PUBLIC BILL COMMITTEE

HEALTH AND SOCIAL CARE BILL

Third Sitting
Thursday 10 February 2011
(Morning)

CONTENTS
Written evidence reported to the House.
Examination of witnesses.
Adjourned till this day at One o’clock.

PUBLISHED BY AUTHORITY OF THE HOUSE OF COMMONS
LONDON – THE STATIONERY OFFICE LIMITED
£4.00

PBC (Bill 132) 2010 - 2011
Members who wish to have copies of the Official Report of Proceedings in General Committees sent to them are requested to give notice to that effect at the Vote Office.

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

not later than

Monday 14 February 2011

STRICT ADHERENCE TO THIS ARRANGEMENT WILL GREATLY FACILITATE THE PROMPT PUBLICATION OF THE BOUND VOLUMES OF PROCEEDINGS IN GENERAL COMMITTEES
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)
† Smith, Owen (Pontypridd) (Lab)
† Soubry, Anna (Broxtowe) (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

David Bennett, Chief Executive, Monitor

Sonia Brown, Chief Economist, Monitor

Sue Slipman, Director, Foundation Trust Network

Sir Stephen Bubb, Chief Executive, Association of Chief Executives of Voluntary Organisations

Sir Andrew Dillon, Chief Executive, National Institute for Health and Clinical Excellence

Richard Douglas, Director General of Policy, Strategy and Finance, Department of Health
Public Bill Committee

Thursday 10 February 2011
(Morning)

[Mr Mike Hancock in the Chair]

Health and Social Care Bill

Written evidence to be reported to the House

HS 18 Mencap
HS 19 National Children’s Bureau
HS 20 Children’s Sector
HS 21 Roger Rymer
HS 22 General Social Care Council
HS 23 British Heart Foundation
HS 24 Royal College of Psychiatrists
HS 25 Age UK
HS 26 Children’s Rights Alliance for England
HS 27 Royal College of Nursing
HS 28 Every Disabled Child Matters
HS 29 Optical Confederation

9 am
The Committee deliberated in private.

9.2 am
On resuming—

The Chair: Good morning and welcome. We are very pushed for time, so I will not invite you to introduce yourselves and tell us all about where you have been for the last 20 years. However, I do want us to get as much out of the session as we can, so if you want to make some comments about your own situations, I suggest that you do that in response to the first question that you are asked.

I am grateful to you all for giving up your time to give evidence, which will enable the Committee to function far better than it could have expected to without your assistance. I am sure that you will give the advice that the Committee needs to take it through the next six or seven weeks.

Q174 Emily Thornberry (Islington South and Finsbury) (Lab): I thought that I would kick off the proceedings with a fairly general question, which I have been asking many witnesses. Do you think that there are any risks associated with the Bill? Could each witness answer in turn?

Sir Stephen Bubb: Thank you, Emily. Yes, I think there are risks, but I want to start by saying that in terms of third sector organisations—charities and social enterprises—we are strongly behind the concept of “any willing provider”, because we believe that third sector organisations are an untapped resource that can provide a more cost-effective service and certainly a more citizen and patient-focused service.

I see this as an opportunity for us to step up to the mark and expand what we do. The risk is that if that does not happen because Monitor fails to do its job effectively, or GPs do not step up to the mark and involve third sector organisations, “any willing provider” will not mean an increase in third sector provision and will mean an increase only in private sector provision.

Q175 Emily Thornberry: Have you any comments about price?

Sir Stephen Bubb: Price, absolutely. One of the problems with commissioning and procurement is that it is stuffed full of people who, in that famous dictum, know the price of everything and the value of nothing. They do not understand the concept of social costs and benefits.

One of the problems that I suspect we shall have is this. Monitor is used to regulating foundation hospitals, but will it be able properly to regulate community mental health services? Will it be able to take account of the wider social benefits that you get from third sector provision, which joins up services across boundaries, as wider benefits of its activities in the community?

The Chair: Does anyone want to add anything to that?

Sue Slipman: We do not see any risks in the foundation trust bit of this policy, in the sense that it is the completion of the journey of foundation trusts that was started seven years ago; they remain fully part of the NHS, but will enjoy greater freedoms in order to serve NHS patients. We think the risks are in the transition. There are many risks in the transition period and they are largely about provider sustainability during that time. We think that those ought to be separated out and addressed separately from the longer-term structure that is being set up.

We certainly have some worries about quality in the new system—how we maintain quality and ensure that that is driven down the commissioner line in such a way that GP consortia take responsibility for quality, pushing it through contracts and performance. We would have some real issues about price competition if that were to become part of this system.

David Bennett: I identify two risks from a Monitor perspective. First, as Sue says, there are inevitably risks in significant change of the sort that we are looking at, although frankly there would be significant risks if we did nothing. Therefore it is very important that those risks are identified and managed, but in a sense that is always the case for such a large and complex system as the NHS.

The second risk that we would be somewhat concerned about is that in the course of the passage of the legislation, the reforms themselves lose coherence. It is important that what we have here is a set of different changes that collectively make sense, so there is a risk that individual changes might lose the coherence of the reforms.

Sonia Brown: I have nothing to add to David’s response.

Q176 John Pugh (Southport) (LD): Sir Stephen, you have just mentioned the third sector. The third sector is a very wide category, and you are down on the list as voluntary organisations. Are we assuming that the third sector includes other things that are not voluntary organisations?
Sir Stephen Bubb: There is a lot of controversy about what we call ourselves.

Q177 John Pugh: There are some quite big players in the third sector, are there not?

Sir Stephen Bubb: The way I am talking about the third sector, it means charities—big charities, small charities operating at a local level and social enterprises. In Henry James’s terms, it is a loose baggy monster. That is one of our problems. People do not realise that the sector as a whole employs 1.5 million people and has an annual turnover of some £143 billion, so it is a significantly bigger player than people understand.

Q178 John Pugh: May I ask David Bennett a question, given his position in Monitor? You have two roles, do you not? One involves price competition and the other is sustaining core services or designated services. Do you think that you will do the designation or will that be left to local organisations? How will you be able to balance the two drivers of your job, which is basically to sustain core services and encourage competition?

David Bennett: First, I would say that we have three roles.

John Pugh: Three?

David Bennett: Yes. The roles are setting prices, promoting competition and protecting continuity of services. In terms of the designation of services, the way in which that is intended to work is that we will set some guidelines, but then the application of the guidelines will be done at local level—there are requirements for consultation and so on—driven by commissioners. Essentially, as long as those guidelines are appropriately followed and there is appropriate consultation, we will then just confirm the decisions that are made locally.

Q179 John Pugh: Just on that precise point, it could be that in one area a maternity service is designated within the guidelines and in another area, abiding by the guidelines, a maternity service is not.

David Bennett: That is right. The purpose of the guidelines is, in part, to ensure that services are designated only where they really do need to be protected.

Q180 John Pugh: In terms of the balance between the two roles—competition versus protecting core services—how do you get that balance right?

David Bennett: You start by identifying those services that need to be protected. Then you look at where competition can be appropriately applied.

