Public Bill Committee

HEALTH AND SOCIAL CARE BILL

Fourth Sitting
Thursday 10 February 2011
(Afternoon)

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Examination of witnesses.
Adjourned till Tuesday 15 February at half-past Ten o’clock.
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Monday 14 February 2011

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The Committee consisted of the following Members:

**Chairs:** Mr Jim Hood, Mr Mike Hancock

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

† attended the Committee

**Witnesses**

Don Redding, Policy Consultant, National Voices
Paul Farmer, Chief Executive, Mind
Steve Ford, Chief Executive, Parkinson’s UK
Sarah Woolnough, Head of Policy, Cancer Research UK
Annwen Jones, Chief Executive, Target Ovarian Cancer
Jenny Bogle, Target Ovarian Cancer
Paul Jenkins, Chief Executive, Rethink
Cynthia Bower, Chief Executive, Care Quality Commission
Jill Finney, Director, Care Quality Commission
Sir Richard Thompson, President, Royal College of Physicians
Dr Peter Carter, Chief Executive and General Secretary, Royal College of Nursing
John Black, President, Royal College of Surgeons
Matt Jameson Evans, Co-Chair, Remedy UK

Right hon. Mr Andrew Lansley CBE MP, Secretary of State for Health, Department of Health
Right hon. Mr Simon Burns MP, Minister of State for Health, Department of Health
Paul Burstow MP, Minister of State for Care Services, Department of Health
Public Bill Committee

Thursday 10 February 2011

(Afternoon)

[MR MIKE HANCOCK in the Chair]

Health and Social Care Bill

1 pm

The Committee deliberated in private.

1.1 pm

On resuming—

The Chair: Good afternoon and welcome to our first witness. Thank you for coming to give evidence. It is a pleasure to have you with us. As we are very short of time, we will not have lengthy introductions. I hope that if you have anything to say about your own position on anything, you will engage us with that in the answer to your first question, which will be asked by Emily Thornberry.

Q261 Emily Thornberry (Islington South and Finsbury) (Lab): Having read your submissions, which have been very helpful, thank you, it is clear that you have concerns about the extent of public and patient involvement in the new structures as developed by the Bill. Could I give you a general opener and ask you explain in your own words why you are so concerned?

Don Redding: First, can I say that I am appearing on behalf of Jeremy Taylor, the chief executive of National Voices, who could not be here? I hope that members of the Committee are aware that National Voices, as well as working in its own right, is working with a group of seven other charities—you might have noticed the letter in The Times earlier in the week, but you will also learn that we are working together on joint briefings and amendments.

When the Government’s policy was drawn up in opposition and first published, it was presented with the tagline of putting GPs in the driving seat, which begged the question for those of us from the patient-centred care side of things as to where the patients were. A lot of that has been heavily addressed in the White Paper and related documents, and we strongly welcome the vision that is set out there. What we want to see is effective implementation.

We think that what we have in the Bill up to this point is not enough to put us alongside the driver as co-directors, or navigators, of our care and treatment and our health services. We think that we are probably still sitting in the back seat, commenting occasionally on the direction that is being taken.

Q262 Emily Thornberry: Enjoyable and colourful though this is, what do you want?

Don Redding: We want to be co-producers of services and of our care and treatment—in other words, public and patient involvement that is effective. We have a long history of its not being effective. We have a long history of token and meaningless consultations, for instance, with which everyone is fed up. We have a long history of interest in and building evidence for the effectiveness of involving patients in their own care and treatment, but a very slow trajectory for changes to the models of care.

This is a key moment for us because new bodies are being set up to procure services for us. It is a kind of Roger Daltrey moment: we do not want to get fooled again. We feel that it is our responsibility, in a sense, to push for the clearest guarantees of effective involvement and effective accountability of the services.

Q263 Emily Thornberry: So can you give us a summary in relation to healthwatch, for example?

Don Redding: With regard to healthwatch, there are two levels. First, at the national level, we want the HealthWatch England committee to be as robust, independent and effective as possible. That means understanding what the appointment process is; who are the people who are going to be selected to serve on it, and why; what the role of local healthwatch bodies is in putting people on that committee—they will strongly want to be able to elect or otherwise send people on to that committee as it represents a national focus for their interests—and whether it will have resources with which to conduct its own research to inform itself sufficiently about the views and experiences of patients and service users, in the way that some of the consumer bodies attached to regulators in other sectors would have a bespoke budget or resources.

At local level there are various places—some of them are covered in our briefing, and some you will find in briefings from the National Association of LINks Members, for instance—where things can be tweaked in the Bill, but a key overall question is not thinking that healthwatch is it, locally, in terms of involvement and accountability. It is not for either commissioners or providers to feel that they have sent something to the local healthwatch and therefore that is that bit done. We are looking, in particular, for much earlier involvement in the way that commissioning plans are drawn up and discussed, and the way that services are designed in a process of discussion and dialogue before the point when a commissioning consortium publishes its plan. That is what I mean: if you only comment on a plan that has been published, that is what I mean by being in the back seat, commenting on the direction. We want to be up front, putting those plans together with the clinicians and others.

Q264 Emily Thornberry: Do you have any concerns about whether the patients’ voice will by heard by a body we heard from before lunch, Monitor, which, speaking personally, sounded like a fairly scary body? Are you concerned about whether there should be any patient voice in relation to Monitor, or, indeed, the national commissioning board?

Don Redding: Certainly with the national commissioning board, and we cover that somewhat in our written evidence. With Monitor, we have not yet turned to that adequately, let us say. I notice that the NHS Confederation did touch on that. In general, the principle we would want to follow is that any body having a regulatory impact on services for patients and service users would...
need an orientation that is about promoting or safeguarding the interests of patients and service users, rather than just fulfilling functions on behalf of a system. I think that that is something that we shall watch as the debates develop.

The section on Monitor and economic regulation in general is difficult for us, but we are trying to crack it.

**Emily Thornberry:** Mr Hancock, I am happy to ask more questions, but in deference to other Members I hope that that is sufficient to get things going.

**Q265 Jeremy Lefroy** (Stafford) (Con): I am speaking really as the Member of Parliament for Stafford in relation to the Mid Staffordshire inquiry. I wondered whether you thought that the new arrangements for healthwatch were an improvement over local involvement networks, community health councils and patients forums, and that they would ensure that cases like Mid Staffordshire would be flagged up at a much earlier stage than that one was.

**Don Redding:** There are others more expert than I who can answer that question, but in general with the architecture of involvement and accountability across the Bill I think it would be wrong to place too much trust in any one mechanism. Many of these things are very welcome, and we are clear about the fact that we welcome what the Government are trying to do through the Bill, but it is a picture—a jigsaw puzzle of pieces of accountability, democratic scrutiny and patient and public involvement.

The good thing about what the Government are doing with healthwatch is that they did not throw out the LINks structures. They have said they will build on those, and that is very much wanted, because the structures of involvement locally have been messed around so much over the past decade or so. I think whether local healthwatch proves to be effective will, in large part, depend on how much resource it is given by the local authorities commissioning it. That may not be a concern, but it is a real concern. Authorities commissioning it. That may not be a concern, depend on how much resource it is given by the local healthwatch proves to be effective will, in large part, whether you thought that the new arrangements for healthwatch were an improvement over local involvement networks, community health councils and patients forums, and that they would ensure that cases like Mid Staffordshire would be flagged up at a much earlier stage than that one was.

**Q266 Jeremy Lefroy:** Thank you for that. Are you saying that the legislative framework is adequate—that it is just a question of how it is implemented, rather than there being any need for the proposed legislative framework to be amended?

**Don Redding:** Again, I think you will find that we have some detailed pieces of the picture that we might like to see tweaked for local healthwatch—I mentioned the one about being involved with consortia. We would also like to see stronger representation on the health and well-being board, because all our experience and all the experience of patient advocates is that if one of you is put on a committee, that is a recipe for being marginalised and isolated. Coming from the National Association of LINks Members, you will find a number of further ideas for strengthening the system, but I think the question of resources is going to be more crucial than anything else.

**Q267 Mr Kevin Barron** (Rother Valley) (Lab): In your written submission you said that the public will want, and I quote, “all NHS (and NHS-funded) bodies to meet in public and be fully transparent.” Their decisions and operations must not be hidden behind commercial confidentiality. Given that National Voices has been in operation now for more than two years, and we have had the independent sector treatment centres and NHS patients in BUPA hospitals and many others, have you had any experience in terms of talking to other operators within the NHS?

**Don Redding:** No, I cannot say that we can speak from that experience.

**Q268 Mr Barron:** Have you attempted to?

**Don Redding:** Not individually, no. It is more a point we have made in dialogue with the Department.

**Q269 Mr Barron:** I just wonder what is behind “commercial confidentiality”? It sounds as though you have been blocked off from talking about that.

