the capability capacity and competence of GPs across the board to undertake that role. We are concerned that the Bill risks widening health inequalities and could lead to worse patient care, and that introducing competition based on price will reduce quality. We are also concerned about the transaction costs, which will inevitably rise if there is an increased number of providers. We are also concerned about the split between choice and competition—we would rather see collaboration, co-operation, shared care and integration. Those are—briefly—some of our concerns.

Before I finish, we have consulted widely with our members on a number of occasions, including with stakeholders in a large consultation exercise and a recent survey. Those are the predominant concerns shared by many of our members who have given answers to us.

Q95 Emily Thornberry: You are confident that you speak in a representative capacity having involved your members?

Dr Gerada: Clearly, it is difficult to say that I speak for 42,000 GPs across the United Kingdom—Dr Kingsland is one of my members. However, we have consulted widely, often and in different forms, with written surveys and so on, so yes, I can safely say that those are roughly our concerns across the board.

Emily Thornberry: Thank you. Dr Kingsland?

Dr Kingsland: I am James Kingsland. I am a general practitioner in Wallasey in Merseyside and president of the National Association of Primary Care. To declare my interests, I do part-time work for the Department of Health and I am a non-executive director of a foundation trust, so I have a fair portfolio of views.

The biggest risk is the status quo—looking at what is now called the Nicholson challenge in the light of the changes we know about and the pressures on our health service, and asking, “Will we deliver by trying harder at doing the same thing?” There is a greater risk in the status quo than in the change. The risk would be to disenfranchise or not engage clinicians, particularly in the realignment of their clinical decisions with the financial accountability that goes with those decisions. Those are completely disengaged at the moment and that is the biggest risk to the status quo. On the process, the NAPC has been lobbying for a long time to return financial accountability to alignment with clinical decision making.

Q96 Emily Thornberry: When you refer to clinicians, do you just mean general practitioners or do you mean doctors in secondary care as well?

Dr Kingsland: Ultimately, everyone whose decision deploys an NHS resource. In the main, it is the referrer and, in the main, the referrer is the general practitioner. Any clinician, who is a resource themselves or who commits resources, would need to have that same alignment. Ultimately, that would be the case within secondary care as well.

Another big risk at the moment is the occasional misunderstanding of the intent of the reforms within the service. Some of the concerns that our members have—or some of the work I have done in the Department—relate to clarifying these misunderstandings, where there are all sorts of extrapolations of what some colleagues think is going to happen, but which I do not think is necessarily part of the reforms. For example, we are talking about the position of AWP—any willing provider—or the process in which clinicians will get engaged, which is not making them into managers. Many of my colleagues think that that is moving them into a different role, as opposed to just doing their job better.

Michael Sobanja: I am Michael Sobanja, chief executive of the NHS Alliance. I am not a GP and the NHS Alliance is not a GP organisation, reflecting in its membership clinicians of all types, managers and laypeople. Like my two colleagues, the NHS Alliance supports the move towards clinical commissioning. Yes, we do believe that there are significant risks associated with the Bill, but that is true in any major change. Some of those risks are certainly associated with what has become known as the Nicholson challenge, but I think about maintaining clear accountability and a grip on public finances. There is clearly a risk that a major change may not work in the interests of patients, but the thought that GP commissioning consortia would be significantly worse than primary care trusts may be without foundation. There is a risk in the Bill that public accountability will be compromised, particularly in relation to the make-up of those consortia. Overall, I agree with James that the greatest risk is to continue as we are—change is necessary—but there are certainly risks associated with this and other changes.
Q97 Emily Thornberry: Before I pass on the baton, you said that there was a risk associated with public accountability to the GP consortia. We heard a little bit about that before lunch. Would you mind just giving us a few more details of your concerns in relation to that and then I shall move on to the others?

Michael Sobanjo: Certainly. Two of us were giving evidence this morning to the Health Select Committee and this issue arose. My organisation believes that there is a need for independent directors of GP commissioning consortia, not only to strengthen public accountability—recognising that independent directors per se will not satisfy that requirement—but for good governance purposes. One of the difficulties with the Bill is that it does not preclude independent directors being members of consortia boards; that is left, as I read the Bill, for the national commissioning board in receiving applications from intending consortia. That serves as an example in my mind of a number of risks in the Bill itself, in the sense that we have not got all the detail coloured in yet. Colleagues in the room will be far more aware than I of secondary legislation, regulations and directions. We have not got the complete picture yet. The Bill has that risk because it is not prescriptive in that area.

Q98 Jeremy Lefroy (Stafford) (Con): First, I declare an interest in that my wife is a member of the Royal College of General Practitioners.

I would like to ask a specific question about GP boundaries and list sizes, with particular reference to clause 21. What are your views on whether the abolition of practice boundaries, presumably within the area of a consortium, is a good thing; and whether, at the same time and in order to protect small practices, which often seem to rate highest in public esteem, should there be some provision for practices to cap list size or at least say, “I want to remain a small practice and not take any more patients on to my list.”?

Dr Gerada: There are two issues there. One involves single-handed and small practices, and the other is the abolition of practice boundaries. If I can deal with the first, which is the single-handed and small practices, the Royal College of GPs values small practices—they often get the highest patient satisfaction. If you look at the research evidence and compare like with like, small practices do as well as large ones if you compare their make-up, but you have to accept that small practices tend to be in much more deprived areas, for lots of reasons. That is just one thing about small practices.

The abolition of practice boundaries perturbs us greatly. The cornerstone of the NHS almost since its inception—in fact, before its inception, with the panel doctors—has been the registered list: a list with a geographical boundary around it. The geographical boundary invariably takes in people close to the GP practice. As I understand the Bill, patients will be given the choice to register with any GP, irrespective of whether the practice is within their local population. That will bring in all sorts of issues, not least continuity of care, the ability to plan for health services and the confusion of local government, with its health and well-being boards, being allied to a local population while the GP consortia are not. It also opens up the question of who is responsible for the total population. Provision may well be made for emergency care provision if you fall down in the street, but there will be nobody responsible for the total population as far as I can see—I have not read the Bill in great detail; it is a complicated document. We have concerns about that.

We also have concerns that unless Parliament puts in some checks and balances, there will be choice for patients of consortia, but consortia will also be able to choose patients. I am not sure how the legislation will pan out, but if Mrs Jones, who has chronic renal failure and who lives in my area, comes to register, there may well be no one who can mandate me to take her on as a high-cost patient. There are concerns about the abolition of practice boundaries. We submitted our consultation documents to the previous Government and said quite clearly to them exactly what I just said. We have the same concerns about this Bill and feel that it will lead to fragmentation of care, worsening of health inequalities and increased costs.

If somebody who is registered in Scunthorpe and lives in Scarborough falls ill away from their home, they will attend the local accident and emergency department—we know that. If you are registered away from your GP practice, you are much more likely to use secondary care services, thus increasing costs.

Dr Kingsland: I will give a personal point of view, then my organisation’s. I fully support the overall choice and competition agenda. As a GP, I want to be the best GP I can possibly be and I want a practice that is, like the Gillette principle, the best a patient can get. Contrary to the reports about 40% or more of GPs being in salaried positions, they are not. As Her Majesty’s Revenue and Customs recognises, 84% of GPs are independent contractors, and of the 16% who are not, half work with independent contractors. It is largely an environment of independently contracted, self-employed GPs who inherently have always wanted to produce a good practice and accept patients.

There is an issue about supply and demand and the doctor to patient ratio, which is usually carefully monitored by the practices, but there is also the principle of choice—allowing patients to go to the service that they see best fits their needs, set against the reasonable geography in which they choose. I would not expect anybody from Southampton to want to register with my practice in Wallasey in the north. There has to be something that recognises that that would be unreasonable, and similarly there has to be some fit between the registered list and the other providers in the area—the secondary care providers.

The principle of allowing patients to move more freely between practices, to not accept substandard practice and to move to where their needs will be met, should be part of the process, and I fully support that. The competitive aspect of it is sometimes what makes practice great. It improves the quality of practice, because we learn from colleagues’ successes and look at other practices in the area and aspire to achieve what they have, and it moves the agenda forward. On the principle of allowing greater choice, in our area, lots of colleagues recognise that the practice boundaries arranged by PCTs were restrictive, but we always had patients who were moving slightly away from a practice saying, “Please can I stay?” and GPs usually allowed them to.

Michael Sobanjo: I will not extend the spectrum because I am somewhere in between my two colleagues on this. I certainly support the notion of small, single-handed practices, and recognise that what Dr Gerada
saying satisfaction and outcomes is true, but what we also have to do is move away from a single-handed mentality—there is evidence that on occasions we get single-handed mentality even within larger practices—to more corporate working within practices.

I share Dr Gerada’s view that there should not be cherry picking, and that neither practices nor consortia should be able to exclude patients because they are difficult or high cost. There is an element here of trading off the advantages of choice and the potential disadvantages. One reason why I think there is merit in the choice argument is that the arrangement gives patients the opportunity of choice of commissioner, and that is a choice that none of us has ever had. I think that there is some international evidence to suggest that when you have choice of commissioner, as opposed to choice of provider, you may well leverage quality of care.

Q99 Mr Kevin Barron (Rother Valley) (Lab): I have just two quick questions. One is directed at Michael, but I would like other witnesses’ views as well. Michael, in your evidence you said that the Bill will be successful only if it is not just about major behavioural and cultural changes inside the NHS, and the risk is that we might simply see changes to the structure and little else, and that if that were to be the case, it would mirror many NHS changes of the past. What evidence can we see that this change is not going to be a change similar to those of the past?

Michael Sobhanja: It is always difficult to see evidence of prospective change. What I was trying to get at was that I have worked in the health service as a manager for more than 30 years. I was chief executive of a health authority, and I have seen many NHS restructurings, which are rather akin to someone firing a large gun at a tree full of blackbirds. All the blackbirds take off and land on slightly different branches, but they are the same blackbirds, doing essentially the same job. That is what concerns me.

I argue that the health service that I have worked in has essentially been a centralist, top-down structure. If you look at the Bill, depending on the behaviour of, for example, the new national commissioning board, the outcome could be a top-down, centralist structure. That is why I suggested that we need to change behaviour and culture. If commissioning consortia are to be successful, this needs to be led from the front line, by clinicians, and not directed from above. I do not have any evidence of changes that are yet to come about, but that is what I had in mind when I wrote that paragraph.

Dr Kingsland: There is some evidence. The National Association of Primary Care evolved from an association of fundholding practices, and although we fully recognise that this is not a return to fundholding, the principle, as I said earlier, of aligning clinical decisions with resource utilisation is part of that behavioural change. If the Bill is legislating for accountability and outcomes, we see the accountability right at the interface where patients define quality, which is between them and their consulting clinician. Behaviour has to change in that environment—in every consultation and in every surgery—and there has to be a recognition that a referral and a prescription do spend taxpayers’ money. The evidence that we have from fundholding over seven years, which was reported by the King’s Fund, showed that within fundholding practices there was, on average, a 4% efficiency gain in their budgets year on year for seven years, despite budgets being set on historical outturn. There was ever-increasing efficiency, and that was achieved by clinicians having some responsibility and accountability for the budgets they were deploying. The cultural change needs to happen within every practice. It is the aggregation of lots of remarkable events in every general practice, every year, that will go to the quality, innovation, productivity and prevention challenge, not the supplanting of PCTs with another large organisation that will, hopefully, do it on behalf of practices instead.