Q181 Liz Kendall (Leicester West) (Lab): I have one question for David and one for the Foundation Trust Network. Apologies to Sir Stephen.

Under the Bill, Monitor gets the powers that the OFT has in relation to the Competition Act 1998 and the Enterprise Act 2002. The explanatory notes say that it is based on the model of regulated industries, “such as telecommunications, gas, electricity, water and sewerage and railway”.

Could you explain to the Committee what that means, and what the similarities are between health and gas, for example?

David Bennett: The consequences of the changes that the Bill is proposing are, in part, clarifying circumstances that are currently unclear.

Q182 Liz Kendall: Can I come back? This is the first time it has been put in primary legislation.

David Bennett: Yes. At the moment, for example, it is not entirely clear to what degree foundation trusts are subject either to the Competition Act or the Enterprise Act. One thing the Bill will do is make it clear that they are. The consequences of doing that—first, in terms of the Competition Act and giving Monitor concurrent powers with the OFT—mean that if there are complaints about anti-competitive behaviour, abuse of market power or forming anti-competitive agreements, Monitor as well as the OFT has the power to examine those complaints and seek remedy, if appropriate.

In addition, we will have the power to investigate the market, if we think there are features of the market that prevent effective competition, where it is appropriate. If we identify problems, we can pass them on to the Competition Commission and ask it to do a further investigation and, if appropriate, make remedies. The responsibility for looking at mergers and acquisitions in the sector will move to the Competition Commission and the OFT as a result.

Q183 Liz Kendall: That means that if a hospital merges, that will go to the OFT.

David Bennett: Yes.

Q184 Liz Kendall: So it will be responsible for deciding whether a hospital could merge.

David Bennett: It will look at the implications of a merger.

Q185 Liz Kendall: I want to follow up on some of your comments. What do you think is anti-competitive behaviour in the NHS? Could you give me an example of what that might mean?

David Bennett: If you had a situation where, for example, commissioners were seeking to use their—

Q186 Liz Kendall: GP commissioners?

David Bennett: Sorry. If GP consortia as commissioners were trying to prevent perfectly appropriate suppliers from entering into the market through putting unnecessary provisions into their commissioning requirements—

Q187 Liz Kendall: Such as what? Just to make it real. What in practice might that be?

David Bennett: An extreme example would be requiring a condition that only an NHS provider could possibly meet—therefore, by implication, preventing a private sector provider offering to supply the market.

Q188 Liz Kendall: So if there was only a local hospital and those commissioners only asked that hospital to provide a service, and nobody else, they could be referred to the OFT.

David Bennett: No. In fact, in the case of commissioners, they are going to be governed by procurement guidelines that will be set.
Q189 Liz Kendall: Are those the EU procurement guidelines?
David Bennett: No. They are the procurement guidelines set by the Department and then enforced by Monitor.

Q190 Liz Kendall: So, for example, if a GP wanted to refer patients for hip operations to the local hospital and did not put that out for tender, would that be considered anti-competitive?
David Bennett: That is specifically about procurement. Perhaps I did not choose the best example of anti-competitive behaviour, given that it is a procurement example. Under “any willing provider” and choice, a patient looking for a hip replacement, say, should be able to choose from any available provider. It is not for the GP, it is for the patient.

Q191 Liz Kendall: May I ask a question now of Sue Slipman? You said you had concerns about who drives quality, and you mentioned GPs, who will be responsible for that under this Bill. What are your concerns—could you explain them some more?

Sue Slipman: I will, but may I first take up a point that you made earlier about who approves mergers and acquisitions? It will be the OFT that decides whether there is a competition issue, but it will be the governors of the foundation trust who approve the merger or the acquisition.

Q192 Liz Kendall: So not the OFT and not GP commissioners? Sue Slipman: No, it will be approved by the governors.

Q193 Liz Kendall: And not local government?
Sue Slipman: Well, there will be a lot of opinions that will be taken into account, but it is the governors, to whom the unitary boards are accountable, who would need to approve a merger or an acquisition. There will be a whole range of inquiries as to whether there are any competition issues, but this is one of the areas in which the accountability to governors of foundations trusts is being strengthened.

Q194 Liz Kendall: Is that a difference of opinion between you and Mr Bennett?
Sue Slipman: No, it is just a matter of fact.

Liz Kendall: He just said that it would be the OFT that would decide—
Sue Slipman: The OFT decides whether there are any competition issues to answer. Should there be no competition issues, it will be approved by the governors.

There are delicate checks and balances in the way the new system is being envisaged to work. What drives quality, as we understand it, is the mandate that the Secretary of State will hand to the national commissioning board, and that will be driven down the commissioning line. Our concern is about how far up the chain of objectives the issue of quality will come for GP commissioners themselves. I have no doubt it will be driven, but it is about focusing GP commissioners on quality.

It is price competition that could drive down quality, certainly in the first years of a market such as this. Price competition would be very dangerous. All the evidence shows that there is a race to the bottom where there is price competition, and that is not desirable. Whether it is desirable in the longer term is an open question, but it certainly will not be until this system is stabilised and we know that quality is a prime objective for the outcomes being commissioned.

Q195 Jeremy Lefroy (Stafford) (Con): I have a couple of questions about the role of Monitor. The first is about the Mid Staffordshire trust into which the Francis inquiry is looking at the moment. It seems to me as the local Member of Parliament that Monitor approved the foundation trust status without going into sufficient detail as to the status of that trust, particularly the quality of care at the time. What assurances can you give us that Monitor’s approval of foundation trusts will be more rigorous in the future than it was in the case of Mid Staffordshire?
David Bennett: Yes. I was not around at the time, but looking at the evidence, the trust was approved at a time when it was not delivering appropriate care to its patients, and that was wrong. Monitor has done three core things in the light of that, all based on an external review of what happened and why, and therefore what lessons can be learned. First, it has set a clear quality bar. That did not exist before—there was no clear definition of what was an adequate level of safe care for any trust to be providing to be authorised. In conjunction with the CQC and the Department of Health, there is now a clear definition of what the quality bar should be.

Q196 Jeremy Lefroy: Sorry, are we saying that there was not a clear quality bar for approval of foundation trusts up till now?
David Bennett: There has been for a while, but not at the time of Mid Staffordshire.

Q197 Jeremy Lefroy: When was that introduced?
Sonia Brown: We carried out an audit of the situation, and as soon as the audit was complete, we introduced the recommendations that followed it. It was a matter of months, but I do not know the exact number.
David Bennett: That is the first thing. The second thing is that we have developed what we call a quality governance framework. We have basically said, “What should the board of a trust be doing to assure itself that the trust is providing an appropriate standard of care to its patients?” Again, one has to say that in Mid Staffordshire, that was not working. Having established what that should be, we now have a whole series of tests that we apply to an applicant trust to make sure that it is doing things at board level to assure itself that the care is safe and to an appropriate standard.

The third thing is working much more closely with the care regulator. Of course, the care regulator itself has changed. At the time of the Mid Staffordshire authorisation, it was the HCC; now it is the CQC. We work extremely closely now with the CQC, and it has changed significantly how it considers that sort of issue.