**Don Redding:** No, I think the concern there—I recognise that we have not substantiated it very far in the rest of the document—is that, with the new system of economic regulation, we may find that there are many more cases arising where it becomes difficult to get information and transparent explanation from bodies because commercial confidentiality is cited. Obviously, that may well apply to new contracts made by the new commissioning organisations. We are concerned that, again to help healthwatch bodies to function effectively, they will need access to that kind of transparent information.

**Q270 Owen Smith** (Pontypridd) (Lab): On the same theme, I wonder what experience you can share with us about the extent to which you have been able to engage with existing foundation trusts? How have you found them in respect of transparency and willingness to engage with patients and patient voices?

**Don Redding:** I need to make it clear that, in general, National Voices works as a small organisation that is an umbrella for a lot of organisations. It works with national decision makers and policy makers rather than at the level of individual NHS trusts and bodies, so it may be that question is better directed to people who have been involved in LINks, for instance, in their negotiations with local trusts. I am sorry not to be able to answer.

**Q271 Emily Thornberry:** Although you have not given oral evidence about it today, I think you have views about lay representation on commissioning consortia as well. Could you use the time you have to explain to us why that is so important, and the relationship between that and the health and well-being boards?

**Don Redding:** If you want patients and the public to be able to influence decisions, the key place that they need to be is where the decisions are being made. In the Bill, you are establishing two types of totally new organisation, full of “new people” which are going to have the budget—£80 billion in the case of the consortia—to spend in the public interest. It is good to have healthwatch locally to comment, and it is good to have a duty to patient involvement and to public involvement, but those things in themselves are not sufficient for us to know we will have the opportunity to influence the commissioning decisions being made.

The Principia consortium that operates in Nottingham has a lay majority on its board, elected from members of the company, who are, essentially, the practice lists. Such a structure would provide us with the knowledge...
that there is going to be strong local oversight and involvement in actually making the decisions—not commenting on them before or afterwards, but giving legitimacy to what is done with the money.

To draw a parallel, we give an education budget to schools and we want head teachers to have autonomy to make the best educational decisions for children, but we do not expect them to do so according to their own whim or preference. We expect them to have a governing board. As the chair of governors for a primary school, I have experience of that. An estimated 300,000 school governors in the country do that job, representing parent bodies, communities, church foundations and so on in how the schools are run. The system brings value to that process and it would bring value to the process of commissioning health services. We think it is a glaring omission from the architecture of the Bill and the new reforms.

Q272 Emily Thornberry: Could you briefly give us your critique of health and well-being boards? A lot seems to have been put on them as being pivotal within local communities. As they stand, are you happy with their status?

Don Redding: Our view, I think, would be different to those who say that the boards are pivotal. We would say that they are another useful piece of the system. We want joint strategic needs assessments to be taken forward; we want the strategies to deal with such needs to be fully agreed between all parties in a local health and social care economy. The boards are not highly decisive, however; they do not have a lot of power, and we would not necessarily expect them to do so. We would much rather be closer to the seat of power, which is where the commissioning consortia and the commissioning board are making their decisions about how to commission services and how those services will be designed.

Q273 Emily Thornberry: Presumably, the health and well-being board will have a key role in integrating social care and health care services, if it works properly.

Don Redding: I think that really needs testing out. We are not Government lawyers, so we are not clear what the meaning of “encourage” is in relation to integrated working. We would like that to be tested. If it does not appear to us to be strong enough, we would like it to be strengthened.

Also—a key point, because having integrated services is one of the key things that would make the lives of patients, service users, their families and carers better—we would like to know from the Bill that there is a purpose for local bodies to work together. Studies such as that of the Audit Commission have found that simply having a process of working together does not necessarily deliver benefits for patients and service users—some pooled budgets might be saved, but where are the outcomes for those who use the services? We would like the purpose of integrated working to be specified as being “to produce integrated services”.

Patients do not want to get lost down the cracks, but it is a daily experience. Patients do not want to have to leave one service and then find that they have to fight their way into another, but it is a daily experience. Patients do not want their information to go missing every time. They do not want to have to stand up and battle for their own values and preferences every time they move from one professional to another. Integrated services are key to dealing with the Nicholson challenge, in particular in relation to long-term conditions, so it is win-win for the system. However, we have made very little progress on chronic care models in this country. National Voices has said, since before the election, that we would support sometimes radical changes to local services, as long as we can see that they are being made in a way that produces better outcomes and involves patients and service users in getting there.

That is where we are coming from on integrated services. The other thing connected to that is multidisciplinary commissioning, which in our view is much more likely to help to produce integrated packages of services. Multidisciplinary commissioning is overwhelmingly a concern for those members of National Voices which are groups dealing with specific, long-term conditions.

The Chair: I have to interrupt you there, Mr Redding, because we have one more question. Sorry, Emily.

Q274 Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): I want to tease out one thing a little more. You gave us an example comparing the role with that of school governors. There is perhaps a distinction, because one of the criticisms of LINk organisations has been that the people who get involved often have their own agenda and do not represent the general issues of concern to that part of the country or locality—the more general health care issues in an area. Often the people who get involved have their own specific medical agenda—

The Chair: Daniel, we have less than a minute.

Q275 Dr Poulter: I was just coming to the question, Mr Hancock. You were saying that you want to have people on the health and well-being boards. If that were the case, how would you avoid people taking a specific medical agenda and hijacking the board?

Don Redding: If the question relates to lay involvement in commissioning consortia, it is possible to elect or otherwise select people. In relation to the parallel with school governors, I am elected to serve on my school’s governing body by the parent body, which has a third of the seats on that body. The Principia model shows that this is possible with commissioning consortia and it will be tested further by pathfinder consortia in the next few years. We would like some provision for it to be there on the face of the Bill.

Q276 The Chair: Don, I am sorry to have to say it, but thank you very much for giving your time up today to give evidence. I am sorry that we impose these very strict roles on ourselves—self-inflicted wounds. I am afraid, because we agreed to this very tight time schedule. Thank you again, and I am sorry if you feel that you have not had enough time.

Don Redding: No, I appreciate the opportunity. Thank you very much indeed.

The Chair: I am very grateful that you came. I invite our next witnesses to come forward.
The Chair: Good afternoon and welcome. Thank you for giving up your time to come and give evidence this afternoon. As I have said all through today, we are working to a very tight schedule, so there will not be time for lengthy introductions or anything of that nature. Rather than invite each of you to make contributions at the beginning, if you have something specific to say, I would be grateful if you say it quickly when you are answering your first question.

Q277 Nicky Morgan (Loughborough) (Con): Good afternoon. I particularly want to direct my questions to Mind and Rethink, although I am sure that the others will have views. You probably came in at the end of the last witness session, when we were discussing multidisciplinary commissioning. I know that there is concern, which all of you probably share, that GPs are generalists—we heard that from Hamish Meldrum on Tuesday. GP may not have specific experience of certain conditions, particularly long-term conditions. What are your views on GPs being able to get expert advice when they are commissioning and how the Bill helps that? Also, what is the role of the third sector in providing those services, taking in multidisciplinary commissioning and “any willing provider”? I would be grateful for your thoughts on the involvement of the voluntary or third sector, particularly in relation to the conditions that you represent.

Paul Jenkins: That hits a really important issue. When the White Paper was published, we very much welcomed the commitment to “no decision about me without me”. For mental health and a whole range of long-term conditions, the involvement of people in their own care is crucial to getting good outcomes. The real focus of what we need to do, if we are going to get effective care pathways and save the NHS money, is to get secondary clinicians, primary care clinicians and patients, their representatives and their carers talking together. That is one of the reasons why we have been keen to strengthen some of the provisions on patient involvement in the Bill. We want to see a greater mandating of the need to involve patient groups as well as other professionals, and to use the word “involve” rather than just the phrase “seek advice from”, so that it is a two-way street and people are there as equals, not as being done to.

Paul Farmer: I agree entirely with that. Our starting point is that, when one in four of us in the population experiences a mental health problem, and mental health comprises such a high volume of the average GP’s workload, it is slightly surprising that GPs feel so nervous about commissioning mental health services. In a way, there is a key need to ensure that consortia are appropriately supported to give GPs greater confidence in being able to commission and support appropriate mental health services. It is particularly in the area of engagement with secondary care that the key issue arises.