Q100 Mr Barron: Do you think GP fundholding changed the culture in those that were fundholders?

Dr Kingsland: If you are talking about the behaviour of how fundholding GPs and their teams acted, then yes, it did. It changed patients’ attitude as well. One of the problems—or an unseen benefit, perhaps—with fundholding was that patients started to see that fundholders were able to create new services and provide better access for some of their patients. The patients would start to say—this was a failing—“Are you a fundholding practice or not? I am going to make my choice on practice on whether or not you are managing a budget.” Fundholding did show behavioural change.

Dr Gerada: I have a conflict of interest here. I used to chair a GP commissioning organisation, which was an umbrella group for fundholders and non-fundholders, and I chaired a group of 420 GPs in south London. My practice itself was never a fundholder and we too brought about change without the flexibilities of fundholding. I practised in an area of south London where, right up to the end, there were very small numbers of fundholders.

To answer your question, Mr Barron, I think that you get real change when you have clinician-to-clinician dialogue, where you see problems, where you have iterative change and where you innovate in order to make a difference at the provider level to meet the needs of your population. For example, many services address the big scourges that we currently have, such as obesity, smoking and alcohol, and address the hard-to-reach groups. Where this may well change, and where we are optimistic, is the recognition that GP consortia will have to work with local government. Integrating local government and public health and having GP consortia working with local government should, if allowed to, bring about a change, although there are concerns about that.

If you ask me, “In its current form, is anything going to change?” again I say—rather parochially having been to several of my local meetings—it looks like the same faces, the same agenda and the same discussions as were there 10 years ago and as were there under practice-based commissioning. I also chaired a practice-based commissioning group in my local area. We are hopeful. The college is doing everything it can. I agree with Dr Kingsland that good commissioning is about being a good GP. It is about using resources appropriately in the consulting room. The college is developing a curriculum and a training programme so that we can engage GPs in the consulting room. I am talking about a hearts and minds transformational change right there. If we do not get it right there, then I suspect that we will not make any change over the next few years, and that is what we hope to do.

Q101 Mr Barron: You mentioned population health. My understanding is that this change will mean that health improvement and illness prevention will be the
responsibility of the local authority as opposed to the local NHS. It will be the local authority and the public health service, which we have not seen much of, that will be responsible for this. If my interpretation is right, do you think that it is a good idea to take responsibility for population health away from the local NHS? Is that a good or a bad thing?

**Dr Gerada:** Again, I think that putting public health within the local authority— I am speaking as a GP now, not as public health clinician; they may have a different view—is a good idea. Some 60% of what we see in our consulting room cannot be affected by anything that we can do. It is down to your genes—who your parents are—your environment, your housing or your education. Therefore, in my vision for the future, I see GPs working more closely with local government, having meaningful health outcomes that are based on giving a tablet and lowering your cholesterol by half a point so that you live for another 10 minutes, but on children completing education and training and getting elderly people in social networks. That is what energises me and my members.

Clinicians want to make changes—unbelievably they do. If we are allowed to do that and to innovate, without the shackles that may well be created, we can see a difference. If we concentrate, as we are doing, on yet another organisational change and all the caveats and all the problems that are worrying my profession—such as the any willing provider concept—we might be setting things back a bit.

**Michael Sobanja:** I don’t think it does shift responsibility; it shares responsibility and relocates the public health function. The NHS locally and nationally and local authorities must play their part in improving the health of the population. I do not see anything in the shift of the public health function into local authorities that should concern us, recognising that we have to learn to work across boundaries. For instance, if you were to take the cardiovascular screening and treatment programme, which is clearly an illness prevention, health promotion service, there would be aspects of that where the local health service and local government must work together, as indeed they do now.

**Dr Kingsland:** As a GP, I provide health care to a registered population. We know the determinants of well-being are not just in the health model. They are probably better determined in that programme that the local authority oversaw. I agree with Mike completely that the key is how you associate and align closely the commissioning decisions of the local authority and GP commissioning consortia. That is going to be one of the challenges, to make sure that they are closely associated, that they have a good working relationship and are closely aligned in their outlook.

**Q102 Margot James** (Stourbridge) (Con): **Dr Gerada,** I was comforted by what you had to say about the public health moving to local authority, and also that the royal college is developing training for GPs who want to take the commissioning role. Hearing your earlier evidence, I was beginning to think that your college was against all the proposals in the Bill, but it seems not. You expressed concern earlier, though, about the competition and greater choice aspects. Do you not agree that the Bill does not rule out collaboration and partnership working? In fact, it sets out to encourage that and greater integration of care. Are those not all good developments? Why would competition, added to those other good things, not achieve what it does in so many other areas, which is to drive up performance standards, both in quality and savings?

**Dr Gerada:** The college is in favour of commissioning and putting GPs at the centre of commissioning. The question that was tossed at me right at the beginning was where our concerns were.

We are equipping our profession to do this. We have absolutely no problem with competition where competition adds value to existing services. The problem we have is competition based on price. All the evidence appears to show that if you base competition on price you drive down quality. That is what we are concerned about, that it will be a race to the bottom.

You are right that we are not against integration, though we are minded to see how this will work in practice, with the separation of the provider and the commissioner. If you think about integration, most of it will happen at the local level. It will happen with clinicians talking to clinicians. The clinicians will inevitably be those sitting on GP commissioning boards, because we all live and work within communities. It is about how that is going to be managed. Is it going to be perceived as a conflict of interest or as anti-competitive? It is measures like that. We need to have the flexibility to have integrated care and collaboration and co-operation but we must not be handcuffed by any legislation that says that that becomes anti-competitive.

**Q103 Margot James:** On the costs side, you mentioned a possible race to the bottom in terms of price. Effective procurement is based on a combination of value, price and quality. Why would GP commissioning groups not want to see it in those terms, bearing it in mind also that they will be inspected by the Care Quality Commission, which will be more focused on quality?

**Dr Gerada:** Again, there are two issues. One is the any willing provider, which does not require procurement so there is not the issue. The other is the requirement, if you have service redesign, to go out to competitive tendering. All I can say is that from my experience, and from my reading, the tender will no doubt inevitably be given to those with the lowest price. There are many examples across the country of that happening. It is inevitable—maybe it is not inevitable, but one would assume—that when resources are very tight, one will go for the cheapest option. Maybe that will not happen, but one would assume that it would.

**Michael Sobanja:** I think that is a potential risk. I am not sure that there is any evidence for that, but I understand the element of concern. It seems to me that people have to be able to use the leverage in the system and competition to produce the best deal for patients, which includes elements of integration as well as competition. In my experience, and I do some work outside the NHS with commercial organisations, some of the most advanced integration and working across—to use commercial language—supply chains actually arises in what is a competitive environment, because people see the value of that collaboration. Perhaps my concerns are a little less than Dr Gerada’s on that matter.

I am concerned about the operation of any willing provider, which started life as a procurement mechanism as an alternative to tendering, and at some stage seems
to have turned into a policy statement. To be very precise, I would like to see any willing provider operate once the commissioner has pressed the button and declared need for a service. If any willing provider were to operate as a blanket market entry arrangement it could undermine the local commissioners—the GP commissioning consortia—and flood the market with providers, which would not be in the interests of the local population. The Bill is not specific on that matter, hence my comments before about needing greater detail about what is to follow as opposed to the Bill itself.

Dr Kingsland: Just to clarify, what we are talking about is this. We are for, certainly in our organisation, competition in the market, and as is, but that does not disallow collaboration with current NHS providers. Where a provider is able to meet a service specification that the commissioner has designed, within that market why would you want to go anywhere else? It is good to have competition to aid quality, however. If you cannot get a provider to supply against your commissioning spec you look for competition for the market and any willing provider should then be an option, to say, “Well, if we cannot find a current NHS provider against our commissioning spec, let’s look for somebody who can.” We would support that as well.

Q104 Liz Kendall (Leicester West) (Lab): Coming back to that specific point about whether it is clear in the Bill about any willing provider competitive tendering, clause 63 says:

“Regulations may impose requirements on the National Health Service Commissioning Board and commissioning consortia”.

Those regulations may impose requirements relating to the “competitive tendering for the provision of services.”

If it were the case that regulations issued by the Secretary of State, which of course would not be discussed by Parliament, could impose a requirement on the national board and commissioning consortia to put services out to tender, what would your view be of that?

Dr Gerada: Sorry if I misunderstand, because it is very difficult reading a Bill. Are you asking what my opinion of that is.

Liz Kendall: Yes. If a requirement is imposed by Monitor on the national board and on consortia, what would your view be about that?

Dr Gerada: Again, we have to be clear that putting services out to tender is very, very costly. It is about £500,000 to put a service out to tender—I got that figure from the House of Lords debate—and, clearly, there is an operational cost in that. It is not money that will go directly into patient care. In fact, it will be lost completely to patient care. The rest depends on what the service, specification and requirement are. Without knowing what service is going out to tender, it is very difficult to comment.

“There is a requirement at the moment to put services of relatively little value—about £120,000—out to tender. I am sure my colleagues will correct me, but the figure is within that region. There would be a worry, if you had to put services out to tender and the cost of the tender is much more than the cost of the contract, that you would run into financial problems. Without knowing what is being tendered, it is difficult to comment.

Q105 Liz Kendall: But that would be if that were what the Bill said. I am sure there will be different interpretations of it, but do you think you would have a problem with that?

Dr Gerada: As I said, we surveyed our members and analysed the 900 or so freetext comments. One of the most common freetext comments was about the apparent privatisation of the NHS and the move of services away from the NHS family. We would need to be very careful because external organisations can provide and have provided very good services to the NHS, so it depends on what the service is. I would like to say that tendering is very expensive and I would want to see very little of it, because that money is not going directly into patient care; it is going into the coffers of various folk—depending on who it goes to.

Michael Sobanja: For me, it is a matter of proportionality. It is, as Dr Gerada says, what is the nature of the service and is a procurement methodology appropriate? My belief is that within a framework set at national level, this ought to be a local, not national, decision. If Monitor, using its powers in the Bill—subject to its passage through Parliament—declared that something was anti-competitive, that might also undermine the local commissioner. Bearing it in mind that the paragraph you quote says “may” make regulations, my only answer is that we may have concerns depending on how that power is exercised. That is part of the problem with seeing how this will be applied in the longer term as opposed to the specific provision for the Bill.

Dr Kingsland: If we recreate the bureaucracy we are trying to reduce through the reform, that will be a major failing of implementation. I was involved in first describing the AWP process about six years ago. It is an unfortunate term, because it is sometimes thought that anyone—any old person—can provide. That is opposed to the process that says that if you need to increase the market—produce new for the market—we should reduce the tendering process. The whole aspect of AWP was to get tendering reduced to the position where if a necessary monopoly service needed to be created due to the nature of the service—its rarity—clearly tendering would be required, but, other than that, the tendering process should be made to be a rarity in this new process of AWP.

Q106 Liz Kendall: There has been a lot of discussion about the fact that the national commissioning board will commission primary care services. I wondered what your opinion of that is.

Michael Sobanja: My view is that in the absence of parts of the structure other than consortia, it should be the responsibility of the national commissioning board. When PCTs were around and we had primary care groups and so on, one thing that damaged the relationship within the primary care groups as they shifted to PCTs, was that people who you expected to work together to commission services in the interests of the population suddenly found themselves commissioning their own services as well. You need to separate those. The responsibility should be with the national commissioning board, supported by local commissioning consortia, but that responsibility cannot and should not be delegated.