For example, one of the things that did not work as well as it should have done at the time of the Mid Staffordshire authorisation was the use of what people
call “soft intelligence”—not actual on-the-ground inspections, but looking at things such as what the local media are reporting and patient groups are saying.

The CQC has developed approaches that allow it to make systematic use—and, one hopes, effective use—of that sort of soft intelligence, and we work much more closely with it to make sure we explicitly understand its position in terms of quality of care. There are lots of other, more detailed changes to be made, but I think those are the three main things we have done to make sure that it does not happen again.

Q198 Jeremy LefROY: Just to follow up on that, the Bill makes it clear that all trusts should become foundation trusts by 2014, so there is a time limit. If you feel that trusts are not able to become foundation trusts, are you prepared to stand up and say that they are not ready, irrespective of the deadline?

David Bennett: Absolutely.

Q199 Mr Kevin BarrON (Rother Valley) (Lab): A question for Mr Bennett. The impact assessment for the Bill refers to “fair playing field distortions” and says:

“The majority of the quantifiable distortions work in favour of NHS organisations; tax, capital and pensions distortions result in a private sector acute provider facing costs about £14 higher for every £100 of cost relative to an NHS acute provider.”

My understanding is that you would be responsible for addressing that system. What is your view of those fair playing field distortions?

David Bennett: In due course, I think one of the things that the economic regulator will need to look at is the issue of the level playing field. The analysis that you are quoting, of course, was done by the Department of Health, not Monitor.

I think I can say that when the appropriate time comes for the economic regulator to look at those issues, we will need to look very carefully at that analysis. There are level playing field issues on both sides. There are additional costs incurred by the public sector, as well as advantages, the obvious ones being—

Q200 Mr Barron: This says that it is the other way around, actually. The public sector costs are higher than private. Do you agree with that?

David Bennett: What I am saying is that we would seek to do a more extensive piece of research before reaching conclusions.

Q201 Mr Barron: If this is the case, what are the implications for public sector workers?

David Bennett: If those numbers are correct?

Q202 Mr Barron: My first point is that our starting point must be to do the analysis more extensively, looking at a broader set of issues. I cannot say that those figures are the ones that we would come up with.

Sonia Brown: I think we can identify areas where we can see that the Department’s analysis has not gone to the point of being able to quantify the numbers. A really good example of that is that the NHS tends to treat much more complex cases. At the moment, the NHS is rewarded at the same rate for doing that as the private sector is for treating less complex cases.

One thing that the economic regulator will need to look at is the way in which prices are set within the NHS—appropriately targeted, to really ensure that all the different moneys that are going in different directions work in a fair and appropriate way. As David says, that is quite an extensive piece of work to undertake, and on the basis of the numbers presented in the impact assessment, we do not feel able to make assertions.

Q203 Mr Barron: I was on the Health Committee during the previous Parliament, when it looked into the independent sector treatment centre programme. I had conversations with more than one company running the programme that said they felt threatened by the pensions implications, with the work force working in the independent sector while keeping the NHS rewards such as pensions. I call them distortions, but most of us have one. By implication, what does that mean?

David Bennett: I think again of Sonia’s point. There are lots of considerations. Yes, pensions are an issue, but as someone said there is an issue around the complexity of the cases that we have dealt with.

Q204 Mr Barron: I accept that. ISTCs were contracted for cases that were not likely to go wrong in surgery, because there was no back-up in the hospitals or institutions if someone needed to go into ITU, and so on. I understand that exactly.

I am not talking about that, but about the implications of the work force transferring when we have these comments in the impact assessment about what is likely to happen. Surely, the implication is that if you have to address these so-called distortions, people are likely to be working for less than they are now.

David Bennett: I think that there are two parts to the answer. First, putting it bluntly, that is an incomplete analysis, and the analysis needs to be finished.

Q205 Mr Barron: So you do not agree with that analysis in the assessment?

David Bennett: It is incomplete. Secondly, even once you have done the analysis and established that there may be some level playing field issues, who knows which way it will come out? Perhaps we will discover that the public sector has a net disadvantage—but once you have worked out which way it comes out, you then have to work out what remedy you are going to apply. And you have to take many factors of the sort that you are raising into account when deciding what is the best way to do it.

Q206 Mr Barron: And obviously you will do those assessments? That will be part of Monitor’s new role, will it?

David Bennett: Yes.

Q207 Mr Barron: And you will publish those assessments?

David Bennett: Absolutely.

The Chair: This is a very important point. I know that Emily wants to come back, but does anyone else want to ask a follow-up question, or do any of the other people at the top, such as Sue or Sir Stephen, want to add anything?
Sue Slipman: The only thing I would add is that it is clearly the public sector that is carrying the responsibility for the education and training of people across the system as a whole. There are balances here in those imbalances, and we would certainly be pressurising Monitor very hard to take them into account.

The Chair: I think that they accept that.

Emily Thornberry: I am tempted to press you further, David, given the profound implications of what you said in relation to work force pensions. We are about to pass this legislation and you are saying, “Take it on trust, as it will all be sorted out.” But we are talking about millions of people’s pensions here, and it is difficult not to push you at this stage.

Worse than that, you said in an incomplete answer earlier that there were other obvious distortions and advantages that the NHS had over the private sector. I wonder whether you could list anything else, on top of pensions, that you might think might of?

David Bennett: I said that obvious distortions are creating advantage within the NHS. I was also saying that there are other distortions in the market, and Sue has just pointed out two of them. At the moment, it is the public sector that has to pay for R and D, and it is the public sector that pays for training. That places the public sector at a disadvantage. That needs to be taken into account.

Q208 Emily Thornberry: Do you have any others?

David Bennett: I do not have a comprehensive list.

Sonia Brown: I think that the Department’s impact assessment sets out the categories of the potential distortions that exist. For example, there is an issue around the cost of capital. At the moment, the public sector has access to the cost of capital of the Government, whereas private sector organisations have to go to market in order to raise capital for their investments. So in those circumstances, the Department was able to quantify the potential cost of that distortion.

The list that the Department has provided in the impact assessment is a good one. We are saying that there is further work to be done to be able to quantify and to be able to understand the full impact of that. It is unfortunate that the majority of quantification is in one direction at the moment, and it would be helpful for all of us to work towards having all of these numbers quantified.

David Bennett: To answer the second part of your question, which was, “Is it a matter of ‘just trust us’?”, it is important that we do it all in a transparent way. If it is viewed that we have not done the analysis well, we can be challenged.

Q209 Emily Thornberry: But we have to take you on trust when it comes to passing this Bill?

The Chair: I am sorry to interrupt, but four other Committee members want to come in on this issue. So to be fair to them, I shall let them do so. Mr Lefroy first.

Q210 Jeremy Lefroy: Would you consider that another of the things that the NHS have to take on board, which the private sector would not necessarily be interested in, is emergency—particularly acute—care and the block of services around that? There is perhaps a risk that, unless you have a duty to ensure some kind of stability of that kind of provision, the services surrounding acute and emergency care will be cherry-picked, leaving it unviable.