There are two key questions about how the new structures will work. The first question is simply: how many consortia will there be? The numbers of people with a severe mental health problem will be relatively small if there are a very large number of consortia. The second issue, which touches on Paul Jenkins’ point, is the need to ensure that the advice is given by a range of different organisations. The work that we are doing with others to try to create some of that commissioning guidance will be really important. Any strengthening of the legislation to ensure that third sector organisations—as you heard in the previous session, patients are heavily involved in that process—will be important and will help to create a much stronger line.

To pick up on the point about “any willing provider,” we are willing, as organisations that provide services, but the key issue is the risk of fragmentation. That is where continuity, cohesion, anti-ordination of care are important, particularly for people with mental health problems, who often also have comorbid physical health problems. Their care journey is often very difficult. We set them huge tasks to help them find the right kind of care. Care co-ordination will be a key part of making sure, in an even more plural environment, that that works effectively and that we do not have a lot of wastage in the system.

Steve Ford: I think there is a real opportunity for commissioning to be improved and developed through using the expertise of patients, particularly people with a long-term condition who, over a number of years, have really come to know exactly what elements of service need to be put in place. In neurology, we have formed the neurological commissioning support service, which is effectively a consultancy of patient groups, who are able to sit round the table with commissioners and even to take over some of the commissioning. There are some real opportunities in the Bill to elaborate on what that kind of duty to involve patient groups means and to provide real incentives, so that patients, by informing the key commissioning decisions, are really at the heart of the process.

Sarah Woolnough: The first thing to say is that cancer commissioning it is not as good as it could or should be. The National Audit Office published a report on it, and in some ways there is certainly an opportunity to improve cancer commissioning. We have cancer networks that currently takes place within a very specialised environment. Multidisciplinary teams operate in specialist centres, and for ovarian cancer those are regional centres. We are not confident that sufficient expertise will be available at consortium level, and it is not clear where that expertise will come from or whether consortia will be mandated to follow any guidance. We would like to see a mandated care pathway that is developed with GP consortia, with clinical involvement from secondary care, tertiary care, the appropriate voluntary sector organisations and, most crucially, patients themselves.

Annwen Jones: In terms of the less common conditions—I speak for women with ovarian cancer, but my point covers many people with less common but life-threatening conditions—the real concern around GP commissioning and multidisciplinary commissioning is that the treatment of women with ovarian cancer currently takes place within a very specialised environment. Multidisciplinary teams operate in specialist centres, and for ovarian cancer those are regional centres. We are not confident that sufficient expertise will be available at consortium level, and it is not clear where that expertise will come from or whether consortia will be mandated to follow any guidance. We would like to see a mandated care pathway that is developed with GP consortia, with clinical involvement from secondary care, tertiary care, the appropriate voluntary sector organisations and, most crucially, patients themselves.

We are concerned about the loss of the one-year and five-year cancer survival measure, which was in the White Paper, but is not in the Bill. With specific cancers being identified in the outcomes framework that are not the majority of cancers—59% of people who die from
cancer die from so-called less common cancers—for people who have less common cancers we are concerned that the focus in primary care and commissioning will not be on those non-priority areas, but will be only on the big three, which are breast, lung and bowel cancers. There may actually be some retrograde steps, such as survival rates getting worse, not better, in cancers that are not covered. We are very keen that there is a clear outcomes environment in which the commissioning takes place, and also that a care pathway or services are mandated to protect those who have less common conditions, to ensure that outcomes improve for them.

**Jenny Bogle:** Speaking as someone who was diagnosed with ovarian cancer 18 months ago, I can tell you that when that happens out of the blue, you are physically ill, you have massive things to take on board, and however clued up you are, the last thing you want to start doing is quality controlling—trying to sort out which is the best hospital for you, or the best consultant, or the best treatment. You are not an expert, but you suddenly have to become an expert overnight. I am certainly convinced that I would not have been equipped to do that, and I am pretty convinced that my GP, who has seen very few cases of this, would have been in the same position. You just want to be confident that you are having the appropriate treatment. You do not want to have to start making complicated decisions. Choices about which hospital for convenience or whatever are fine, but what can be overstated is the ability of vulnerable people to be involved to such an extent and to take on what feels like a rather unfair responsibility to become an expert in a rare cancer overnight. Actually, you need urgent treatment. That is the priority.

**Q278 Nicky Morgan:** Jenny, that is very interesting, but on Steve's point: after 18 months, or whenever you feel ready, perhaps in a few years' time, given your involvement and understanding of the system—I am sure you would rather not have that understanding but you do—do you feel that your knowledge could help your GP to commission services, or that you could offer advice to other patients? That builds on what Steve was saying about how patients do want to be involved. There is a certain cynicism surrounding the Bill sometimes, and localism generally, that people do not want to be involved in their lives or their care. Actually, from what you were saying Steve, that is not the case with many patients, who would want to be involved, perhaps once their treatment has concluded.

**Jenny Bogle:** I think it varies from illness to illness. In my case, for instance, I have four months of chemotherapy starting next week. I will not be in a condition to start being a patient advocate, or whatever it is. Actually, from what you were saying Steve, that is not the case with many patients, who would want to be involved, perhaps once their treatment has concluded.

**Paul Farmer:** That is a really important question. In mental health, we have the primary example of this in access to psychological therapies. The mental health strategy was published last week and it gave us a very clear indication of both the state of progress on access to psychological therapies and the very welcome intention to complete that state of progress, so that there is a wider degree of access to a treatment that is very clearly NICE-supported. In fact, it is not just one single form of therapy that is available, but several forms, yet the reality is that people up and down the country continue to tell us that they wait six, seven, eight or nine months before they can access therapy. If you are a mother experiencing post-natal depression with a young baby, that is no joke.

It is important, first of all, to recognise that we are not sitting in a world in which NICE-recommended guidance is universally utilised, but I think that this gives us a really important opportunity to strengthen the hand and the role of those recommendations, so that consortia are able to make the decisions that lead to the people who need that help and support being able to access it. In the context of the mental health strategy, it sets out a very clear intention to increase the availability of support, but we really feel that the litmus test for this legislation needs to be how the strategy can become a reality for people on the ground in an environment where there is greater scope for choice and a greater degree of local determinism.
We would certainly like to see greater emphasis placed on NICE guidance in terms of not only the support and recognition that GPs should be giving to them, but the role that NICE guidance itself plays in commissioning. Quite often, NICE guidance is seen as a relationship between the individual and the clinician. NICE guidance needs to be absolutely embedded in the heart of the commissioning process, as well as in the heart of the individual.

Q281 Emily Thornberry: You have referred to cancer networks, but some people might not be entirely sure what they are—many of us know, but not everybody. I think it is important for that to be understood. It is also important to understand what the future of cancer networks might be in the light of what might happen under the Bill.

Sarah Woolnough: At the moment cancer networks tend to be funded by PCTs. They are virtual groups of people that cover geographic areas. They operate in slightly different ways across the country, but essentially they provide a valuable service to support commissioners and providers by providing expertise, and they are often where user involvement to support the commissioning process takes place. They have also done some delivery or have facilitated the delivery of cancer prevention initiatives, and they have supported early diagnosis initiatives in communities and so on. Their status at the moment is that the Government have committed to fund them for the next financial year, 2011-12, after which their future is uncertain.

Cancer Research UK would say that many of them provide a very valuable resource and offer expertise that is valuable and has helped to drive improvement. We do not want that expertise to be lost, but recognise that, structurally, things will change. It is a matter of how we ensure we keep hold of the expertise in the system. What we hear from cancer networks anecdotally naturally includes concern and worry about organisational change, and worry about the funding from now until April. With PCTs wanting to reduce headcount, that is an issue.

Where there are really good cancer networks, they are thinking about the future, about social enterprise status and how to make themselves most useful. An obvious concern is about potential inequality. In the areas where the networks are already very strong, they get their act together more quickly and continue to be the fantastic resource that they can be. In areas where they are less good, there is a potential vacuum.

I have a point about the question. We know that there has been significant improvement and progress over recent years, but our cancer outcomes are not currently world class. The key reason, we believe, is because we often diagnose cancer late. GPs have a critical role in improving early diagnosis and sorting out that issue. One of our concerns is whether the incentives are going to be strong enough. If you think about early diagnosis, we know that it is partly about raising awareness of signs and symptoms among the public and encouraging people to come into primary care. Then it is about getting GPs and other primary care professionals to get people appropriately and quickly referred for diagnosis and treatment.

One of our issues—also an opportunity—is that some of these functions will rest with local authorities and their responsibility for public health and cancer prevention, and some will rest with GP consortia. It is a matter of making sure that the incentives are strong enough to drive that forward. That links to a point that Annwen made. We are going to have to monitor this really closely. One-year cancer survival is a good proxy for diagnosis, but there is still lag time. We feel that the Government should be looking at staging data, the stage at which people are diagnosed, trying to shift things along the pathways so that we get people diagnosed at stage 1 and 2 more often.