Dr Gerada: I would agree. The only caveat I would add is that the responsible officer cannot sit in central London and be responsible for Cumbria. So you would
probably require outposts, which I assume will be outposts of the national commissioning board, because that seems to me to be the only way that the system will work.

**Dr Kingsland**: By primary care services, we are talking about the contracts for the four primary care contractor services, which rightly should sit with the NCB. However, it is also right that some of the quality improvements and incentives that could be delivered by GP-led commissioning consortia should sit with the NCB too. The improvement of the provision of primary care should sit with the GP-led commissioning consortia.

**Q107 Mr Steve Brine** (Winchester) (Con): This question is for Dr Gerada, I guess. I just want to probe you a little more on the level of enthusiasm among GPs for this shift to GP-led commissioning consortia. We had somebody here from the British Medical Association this morning, and the gist of what he said to us was that a lot of GPs have seen a lot of changes during the years and frankly they will jump on this one and go along with it, for fear of being left behind. The GPs that I know are certainly not passive sheep who just follow on aimlessly. Given that 55% of the population in England are covered by the GP pathway consortia, what do you think that says about your members’ enthusiasm for these changes?

**Dr Gerada**: I am a GP. I have practices across six London PCTs, just to put things into context, as well as being chair of the Royal College of General Practitioners and as well as having spoken to hundreds of GPs. I think what it says for my colleagues is actually, “Pat them on the back”. They are rolling their sleeves up and they are doing this because they know they have to do it and they want to make it safe for patients and the NHS. So they are getting in there and they are getting stuck in. My work partner spent the whole of Sunday reading documents to prepare himself and to skill himself up. If you translate that into, “We’re really enthusiastic about it”, then I think that the answer to that is, “No”. It is not, “Great, yet another reorganisation. Great, we can sit at some more meetings on a cold Thursday evening”, etc.

We have to do this. PCTs at the moment are losing staff in quite considerable droves. PCTs themselves are the main vehicle for getting pathfinders together and setting up the infrastructure, and the local medical committees are getting the elections sorted out. So this is a process that has to happen, it is going to happen and therefore we have to get involved.

If you ask me what my members say, all I can say is what they talk to me about, and 70% of the people who responded to the survey either disagreed or strongly disagreed with the direction of travel of the reforms. However, that does not mean that they will not have to get involved. They will do this and they will do it well.

**Q108 Mr Brine**: But you think that a lot of GPs are being dragged to this?

**Dr Gerada**: “Dragged” is a difficult word. We have been round the block before. I am not very old myself and I have now been through four major reorganisations: health authorities; primary care groups; primary care trusts, and practice-based commissioning. Now there is this one. And do you know what? We know, we absolutely know, that as day follows night there will be another reorganisation in about three or four years’ time. But we will get on with it, because we have to make it work. We cannot have patients in the middle of this not being provided with a service. We cannot have GP consortia being set up without responsible officers, accountable officers, governance structures and the staff to make them work. We will get on with it. GPs are chameleons, really—we can do what is asked of us and we will get on and do it.

**Q109 Mr Brine**: Your eyes lit up when you talked about the public health opportunities.

**Dr Gerada**: Absolutely.

**Q110 Mr Brine**: And I saw enthusiasm in you then for that. I thought, “Well, don’t things turn out best for those who make the best of the way things turn out”.

**Dr Gerada**: Yes. Let us be clear—GPs are best at providing, at innovating and around education and training. Those areas are where GPs are at their strengths. Managers are at their strengths doing all the organisational development and the organisational finance, etc. It does not mean that GPs do not want to be part of that process. What we are seeing at the moment is a large amount of organisational change, which those of my generation and younger have been through before. We have seen it and done it. The real excitement is in actually making a difference—working with our local government, looking at the big issues around public health and designing services that meet that need. Commissioning? I think that James Kingsland is very excited about commissioning. But in terms of planning services, I think that there is not that much enthusiasm, to be absolutely honest.

**Q111 Mr Brine**: It is not what my GPs say, but thank you very much.

The Chair: We have one minute left. Owen Smith.

**Q112 Owen Smith** (Pontypridd) (Lab): You mentioned privatisation earlier on, Dr Gerada.

**Dr Gerada**: I tried to avoid it actually, but it came out.

**Q113 Owen Smith**: It did slip out. Was it a slip, or is that what most of your members actually see here?

**Dr Gerada**: Of those who gave written comments, 90 expressed concerns about reforms leading to privatisation.

The Chair: Dr Gerada, I am sorry, but I have to bring this to a close as we have run out of time. That brings us to the end of our allotted time.

I thank you all on behalf of the Committee. Thank you.

4.45 pm

The Chair: We will now hear evidence from the Local Government Association. Welcome, gentlemen. As with our previous guests, would you introduce yourselves when you answer your first question, so that we can get more into our evidence session? Thank you very much for coming.
Q114 Emily Thornberry: I shall ask a couple of questions about two main things. The first is about integration, particularly of health and social care, and about whether the Bill will be of any assistance in that. The second will focus on the power of health and well-being boards—if, indeed, there is any. Perhaps I could ask Councillor Roberts the questions about the health and well-being boards. Would that be appropriate?

Councillor Roberts: That would be very appropriate.

Q115 Emily Thornberry: Will the health and well-being boards have any teeth? Will you have sign-off on GP consortia’s plans, as has been claimed? Can you ensure that GP consortia or any health provider will do anything that they do not want to do?

Councillor Roberts: Members of the Bill Committee will be aware that, at present, OSCs operate in local authority areas—in my area, in Hampshire and Surrey. There is a reason why I mention both, and I will give it later. They are democratically accountable—that is, the people on the OSCs are elected—and they bring in co-opted people as well. They have a work programme, and they call people in and so on. There is some element of democracy and governance there already.

With health and well-being boards, there is a view that they are welcome in relation to the added position that they will bring to the governance procedure but that, nevertheless, there is a need for a strengthening of that governance procedure. That could be done in a number of ways, particularly with regard to GP commissioning.

There is a need to have a look at how GP commissioning has evolved—whether it evolves on a sub-regional basis, and whether there is coterminosity with local authorities or first-tier authorities. I am a district councillor on Rushmoor borough council—this is my 35th consecutive year—in what is a very tough town, for those who know it from Aldershot. I have been a senior member of Hampshire county council for 16 years as well, so I know what it is like on a two-tier authority. I shall come to the difficulties in a sub-regional area later. There is a need to have a look at what we can do to strengthen those particular areas.

I think there is a general view that, on the development of GP consortia, which are private contractors—let us not get away from that; that is what they are under the existing model and they will be even more so under the future model—there is a need for openness, transparency and democracy, and that democracy needs to be part of the scrutiny process. The OSCs have some kind of scrutiny now, but more so under the new arrangements.

Q116 Emily Thornberry: May I pause you there? The area that you may get under a health and well-being board will not necessarily be the same area covered by a GP consortium. Is that right?

Councillor Roberts: That is another great unknown at the moment. In my area, it is a very large unknown.

Q117 Emily Thornberry: But you could have one GP consortium covering one bit, and another covering another—or, indeed, one GP consortium straddling two local authority areas. You are aware of that?

Councillor Roberts: I am. My area of Rushmoor borough council is part of the Blackwater valley, which is an area of about 350,000 people. We have five local authorities and three strategic, or unitary, authorities—two of them are county councils and the other, Wokingham, is a unitary.

Most of my health care comes from Surrey, as does most of my mental health support and service. That is the way it carries on, while the western part of the Blackwater valley area looks towards Basingstoke. If a GP consortium is formed either in part or in whole, or if more than one is formed, you can see the difficulties that we will face just trying to make sense of it, even on a scrutiny basis.

Q118 Emily Thornberry: I shall stick to the executive function and the health and well-being boards. According to your understanding of the Bill, do you think that those boards will have enough power over GP consortia or any other health providers to get them to do anything? Do you believe that health and well-being boards, under the Bill as drafted, will give you sign-off on the plans of GP consortia?

Councillor Roberts: From the local government perspective of the LGA, we welcome where we are at, but the LGA and I have made it fairly clear that we believe that we need much more to be done with regard to the consortia having their commissioning proposals looked at, scrutinised and signed off. Much more work needs to be done in that particular area. It is something that the Government should look at very seriously.

Q119 Emily Thornberry: Thank you very much. Mr Hood, may I also ask a couple of questions about social care and health care?

I am sure that Mr Cozens is aware that Richard Jones, the chair of the Association of Directors of Adult Social Services, says that between 35% and 40% of hospital admissions into acute beds are avoidable, and that, of that group, 70% stay longer than they need to. It is, therefore, to the advantage of those who go into hospital but need not, and to all of us as taxpayers, that there should be more working together at social care and health care. Do you feel that there is anything in particular in the Bill that may help the integration of social and health care? If not, what else ought to be in it?

Andrew Cozens: To clarify, I am the strategic lead for the Local Government Association for adult social care and health. That explains my credentials. On the previous point, which I think is linked to this, the key phrase of the Bill is “have regard to”. The commissioning plans of consortia need to have regard to the joint strategies of the health and well-being boards. Of course, “have regard to” can be placed on various extremes on a continuum, from, “We’ve read it,” all the way through to, “We’ve altered what we intended to do as a result of it,” or, “We have been very actively part of that.”

We have an immediate short-term concern about integration. The proposals to cluster PCTs must not disrupt the existing integrated arrangements, where local authorities and PCTs are already working closely together. The reason why most of those authorities and PCTs have come together is that they recognise the point you make about the pathways across health and social care. There is a short-term risk of dismantling in order to deal with the need to have effective clusters of PCTs affecting the future integration arrangements—so you are disintegrating in order to re integrate later.
There is enormous potential in the idea of the duty to co-operate in both an assessment and a health and well-being strategy, to look at the pathway of people across health and social care and to develop joint solutions to the exact problems you described—the interdependency of health and social care—provided that consortia co-operate on the boundaries of the local authority where those services have a strong pathway across into local authorities.

We have particular concerns from a social care point of view about those populations that do not naturally fall into a practice population. There are also groups of services that require strong co-operation, not just with social care but with other parts of the council—those dealing with mental health or learning disabilities, for example. We are also concerned about services for homelessness, HIV/AIDS, drugs and alcohol, as well as things such as dementia and carers, where we would argue that we need a whole population strategy, not just a practices strategy.

One of the key issues is the effectiveness of the relationship between consortia and health and well-being boards in shaping a more cohesive approach. We feel that the Bill is not specific enough about those sorts of issues, and it is silent in a couple of particular areas that are important for the integration of health and social care. One of those areas is safeguarding, and the other is arrangements for free nursing care.

**Q120 Emily Thornberry:** Could you tell us a little more about the safeguarding? Clearly, that ought to be a priority for us all.

**Andrew Cozens:** It is something that needs to be probed. The PCTs currently have a range of responsibilities in relation to safeguarding—designating doctors and nurses for safeguarding arrangements, for example, or the duty to co-operate in local safeguarding boards and other such issues. We want to know where that function will go under the new arrangements. Will there be a lead consortium? Will all consortia carry that responsibility? What happens where consortia cover more than one local authority area, as many will?