Sonia Brown: The issues around emergency care, particularly in rural communities, are one of the areas that we need to look at very carefully. It is my expectation that the majority of rural emergency care, as you have described, would be protected by designation and by commissioners. That in and of itself will afford it additional protection.

An example of that is that if the provider felt that the national tariff was not fully covering the cost of providing that emergency care, it could make an application to Monitor so that additional funds could be released in order to ensure the sustainability of that care. So we do think that there are already some good checks and balances around this area.

The Chair: Before you come in, Sue, I invite Grahame Morris to make his point on this issue.

Q211 Grahame M. Morris (Easington) (Lab): We have moved on a touch, but I will bring it back if that is in order. I refer to an article that David Bennett published in the Financial Times on 6 January, where he queried the independence and stability of the Government’s flagship NHS proposals, which he said could be “compromised by the coalition’s refusal to create an independent body to oversee them.”

My interpretation was that you were raising concerns about what you referred to as “the operationally independent banking function”.

Presumably, that is the £24 billion, aside from the £80 billion that has gone into GP commissioning, that you are raising concerns about and that would be retained by the Department of Health and would oversee loans to hospitals at commercial rates. Sue Slipman said that if the responsibility is left to the Department of Health, it could be used as a policy transmission belt that would affect independence.

So is it correct that Monitor would lose direct oversight over this budget and would that leave a possibility that there would be some political influence in what we are being told in the Bill is a wholly free-market and independent system, particularly in relation to reconfigurations and withholding capital for a particular purpose?

David Bennett: There are lots of issues there. That is misquoting an interview, not an article I published. However, it is right to say that there is an amount of capital that funds the foundation trusts. That is the £24 billion, which is quite different from the £80 billion, which pays for the services they provide. On behalf of the Treasury, we seek to make sure that the foundation trusts do not destroy that capital. That is public money.

The proposal in the Bill is that, because there is a potential conflict of interest for Monitor to do it as well as our role as an economic regulator, in the future that responsibility should go to the Department of Health.

The concern I was expressing, which is somewhat reflected in that article, is that if the Department of Health is responsible for protecting taxpayers’ interests, it must have some powers over the FTs and there is risk that those powers might be misused. Therefore we were
anxious that those powers be exercised as far as possible at arm’s length from the Secretary of State. The proposal in the Bill—because it has listened to our arguments—is that it should be done through a vehicle that is placed at arm’s length from the Secretary of State. It talks about operational independence. I need to see the details, but, in principle, that addresses my concern.

**Sue Slippman:** I have just two concerns. One was about designated services and the protection of services. What exactly will be designated? If you designate at a minimal level, or do it around HRGs within the tariff, what you could potentially end up with is a bundle of services that would not be broad enough to sustain the quality and safety of the service overall.

Therefore we have a concern about how that designation works. Of course we expect that to be probed by economic regulators, so we are not arguing for inefficient service bundles. What we will have a concern about is that the service bundles that are designated protect both quality and safety for patients. There will be a fine line on some of those things, and we expect to be involved in detailed discussions with the regulator about that.

The second issue is about what happens with the financing facility and its relationship with the Department. Ideally, we have one too few arm’s-length bodies to resolve this in a way that satisfies everybody. This is something that we have raised with the Secretary of State. We will be looking for words of comfort that operational independence means just that during the passage of this Bill. It has worked with the competition panel, which has been part of the Department, but we want to be pretty secure that it will work. It is not that we suspect in any way that the Secretary of State or the National NHS commissioning board that would be in the lead, and this is a good example. In this example, it is the NHS commissioning board that would be in the lead, associated with this area, and Monitor would take account of what it wanted.

If we go back to designation of services, it would be for the commissioners effectively to determine how far it was reasonable for patients with certain conditions to have to travel, which would be one of the things that would be key in determining how many services should be designated. It is right and appropriate that that responsibility sits with the commissioning board.

**Debbie Abrahams:** May I just follow that up?

**The Chair:** We must be fair to everyone. Can we keep our questions short and our answers shorter?

**Q214 Debbie Abrahams:** If we find, as we strongly suspect that we will, that fairness in access to services does not happen, what will you be able to do about it? Will you be able to withdraw the licence of certain providers?

**Sonia Brown:** The answer is that it will depend. There are certain circumstances where Monitor will be able to take action, and others where I expect the commissioning board would take action over commissioners.

**Q215 Liz Kendall:** I am sure many of you will remember the controversy the last time a foundation trust Bill went through Parliament. There are two key things I am completely confused about. One is that there does not appear to be any clarity about which body will be responsible for the £24 billion of FT assets; it is just a vehicle with operational independence. Secondly, I am not clear whether it is a GP, a local authority or Monitor who designates which services are saved.

**The Chair:** Who wants to take that?

**David Bennett:** Let me. On the £24 billion, it is a vehicle within the Department. It may not be fully specified, but it is in the Department of Health.

**Liz Kendall:** But just a vehicle.

**David Bennett:** For details to be specified.

**Q216 Liz Kendall:** And who designates?

**David Bennett:** As I said before, the guidelines for designation are developed by Monitor.

**Q217 Liz Kendall:** We do not have the detail yet of how we say which services will be guaranteed.

**David Bennett:** No. We have to develop guidelines. They will be applied locally and then we formally make the designation.

**Q218 Dan Byles** (North Warwickshire) (Con): A number of people have been expressing concerns about the issue of competition—particularly focusing in on competition on price. A view has been expressed on some sides that that inevitably would push down quality. Obviously, that would be a concern, if it was the case. Given that competition is a core part of Monitor’s function, I would quite like your view on that.

**David Bennett:** It is controversial, that is true, and we would share the view more or less expressed by Sue, which is that there are risks to applying price competition in health care. A major risk is the possible implications...
for quality. Therefore I think any introduction of price competition should be done very carefully after lots of consideration and consultation. My expectation would be that it would emerge in a very limited way and very slowly.

Q219 Dan Byles: So you believe that the competition element of Monitor is not purely about price; it is also about quality.

David Bennett: Far from it, no. I would expect most competition to be around quality.

The Chair: We have five on this point.

Q220 Owen Smith (Pontypridd) (Lab): It is interesting that there is obviously clear agreement among the panel that the evidence shows that price competition in health care drives down quality, or tends to. Sue, you said earlier that therefore you thought there ought to be some sort of stabilisation period. What does that mean? Does it mean that you do not think that the maximum tariff that effectively drives the price competition should come in at the onset of the new regime?

Sue Slipman: We need confidence about any areas that are safe to open up to price competition—because we have thought about them and they have been tested in theory. I do not think anyone would be against any form of price competition in the long term, but in the short term, because of the dangers of transition in particular, we need stability around price expectation, so that when competition is forced it is forced on quality and not on price.

Q221 Owen Smith: Can you bring that alive for us? Can you give me two examples—one area where you think price competition would be safe on current evidence, and one where you cannot imagine price competition would ever be safe?