We are also looking at the number of patients presenting with cancer as an emergency. The new cancer strategy published last month showed that 23% of cancer patients are diagnosed through an emergency pathway. We are all agreed on what we need to do. We need to keep our eye closely on the ball.

Emily Thornberry: May I ask a further question?

The Chair: I want to be fair to everyone. It must be quick.

Q282 Emily Thornberry: Given that you are the layperson here, Jenny, I wondered whether we had fairly given you an opportunity to say everything. Is there anything else you would like to say?

Jenny Bogle: It is related to what was just said. From my point of view, I had fantastic treatment, but it was largely a matter of luck. I feel strongly that that is a shame, although lucky for me. In my case, a strengthening of co-operation and co-ordination between experts was needed. Things very nearly fell over in my case when I was told by a specialist multidisciplinary team that I had inoperable tumours. By luck and happy chance, a friend paid for a second opinion. It happened that, after a bit of pressure, an NHS team literally two miles down the road was able to do the operation. That had a happy outcome and I had the surgery, but if my expert team in one very big hospital does not know what is happening just down the road, how much less likely is my GP to know what is going on? We need to strengthen the relationship between the centres of expertise and specialism, not do anything that it is going to make them work against each other or damage them by competition. That is a real concern from my own experience.

The Chair: Jenny, I think that point is not lost on the two Ministers sitting here. I am sure they will take that back.

Q283 Mr Steve Brine (Winchester) (Con): Jenny, I wish you well. You also gave evidence very well to the all-party group on ovarian cancer recently. Thank you for coming today. I was going to ask about cancer networks, but Emily has covered it so well. I spoke about them on Second Reading.

Sarah, you have two Ministers here and the Secretary of State will be here later. What would be your advice to Government to secure the safe transition of the cancer networks to consortia? I think that that is the nub of good cancer commissioning. There are, as we know, more than 200 cancers.

That was part one. The other part is really for Steve Ford. Nice to see you, Steve. We met before when you launched your Fair Care for Parkinson’s campaign. I pay great tribute to the work that you have done through
the Neurological Alliance. You have taken a really positive approach to embrace what the Bill is about. If you were launching Fair Care for Parkinson’s now, as opposed to when I first met you 18 months ago, what opportunity would there be for an organisation such as yours to work with consortia and see that the request that you made in that very good campaign had even more impact?

**Sarah Woolnough:** I think there is an issue, as I outlined, of transitional risk. There is uncertainty in the networks. One other piece of anecdotal feedback that we have had is that the pathfinder consortia that are being set up in their localities often do not match the areas that they are covering. There are lots of structural, organisational issues and uncertainties that they are having to deal with. Good communication out to them and an offer of help and support are required.

What has been mooted as a potential way forward is seed funding for some networks that move forward more quickly and think about social enterprise status and so on. Of course, there is a risk that the good ones get their act together more quickly and you exacerbate inequalities.

The other thing is to learn from the good practice that has been developed. Lots of people have said that the cancer network model could be applied to other disease areas, so let us make the most of the opportunity that we have to share best practice and learn from them—particularly, for example, in patient and public involvement, where many of them have done a wonderful job in helping redesign patient pathways for cancer patients.

**Steve Ford:** Our Fair Care campaign was effectively about inequalities. The NICE guidance states that everybody should have access to a specialist nurse, and 25% of people with Parkinson’s have never spoken to a specialist nurse, so it is about how we deal with that. I think our approach—and, I guess, the role of the patient groups—is two sides of the coin. One is to do everything we possibly can to support, advise, engage and make sure the mechanisms enable us to do that, but the second bit is about holding services to account and wanting those NICE standards to mean something.

We have invested in producing this evidence about what works. Any commissioner, whether it is a PCT or a group of GPs in the future, needs to be able to give a very explicit reason to their local community about why they have no intention of meeting that standard. What has been mooted as a potential way forward is mandating services—it is actually a good communication exercise for the whole of primary care and implementation and monitoring are critical. We have discussed accountability and how we can create pressure from the bottom up. Some of you sent a letter to *The Times* this week, in which you stated that you were concerned that plans to make GP consortia accountable to the public were “far too weak”; that the reforms would “allow local authorities to replace existing democratically elected overview and scrutiny committees with their own systems”; that you wanted the Bill to have a stronger “independent scrutiny function led by democratically elected representatives” and that healthwatch bodies would not have the “powers or resources” to ensure that patients’ voices were heard. It seems that you are saying that to get high quality for everyone, there must be much more accountability. Will each of you say one thing that you would like to see in the Bill to make such accountability real?

**Paul Jenkins:** I was one of the signatories to that letter. I would like to see that clear local authority scrutiny function, which should be clearly independent of those parts of local authorities that will be involved in devising the quality standard.
in health and well-being boards and in the commissioning of services. It should be linked with leadership from democratic representatives.

Sarah Woolnough: Cancer Research UK did not sign the letter, but we would say that it is critical to ensure that there is accountability between GP consortia and local authorities to promote early diagnosis, which can be achieved in various ways, but there should be a joint incentive to work together.

Q285 Mr Brine: I do a lot of work within the field of breast cancer. The screening programme has been phenomenally successful, but with 12,000 women a year dying of the disease, boy, do we have work to do. That is a classic role in which consortia and local authorities could work together—we need to do much better on our screening.

Sarah Woolnough: Absolutely. Of course, screening is a success story in many ways, but of course we can do better. Another point is that people trust their GPs. If a GP gives a brief intervention, be it about smoking cessation or another lifestyle activity, a patient will often listen—we have NICE guidance to that effect. We know currently that GPs and primary care are not as involved as they could be in cancer prevention and encouraging earlier diagnosis. The big push in cancer policy is making this happen, so we want the Bill to help make it happen, so we want the Bill to help make it happen. We think that in order to do that, you have to monitor what is going on closely and think about staging data and various other metrics, and you have to ensure that local authorities, health and well-being boards, joint strategic needs assessments and GP consortia are forced to work together to that end.

Q286 John Pugh (Southport) (LD): One of you—I forget who—said earlier that there was a certain nervousness on GPs’ part about commissioning mental health services. Can you say anything about the evidence for that and whether it applies to all mental health commissioning or only to severe mental health conditions? Do you think the remedy is to put somebody with psychiatric training—maybe a GP for whom that is a specialism, or a psychiatrist—on the GP commissioning board, given that mental health issues are very common?

Paul Jenkins: I think that is right. We collected some evidence from a survey of GPs that indicated that, compared with physical conditions, about half as many GPs—about 30%—were comfortable commissioning mental health services as were comfortable commissioning for long-term conditions such as asthma and diabetes. It is more significant with more severe mental illnesses such as schizophrenia, because those conditions are more complicated and less common.

The answer has to be that GPs must have a duty to involve secondary clinicians such as psychiatrists, service users and carers, because expertise comes from both ends of that spectrum. It would give a powerful message for the boards of GP consortia to have lay representation that included somebody with a mental health diagnosis.

Q287 John Pugh: On a second, related question, the PCTs have various statutory functions under the Mental Health Act to place individuals in time. That is obviously a highly mission-critical role. Are you clear about who takes over that role in the legislation, given that those people are potentially very difficult individuals?

Paul Jenkins: Not in total detail at this time.

Paul Farmer: To add to that, the Mental Health Alliance will be putting forward some comments on the specific amendments to the legislation, I think on clauses 130 to 139. It is important that there is clarity around discharge of duty in terms of the direction of travel. If the consortia are going to take those responsibilities, that would make almost essential your suggestion that someone with direct mental health experience should sit on those boards. It is a very serious duty that they have under mental health legislation. They are effectively the jailers of people with severe mental health problems, and that is not a task that should be taken lightly.

Q288 John Pugh: Do you anticipate GPs taking on that task?

Paul Farmer: There are only two ways that you can go: up or down. It is going to be a responsibility either for the commissioning boards or for consortia. In either case, it has to be discharged extremely carefully. The current logic would suggest that it is going to land with the consortia, but we will wait to see.

Q289 John Pugh: Would there not be a concern that a small GP commissioning body would not have the legal expertise or background to discharge that duty?

Paul Farmer: Indeed. That comes back to my opening remark about the size and scale of consortia. If we end up in a situation where there are, say, 100 consortia, that is a very different picture from if there are 500 consortia. Particularly on these kinds of issues, where highly specialised technical skills are required, you will then need systems that enable consortia to cluster together to provide that in a safe and effective way.

Q290 The Chair: Steve, I apologise. I missed it when you indicated that you wanted to comment on a previous question from Liz Kendall.