**Q121 The Minister of State, Department of Health (Mr Simon Burns):** Thank you for your evidence so far. So that my colleagues and the rest of the Committee can fully consider the views that you have given, would you be kind enough to tell the Committee, given your long and illustrious career in local government, which political party you represent?

**Councillor Roberts:** The Labour party.

**Mr Burns:** Thank you.

**Councillor Roberts:** I have to reiterate that I am speaking on behalf of the Local Government Association and the health and well-being board tonight.

**Mr Burns:** I fully accept that. I just thought it would be useful for the Committee to know the whole story.

**Q122 Liz Kendall:** I want to come back to the relationship between the health and well-being boards and GP consortia. We are trying to get to the bottom of whether the health and well-being boards can require a GP consortium to do anything, and whether if a GP consortium proposes to change a hospital service, the power of the local health and well-being board will trump that. I ask that question to Mr Cozens.

**Andrew Cozens:** There are very few obligations between the local authority and the consortia; the relationship is between the consortia and the national commissioning board, and the mandating arrangements and signing off the financial plans. As I understand it, there is a shared responsibility on consortia and councils to have regard to the strategy, and a duty on both to consider how best to use flexibilities and pool budgets. That is the limitation of the constraints.

There is a duty on both to co-operate in relation to the preparation of the joint strategic needs assessment and plan that follows that, and there is separate accountability to deliver those agreed parts of the plan. The trumping element is the national commissioning board, rather than the health and well-being board. It comes back to the phrase “have regard to” in the Bill.

**Q123 Liz Kendall:** So in the end, in your view the national commissioning board, not local health and well-being boards, will have the ultimate say over the consortia.

**Andrew Cozens:** As in all partnerships, accountability around the table remains with the organisations that come to the table. A local government is accountable for its responsibilities in relation to the plan, and NHS bodies are responsible for their parts of it.

The intention is to have a shared commitment through the health and well-being board, but in the history of joint planning between health and social care, it is the behaviours and culture of the organisations, not necessarily the statutory requirements placed on them, that sometimes lead to the greatest progress.

**Q124 Liz Kendall:** You mentioned concerns about where the responsibility for safeguarding lies. I think that is a real issue. The other area where there has long been a challenging relationship between the NHS and local authorities, as you say, relates to free nursing care and continuing care. Will it be the responsibility of GP consortia or the national board to pay for those services?

**Andrew Cozens:** I do not know, is the answer. It is not clear. It is one of a number of PCT functions where it is not clear where the destination is. My assumption is that the national architecture for free nursing care and continuing care will be a commissioning board responsibility, because local authorities legally cannot.

At the moment, the vexed issue of continuing care is overseen by the strategic health authorities, but delegated to the PCTs. It is a real fault line that, when there are changes in the economic circumstances of local government or of the health service, or both, widens to the detriment of those who need continuing care. It is really very important and of great concern to us that there should be clarity about that as soon as possible.

**Q125 Julian Sturdy (York Outer) (Con):** The importance of public health and the role it plays in bringing about key health outcomes was touched on in the previous session. I would just like to know your thoughts on whether you believe the transfer of the public health functions in the Bill are an important step forward in tackling the key issues of poor health.
Councillor Roberts: Many of us in local government—as I said, I have been in local government since 1976, at two levels, in one form or another—have always looked on the relationship with public health as something that local government should have been doing during all that time. In fact, as most of you who have been in local authorities will know, local authorities did cover that particular role. So I think there is a manifest need for public health to come back to where its real focus, of local need and priority, is based.

The biggest problem that we have with public health, of course, is that we are still awaiting clarity as regards the detail. More important is the relationship between public health in England, where we have had no detail whatever as regards its functions, role, coverage and, more importantly, the funding, because I think that some view has been expressed that we are only talking about £4 billion going possibly to local government or wherever. Some estimate that the amount of money that may filter down directly to local government may be only 20% of that. We need to have that clarified.

We can, given all the contacts that we have and the work that we are involved in, be very positive in tackling a lot of the issues, from health inequalities to the many aspects of obesity and health care that public health covers, but we need to know the detail. If we have not got the detail at the moment, we cannot look to moving our consideration on.

Andrew Cozens: One of the key issues is the disaggregation of public health function—the different elements and where they are going to go, as Councillor Roberts said. It is unclear how much the joint relationship between the Secretary of State, Public Health England and local government, in relation to health outcomes, needs to be clarified. It remains uncertain.

What we welcome and have very substantial evidence of is the contribution that local government can make to the health of the public, which I think is distinct from the public health functions, some of which are quite technical and are best organised at a national level. Local government invests considerably in those services, both directly and indirectly.

One of our early concerns, although it was somewhat assuaged, was that the public health funding transfer and the responsibilities would be in some sort of bubble within local government—that local government would have less scope for influence than we would like in order to make the broader connection to the other things that local government does. We feel that the greatest impact will come when health and well-being boards are able to demonstrate the wider health outcomes that they are trying to achieve for the whole population, and their accountability for that. We see considerable scope. As Councillor Roberts said, there is potentially a “bricks without straw” problem. If the transfer is very small—and, indeed, if it is partly taken up with the commitment to fund health visitors, for example—there could be very little other than the staff transfer to get our teeth into.

Q126 Grahame M. Morris (Easington) (Lab): In relation to strengthening the role of local government, do you feel that the Bill goes far enough in its representation on local commissioning boards, or would you prefer to see that aspect of the Bill tightened up?

Councillor Roberts: The Local Government Association welcomes what is being proposed, but we would certainly like to see it strengthened. If health and well-being boards are to do their job, their role in scrutiny, then, as I know as a senior member of my local authority, you need that democratic governance available—more than one person.

In general, most local authorities are not made up of single parties; they are made up of a number of groups. My own authority—we have been like this ever since we came into being in 1974—has always had the three main groups. There was a need for that proportional representation as well, to get the full governance arrangements very much before the health and well-being board. I think that is another area for the Government to consider.

Q127 Grahame M. Morris: Would it assist closer working between health and social care, particularly in addressing issues on health inequalities, if there was a greater input—perhaps even with the director of public health being part of that arrangement?

Councillor Roberts: The answer is yes. There was also a relationship between not just health and social care but, as those of us in local authorities at the district level would say, housing as well. If you’re going to tackle health inequalities, you need to have those three policy areas and the governance arrangements for those three areas much more certain than they currently are in the Bill.

Andrew Cozens: Can I just clarify whether you meant commissioning consortia or health and well-being boards?

Grahame M. Morris: I was thinking more about the local commissioning consortia.

Andrew Cozens: There is no local government involvement at all in commissioning consortia, and none of the transparency expectations associated with local government. There is local government representation, but it is not clear what influence, if any, local government will have on the national commissioning board.

Nick de Bois (Enfield North) (Con): I would like to explore a little bit about democratic accountability with you two, as I am getting slightly mixed signals. If you could bear with me, I shall pick up on some of the comments made by my Opposition colleagues.

Suppose, for example, we were facing a reconfiguration of services; I do not know whether you have had that in your patch. At present, the process is pretty much driven by the NHS—in London, by NHS London—down to PCTs, very much with a tick-box approach, and it gets done. If that was to happen under the Bill, would you agree that, to begin with, you would need the support of the GP consortia that ultimately would be buying services, say, from a reconfigured hospital? Would you both agree that that is something that would have to happen as part of this process?

Equally, it would have to have the support of the health and well-being board. Do you agree that if reconfiguration is to happen with confidence, it would fly in the face of logic, for example, if it did not have the support of those two organisations, Mr Cozens?
Andrew Cozens: You are right in the sense that there is a much stronger role for primary care in reconfigurations than is currently the case. That is obviously not the same as local government’s, but it is a very strong role. It is unclear about the role of health and well-being boards in relation to reconfiguration if that reconfiguration is sub-regional or regional, in which case there will be multiple health and well-being boards involved.

We have argued and encouraged the pathfinders to think about flexing up and down in terms of health and well-being boards, and where, for example, a number of unitaries in a county are affected by a reconfiguration proposal, to work together on that. The reforms are intended to create a greater consensus about the case for change that involves local government in those decisions, so it is less a question of presenting a fait accompli to local government, scrutinising it and then the scrutiny not liking it and referring it to the Secretary of State, which is the worst-case scenario now.

In many situations, the case for change can be debated much more transparently through the health and well-being boards, with more people involved in those situations. I think the tension for health and well-being boards will be between their natural interest in protecting access to a local health service and seeing the case for a sub-regional centre or a national pathway. Which is better for clinical outcomes? GPs explaining that to councillors may well improve the outcomes.

Q128 Nick de Bois: I do not doubt that tension. Councillor Roberts, do you share the view in Mr Cozens’s summary?

Councillor Roberts: I share the summary, but I think there are wider issues which we cannot neglect, and I will try to expand on them. There are particular reconfiguration issues in areas in Hampshire—Salisbury, Andover, Chichester, Bournemouth, Havant and so on—as well in my own area. We need to understand the nature of the situation on the ground and the architecture. I forgot to mention that we also have the Ministry of Defence involved, at one of the biggest centres for health in the whole of Europe, in Aldershot. There are some very difficult challenges in relation to sorting out the architecture. At the moment, I have not seen that coming forward.

Other areas need to be considered: for example, what will happen to the currently legalised joint arrangements between PCTs and councils? Care trusts, pooled budgets, integrated teams—

Q129 Nick de Bois: If I may interrupt you there. I think we are going off the subject slightly. I think you are almost supporting the point that there is greater involvement through the two processes and through the GP commissioners, which are not local authorities. I think that you are agreeing that you would like to be engaged in that democratic process involving the health and well-being board, be it one or multiple, should the process come up, and that that might be a vehicle for doing so.

Councillor Roberts: I think both of us have already said that we would support that.

Q130 Nick de Bois: So would it be fair for me to conclude, then, that on balance, the Local Government Group thinks that the Bill will tip the balance of health care decision making in favour of communities, which has not been the case to date?

Councillor Roberts: I remain open to that. There is a lot of—

Q131 Nick de Bois: You do not see any progress at all?

Councillor Roberts: A lot of clarification is needed in relation to the detail.

Andrew Cozens: I think it is fair to say that we welcome the greater involvement of local government in these decisions. As I said, the bit that remains a blank canvas for us is the decisions of commissioning consortia about the commissioning of health services. I can see how it works in relation to reconfiguration and the bigger picture, but we are unclear about influence and some of the detail of those decisions.

Q132 Nick de Bois: Equally—if I can conclude and move away from reconfiguration—do you agree that the joint strategy needs for health care process engages with the local authority as much as anyone else? I do not think you have really had that before.

Andrew Cozens: We have had many joint plans over the years. We had a predecessor arrangement through the joint consultative committee. We had a duty to produce a community care plan and various other things. The key issue is the extent to which all parties feel they are bound by the shared parts of the plan. It is the bits in the middle—the joins between the two organisations—where the greatest gains will come from these reforms, if we are able to put those pieces together.

Q133 Mr Barron: Councillor Roberts said earlier that there is not much detail about public health functions. What we do know is that, as of next year, local authorities will be responsible for local health improvement and illness prevention, including health promotion. If my memory serves me well, you said—and rightly so—that public health was a matter for local authorities prior to 1974. Sanitation, clean water supplies and environmental health are big issues and housing is still an issue in terms of public health, I am sure. But one of the major issues that threatens the public health of the 21st century is lifestyle—what you eat, what you drink, whether you take exercise, whether you drink too much alcohol or you smoke. Do you think that local authorities are going to be comfortable telling their population that they have got to take action around those areas of lifestyle?