Sue Slipman: I cannot think of many areas where I would think it was safe to introduce price competition now, but there may be areas of community service. I would not do it around emergency or certain areas of elective, because until you have got the quality standards stabilised and people working to those standards—and proving, through performance, that they are doing so—it is fairly dangerous in every area.

Q222 Margot James (Stourbridge) (Con): I would like to bring Sir Stephen in on the discussion. Most of us have hospices in our constituencies and end-of-life care is dominated by the hospice movement. From my observations, the service has been provided on a very price-competitive basis and is of high quality. Do you have any comments about the role of the third sector in competing on both price and quality?

Sir Stephen Bubb: That is a good question. The hospice movement is a brilliant example of an innovative way in which the sector delivers end-of-life and palliative care, begun just across the river in St Thomas’ hospital. This is a very good illustration of some of the arguments we are having because many people end up in a hospital bed at the end of their life, when they would prefer to be either at home with community care or in a hospice. It is more expensive for them to be in a hospital bed and it is usually not what people want. It is an example of where you can deliver a more cost-effective service, and a service that meets people’s needs. There is great potential for the hospice movement to expand the work done in the community and in palliative care. I would like to see commissioning processes that look at how you involve those third-sector organisations more in the process. There are plenty of examples where, if you use the concept of quality and look at what we do in community care and adult social care, we provide a more holistic service.

I shall give you a couple of examples of where we need to commission effectively. The first example is what happened—this is a point I particularly want to make to Monitor—with meals on wheels. One county council procured its meals on wheels through a tender process and WRVS, which was providing the service, was sucked in favour of a private sector manufacturing company, which did a week’s worth of microwaveable food that it delivered in and out the house in five minutes. That was a cheaper service, but of course it was disastrous for old people because the contact provided by WRVS and the volunteers was more important than the meal in many cases, and many people lost that contact. That was a very stupid decision and it was based entirely on price. That is why the wider benefits that we bring have to be taken into account. I suppose that illustrates what could go wrong if the process is just based on price.

Let me give you another example in relation to the potential. If you have diabetes, you have an annual retinal eye test. Mostly, that is conducted in a hospital or a doctor’s surgery, but that is not an efficient or cost-effective way of doing it as it costs something like £400 a go, whereas you could actually go and buy the test in Specsavers for about £20. It would be interesting if you explored the potential, which Diabetes UK and Specsavers have done, of a service whereby you go to a high street optician for the retinal eye test and the results go back to your GP and to Diabetes UK. If there is a medical issue that needs addressing, the GP does that; but in diabetes what is more important is diet, control, exercise, support and advice, which you do not get from the GP, but you could get from Diabetes UK. You could really intervene effectively because diabetes is a huge and growing cost to the health service. It is not often dealt with medically; it is best dealt with by organisations that can work on exercise and diet. Sorry to give such a long answer.

The Chair: It was a very good and interesting answer, but we have to move on.

Margot James: Can I just ask one supplementary?

The Chair: I am coming back to you. I think that Tom Blenkinsop wanted to ask a question on this issue.

Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab). Sir Stephen, under the new provisions, competition on price will be a key factor, and where big private companies believe that one of your members has been picked on the basis of organisational structure and not on the basis of price, they will be able to call for the regulator to look into that decision. Do you not...
think that those companies will be able to throw money into litigation to back up their argument?

Sir Stephen Bubb: There are issues there. One of the Bills currently going through Parliament, sponsored by Chris White MP and which the Government are supporting, is about social clauses and the need to take account of social clauses when you are making decisions. Social clauses consider the social costs and benefits, which was a point I made earlier. That should be extremely important and helpful to our case. Of course, one of our disadvantages against the private sector is the lack of access to capital; that is a serious disadvantage for us and obviously one of the issues that Monitor will need to take account of.

Q223 Margot James: I want to follow that up. Do you think, Sir Stephen, that the Bill provides enough scope to allow the third sector to develop into new areas, where it might be able to drive innovation?

Sir Stephen Bubb: I certainly think the Bill is opening up areas for us. Some of this will depend on our usual chutzpah sort of approach to stuff—we get stuck in. The any willing provider approach actually allows us to get stuck in in a way that has not been possible before. We are usually extremely good at exploiting opportunities if we are allowed the chance. There are other things the Government are doing to support that: the big society bank capitalising the sector will be very important to helping us do that.

Q224 Phil Wilson (Sedgefield) (Lab): On the face of it, patients at a GP practice, for example, have a choice of where they go for a hip replacement, but generally they end up going to their local hospital. Could that be challenged on the ground of anti-competitive practices by another hospital?

David Bennett: If patients are choosing to go to one hospital just because it is nearer, then no, it is their choice.

Q225 Phil Wilson: But could not another hospital challenge that?

David Bennett: No, what they could do is try to understand why patients are not choosing to go to them, and if they can offer a better quality of service which attracts patients to travel a bit further to go to them, then that is what they should do.

Q226 Nick de Bois (Enfield North) (Con): Mr Bennett, I just want to seek a bit of clarity on the competition point. Given what you have said, and your role in Monitor on this, are you saying that over the medium term, the advantages of introducing competition outweigh any of the disadvantages that have been discussed?

David Bennett: There are benefits to be gained from introducing competition, but it needs to be done carefully and thoughtfully. Competition does not necessarily mean—often it will not mean—price competition. It will be competition to provide a higher-quality service at a regulated price. Broadly speaking, do I think it is likely to produce benefits? Yes, but we need to look very carefully at the speed at which is should be introduced and where it should be introduced.

Q227 Nick de Bois: And Monitor will do that?

David Bennett: Yes, but in a transparent way.

Q228 The Minister of State, Department of Health (Paul Burstow): I want to follow up that point. Am I correct in understanding you to have said that the majority of—the competition activity that would take place as a result of this Bill would be on quality, not price?

David Bennett: Yes, that is what I would expect.

Q229 Grahame M. Morris: I want to return to the point that Nick made a little earlier about competition on price. I want to be clear in my own mind about this cost-based argument. It strikes me, as was mentioned earlier, that it is a real barrier that, in general, NHS providers are 14% cheaper than private sector providers, given the Government’s intention to introduce competition and private sector providers into the system. What remedies could be applied? Could you give an example? Could it be a tax break given to a private sector company as an incentive to enter the market, in order to overcome that market distortion?

David Bennett: I have to start by saying again that the 14% figure is an incomplete analysis. It may not be right—well, it almost certainly will not be—because there are certain bits of it that have not been analysed.

Q230 Grahame M. Morris: But it is in the Department’s own impact assessment.

David Bennett: Yes. I am just saying that I do not think that number represents a complete analysis.

Q231 Grahame M. Morris: Even if that is not correct, as a bit of supposition, how would such a distortion be corrected? How would you create a level playing field to bring in the private sector as the Government clearly wish to, to introduce competition?

Sonia Brown: I do not think that anything in the Bill is aimed at bringing in any particular sector. It is about trying to make sure that patients’ interests are put first and, as we have discussed, that will be largely about quality. What Monitor will need to look carefully at, after doing a thorough analysis, is the extent to which the current pricing mechanism, which is a bit one size fits all, is appropriate in the future. We may see the need to have, for example, differential pricing in the event that there are true market distortions that need to be remedied, but we are far from reaching the conclusion that that is the case at the moment.