Steve Ford: It was on the issue of local accountability. Although we have to get the structures right, there could be real merit in articulating in more detail what the duty to involve actually means in practice. It is about a real cultural shift that means all commissioning decisions are involving local communities and patient groups within that, rather than just the political structures around consultation and big configuration type issues.

Q291 Mr Barron: I have a very short question for Paul Jenkins. On the issue of quality, you talked earlier about local authority scrutiny. It seems that the idea that they will be able to understand NICE quality standards is a bit difficult. Do you not think that the national commissioning board has a role to play to ensure that commissioning streams are done within these types of guidelines?

Paul Jenkins: Yes, but it is not an and/or; it is an and.

The commissioning board needs to police standards, so that local commissioning plans are delivering the outcomes in the frameworks and there is evidence that they are adhering to NICE guidelines, as Paul said earlier. Mental health has an appalling record of adherence to what are very well-respected and supported guidelines right across the piece.

Q292 Owen Smith: Sarah, research and development has been one of the fociuses of Government policy recently. They have tried to get the NHS to concentrate
on research and, hitherto, PCTs have held the funding budgets. What will happen to that research and who will pay for it? If it is GP consortia that will henceforth be involved with that, will they have either the requisite expertise or the interest to engage in R and D?

Sarah Woolnough: The Bill does not make clear what will happen. It is really the excess treatment costs that PCTs currently cover for clinical research. What we have said is that this urgently needs to be resolved. It could be GP consortia or it could be a proportion of budget taken from the NHS commissioning board that would cover excess treatment costs. What we absolutely want to happen is for research to continue to be championed in the NHS. Although the commissioning board has a duty with regard to research, we would like a research champion to be on the commissioning board. We would like a research champion—or somebody with a duty to promote research—to be on or involved with every GP consortium to ensure that we get the kind of support for research in the NHS that we think we need. The context is that patients treated in research active environments tend to do better. Cancer has been a real success story. Nearly one in six cancer patients are involved in a clinical trial. We are world leaders, so we have to ensure that we maintain momentum and continue to progress.

One other critical point relates to where we are not very good. We are not very good at getting trials off the ground quickly, smoothly and efficiently. The Academy of Medical Sciences recently published a report with some recommendations that have been broadly welcomed by the community. We would like them to be taken forward in parallel with the Bill. The most important matter is trying to solve the problem of NHS trusts duplicating because they are all having to approve trial protocols. That is ridiculous and delays trials totally unnecessarily and in a lengthy way. We want the Bill to take account of that and be an opportunity to get this right.

Q293 Owen Smith: So to bring it alive, the risk is that a patient will turn up at a GP's surgery with a cancer and the GP may not have—as would happen under current circumstances—sufficient insight into where the clinical trials that might be of relevance are going on. They also might not understand how to navigate the patient to those trials.

Sarah Woolnough: Then, it is a couple of different issues. One critical issue is that we know patients want to be told about research opportunities and want to be involved in research if they can be. We would like to make sure that patients have every opportunity to do so. Often that will be through primary care or early after a diagnosis. They want to be told about research opportunities. That is one side of it. The other side is making sure that, as we go through this big organisational change, we do not lose sight of the importance of research. We know that PCTs sometimes disagree with trusts about paying the excess treatment costs and I suppose that our concern would be that, in a time of financial constraint, research might not be at the top of a GP consortium's list as something to support. However, it has been critical in driving improved cancer outcomes, which is why we have highlighted it in our evidence.

Anwen Jones: I endorse everything that Sarah has just said. This is such an incredibly exciting time in cancer research, and we are seeing so many new approaches, particularly in targeted therapies. In ovarian cancer, we have not had any new treatments in more than 20 years. That is shocking, and it is one of the reasons why we have had such poor survival rates, with late diagnosis, of course, being the main reason. We would like some clarity on how we can protect the clinical trial process and how that will work. We strongly support the need for better information, but we would like to know how the funding for those clinical trials will work in the new environment, and where the decisions will be made.

Q294 Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): How would you define “meaningful consultation by a commissioning consortium”? How would you define that consultation with the public, especially in relation to lay representatives?

Jenny Bogle: I understand that there is an emphasis on patient choice, and obviously you cannot make a choice unless you have the information. It is different with different illnesses. If you need a hip replacement, you might want to shop around: some hospitals might be able to do it quicker and others might have more private rooms or whatever it is you are after. With a life-threatening illness, when you are very ill and need treatment quickly, you just want to be confident that you are having the right treatment. You do not want to have to start massive rounds of consultations, trying to get your GP, an expert and a commissioner in the room at the same time. I just cannot see that working, and I cannot see seriously ill patients being able to engage. The more vulnerable and the more ill you are, the less able you will be to do that sort of thing. It sounds fine, but I just do not know how it will work for individual patients. Particularly with a rarer cancer where there are a lot of us nationally, but on a local level the GP is possibly as ignorant as you are, I am not sure how it will work.

Paul Jenkins: At the wider patient group level, we think that it is important that there is some clarity about what is meant. We prefer the word “involvement” to “consultation,” because what the NHS needs to develop with patient groups is a long-term relationship. Consultation has the ring of a one-night stand about it, and what we want is the involvement of a longer-term relationship. Patients have important expertise to give and they want to feel that that expertise is respected and will be listened to over a period of time, having a real impact on decisions that are taken at the end of the process. It is important that, whether it is in the legislation or in the policy guidance that follows, there is some clear guidance about what kind of involvement “involvement” means.

Paul Farmer: I agree with that. The issue here is to be really clear. It is easy for there to be confusion between what goes on at two different levels. The first is between the individual patient and the individual clinician in the discussions about individual care, and there are key proposals on that in the legislation, which needs to take account of the balance between an appropriate amount of information being given and informed decisions being taken, especially when you have a genuine choice about the kind of treatment that you can pursue. The other level is how you ensure informed contributions from people who have had experience of particular conditions. The two who commented previously absolutely illustrated the need to have both, because they are part
of what needs to be a transformatory approach to how health care is provided, with the patients, both individually and collectively, running right the way up through the system.

One thing that we have heard a lot about in the discussion has been this “no decision without me” mantra. The strengthening in the legislation is still needed to make that real in terms of embedding it in the system. To take Paul’s analogy a little further, the relationship often takes place between managers and clinicians, between whom there are all kinds of rows and relationship breakdowns, and it is often the patients who do not get the chance to have a voice in that debate because the others are going at each other very strongly and forget about the patient. This is that opportunity to embed the patient experience right the way through the spine of the system, which includes patient representation on the commissioning board right through to individual quality and the ability to make informed choices on a personal level.

Annwen Jones: Dare I mention the big society? Certainly from a voluntary sector point of view, when we first saw the health White Paper it was quite exciting. There was a sense that the patient community could finally engage rather than be at arm’s length, and there would be meaningful participation either nationally or locally—specifically in terms of potentially being able to partner to deliver local services, whether that be on the early diagnosis front or the treatment front. I think there is a huge appetite, though not necessarily among individual patients. Naturally it depends on where they are within their treatment, and it is quite difficult with less common conditions to have an active patient involvement in every region, but it should be recognised that there are a lot of patients and groups sitting here waiting to participate and help improve outcomes. However, it is not clear at the moment how that engagement can take place.

One issue that we are really keen to pursue is an awareness campaign around the varying cancer symptoms—for example—under the national awareness and early diagnosis initiative. We are so keen to take advantage of the opportunities to improve outcomes under the new framework, and so concerned about the number of lives unnecessarily lost if we do not, that we are prepared to put up some money—but how do you engage in that way in this new system? There is an appetite, but what patients do not want is to be ultimately responsible for the success or failure of the system. It is a major reorganisation, a huge opportunity to make progress, but also a huge change, so there are risks. Patients do not want to blamed at the end of the day if and where things go wrong.

Q295 John Pugh: Would I be wrong in saying that research is being conducted which shows that very few of the pathfinders we have got so far actually have patient engagement plans, or have been asked about those plans?

Steve Ford: It is not something that we have been asked to get involved in, but we really want to. I have masses of information about every Parkinson’s service in the UK and I want to make that available to the system because I think that could really help to drive standards. Around this table there is all the information, and to have mechanisms within the system to involve all of that information could be incredibly powerful.

Q296 Margot James (Stourbridge) (Con): What do you consider the opportunities for patient organisations inputting into the system via healthwatch, and also the well-being boards at the local level? These seem to me to be a very valuable channel for patient groups to engage with the commissioning process.