Councillor Roberts: There is obviously a discussion to be had over that. But if you are talking about lifestyle, obesity and other issues such as that, there is a cause and effect on other services. I think that doctors have very recently said that obesity is a big problem. I have heard it said that if you weigh all the obese people in the country, we are carrying around something like 4 million extra tonnes. There are particular issues that need to be grasped. The best way of dealing with that is surely from a local point of view, because you know the people, you know your area and you are best set to engage with them to try to get those changes.

Andrew Cozens: Many of the responses to some of these wider public health issues are existing local authority services and/or things that local communities have a say in. We run a programme called the “Healthy Communities” programme, which has been running for the last five
years. There are thousands of examples where councils are already getting stuck into these sorts of issues, working jointly with PCTs to promote healthy lifestyles, smoking cessation schemes and a whole range of other things. We have had a number of joint programmes over the years. There is a real shared understanding about the social determinants of health by local government and our public health colleagues. This is a very productive area for joint working.

Q134 Mr Barron: You are not an elected councillor.
Andrew Cozens: I am not an elected councillor.

Q135 Mr Barron: Do you not think that elected councillors are going to be nervous about being seen to be, in some instances, preaching about individuals' lifestyles?
Andrew Cozens: Councillor Roberts has to speak for councillors. My experience of working with members on these issues is that they recognise that, for a lot of people who want to change their lifestyles, it is the local availability of services that helps them to do that and the incentives that draw them in. There are many things that councils can do and have done to encourage exercise and better lifestyles. In my experience as an officer, I have seen that one of the strengths of the local councillor role is that they see how things join up in a way that we sometimes do not when we have responsibilities for different bits of service. Councillors and public health workers have real alignments here. We certainly found that that was the case in our national discussions between senior councillors and the public health profession. We had an enormous amount in common around trying to work on these issues.

Q136 The Minister of State, Department of Health (Paul Burstow): I wanted to explore a bit further the duties that the Bill will place on both GP commissioning consortia and local authorities to facilitate collaborative working and integration. Could you say from your experience, looking back over past legislation, to what extent the duties being imposed here are novel?
Andrew Cozens: The architecture is novel and the duties are not that different in some respects. I have been reflecting on this recently, and I think the closest direct parallels are the joint consultative committees and the joint care planning teams in the early '80s, where after local government lost responsibility for all sorts of NHS functions, there was a deliberate attempt to create a new forum to bring together health and social care and to find common cause and work on joint things. In those days, the issue was particularly the closure of long-stay hospitals and the impact on local government of changes to the health service and changes to the pattern of activity. Joint consultative committees were statutory. There was a similar duty on both parties to co-operate. There was a requirement to produce plans, and there was joint finance to facilitate working together. My summary would be that it created a strong bridge between one part of the health service and local government, but not the health service as a whole.

There is the opportunity in this legislation to bring all this together in the health and well-being boards' interest—the strategic needs assessment—in a sense to give greater weight to those in terms of shaping better health outcomes for the population but also better services. There are quite a lot of incentives, if consortia choose to take them up, to design new sorts of services that straddle health and social care, building new services around primary care or in local government that deal with the crisis that the NHS faces; an ageing population and too much use of emergency health care. So the thing that binds consortia and local government is the need to develop services outside hospitals, because otherwise the whole system could well be unaffordable, and the same situation faces social care, which has to work on early intervention, re-ablement, prevention, different sorts of services.

The potential is there. What we are looking for that is different this time is what the incentives are to co-operate in the difficult areas between health and social care, rather than in the broader pattern of health services for the population. We would be very disappointed if the lessons already learnt from integrated services—in those places where the local authority and the PCTs merged, there are care trusts, or other sorts of arrangements—are forgotten and if those arrangements are accidentally broken up in the creation of PCT clusters. Building on the experience of the things they have been able to do without this architecture, and the opportunities they now see with the new architecture, gives us the best hope of understanding how some of this might work to best advantage.

Q137 Jeremy Lefroy: I want to explore the consequences of the Mid-Staffordshire inquiry in my constituency. The Government have rightly said that lessons will be learnt from the inquiry and included in the Bill, and in the way that they approach scrutiny of the health service. Do you believe that the way in which the oversight and scrutiny committee is presented in this Bill, together with health and well-being boards and other methods of oversight—for instance, HealthWatch England—would be adequate to prevent an occurrence such as the Mid-Staffordshire problem from reoccurring?
Andrew Cozens: That is quite a difficult question to ask local government, because much of it is about the internal processes of the NHS itself and the relationship between the regulatory system, the inspection system and the role of Monitor in relation to foundation trusts. There are a whole host of issues related to that. Councillor Roberts may have his own view on this, but the one of the key tests of this is the extent to which a concerned individual, picking up issues about their own care or that of a relative, has immediate and constructive access to the system through, initially, the advocacy role that is proposed for local healthwatch, the rights of access and challenge that local healthwatch has and the escalation of that into an inquiry by the overview and scrutiny committee. In parallel to that, it will depend on what the relationship is between local healthwatch, the Care Quality Commission Monitor, national HealthWatch and then, ultimately, the national commissioning board.

For me, one of the key issues is the escalation process for concerns. I must say that this is not unique to the health service; the debate is exactly the same for a self-funder in a residential nursing home, which is social care-related. There are exactly parallel issues. The role of the GP in this situation is also key. In the design of the arrangements, as well as the constructive opportunities, the extent to which there is safeguarding more broadly
built into the system needs to be explored further. I do not know enough of the detail of the NHS workings to answer that fully.

Councillor Roberts: I concur. The only thing that I would add is that it is a bit like Every Child Matters. We all learn lessons from what happened, and we hope that the architecture that we bring forward actually seeks to respond to what has occurred.

Q138 Jeremy Lefroy: To conclude, one of the things being brought out by the Francis inquiry at the moment is that the overview and scrutiny committee felt that it often did not have the power to summon people to give evidence and, at the same time, that it perhaps did not have the expertise available with which to question. Do you feel that the Bill could help to address that?

Andrew Cozens: We are very pleased that, between the White Paper and the Bill, the powers of the overview and scrutiny committee to summon any provider for the NHS were strengthened, and we welcome that.

Councillor Roberts: Obviously, from a local government perspective, local government people are on the periphery at the moment on many of these issues. There is, however, an expertise that could and should be drawn in, and it would perhaps be no different from the Select Committee scrutiny work that happens here, because you bring in professionals to advise you in the work that you do.

The Chair: I think that this will be the last question.

Q139 Mr Barron: Again, Councillor Roberts, my experience of local scrutiny committees is quite positive in terms of how I have seen them operating. The difference with the health and well-being boards is that they will be overseeing the commissioning, but they will have commissioners sat on them. Do you think that that would in any way hinder good scrutiny?

Councillor Roberts: That has to be looked at. If they were there in an observer role, without, when push comes to shove, the power to make decisions related to the work, I do not think that there is anything wrong with having them there. If, however, they were there as part of the new structure with the same relationship as their local democratic side, I think that may be a bit more of a question mark.

Andrew Cozens: We were initially very concerned about the proposals that the scrutiny function might be undertaken by health and well-being boards, and we pushed very hard for the overview and scrutiny committee to have the ability to scrutinise the decisions of the health and well-being board. I think that provides greater safeguards.

The Chair: If there are no further questions, I thank our witnesses for coming along today, and thank you very much for useful evidence. I am sure that it will be very useful to the Committee as we go through the Committee stage.

5.30 pm

The Chair: We will now hear evidence from the NHS Confederation. Welcome, Mr Edwards.

Q140 Owen Smith: Mr Edwards, thank you for coming to see us. In your evidence, you highlighted an area of the Bill that lots of people have grave concerns about, and that is particularly the reconcilability of greater competition and price competition, as well as integrated care, and integrated pathways.

You highlighted two aspects of our concerns, and I wonder if you could elucidate on those. The first is about where pieces of care pathways are being commissioned under the new provisions by both the national board and local GP consortia. Where might you see problems there? The second is, essentially, about competition being kept out of the system, because you think it will inhibit integration and cause problems in respect of health care.

Nigel Edwards: It is possible to create integrated systems using competition, by having competition for the market at the time. Asking people to come forward with bids to produce an integrated care programme, for example, has to be done through some form of competitive tender, and there are a variety of ways to do that. A problem has been that the NHS has tended to have a purist approach to how it has handled procurement. It has been a gold-plated approach—or perhaps I should answer the question by putting it this way: it has either completely ignored the competition rules, or it has taken a gold-plated approach. There is a limit to what you can do in legislation. A lot of this comes down to how people will behave, but there are mechanisms through which competition can be used to create integrated systems. We just have to make it clear to people that it is permissible to talk to their potential suppliers, and for clinicians from different organisations to talk to each other, which is common practice outside the NHS. However, the new ways of behaving are such a big culture change for people to get used to that they tend to rush to one polarity, which is to believe that none of this is allowed.

On your first point, that is a difficulty. One could imagine a situation in which a pathway involving a pharmacy, a general practice, and a local acute hospital and its specialist service is commissioned by a variety of different organisations. A way to do that—and indeed, to get better integration—is to ask one organisation to take delegated responsibility from others. We are back, again, to levels of trust and how people behave in this system, which is not something that one can necessarily legislate for.

Q141 Owen Smith: I have a supplementary question, which is about the time frame, or choreography, of all these very complicated changes. In your evidence, you seemed to suggest that perhaps there ought to be pilots or some consideration of how these things will bed down, and particularly, how the maximum price tariff might play out on the ground. Do you think the Government are being hasty and that the Bill’s timetable is just too rapid?

Nigel Edwards: Once you have started this sort of process, the argument, or the analogy, rather, is that once the trains had started rolling in the first world war, it was too late to stop. It is not the happiest analogy, but this will not be over by Christmas—that is for sure. We are at a point where going slower, even if you wanted to, is probably not an option. However, a large set of new behaviours, techniques, ways of thinking and ways of behaving will need to be developed. As is being done...
with the current pathfinder, there are opportunities to try some of those out, perhaps in slightly more protected environments.

Price competition, particularly, is an area where caution is necessary because, as Clare Gerada said in a previous session, it is very difficult to measure outcomes. There is massive overestimation of how easy it is to measure outcomes reliably in health care. We cannot even agree on a methodology for measuring hospital standardised death rates, and you would have thought whether a patient is dead or alive is one of the easier outcomes to estimate. There are problems here, because even in areas where it is easy to measure quality, if you add price competition there is the prospect of cross-subsidisation from the areas where you cannot. That would be an area where one would probably want to take it in a more measured way and build in a lot of evaluation and opportunities for learning while you do it.

Q142 John Pugh (Southport) (LD): You reflect the views of the chief executives of the ambulance services, as well as the hospitals. Is that right?

Nigel Edwards: Yes.

Q143 John Pugh: At the moment the ambulance service is basically a regional service. It is a regional monopoly provider commissioned by PCTs, normally with one lead commissioner. How do you see that system changing under the new order?

Nigel Edwards: One of the problems with the ambulance services, as with other health services, is that we tend to talk about them as if they are the supplier of one product, which they are not. They do a whole range of different things, some of which are amenable to a more competitive approach and some of which are not.