Q232 Grahame M. Morris: In layman’s terms, does that mean that a private sector provider would be paid a supplement above the normal tariff? Is that what you are alluding to?

David Bennett: Not necessarily. Another way of doing it, which one might easily conclude is the better way, is this. You might say everyone gets the same price, but an element of the payment to some providers is used to fund those things that are causing the distortion. For example, if the distortion is that the public sector is having to pay for training that the private sector is not paying for, you can take an element of what you would have paid to the private sector and use that to fund the training. In that way, you establish a level playing field.
There are lots of different ways you can do this. It does not have to be that you straightforwardly pay one differently from another.

**Sue Slipman:** You can be assured that we will be fighting the case. Where those distortions arise as a result of the public providers providing public good, we will be fighting for recognition of that in any attempt to address a level playing field argument.

**Q233 John Pugh:** To précis what you have told us—you can tell me where I have gone wrong—when I asked my first question, about competition, you seemed to be saying that there were designated services and outside that, it was just crude financial competition of one kind. You are clearly not saying that, though. You are clearly saying it is not like competitive tendering in local authorities; it is more like best value, although we are not quite clear about how it is going to go. What we are not clear about yet is what you will do to prevent yourself from ending up like another Postcomm. You are aware that competition in the Royal Mail system, in the mail delivery system, has led to one major supplier—the state supplier, in that case—bearing the costs of the last mile for all its competitors. In pure competition terms, that does not happen normally. Tesco and Sainsbury compete, but Sainsbury does not ask Tesco to deliver its stuff. Given that clinical processes are fairly complex and often involve long-term treatment of a variety of kinds, how will you avoid ending up like another Postcomm?

**The Chair:** You will have to be fairly sharp here.

**Sonia Brown:** I go back to the fact that my expectation is that the majority of services that you are describing will be designated services and, in the circumstances in which a provider thinks that we have got the national number wrong—

**Q234 John Pugh:** Sorry, but not necessarily. You might have a clinical process such as a hip replacement—that is quite a good example—which might involve a range of different sections of treatment, only one of which is the operation side; the others will be physiotherapy and so on. If the private supplier or third sector supplier works from the assumption that the NHS will, as it were, pick up the pieces, you are into the Postcomm situation, are you not?

**Sonia Brown:** This is where we need to be clear that, in the future, tariffs need to reward the full costs associated with treating. Some procedures might well be more expensive and some groups of patients might well be more expensive to treat. We need a sophisticated tariff mechanism to differentiate between the two, and the Bill provides for the flexibility for that to be produced.

**David Bennett:** That is why pricing and competition—

**The Chair:** I am sorry, Mr Bennett, but we have one last question and then we have to call a halt, I am afraid. It is from Mr Smith.

**Q235 Owen Smith:** It is a question of where the buck stops where there are service reconfigurations. Let us take the example of a merger. You said earlier that the OFT and the Competition Commission have a potential role here. In the event that the OFT or the Competition Commission deems that there is a competition issue, who has the power to stop the merger occurring? In the event that there is not deemed to be a competition issue, but there is some other reason for not wanting a merger to happen, who has the power to prohibit the merger?

**Sonia Brown:** Who has the power to stop a merger from occurring? This is as Sue explained. In the first instance, it will be governors who need to support the proposal, because otherwise it will not get off the ground. If the governors support the proposal, there will be a check and balance in terms of the Competition Commission or the OFT checking that there is no potential harm to patients in those circumstances from a deterioration in quality as a consequence of the two organisations coming together. If the OFT or, more likely, the Competition Commission feels that there is harm, then it can put in place remedies to address that harm.

**Q236 The Chair:** Can I intervene? Not for the first time, and probably not for the last time, I will give the last word to Sue Slipman. Then we have to finish. We are committed to end this part of our session at 10 o’clock, and we have other guests who are coming to give evidence.

**Sue Slipman:** I think Sonia has outlined the position extremely well. As with the whole of the Bill, there is a system of checks and balances that needs to work to give comfort that will work in the patient interest. It is a check and balance that we will clearly need to see works properly.

**The Chair:** On behalf of the Committee, I thank all four of you for your answers to the questions. I am sure that a lot of what you have said will come back in this Committee over the next few weeks, and I am sure that you will wait with interest to hear what is said about what you have had to say. Thank you all for coming, and for the precise way that you have answered the questions.

10 am

**The Chair:** Good morning, gentlemen. Thank you very much for coming to give evidence to the Committee and answer our questions. I will not ask you to introduce yourselves or tell us too much about why you are here, as I think everyone in the room knows why you are here. We have a series of questions for you, and I invite Emily Thornberry to ask the first.

**Q237 Emily Thornberry:** As an opener, I will ask the question that I have been asking most of the witnesses. Do you think that there are any risks associated with this legislation? If so, can you explain what they might be?

**Richard Douglas:** The risk associated particularly with the legislation or with the public bodies element? On the public bodies element—sorry, I am losing my voice—and the wider legislation, the risks are those that you get in any transition—that you do not focus sufficiently on business as usual and lose capability at a time of change. Those are the risks that we in the Department are focused totally on mitigating.

**Q238 Emily Thornberry:** But do you not think that there are any other specific risks associated with this legislation and these changes—it is simply the risks associated with change?

**Richard Douglas:** Transition risks are the main risks.
**Sir Andrew Dillon:** I echo Richard’s point. It is an enormous organisational change—lots of people are affected, and some people, particularly general practitioners and those who work with them, are getting fundamental new responsibilities. There is inevitably risk associated with that, but the opportunity, particularly the opportunity of placing GPs, with their understanding of patients’ needs and their ability to create a dialogue with their colleagues in secondary care, in a new position is enormous and, in my view, outweighs any of the organisational risks associated with the change.

**Q239 Mr Barron:** On the issue of transitional risks, I have a question about costs. Most people think that the costs of transitions and reorganisation in the NHS adds to what is currently around. I wanted to ask Richard Douglas, given the position that you hold in the Department, about the issue of costs running alongside the efficiency savings outlined last year for the national health service. What do you think is likely to happen?

**Richard Douglas:** There will clearly be costs associated with change. The main costs are the ones that we have recognised are the likely costs of redundancy, but we would have had those costs anyway, to reduce administration costs to the system. We have to look at a third reduction in our administration costs across the whole system over the next four years. What the Bill and the programme of work that we are embarked on does is try to find the best way of delivering those administration costs savings, so that they are factored into our spending plans for the next four years, as are the benefits that we will get from that.

**Q240 Mr Barron:** Do you think it just makes the £15 billion to £20 billion savings more difficult to reach?

**Richard Douglas:** Well, it is part of the £15 billion to £20 billion to pay for it, so a large element of the £15 billion to £20 billion savings is a reduction in the administration costs across the system of 33%, which takes us down from about £5.3 billion to £3.7 billion. There would be a cost of achieving that reduction. It pays for itself very quickly.