Paul Farmer: They are both tailor-made, but I would go back to Paul Jenkins’s earlier point that, at the moment, there are no constraints around them. It will be important to embed patient voice into the structures of both health and well-being boards and local healthwatch, however you might want to describe that—whether it is directly through individual patients, or through patient organisations. The strengthening of the composition of those groups would really help. Many organisations have managed to stick with the various incarnations of patient and public involvement mechanisms. By way of example, in one of those mechanisms, the Commission for Patient and Public Involvement in Health system, which revolved much more round trusts, many mental health service users actually played a fabulous role in engaging with their mental health trusts and are actively engaged in wanting to continue. Some continuity would be important so that people receive the right training and the right support, but also to ensure that they are welcomed to the table.

People’s involvement has improved significantly in recent years, but often their experience of such meetings is being confronted with three inches of paperwork, with no explanation of how it was developed. The support available has been limited. We can look at the role that members councils and foundation trusts, for instance, in some parts of the country have taken in encouraging more direct involvement from patients and patient organisations. We want to see strengthening in the legislation that puts patients there as of right, but we also want encouragement for appropriate training and support so that the places are not just token.

Paul Jenkins: Healthwatch will clearly have challenges involving the harder to reach groups. Mental health service users have some patchy involvement in the predecessor bodies—some good, some not so good. It is important that we do not just have a system that leaves every local healthwatch to its own devices. HealthWatch England needs to have a really strong leadership role in setting standards for how to engage different groups and how to share information.

As we move to an information-richer era, there is an opportunity to use online channels to gather patient experience and information that can be at the bone of what HealthWatch England does in more effective ways than in the past. There is also a fundamental need to strengthen some of its role. I alluded to its input into scrutiny, but we must also give it a statutory commitment that it will have a role in commenting on local commissioning plans.

Steve Ford: I want to make a point about the difference between patient involvement and public involvement. We need to make sure that the system recognises that. This morning, I was with a number of people who have Parkinson’s, who would be desperate about getting involved in decisions about Parkinson’s neurology services, but would have less appetite and, to some extent, less energy to get involved in system-wide, trust-wide mechanisms for engagement and configuration of services. While we need those really strong healthwatch mechanisms, that
is just the tip of the iceberg. We need to make sure that every single planning group or commissioning decision involves patients as much as the public. That is an important distinction to make.

Q297 Grahame M. Morris (Easington) (Lab): I would like to ask a question about the elephant in the room, the price competition issue in relation to both cancer and mental health illnesses. As with many other types of care and treatment, we are all agreed it is essential that we have a co-operative and co-ordinated environment where patients get the most clinically, appropriate care. I wonder about your views on the introduction of price competition and an open market. Do you think that that would be the best way to achieve a co-operative and co-ordinated approach?

Paul Jenkins: From a mental health perspective, we already have price competition. There are no fixed tariffs for mental health services. It is not necessarily a bad thing. What needs to be fixed is the quality element. You can have price competition in quality that is fixed and transparent. Encouraging greater diversity in the provision of services, which has happened to a significant extent in mental health involving both the voluntary sector and the private sector, can be a good thing. The importance is the transparency of quality and avoiding fragmentation and cherry picking.

Sarah Woolnough: Just a couple of quick points, which are related. We know that excellent cancer services are well integrated, high quality and, often, cost-saving, so a big focus for cancer has been reducing a patient's stay and getting people back to their homes or in the community more quickly, which relies on integration and, of course, can be cost-saving and good for the patient. That is one point and, whatever happens, we cannot lose the focus on integration.

The second point, which applies to commissioning as well, is the critical importance of information as a driver: information for cancer patients about cancer, but also information about cancer services and the clinical outcomes that they are likely to see. There has been huge progress in cancer with the creation of such things as the national cancer intelligence network, and some really exciting data is coming out which will tell you things like how likely you are to get access to surgery for different types of cancer, depending on where you live in the country. This is incredibly powerful stuff. In commissioning and the provision of treatment alone, we need to shore up and support the provision of such data and information, so that the reforms can have the best impact.

Annwen Jones: The objective is that competition will drive up standards and improve outcomes. Clearly, the quality issue is absolutely central to all of that. Thinking about cancer diagnosis as an example, the increased access to diagnostics is incredibly good news for cancer patients, but will GPs access those diagnostics, and will they do so based on cost or clinical judgments? I think that some issues need to be looked at in terms of referrals and how services chosen. What safeguards will be in place to ensure that patients have access to the specialist services that they want and need and that they are not perhaps sent somewhere that is not such good quality but cheaper?

Q298 Emily Thornberry: That takes me to exactly the question I wanted to ask. If GPs are, essentially, generalists who hold the gate for people going to see the specialists, are you concerned about the possibility that, instead of a patient going off to the hospital and specialists there saying, "Right, the treatment you need for cancer is surgery here, chemo here, radio here, and in this order, let's get it done—chop, chop, chop," you have a generalist who has to commission all of that? Is that not problem No. 1? Problem No. 2: as gatekeepers with a budget, is there not a concern that GPs might feel there are times when they need to lock the gate?

Annwen Jones: Yes, those risks are there and we are concerned. We want to see provision in the Bill for managing such risk. In the past 10 years in cancer, with the reorganisation of services, we have seen significant progress in outcomes as a result of that specialisation. We do not want to see fragmentation happening as a result of considerations other than clinical need. Concern about that is real, and we want to see how it will be addressed.

Sarah Woolnough: I would add that if the incentives are right, that should not happen. If GPs are incentivised to improve cancer outcomes and if things are working well, of course that should not happen. However, to make one point about the support that GPs will need, I echo that the new resource for increased access to diagnostics is incredibly welcome. It will be complex to think the system through and think it out. We are starting from a relatively low base of knowledge in terms of baselines—what tests GPs order, and the wait time for test results, which varies hugely throughout the country—so GPs will need a lot of support to make some of those things happen.

Going back to my earlier point, we will have to monitor the system, because if it is about getting the incentives right, then we have to keep a close eye on whether it is working. For cancer, the lag time on something like five-year cancer survival is seven or eight years, so we will have to—it looks as though we will—keep a number of proxy measures, which means that we can performance manage what is happening and ensure that GPs are acting in the best interests of patients.

Q299 Emily Thornberry: So if we get it wrong, people could be dying and we would not know fast enough?

Sarah Woolnough: Certainly I think one of the roles of cancer organisations will be to monitor very closely what is happening and keep an eye on things.

Paul Farmer: There are three key elements. There needs to be condition-specific guidance that is based on the best practice around, so that clinicians can make the best possible decision at the start. Secondly, there needs to be real-time outcome monitoring, which is particularly focused on the role of the provider in providing the services they are supposed to.

Q300 Emily Thornberry: Who will do that monitoring under the Bill?

The Chair: We have to be very quick on this.

Paul Farmer: Well, a care co-ordinator, particularly for people with long-term conditions is a key part of how those pathways could be provided. Briefly, thirdly, there needs to be a retrospective clear assessment of the impact of a particular provider, as well as in terms of outcome data. We need to ask whether they are actually delivering the quality treatment and saving lives.
Cynthia Bower: Since the publication of the Mid Staffordshire inquiry, an enormous amount of work has been done, both formally and informally, to establish a relationship between Monitor and the Care Quality Commission. At one level, we have a memorandum of understanding that shapes our relationship, which we are reconsidering at in light of the demands of the legislation. We have a formal agreement with Monitor about a standard of quality—a threshold—that trusts must meet through the authorisation process to become foundation trusts, and we have formal and informal meetings with it to share our concerns about trusts we both regulate. There is a clear understanding that if we have concerns about the quality of care in trusts, they are shared with Monitor through its compliance team and my operations directorate. We meet extremely regularly.

Q305 Jeremy Lefroy: If I may, I will just follow up on that. One witness this morning talked about the importance of so-called soft intelligence, which comes not necessarily from official organisations, but through patient groups or even MPs. How do you see that feeding into the work of the Care Quality Commission, both in your normal work of reviewing quality standards in trusts and elsewhere and in approving foundation trusts?

Cynthia Bower: We have something called an equality and risk profile on every organisation we regulate, and particularly NHS trusts. The quality and risk profile holds all the information that we have about a particular provider. In NHS terms, that can be a lot of quantitative information, which trusts submit as part of their normal process of dealing with patients. We take information from things such as the Dr Foster unit at Imperial on mortality outliers; we have our own outlier programme that looks at that as well. More particularly, we have developed pro formas for local involvement networks and for foundation trust boards of governors to upload information to our system, so that they can tell us about work they do and concerns they have about quality of care. We regularly look at websites, such as Patient Opinion or NHS Choices, to see what is said on the web about individual hospitals.

We are also developing digital tools that allow us to search a large amount of quantitative information about what patients say about quality of care. Obviously, we do not deal with complaints, but patients write to us regularly about their experiences of care. All that is fed into our quality and risk profiles. The inspectors on the ground use those risk profiles to make judgments on whether they need to do an inspection or to seek further information about the quality of care. We have a constant process of monitoring, which allows us to look at whether we have information that a trust may not be compliant on the standards of care and there is therefore something for us to worry about.