Q144 John Pugh: What do you mean when you say “a more competitive approach”?

Nigel Edwards: Competing services. So, for example, in patient transport to hospital for out-patient services, there is already a thriving competitive market in which ambulance services compete. In 999 services, however, the carnage caused by South Africa's competing ambulance services' racing for business will give you some clue about why redundancy, robustness and dealing with civic contingencies are arranged for in the service and why it is an area that is less amenable to a market solution.

Q145 John Pugh: So you do not visualise it being possible for different commissioning consortia to demand different levels of blue light cover?

Nigel Edwards: Indeed. If you look at London ambulance service, which is commissioned by some 30 PCTs, it provides a range of different home care. One of the bits of ambulance services that is extremely important going forward is their ability to use emergency care practitioners to care directly for people in their own home, to run out-of-hours services or to be add-ons to the wider emergency care system. London ambulance service provides different bespoke service to different PCTs in London. Obviously, there are transaction costs for doing that, but I see no reason why there should not be the ability to customise services.

I suspect over time you may find that some commercial operators or existing ambulance services will want to offer outside of their existing area not just the operation of emergency vehicles, but some of the value-added services that they currently provide. We are some way off that right now.

Q146 John Pugh: If the block contract arrangements continue to exist for blue light services and the like, which we assume they must, one runs into the difficulty that, at the moment, the ambulance services bill people on historic business, as it were—I hate to use that word. There will be no historic business for GP consortia, because they will exist in different frames and different time scales. The ambulance services currently bill by postcode, rather than by doctor, do they not?

Nigel Edwards: I am not fully up to date with the way ambulance services bill. You might want to ask Liz Kendall, who is probably more of an expert on that than I am.

There is a general point about moving to a system in which you pay providers to a tariff. It is fair to say that we are some way off having a good enough tariff for ambulance services, community services and most mental health services to be able to make our competitive market system operate with sufficient delicacy and power to produce the results that we want. If you particularly want to move from the ambulance provision model of picking people up off the street and taking them to hospital to something that looks more like a modern ambulance service and is better able to care for people in different ways, you need to develop clever pricing systems. One of the observations I would make is that, historically, the Department of Health, when compared with other health care systems that operate such tariffs, has woefully underinvested in people who do such work. By factors of many multiples of 10, it has far too few people. So, when you start new services, how you pay for them is often a problem. Ambulance services are just one example of where that is going to be an issue.

Q147 Emily Thornberry: I would like to ask you some questions about the patient voice. Where under the new system do you think that patient voice is likely to be loudest and most effectively heard? How would a hospital configuration work? Who would make the decisions and where, if anywhere, would the patient voice be heard in relation to that?

Nigel Edwards: One of the interesting paradoxes in the White Paper is the proposal to put patients at the centre and to empower them while giving the power to GPs. It carries an implicit assumption that there is not a principal agent problem, as health economists call it. In other words, that there is an alignment between the interests of the GP and the interests of the patient, which is not necessarily the case for good and legitimate reasons. There is also an issue which is that the sum of lots of individual patient consultations does not constitute a population health view. There is a load of rather clever economics that I do not understand, but basically, you cannot sum lots of individual preferences and determine a societal or global preference for population. You need other tools and they are classically held by epidemiologists and public health doctors. There is a need to bring that in. In terms of the patient voice in this, I tend to concur with the views that were expressed.
In *The Times* this morning. Some of these mechanisms appear to me to still be underpowered in terms of their ability to provide patients with sufficient voice in this.

Q148 Emily Thornberry: Could you give us some particular areas where you think more power should be put in? You do not have to cover them all, but just give us your top three.

Nigel Edwards: One element of these reforms that has not received a huge amount of attention, but is enormously powerful and influential, is the role played by Monitor, both in terms of price setting and of market studies and other decisions that it makes that have the potential to shape local systems. There is an issue there. Secondly, we recognise that some steps have been taken to deal with this, but the embedding of the national HealthWatch in CQC raises some interesting issues.

Anecdotally, and this requires some further research, GPs themselves have not generally recognised the need for additional patient representation in the types of mechanisms that they have set up. Some of the better pathfinder consortia seem to be doing that but there is a sort of gap there. There is no direct patient representation on the decision-making bodies of the consortia. They have a requirement to have an annual general meeting and produce a report, but beyond that—it is very complex keeping all of these hundreds of pages in your mind—I do not think they have any other obligations to meet in public or to be otherwise visible. So that would be a small selection of some of the issues.

In terms of configuration, I have listened to the conversation here and it is worth pointing out that there has been a presumption that reconfiguration will be commissioner driven. You may want to think about that. First, there is a sort of implication in the White Paper and the Bill that a lot of GP commissioning is lots of individual decisions, which may not drive configuration choices. At some point someone needs to take planning decisions. For things like cancer services, vascular surgery and trauma, they either need to get together into large groups to make those decisions, or you may find, because of some of the drivers of decision making on configuration are to do with work force Royal College accreditation, that increasingly providers make decisions about change.

Here is an interesting point. If the services are not designated, my reading of this is that the current regulations on consultation apply. So if I am the chief executive of a hospital and I want to close the maternity unit at one of my sites because I feel it is unsafe, first I might just close it because I have emergency powers. If it is not a designated service I can just close it. I then have to go through the normal statutory consultation and I am not under any particular obligation to involve anyone in making that decision up to that point. I would just say that a lot of commissioner-driven reconfiguration over the last few years has done an awful lot of work in involving the patients and GPs. Some of the conversation here suggested that that was not the case.

If you are creating a highly dynamic, regulated market that depends for its dynamism on the mechanism of creative destruction and exit into the market, then one of the corollaries is that agile providers need to be agile. They will leave if they need to. So you may need to think about the possible implications of that. Of course, a level playing field in this would mean that anyone who wants to leave, whether NHS provider or independent provider, should leave. The patient voice in that may be very limited. I make no judgment about whether that is a good or a bad thing. That is just my reading of how the system works.

Q149 Liz Kendall: I should declare an interest here. I ran the ambulance service network of the NHS Confederation for a couple of years before I became a Member of Parliament. You have already said that you think some of the accountability on the commissioning side is very weak, because the consortia only have to produce an annual report, they are not required to meet in public and they do not have to have members of the public or patients on their boards. I wanted to talk about the accountability on the provider side, as it is something that we discussed with David Nicholson this morning, and it is an issue that I know the hon. Member for Stafford is very interested in.

As Monitor stops being responsible for foundation trusts and moves to being an economic regulator, it loses the power to appoint to the board, or remove people from the board, or to bring people in to improve an FT that has been failing. Under the Bill, there is an idea that governors will have more duties and be better trained, but what will prevent an FT from failing under the new reforms?

Nigel Edwards: My reading of the Bill and the material that has led up to it, is that it is based on the not unreasonable presumption that if you remove the net underneath someone who is walking the tightrope, their tightrope-walking will improve. The idea is that increased autonomy and the removal of some of those mechanisms will concentrate the mind and improve the quality of governance. If I can pursue the metaphor, occasionally people will fall off, at which point there is no net.

Your question is: who is holding the ring on quality and safety and performance? My reading is that there is a minimum standards regulator. The lesson of mid-Staffordshire, of Buckinghamshire hospitals and previous problems, is that the only custodian of quality has to be the professionals at the front line and the board of the organisation. Regulation can only ever be a backstop. Inspection-based regulation, particularly, for a whole number of reasons, is periodic. You can teach to the test if you are being inspected, and you have to have the good fortune to visit the one or two wards where there is a very serious problem. You cannot fully rely on regulation. We are left with the board, which then raises the question of the competence of governors. Looking internationally at similar types of models, there are risks involved in that. There is a deliberate trade-off; there is no right answer. You are saying that we think that continued oversight—and the confusing lines that that creates in the current system—has to some extent removed responsibility and reduced people's willingness to step up and take responsibility.

Q150 Liz Kendall: Can I come back on a supplementary question because we have a few minutes? The analogy of the tightrope and no net speaks volumes. The directors of FTs will take on the responsibility of directors under company law, which means it is not just the interests of patients and the public they will have to bear in mind, but the interests of that entity. What do you think that
will mean, if directors and governors have to think about the financial success of that organisation as much as what patients and the public want?

*Nigel Edwards:* Effectively, they do now. The argument goes—

**Q151 Liz Kendall:** But they will be made company directors with similar powers under the Bill.

*Nigel Edwards:* I am not familiar with that bit; it may be buried in there.

**Q152 Liz Kendall:** That is what the Foundation Trust Network, which is part of the NHS Confederation, said to the Committee.

*Nigel Edwards:* I missed that. I read its response but I missed that. I will go back and look at it again. I am not sure that it materially changes the responsibility that people currently have now. There is a responsibility to manage an organisation properly financially. We do know that organisations with financial problems are generally ones with quality problems, too. Running all organisations is a balancing act between the requirements of different stakeholders. I am not sure that changing the duties in that sense goes beyond that big challenge I described earlier: the removal of the oversight. That is the thing that I would pinpoint as the biggest change. The organs of the state stop being responsible for the detail of what happens in providers. That is a big change.

*Liz Kendall:* Thank you.

**The Chair:** If there are no further questions, that is the end of the evidence session. I thank you very much for coming.

5.50 pm

**The Chair:** We now take evidence from Unison, Unite and GMB.

**Q153 Emily Thornberry:** Thank you very much for coming. I will kick off. If you don’t mind, may I start with a standard question that I have asked many of the witnesses? Do you think that there are any risks associated with a standard question that I have asked many of the witnesses? Do you think that there are any risks associated with the legislation and the changes that it hopes to bring about, and if you do, what are they?

**The Chair:** May I ask you to identify yourselves to the Committee when you answer your first question?

*Karen Jennings:* My name is Karen Jennings and I am assistant general secretary for Unison.

**The Chair:** Welcome Karen.

**Emily Thornberry:** Karen, what we have done in the past—I do not know if this is all right—is that as each person answers they tell us who they are. So, since you have introduced yourself first, would it be all right if you explained to us what, if any, risks you see might coming if the proposed changes to the NHS are brought about?

*Karen Jennings:* There are enormous risks for the very fabric of the NHS. We are removing from the NHS the very structures that make it a cohesive, comprehensive service, based on solidarity. I think that the legislation will introduce greater litigation, particularly from private contractors, two-tierism in standards of care and access to care, and opportunities in the long term for other systems of payment, such as top-up or insurance-based payments. Eventually, I think that we will see a rump service delivered by the public sector, and the private sector entering at a greater pace and introducing competition, which will introduce insecurities in the services being provided. I think that we will also see greater weaknesses around competition and contestability, GPs contracting out the commissioning services to private contractors and, increasingly, the inadequacies of that system in terms of knowing what the needs of local communities are.

**Q154 Emily Thornberry:** Just for the record, how many Unison members work for the NHS?

*Karen Jennings:* We have 450,000 NHS members, but we have 1.4 million members working right across the public service, including in the voluntary and charity sector, and in local government and social care.

*Rehana Azam:* Hi, I am Rehana Azam, head of health in the GMB trade union. In response to your question, I think that Karen has made a very good opening. The reality is that all the workers have worked so hard to build the NHS up into what it is today, which is something to be really proud of, and my concern is that the risk attached to the Bill is that a lot of the NHS workers unfortunately will get sidetracked in terms of what will happen to their jobs, when what they have been doing fantastically is caring for the patients. That is one of the biggest risks that I feel is attached to the Bill. In the short term, in terms of how we can engage in ensuring that the concerns are raised effectively, that has been quite tight in most cases, since the Bill was launched. For us, the risk is that we might lose a lot of NHS workers, because they are not quite sure what is going to happen to them.