**Q241 Mr Barron:** Do you have good evidence of that in terms of NHS? Do you think they have? You did not say yes.

**Richard Douglas:** I was just getting some water. One of the big differences we have got this time from where we have been with other changes is that we are taking tiers out of the system entirely, so things are going from the system—it is not just a reshuffle. The other is that we have set a very clear limit on the cost of administration in the system. What has happened before when we have made changes and made cost reductions, and what happened the last time we reduced the number of PCTs and strategic health authorities, was that we made significant savings in the first couple of years, but the cost then drifted back up again, so within about two years we were back to where we started. The big difference this time is that we have set very clear administration cost limits on the system that we, as a Department, actually cannot breach, so part of the spending controls that the Treasury now impose on us will require us not just to deliver those savings, but to keep to them and not allow us to drift back.

**Q242 Mr Barron:** I have question for Andrew Dillon. NICE will no longer make a judgment on the cost of new drugs and whether the NHS can afford them. Instead, the Government want to move to a value-based pricing system where they take a central role in deciding on price and, GP commissioning aside, if the local NHS can afford it. Given your organisation’s involvement in new drugs particularly over the past few years, will you retain responsibility to advise Government? What change will it have on the provision of drugs to patients? Do you think it will result in major changes?

**Sir Andrew Dillon:** The ambitions set out in the consultation document, and we are still in a consultation phase, are entirely laudable: to fix a price of a drug that reflects accurately the additional benefits it brings over current standard practice; and the plan calls for more transparency and more clarity in what the NHS regards as value for new treatments, so that there is greater predictability in the process for everybody. The consultation document indicates that NICE will continue to undertake an evaluation of the clinical and cost-effectiveness of the treatment and will set that out in a context that allows anybody to see the optimal use of the treatment in clinical practice, so we are still going to make our contribution to the process. It will still be possible for prescribers and the public to see just where a new treatment really scores in terms of additional benefit compared with what is available at the moment. We need to wait and see what the outcome of the consultation is to see the final arrangements and then to make an assessment of their ultimate impact.

**Q243 Mr Barron:** This is really a question for both of you, though you may not have direct responsibility for it at the moment. For many years now, there has been an argument that the pharmaceutical price regulation scheme has helped to sustain a large part of manufacturing in this country—drugs manufacturing exports total about £9 billion a year. Do you think that changing the way the NHS purchases from the pharmaceutical companies will change that? Do you think it will have an effect on our potential to keep a healthy part of the economy running?

**Sir Andrew Dillon:** The answer is that it is likely to be on a range of neutral to positive. It can be positive if it achieves the aim of the Government’s proposals—achieves our ambition of providing a clearer signal to the pharmaceutical industry about the sorts of products and the sorts of disease areas that we really want the industry to concentrate on. We have to recognise that the UK is a small component of any global pharmaceutical company’s market, but we are not unimportant. We are significant in lots of different ways, not least because of the status of the NHS and British medicine internationally, and to some extent the work of NICE, so we should not underestimate the impact. There is a real potential for having a positive impact on what the industry innovates in. If we are clearer with the industry about what we want, and we carry on paying a fair price for the products that it brings to market, it is a win-win.

**Q244 Margot James:** Sir Andrew, leading nicely on from the clinical and cost-effectiveness guidance that you are already producing in your organisation, can I ask how you envisage care pathways, which are going to be the next big thing, being taken up by GP commissioners?
Do you see it as being almost as ubiquitous as the clinical and cost-effectiveness guidance has been in the past? What are you expecting from Monitor and the commissioning board by way of enforcement?

Sir Andrew Dillon: The great thing about care pathways is that they display the evidence and recommendations based on the evidence for different forms of practice and lay out the options. Although that is actually what happens in most cases—there is rarely a single solution that fits every patient—they do that not just in a way that GPs and other health professionals understand, because it is how they go about their work, but in a way that we all understand, as we experience the evolution of the diseases and conditions that we are going to live with through our lives. It is a great way of doing the job.

From May, NICE is going to reorient everything that it produces along disease and condition care pathways. Everything that we produce for the NHS—the quality standards, which are a very important component of the new architecture that is being put in place; our work on indicators for the quality and outcomes framework and for the new commissioning outcomes framework; and our contribution to the commissioning guides—will all be laid out along those disease and condition care pathways. General practitioners, both as health professionals and in their commissioning role, can get very easy access to and can reach straightaway for the things that they need to inform the decisions that they take.

The relationship that we have with the Care Quality Commission is very good. We have worked very closely with it to make sure that there is a clear understanding about the distinction between its registration standards and the more stretching NICE quality standards that are coming out. We can work with the CQC in circumstances where there is a particular need to look at the performance of individual institutions or of the NHS generally, in relation to individual aspects of the service that is being provided, by giving it the opportunity to reach for the standard, the evidence or the guidance that it needs to reference its judgments on. There is a good relationship there.

The role of Monitor is, of course, changing fundamentally. Quality is going to become a much more important component of its work. Again, NICE can provide that evidence-based reference for the judgments that it needs to make, and we have a very good working relationship in place at the moment.

The Chair: Many Members want to ask questions. Have you got a supplementary, Margot?

Margot James: No.

The Chair: Grahame, is it on this point?

Grahame M. Morris: No, I wanted to ask Richard a question.

The Chair: I will come back to you, Owen, is it on this point?

Q245 Owen Smith: On a previous point about value-based pricing.

My question is for Sir Andrew. Given the complexity of introducing value-based pricing, and the extent to which it is very much understood to be a very difficult issue, are you confident that you will be able to get that resolved and agreed with the industry in time for your divesting your responsibility to provide cost-effectiveness advice to the NHS?

Sir Andrew Dillon: Yes, I think so. There is quite a long lead-in time. The existing pharmaceutical price regulation scheme does not run out until the end of 2013, and unless everybody thought that there was a great solution that could be put in place straightaway, which would obviously have to include the pharmaceutical industry, there is an opportunity to work this through, test it out and put it in place easily in enough time to convert or amend the current PPRS to take into account value-based pricing from the beginning of 2014.

Q246 Owen Smith: This is a very big change in your role, potentially giving you much more influence over pricing at the outset—at the beginning of the food chain, if you like—but giving you much less influence over prescribing practices. In some respects, NICE was set up to deal with irrationality in GP prescribing practices, but GPs will now be holding the ring and holding the money. Are you worried that you will see less rational prescribing when you have less influence over their activities?

Sir Andrew Dillon: I am not sure that this change will diminish the potential we have to inform the decisions of GPs and, indeed, other prescribers. I am pretty confident that the value-based pricing arrangements will contain the opportunity for NICE to express the optimal use of a treatment in clinical practice. Clearly, there will be an associated mechanism in which someone else makes a judgment about whether the offer price is reasonable and whether it stacks up against the additional benefits that a new treatment brings, but the key thing for patients is that there is a national point of reference to go to—we will continue to do this—where you can quickly understand what the new treatment offers and where it fits in with the other options that are available for the treatment and the sequencing of care that patients need.