Q306 Jeremy Lefroy: To follow up on that, since MPs are often at the forefront of getting information from constituents, would it not be a good idea for MPs to be included in those quality and risk profiles, or at least feed into them?

Jill Finney: If we receive a letter from an MP to our private offices, we would feed that into the quality and risk profile. We can take intelligence from any source directly into the quality and risk profile. We can put that formal arrangement in place very easily.


Q307 Jeremy Lefroy: Does it happen now?

Jill Finney: It does happen. If an MP writes in, it goes into the quality and risk profile, so, yes, it does.

On your other point about the regulators working together, one point worth understanding is that, in a sense, as the three new regulators emerge—the NHS commissioning board, Monitor and CQC—we are setting up a completely different culture. Those regulators are almost growing up together through the new changes. They will work together from the start, as opposed to being forced to work together at different stages.

The other thing is that during the time of the Mid Staffordshire issue, Monitor and the Healthcare Commission were relying on periodic data—data that had been made at a point in time. The reason why the dialogue has to be continuous now is that we update our own systems continuously, so in a sense there is an ongoing dialogue because there is a permanent information flow that changes the picture.

Q308 Mr Barron: Your organisation and Monitor will also be responsible for operating a joint licensing and registration scheme. Are the roles of the two organisations accurately defined in terms of what they have to do? Will you be equal partners, or will one organisation have greater authority than the other?

Cynthia Bower: From my point of view, we will be equal partners. There is very little overlap now in the role of the Care Quality Commission and Monitor, so the compliance regime that Monitor currently operates will go over a period of time as foundation trusts move to maturity. Monitor is very clear that it is dependent on us for information about quality of care, so we are not treading on one another’s toes, so to speak. We are very clear that we have a different remit. We give Monitor information about quality, and it uses that at the moment to take regulatory action against foundation trusts, but it will also use the information as part of its licensing process.

Q309 Mr Barron: It is Monitor’s licensing process, so do you assume that it will have the upper hand in this?

Cynthia Bower: Not at all. It is absolutely clear that, in terms of licensing the remaining NHS trusts to become foundation trusts, there is a quality threshold that we have established with Monitor. Both organisations are clear that if a trust does not meet that threshold, it will not be licensed.

Q310 Mr Barron: We understand that the licensing and registration scheme will have a single application form. Is that correct?

Cynthia Bower: We are working on that now.

Jill Finney: We are.

Q311 Mr Barron: Who is working on it—both organisations or just you?

Jill Finney: No, we are both working on it together. We have the administration processes in place at the moment, so we hope to be able to leverage our administration processes so that Monitor does not have to build separate processes.

Mr Barron: So effectively you have a joint operation?

Jill Finney: Exactly.

Q312 Owen Smith: We heard this morning a surprising amount of agreement that price competition tends to drive down quality in health care. What is your view of that evidence?

Cynthia Bower: Our fundamental job is to look at quality of care and to be uncompromising about that. Part of what is clear to us, particularly in terms of our future relationship with Monitor and with economic regulation, is that the system is clearly set up so that we are not there to make judgments about the finances of an organisation above and beyond the organisation’s financial ability to continue providing a service, which, particularly in social care, we examine at the start of our licensing process. Other than that, we are deliberately set up to be indifferent to issues of money. We are there to establish whether or not organisations meet essential standards of quality and safety. That is our job. In “The state of health care and adult social care in England” report, which we published in 2009, we made a number of comments about the way in which, for example, the NHS could be more efficient and therefore save money through things like lengths of stay, delayed discharges and so on, so we have commented on value for money in terms of the NHS, but the Bill removes our specific responsibility to make comments on value for money in the NHS.

Q313 Owen Smith: With respect, can you afford to remain indifferent to the impact of price competition, given that it is being introduced for the first time and that all the evidence seems to show that it drives down quality? Even the economic regulator seemed very wary of accepting that it has a role to play.

Jill Finney: What we cannot afford to do is ignore whether essential standards of quality are being met or not. That is our remit. If they are not being met, we have to say, “That is a matter for you to take up with the commissioner.” It is not our job to intervene in the price negotiation between the commissioner and the provider.

Q314 Owen Smith: What would happen in the event of your discerning that price competition was impacting upon quality? To whom would you articulate your concerns?

Cynthia Bower: If we believe that a provider service is not meeting essential standards of quality, we will take action against that provider. Our debate is not with the commissioners, but with the provider. Our discussion is always with the provider and about what it needs to do to become compliant. To some extent, this happens in social care to this day: if the provider is saying, “The commissioner is not paying to a level at which we can afford to deliver the appropriate level of quality,” we have to say, “That is a matter for you to take up with the commissioner.” It is not our job to intervene in the price negotiation between the commissioner and the provider.

Q315 Nick de Bois (Enfield North) (Con): Can I clarify this point? Your concern is the quality of care. Whether it is done for less or for more is not really in your remit, because you are only going to draw attention to where you think care is either failing or succeeding. Do I understand correctly?

Cynthia Bower: Yes.
Q316 Nick de Bois: So, with you, we should focus on that. If you are satisfied that care quality is at a high enough level, we will be succeeding in improving the quality of care and hopefully outcomes. Is that a fair summary?

Cynthia Bower: Yes.

Grahame M. Morris: Could you clarify a point that has been raised by my colleague, Tom Blenkinsop in relation to your role in assessing the standards of providers? Is it not true that providers can be commissioners as well? For example, from responses to parliamentary questions, it is clear to me that applications may not be only from GPs in consortia but from private companies. I have not seen anything to contradict that. Is there a conflict of interest there? It could be that a private health care company is a provider and also a commissioner. How will you deal with that?

Cynthia Bower: The law that relates to us is absolutely clear. It is set out in law what services you have to be registered to provide. The law is very clear: it describes a range of services; if you are providing them, you have to be registered with the CQC to legally provide those services. At that level, there is not a conflict. I can see that, from the public’s point of view, there might be a conflict of interest if you are paying yourself to provide services. From CQC’s point of view, it matters not one jot. What matters is that the service you are providing comes into our ambit, because it is a regulated activity under the Act, and you are providing services for that level of quality. We deal, as did our predecessor organisation, the Commission for Social Care Inspection, with local authorities as both providers and commissioners of services in adult social care, so we are accustomed to dealing with that.

Q317 Liz Kendall: Throughout your experience of trying to determine whether a minimum standard of quality has been provided, can you reach any conclusions about the kinds of organisations that have failed to do that and their problems are? I know it is a massive question, but are there any two or three key problems that you found in providers that have not met standards?

Cynthia Bower: From my point of view, the most obvious problem is the standard of management. I know that we are talking about the NHS, but in social care, for example, we are absolutely clear that the quality of the registered manager of a social care service has a fundamental impact on the organisation’s ability not only to meet the essential standards but to engage with patients or service users and offer a high standard. We are constantly looking at that. When we make a judgment about quality concerns, we also make a judgment about our confidence in that organisation’s ability to improve services. Poor care happens all the time in all sorts of circumstances—people make mistakes. The general point that I would make is that we look to the managers of that system to make sure that people are given the optimum opportunity to deliver high-quality care.

Jill Finney: Also, you can have a prevailing culture—a culture that begins to tolerate poor performance. Mid Staffordshire is a good example of that. People do not necessarily understand where the benchmark is any more, because they have learned to live with low performance.

Q318 Liz Kendall: It is clear from previous evidence that under the old system, Monitor, strategic health authorities sometimes and others were able to intervene on poor management in hospitals. Now that Monitor will become an economic regulator, FTs will be stand-alone entities. David Nicholson said that the buck stops with the board; Sue Slipman from the Foundation Trust Network said it is up to the board of governors. What checks and balances are there on the people you know are crucial to ensuring quality?

Cynthia Bower: That is one of our concerns. We have tried to develop a system. In the wake of the Mid Staffordshire inquiry, we have tried with many others to develop a system where there is no overt co-operation between the different players. Our key partners at the moment are the compliance team in Monitor, the strategic health authorities and the Department of Health’s performance team. We are very conscious that other players—the GP consortia, the health and well-being boards, HealthWatch, local healthwatch, the foundation trust boards of governors—will have to step up to the mark in a very different way.

We are already having discussions with the pathfinder GP consortia about what information we are able to give to them, for example, though the quality and risk profiles, so they do not go off and commission expensive work from elsewhere. We can supply them with a lot of information. Certainly, we have local managers on the ground who will be working rapidly to develop relationships at local level. That is our issue, yes.