*Nick Parrott:* I am Nick Parrott, a health policy specialist for Unite, which represents 100,000 health sector workers. I echo the comments that both other witnesses have made. We feel that there are risks to the quality, range and cohesion of services. The Bill certainly puts at risk the terms and conditions that we need to retain good staff to deliver health care out in the community and on the ground. We believe that, ultimately, it will also lead to higher costs, more bureaucracy, and public assets in private hands, and that in turn means that there is a risk to democracy itself in the running of the national health service. I would add that I believe that it will lead to large-scale closure of services, but in terms of the Government’s policy, that will be taken as a sign not of failure or risk, but of success—a sign that the medicine, if you like, is working.

**Q155 Emily Thornberry:** We have heard evidence about public accountability and the different layers in which there may be a patient voice. Before I hand on to other Members, would you mind outlining briefly whether you have any concerns about whether there will be additional democracy in the NHS as a result of the legislation?

*Nick Parrott:* I am happy to come back to that. There are issues at all the different levels at which the Bill works. There are issues about whether consortiums will have lay or elected representation, how accountable they will be, and whether transparency and the application
of freedom of information will apply to contractual arrangements, rather than just members and employees of consortiums. There are also issues around the involvement of local government. There is no guarantee of trade union representation, and only one elected councillor is guaranteed on the boards that are being created, but, ultimately, there is also the issue of how the Government envisage the free market working. They are quite clear that it means that you cannot have democratic pressure over local health services. They made it absolutely clear throughout the impact assessments that if you let democracy intervene in the market, the market cannot deliver the benefits that they anticipate from everything else that is in the Bill.

You all know about people writing and getting angry about their local hospital departments closing and all those kinds of issues that affect people on the ground. They will suddenly find that their voice is no longer that of a citizen, but only that of a consumer.

Karen Jennings: I think that we are far better off with a structure that enables us to be comprehensive, that enables our service to be universal and that enables us to plan properly. My vision of what I think will happen as a result of these reforms is that we will wipe away valuable tiers of management and planning structures, and create consortia that will themselves proliferate management costs, because the market brings with it a bureaucracy. We do not know yet what that will look like, but I suggest to you that this exercise is unnecessary and that the new structure will grow and proliferate.

Q156 Nick de Bois: I am not quite sure where to begin. Perhaps I could just ask you, Miss Jennings, whether you think that any cuts in management need to be made in the NHS.

Karen Jennings: The trade unions, through the social partnership forum, have all agreed that we need to look at productivity and improving efficiency. The circumstances that we are in at the moment are that there will have to be £20 billion of savings made because of the budget that was given to the NHS; in other words, it is not keeping pace with inflation. On that basis, there will have to be cuts in the NHS.

The Government believe that there are too many managers in the NHS—that it is top-heavy with managers—and therefore are committed to a 45% cut in managers. They have also been very disparaging about the role of managers. Over-bureaucratic, over-inflated, inefficient, very weak on commissioning—the literature is littered with negative stereotyping of managers. What I would say to you is that there is potentially scope for reconfiguring and slimming down, but what is happening at the moment is a very unpleasant and deeply offensive process. It is going over the top, in terms of the amount of cuts that need to take place.

Karen Jennings: If I could restate it, my position is that there will be £20 billion-worth of cuts—

Nick de Bois: I am sorry to stop you, but I understand that.

Karen Jennings: And those cuts are taking place.

Q157 Nick de Bois: I am not quite clear. You think you have to have cuts, but Unison does not believe that there should be cuts in management—in the NHS bureaucracy. Is that your position?

Karen Jennings: If I could restate it, my position is that there will be £20 billion-worth of cuts—

Nick de Bois: I am sorry to stop you, but I understand that.

Karen Jennings: And those cuts are taking place.

Q158 Nick de Bois: Okay, let us look at it another way, shall we? You are now in the position of defending a massive increase in bureaucracy in the primary care trusts, for example, yet you do not think that there is room to make cuts there, or that you should actually welcome the cuts, however painful they may be, as a way of reducing the imbalance and over-management. Is that correct? You are defending the status quo.

Karen Jennings: You may.

Nick de Bois: So you are saying that your judgment is more valid than that of a clinical director, which I have just read out?

Karen Jennings: No, Sir. I am not saying that. What I am saying is that the NHS was not perfect, but what we don’t need are the biggest reforms ever to take place in the NHS to correct some faults that could have been put right had they consulted properly. Let us not forget that these reforms were parachuted in two weeks after the coalition agreement. They came from nowhere. It was undemocratic.

Nick de Bois: On that basis, do you believe that patients do not want more choice about where and when they are treated? They have not had that for the past 13 years.

Grahame M. Morris: Chairman, we have limited time.

The Chair: May I remind members of the Committee that others want to ask questions? Does the hon. Member for Enfield North want to ask any more questions?
Nick de Bois: I will end it there.

Q161 Mr Barron: Past and recent reorganisations of the NHS have meant that some NHS employees have transferred to other organisations. They have had the protection of the Transfer of Undertakings (Protection of Employment) Regulations 1981 and 2006. Do you have any examples where that is under threat if any transfers to different organisations happen under this reorganisation? Who would like to start?

Karen Jennings: I am very happy to start. Staff in the NHS, particularly those in strategic health authorities and PCTs, feel extremely vulnerable at the moment, because there is very little detail on what the function and form of the new set-up will be. In other words, if you have valuable staff, you have no way of knowing whether you will be able to transfer across under the TUPE regulations, because the new system is so ill-defined, and staff therefore feel extremely insecure.

We also have other services that are meant to develop and evolve, involving any willing provider or social enterprise. All sorts, and potentially a plethora, of new providers are due to come in. The human resources framework has yet to be properly developed for that. There is no guarantee about portability or terms and conditions of service. Staff are frightened about what will happen to their pensions and what they have contributed to, and about what will happen in the long term to their pay, and their terms and conditions of service. There are major insecurities about the whole nature of the reforms.

Rehana Azam: To add to that point, it is useful to share the GMB’s experience, as a general union, of where workers have been outsourced to different providers. In our experience, there has always been a race to the bottom. Although under TUPE regulations terms and conditions are protected, that is only for a foreseeable amount of time. In our experience, the new provider tends to issue a notification and start reducing terms and conditions. Unfortunately, we have not had many experiences where our members have been transferred to another provider and their terms and conditions have been levelled up. It has gone the other way.

Karen Jennings: May I come back in, Chair? Schedule 2 makes explicit the suggestion that the transfer scheme can be modified by agreement after it comes into effect. That is being advertised, and TUPE is being threatened in the schedule, which is a very worrying development.

Nick Parrott: It is not just a matter of the existing staff being transferred; we are also concerned about the development of a two-tier work force following that. In addition, there is the question of what happens to NHS organisations that fail and get taken over by a private provider under the failure regime. Finally, we are not just concerned about the transfer of staff but about the transfer of property. Under schedule 21, the Secretary of State can simply hand over the assets of PCTs or strategic health authorities to any NHS provider, including a private provider, without any further scrutiny.

Q162 Mr Barron: The NHS has been quite proud of keeping its work force skilled and up to date. Do you have any evidence at this stage of where the reconfiguration would detract from the skilling, reskilling or upskilling of your members?

Karen Jennings: Again, the White Paper and the Bill contain precious little detail about the future education and training of staff, and we do not really know how that will be commissioned. There is a real worry about the projection of what the future staffing complements are going to be. This is a highly technical and difficult area to grapple with, and it has been thrown up in the air. In itself, that will create huge difficulties for the future training of doctors, nurses, occupational therapists and so on. It is certainly an area where the future work force is at risk, particularly with the demographics. The average health worker is something like 45 to 50 years of age. If we are not looking at future work force planning, we will be in a serious place, in terms of the number of staff in the NHS. You have to get people in and train them now.

Q163 Julian Sturdy: First, I agree with some of the earlier comments. You paid tribute to NHS staff and the role they play. That is important, and I am pleased that you said that. None of us can deny that more money has gone into the NHS over the past decade—it certainly has. Do you think that the money was well spent and well targeted? Did enough get through to front-line services and result in real patient outcomes?

Karen Jennings: I would love to answer that question—perhaps we can all come in on it. If you look at where the NHS was in 1997, it was on its knees. Major shortages of staff required us to recruit internationally in a profound way. We were at the bottom of the European measurements, in terms of our outcomes. We implemented, during that decade, an equal pay system for 1.4 million staff. It was the most momentous piece of work; it ended pay discrimination against the majority of the work force, who were women. That also included a framework for education and training. It was recognised that the human resource element of the NHS is about education and training, and about modernising the work force.

Health is a service that is continuously modernising, with new technology and new pharmacology, and you have to take your staff with you. In the last decade or so, that was recognised and the investment was put in. There has been a huge amount of negative stereotyping about where we are, in terms of the European average. We have one of the best primary health care services in the world. Our health care on cancer, our coronary care, our anaesthetic care and so on. It is a remarkable service. It is a remarkable service working in a collective way. The World Health Organisation said that the NHS was best placed to fight a flu pandemic. I do not think that it could say that this time round, because it was not in anyone’s mind last winter. We have an amazing NHS service.

Q164 Julian Sturdy: My key question is: did enough get through to front-line staff?

Karen Jennings: I am a former nurse and represent 450,000 front-line staff. Those who were in the NHS for that decade saw a massive change, and they worked with it. Make no mistake about it: they feel proud about working in the NHS. They will be the first to support the NHS as it is dismantled.

Q165 Julian Sturdy: Do you think that enough money got through to front-line services?
Karen Jennings: I do not think that all the money that was spent on the NHS was spent wisely, but the decisions taken about the NHS were far wiser than the decisions that we are about to enter into.

Nick Parrott: One thing, at least, that did not happen is what is happening now. Around the country, primary care trust senior managers are walking out the door, sometimes with six-figure redundancy payments, and then the following week, they are walking straight back in through the door of the new GP consortia, with a similar amount as a golden hello. I think hundreds of millions of pounds will end up being spent that will not go on front-line care. It was completely needless, not only in terms of the change, but in terms of how it was done. For me, the question is not so much what happened over the previous 10 years but how the Bill does or does not improve things.

Q167 Grahame M. Morris: Is there any organisation in the world that you could not pose the same question to? I am not sure that this is getting us very far.

Karen Jennings: There was 18-week waiting, down from three-year waiting lists. I think that it got to the right place.

Rehana Azam: I think that we have to respect the fact that the NHS is evolutionary. It is wrong to say, “Did enough money go through?” Karen has just made the point that I was going to raise. Certainly in the GMB, we have done some research on those targets from referral to treatment. The vast majority of PCTs came in below the 18 weeks. That demonstrates that money was going in the right places. We can all sit round and work out whether an outcome was the right one for a particular area. I do think that money has gone in the right place. On Karen’s point about terms and conditions and the agenda for change, and what that has brought to the workers in the NHS, I have to say that we have equality. Surely we want to retain equality for the people who work in the NHS.

Karen Jennings: There have been higher rates of satisfaction among patients—97% satisfaction.