Q247 Owen Smith: But there will not be the same obligation to follow your guidance in respect of prescription of medicines as there was hitherto.

Sir Andrew Dillon: That may depend on the view that the NHS commissioning board takes of NICE’s output. Of course, the board is not in operation yet, so we do not know what line it will take.

The Chair: We have nine minutes and nine questions still to be answered. Dan, you had something on this point.

Dan Byles: It has been covered.

The Chair: Fine, Liz?

Q248 Liz Kendall: Hello, Mr Douglas. I have a money question and a NICE question. David Nicholson made it clear in his evidence to the Public Accounts Committee that, in terms of finances, in the new world the buck
stops with foundation trusts. Does that mean that in the new world, when Monitor is an economic regulator and is not looking after the finances of FTs, it is up to the board, full stop, and there is no one else who can check? That is what I am worried about. I do not understand who will check that stuff is okay in terms of the budgets of the FTs.

Richard Douglas: The real focus will be on the board of the organisation itself. It will be responsible for living within the resources it has and using them to best value. There will be a degree of transparency about how it uses the resources, but the real pressure will be through the board itself.

Q249 Liz Kendall: Thank you. This is a question to Sir Andrew. The long-term problem is how we get the best health and other value out of the NHS budget. You did the guidelines and PCTs often implemented them, but sometimes did not because, they said, they did not have enough money. What will be the difference now with GPs being responsible? They still have to decide whether to implement your guidelines, so in that way it is no different—it is just up to GPs now. Is that right?

Sir Andrew Dillon: That is a really good question. There has never been immediate and slavish adherence to anything that NICE produces. The NHS does not behave in that way in response to national guidance—apart from national pay awards, of course, which are implemented immediately.

Q250 Liz Kendall: So it will now just be up to GPs?

Sir Andrew Dillon: We have to argue the case for the guidance that we produce, that it is in the interests of patients that GP consortia are responsible—

Q251 Liz Kendall: Just as you did with PCTs?

Sir Andrew Dillon: It is, by and large, the same job.

Q252 Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): Sir Andrew, you mentioned having an effective dialogue between primary and secondary care providers. How effective do you think that dialogue is currently? Could it be better, and how would the Bill help to improve it, in your view?

Sir Andrew Dillon: The easy but terribly unhelpful answer to the first question is that it is hugely variable, but of course it is. There are outstanding examples, sometimes across whole PCTs, sometimes in individual clinical areas, where the dialogue is really very good. Actually, what I think the GP consortia need to concentrate on is creating a dialogue at individual service level. Institutional mechanisms need to be put in place to allow GPs to do their business with their providers, but I think that a consortium would do well to concentrate on looking at how the clinical networks that have been put in place for different diseases and conditions in some parts of the country, and other networks such as the cancer networks that operate at national level, have worked. That is where you really can create a good dialogue, and it becomes much easier to introduce new technologies and new methods of working. It becomes easier to do things that are sometimes very difficult such as changing service configuration.

Q253 Debbie Abrahams: I would like to ask a finance question as well. We know that not all treatments and medicines have NICE guidance currently and that some, but not all, areas have effective use of resources groups, for example. How do you think that that will change with the Bill?

Sir Andrew Dillon: I do not think that the Bill itself will have a direct or immediate impact on the coverage of NICE guidance across the range of diseases and conditions that for which we will be responsible. The Bill talks about a catalogue or library of 150 quality standards; that will certainly cover a broad swathe of both health and social care—NICE will extend its responsibilities into social care under the legislation. Assuming that NICE continues, and it looks as though it will, we will continue to produce original pieces of work, and over time there will be very little in the way of routine clinical practice—concentrating on the NHS—that will not at some point be covered by some form of NICE guidance. Not everything needs to be, and we need to concentrate on those questions where there is real uncertainty—where either the evidence is equivocal, or there is variation in how the evidence is being interpreted. That, I think, is where we have been most helpful, but I agree that there are areas that we have not looked at yet. Learning disabilities would be an example, which given our responsibilities in social care might be a useful area for us to look at. We have not touched on that area, and it would be very useful for us to extend our working to it.

Q254 Debbie Abrahams: That relates to what Ms Kendall said about there being more opportunities for GP consortia to decide whether to apply NICE guidance, and to make their own decisions in the absence of NICE guidance.

Sir Andrew Dillon: Yes, but we have not just our own guidance but NHS Evidence, which is about the best single access to around 200 sources of evidence, which we quality assure. If people cannot get it from NICE, they will be able to get it from NHS Evidence.

Q255 Debbie Abrahams: Assuming that they want the evidence. What percentage of the NHS budget do you think will be spent on private health care providers by 2014?

Richard Douglas: We have not set a number. There is not an assumption because there is no plan to deliver a particular proportion.

Debbie Abrahams: Okay, I will accept that at face value.

The Chair: I do not think that we can pursue that much further today, Daniel, I apologise, did you have a follow-up question?

Q256 Dr Poulter: No, I have another question on setting national care pathways. What role do you envisage the royal colleges playing in that?

Sir Andrew Dillon: A direct and intimate one, just as they do at the moment, and will continue to do, in the development of NICE guidance. Those pathways, however they are created and whatever they cover, will need to be populated by evidence-based advice of one kind or
another. I very much hope that NICE is the first port of call for that, but critically, for anything—whether it is generated out of NICE or any other part of the system—to have traction in the system and have its effect it needs to engage and enthuse both the NHS professionals who are delivering care and individual patients and the organisations that speak on their behalf, which are important advocates for designing services locally. The colleges are an enormously important input into anyone’s work.

**Q257 Nick de Bois:** Mr Douglas, are you confident that the GP commissioners will be able to keep their management costs strictly under control, so that we do not get any threat of overspend? I am talking about the management portion of their budget.

**Richard Douglas:** Yes. A very clear management costs limit will be set for GP commissioners, based on a figure per head of population. With the structure of support that we are seeking for GP commissioners, with people drawing on commissioning support for organisations of various types, there is no reason why they will not do it within that limit, which will be firm.

**The Chair:** We have one minute. John Pugh.

**Q258 John Pugh (Southport) (LD):** Had we not had this piece of legislation, administrative costs of PCTs were going to be managed down by 30%. Is that right?

**Richard Douglas:** We were going to reduce the whole administrative costs of the system by 30%.

**Q259 John Pugh:** What was going to be the next saving after that and what were going to be the redundancy costs attached to that?

**Richard Douglas:** On the overall savings from it, costs across the whole system would reduce from £5.3 billion to £3.7 billion, which is roughly £1.6 billion. The costs of doing that depend on how much of that we end up getting done.

**Q260 John Pugh:** Is that a net saving or a gross saving?

**Richard Douglas:** That will be the recurring saving that will happen every year from the point at which it is implemented, so every single year in perpetuity.

**The Chair:** Thank you very much indeed. Apologies to Jeremy and Grahame for not getting to your questions. Thank you, Richard and Sir Andrew, for your precise answers and for the way in which the meeting was conducted.

10.25 am

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

*Adjourned till this day at One o’clock.*