Nick Parrott: Finally, let me refer to a more expert opinion than mine: that of Professor Ian Kirkpatrick of the Leeds university business school, who, in an analysis of the NHS reforms, pointed out that the total administrative and management staff of the NHS in 2009 were 13%, yet in the average business in the UK, the figure is 16%. The total, therefore, is somewhat lower. He also points out that the overall administrative costs in the NHS as a proportion of the total is, at 5%, around the lowest in the developed world. He says: “The White Paper talks about ‘radically simplifying the architecture of the health and care system’, but ironically the proposed changes seem to point to a far more complex system. More importantly, far from reducing the need for managers and administrators… the demand for these services will be greater than ever. As taxpayers, we will need to get used to the fact that for every pound we pay towards healthcare, administrative overheads will account for a larger not smaller cut.”

Q167 Grahame M. Morris: At the very outset, the witnesses from the trade unions identified their concerns. If I focus in on three specific issues, perhaps you can elaborate on those for the benefit of the Committee. In relation to public assets coming into private hands, a failure regime is envisaged in the Bill—this is for a foundation NHS trust. Could you say a little bit about that asset lock and tell us that the consequence will be, as set out in the Bill, of lifting the private income cap for NHS foundation trusts? If you have time, could you also say a little bit about corporate subsidies—that is in paragraph 55 of the comprehensive spending assessment—in relation to private sector providers being 14% more expensive than in-house NHS services?

Nick Parrott: First, on the public assets, there are quite a few potential mechanisms in the Bill whereby assets that are currently publicly owned may end up in private hands. I have already mentioned the provision in the schedules for the Secretary of State to simply transfer the existing assets of primary care trusts and strategic health authorities to any provider of NHS services, as well as to the consortia.

That is one matter. The other is that the Bill is extremely light on what kind of corporate form the consortia themselves might take. Some of them are already forming as limited companies, so that they would literally be a limited company themselves and, by definition, all the assets they take over will be in private hands. In the secondary sector, you also have to look at removal of the asset lock that was originally in the legislation under which Labour created foundation hospitals. In that legislation, certain property would be designated as necessary for the provision of health care for the public good. That could not then be sold for the commercial ends of the foundation trust without approval from the regulator on the grounds of health rather than economics. The Bill will remove that provision.

There is also the potential for them to borrow using public assets as collateral. That comes back to the point you raised about the failure regime. There are two possibilities for a foundation trust and its services. They—or the commissioners of that service—may apply for what is called designation. That means that the regulator will determine whether those services are completely essential to maintain health care in the area. The impact assessments suggest that that would be quite a strict test. Particularly in large urban areas, they certainly do not seem to envisage that every A and E or maternity unit hospital will be designated. At any rate, although there can be some public input on the decision on whether to apply for designation, the decision on whether the service will be designated has to be taken by the unelected regulator, who does not have a mandate to be concerned with the kind of issues that your constituents might be.

If they are not designated, it is pretty simple. The normal provisions of insolvency law will apply, so they simply go bust and the creditors take over the assets. If they are designated, a special health administrator will be appointed. The impact assessments suggest that that will not be a health professional; it will be a qualified finance professional. They will have a duty either to find another trust that is willing to take it over—or of course, if the trust has failed the first time around, other trusts may be somewhat unlikely to take on a potentially difficult service—or they may ultimately try to rescue the service. Obviously that seems to imply that the administrator will be able to turn around a service in double quick time, when the original governance
arrangements were not able to do so. If none of those things happen, they simply tender on the open market and a private provider may take over.

On reading the Bill, I am still slightly unclear about what happens to the ownership of the assets—the physical hospital. At the moment, the legal position seems to be that a foundation hospital is owned by its members—the staff, the patients and the public. If they have, by definition, failed, it seems that the ownership of that hospital would be in the hands of whatever private provider won the competitive tender to take it over. So you may find your local hospital is being run by BUPA or Serco, or whatever. There is a variety of different ways in which public assets may end up in private hands, but that was certainly never the intention of Labour’s legislation. Even now, the Social Enterprise Coalition is particularly concerned about this because, where there is a community interest company or some other kind of social enterprise, that is not allowed to happen.

Karen Jennings: This is quite a complicated area, and I do not pretend to be an expert, but I would like to make a couple of points.

You raised a point about higher costs in relation to distortions, where the public sector is favoured. In other words, out of every £100 the private sector has to pay an additional £14 because of pension costs and so on and so forth. We talked about bureaucracy earlier, and this is an example of where the private sector is going to tie us up in all sorts of litigation; it is quite clear that if there is not a level playing field it is going to sue our arms off. It is going to cost us a lot of money in terms of lawyers and court hearings, and goodness knows what else.

I suggest that the private sector will be looking for distortions, and it will be suggesting that staffing costs such as pensions are creating those distortions. However, they will not be looking at the distortions on the other side—for example, the cost of educating and training staff, which the public sector does at the moment. There are all sorts of ways of evening out that playing field.

The other issue that you asked about was the private patient cap, and I would like to give some evidence on that. Unison has long campaigned on that. When the foundation trust was first introduced we tried to prevent it, and we were very concerned about the patient income cap because there is no transparency of accounting, and certainly no level playing field. The public service has to have open books, but in the private sector accounting is secretive. Its business interests are over and above the public interest. So within one trust, you have two separate forms of accounting.

We would be at pains to make sure that the cap was not lifted; we would be very concerned, where there were tight constraints in the public sector, that trusts would need to continue to generate private income to keep going and would therefore invest in the private sector. Certainly, in all the foundation trust hospitals that have a private patient income cap, all the services that have been invested in have been private, and not returned to the public sector. At the very minimum, we would want to see open, transparent and separate accounts for those two separate entities within the trust.

I am very concerned about failure regime. Last year, or was it the year before last, the Labour Government introduced legislation that enabled foundation trusts to come back into the public sector, were they to fail. This Government want to repeal that. That is deeply unfortunate, because what will happen to a local community when a foundation trust fails? We need the safety net that was spoken about earlier.

Rehana Azam: To add to Karen’s point, once a trust goes bankrupt—the Bill says that the usual insolvency legislation will apply—that trust is then moved to the private sector. Certainly my experience is that when the insolvency agents come in, it is a case of paying off the various creditors. When you look at the stress of getting that sorted, what happens to the patients? What happens to patient care? You will have a trust going to the private sector—or whoever is going to buy it; there would have to be that kind of discussion—but my concern is what happens to our members who deliver that service? I can give you numerous examples where the administrators have gone in and we are not quite sure what will happen tomorrow. In the NHS, that is almost a suicidal way of doing things, because at the end of the day people still need looking after. How do you do that? Perhaps the scrutiny Committee can look at the introduction of insolvency and what that might mean to the NHS in the future.

The Chair: The clock is ticking and I have more bids for questions than I have minutes left in the evidence session. Steve Brine.

Q168 Mr Brine: Thank you to the three of you for coming. It has been very interesting. Very briefly, Mr Parrott, on the six-figure sums—golden goodbyes and golden hellos—I would love to know where they are. Maybe you cannot tell me names and places now. Or can you?

Nick Parrott: I cannot. I am afraid that I was told by one of your colleagues who, as an hon. Member of the House, would not break his word by—

Q169 Mr Brine: Sure. I did not think that you could tell me. Perhaps, however, you could write to the Committee, because I am sure that the Department would like to know about that issue and I, as a Member of Parliament, certainly would, because my constituents pay a lot of tax, as you can imagine.

I have a quick point about this being “sprung on us two weeks after the election”. That is an accusation that is eerily close to what we heard from the Opposition Benches on Second Reading, strangely enough, and it is totally untrue. If you check the Hansard report of that debate, you can actually see page references to the part of the manifesto where this issue was mentioned.

Karen Jennings: You did not win the election.

Q170 Mr Brine: Well, I know who did not win it. I have a question for Miss Jennings. Miss Jennings, you said that there is “scope for reconfiguring/slimming down”. In my area of Winchester, the Royal Hampshire County hospital—the Winchester and Eastleigh NHS Healthcare Trust—is merging with the Basingstoke and North Hampshire Foundation Trust to create a new foundation trust, which will serve north Eastleigh, Winchester and the Andover-Basingstoke area. In our area, Unison is being remarkably sensible and helpful, and understanding of the fact that to safeguard the jobs
at Winchester’s Royal Hampshire County hospital that merger is necessary, to put that hospital on a sustainable long-term footing.

There is a reconfiguration that has the support of the local MP, and I think it will have the support of the people whom I represent, and the support of the people in the other constituencies nearby. Is that a good thing or a bad thing? I ask because if that reconfiguration does not happen, Winchester’s hospital will undoubtedly close and then everybody at the hospital will lose their jobs—the people you represent. So is that reconfiguration—that slimming down—a good thing or a bad thing?

Karen Jennings: Could I just respond to your first point and then come to that?

Mr Brine: Yes, of course.

Karen Jennings: The coalition Government produced a coalition agreement that did not have any of the material that is contained in the White Paper. That is my point.

In relation to reconfigurations, the NHS is an organic body that changes and reconfigures. I do not know the particular circumstances that you mentioned, but I know that we have remarkable structures in place: national social partnership forums; regional social partnership forums, and local ones. That means that all the trade unions and the employers have a respect for each other’s side, they come together and they look for solutions to issues, problems and reconfiguring. We have done that since time immemorial.

Q171 Mr Brine: So what is happening in my part of the world would be a good thing?

Karen Jennings: I think it is wonderful when the trade union and management sides come together to find solutions. As for your particular hospital, I do not know what is going on there but it sounds very good.

Q172 Mr Brine: The reason that the trusts are coming together and the reason that Unison is being sensible and helpful is because—bluntly—without the merger there is no future for Winchester’s hospital, so they understand the pragmatism of that.

Karen Jennings: Sorry, I am not going to agree with anecdotal evidence. I have given you my broad opinion on that.

Mr Brine: You have answered the point.

The Chair: Order.

Emily Thornberry: I just wonder if this is to do with the Bill. We seem to be straying quite a long way.

Mr Brine: I am not sure that an awful lot of this was to do with the Bill.

The Chair: Will the hon. Gentleman make his point?

Mr Brine: I have finished.

Q173 Owen Smith: Obviously, all of you have spoken a lot about staff in the NHS and the Government have been at pains to say that they do not want to see the public service ethos of the NHS diminished. Do you fear that that will be a by-product of moving to a more disaggregated system and in particular a system where terms and conditions for the staff, who are the guardians of that public service ethos, are being radically changed? Will staff feel any longer that they are part of a national health service?

Karen Jennings: Again, I think we are in serious danger of the ethos of the NHS changing in the not-too-distant future. I think that currently the staff are immensely proud of being part of the NHS. They have made the NHS and that ethos—they and the patients, who appreciate what they do. National bargaining is all part of that, because the equal pay system is about ensuring that there is fairness across the public service—fairness where it is hard to recruit and fairness where there is a glut of staff. The NHS is about a collective and the big fear is that this market, which will enhance the European directive on marketisation, will enable more and more private sector companies to come in, greater diversity and a greater threat to any sense of collectivism.

The Chair: Order. I am afraid that the evidence session has now ended. I thank our witnesses very much for coming along today. I am sure that the evidence that you have given will be discussed in greater detail in Committee. Thank you.

Ordered, That further consideration be now adjourned.—(Stephen Crabb.)

6.31 pm

Adjourned till Thursday 10 February at Nine o’clock.