Q319 Liz Kendall: Let me clarify. Normal routes for intervening on boards—the performance unit in the Department of Health and SHAs—are going; under the new system, it will be down in the end to GPs and local authorities. Following from that, do you often receive formal or informal complaints—soft intelligence—from GPs about poor-quality hospitals?

Cynthia Bower: No, we do not receive information at the moment from GPs about poor-quality care. That information might be mediated through other groups to us, but we are not conscious of that.

Q320 Nicky Morgan: From whom do you receive information? We talked about patients. Your predecessor was the CSCI, and CQC has been around for a couple of years. Are there any lessons you have learned, either from Mid Staffordshire or elsewhere, for the way you handle risk and information gathering that you would like to share with the Committee? Perhaps you could explain your inspection regime. How often do you check providers? Do you wait until you are prompted by a series of complaints, or do you have a regular monitoring schedule—a bit like Ofsted with schools?

Cynthia Bower: One of the crucial lessons from Mid Staffordshire was about the voice of the user and how it was not heard, or heard effectively, through that process. There were also problems of co-operation between regulators. From our point of view, there was also the length of time that the investigation into Mid Staffordshire took, while many patients were still going through the hospital unaware of the issues about care that were being raised elsewhere.

We have tried as a regulator to put the user voice centrally into what we do. We gather information from LINks and from foundation trust boards in order to
understand and enrich the information that we have. We certainly get information from those sources, and we work a lot with LINks, so they understand how they can work with us effectively.

If we have reason to believe there are compromises in the quality of care in an organisation we have an inspection process. Again, inspections were not really part of the Healthcare Commission's work. Learning from Mid Staffordshire, we made learning from conducting inspections a central part of our intelligence gathering about organisations. We are clear when we do inspections that our first priority is to observe patient care and to talk to front-line clinical staff, patients and their carers. We use that to enrich the information that we get. We use that information to make judgments about what action we believe the organisation needs to take to improve care. We can either ask them to improve care or we can demand that they take certain action to improve care, because we have enforcement powers.

Throughout the process of developing the way in which CQC is going to operate, we have had two things very much at the forefront of our minds: first what we can learn from Mid Staffordshire; and secondly, how we can not only put users at the centre of our information-gathering exercises but also make them recipients of the information that we give and get information into the public domain as quickly as possible.

Jill Finney: It is also worth saying that we have a large call centre which takes information directly from the public, but which also prioritises all safeguarding and whistleblowing calls. We receive a lot of whistleblowing calls, which we take very seriously, and safeguarding calls.

Q321 Nicky Morgan: The whistleblowing calls are presumably from health professionals within the service.

Jill Finney: All the time.

Q322 Nicky Morgan: Are they anonymous?

Jill Finney: There is a variety, but we receive a lot of calls and we do take action.

We also have arrangements with organisations such as Age UK. There are some charitable organisations that we think have the closest relationship with care. They feed intelligence into us directly and we put it into the quality and risk profile that Cynthia described. That sort of intelligence, like whistleblowing or distressing information, has a higher weighting in that profile. Not all the information is treated equally: some pieces of information have much greater priority than others, and that information is pushed to our inspectors. They receive it as an alert, and are accountable for explaining what action they take as a result.

Q323 Nicky Morgan: So there is no schedule. Do you wait for something to become a problem?

Cynthia Bower: Sorry, I recall that you asked a second question. We do two sorts of reviews. Many of our reviews are exactly as you say. We do responsive reviews on issues that have been brought to our attention, and between April, when we began to work with the NHS on issues that have been brought to our attention, and August, we conducted 52 responsive reviews in NHS organisations. We also are carrying out a process of planned reviews of compliance, and we have said that every two years we will take a look at every quality standard in an organisation and ask, “Are we confident that this organisation still meets those standards?” We might then follow that up with an inspection, or we might not because we think we have enough information, but that is the model that we use.

The Chair: We have two more people who want to ask questions, and we have roughly three minutes, so short questions and short answers please.

Q324 Mr Barron: Have you had any discussions in the past two years with the Government about whistleblowing?

Jill Finney: I would say that we would advise them when we were talking about the performance of trusts and when we had received whistleblowing calls as a source of intelligence.

Q325 Mr Barron: You have not looked at the current regulations and how things operate here compared with other parts of the world.

Jill Finney: No, we have not.

Q326 Owen Smith: I have two short, specific questions. How many inspectors do you currently have, and how many new institutions will you be called upon to inspect under the new arrangements?

Cynthia Bower: We have approximately 900 inspectors who between them are doing registration work and ongoing compliance monitoring, with the vast majority doing the latter. By the end of the process of bringing all providers into the regulatory system, there will be about 30,000 separate organisations, including NHS trusts, independent health care organisations, dental practices, GP practices and adult social care, and between them they will probably run about 40,000 services. We expect each compliance manager to have a case load of about 50 providers to regulate.

Q327 Owen Smith: Are you therefore increasing the number of inspectors?

Cynthia Bower: No, it will remain the same.

Q328 Debbie Abrahams (Oldham East and Saddleworth) (Lab): Bearing in mind that patients are not an homogeneous group, how do you take into account the different experiences of patient populations in assessing the quality of a provider?

Cynthia Bower: I will give you two quick examples. First, we have a contract with a university—Central Lancashire, I think—to work with hard-to-reach groups such as travelling communities. The university maintains for us local groups of hard-to-reach communities, who we then work with to consult on various pieces of work that we are doing. That infrastructure offers us general support and advice in our work as a regulator, and we then have a range of tools for when inspectors go into organisations. For example, we have the short observational tool, which allows us to observe the care of people with dementia in an organised fashion, so that we can understand the experiences of people who perhaps cannot communicate with us in straightforward ways.
Jill Finney: Also, we work with what we call experts by experience. We take out an expert with us on an inspection visit of somebody who may have experienced a particular circumstance, so that when they go with us, they can view that service through the lens of that sort of person.

The Chair: Right ladies, that was a splendid session. I would like to thank you, Jill, and you, Cynthia, for your time and the effort that you put into answering the questions so speedily and correctly. Thanks again for your help.

2.55 pm

The Chair: Good afternoon, gentlemen. I do not know how long you have been in the room, but if you have seen the format, it is pretty tight for time. I urge Members to ask short, sharp questions, and I ask you to indulge us by giving us short, sharp answers where possible. If you want to add anything by way of a statement on your feelings on this, if you can do so in answer to the first question—that will be fine. I agreed earlier that we would indicate who would ask the first question, and on this occasion it was Grahame Morris who asked to ask the first question.

Q329 Grahame M. Morris: Dr Carter, we have met before, as you have given evidence on a couple of occasions to the Health Committee. I want to refer to your evidence—I thank you for submitting it to this Committee as well—as you said that “efficiency savings could negatively impact on the quality of patient care”.

You went on to say:

“In May last year the average waiting time was nine weeks. Our concern at the moment is that short-sighted false economy will end up costing the public money and result in patient care going backwards.”

My question is: who benefits most from the reforms as set out in the Bill? Is it nurses, patients, the taxpayer or private health companies?

Dr Carter: Ultimately, Mr Morris, it should be patients—the public. Of course there are other organisations and component parts. Our concern is that the £20 billion, which is 4% a year for four consecutive years, is something that has never been asked of any public sector organisation. Blue chip companies that were making profits would struggle to do that. The evidence that we have is that because people are under pressure to do this, they are taking short-term, short-sighted measures such as blunt instruments—recruitment freezes—which ultimately do not demonstrate intelligent thinking. We want to see a more efficient NHS and we want to see money spent better, but the evidence from some trusts—not all—is that this is not well thought through.

Sir Richard Thompson: The combination, as the British Medical Journal said last week, of trying to make these huge savings, while at the same time completely reforming healthcare, is deluded. It is extremely difficult to make these savings quickly at the same time as all these changes.

Q330 John Pugh: There is a conundrum here, isn’t there? In a sense, many people who have spoken to us have rather liked the idea of adding to the GP commissioners, and some of you have put in representations, which say that secondary care should be part of the commissioning process, and that there should be a clinical commissioning panel, rather than a GP commissioning panel. There is another thought, which obviously crossed the minds of Ministers, that one of the objectives of having greater efficiency is to make less use of the secondary care sector and hospitals. There therefore does not seem to be an easy solution to how you can achieve good clinical input and, at the same time, involve the secondary care sector. It might get you a nice clinical network, and it might work seamlessly, but it would not have those strong drivers to reduce the number of hospital admissions. Could you comment on that?

Sir Richard Thompson: That is a very interesting point. We are very keen, as you have correctly picked up, that secondary care clinicians, nurses, public health and social services all sit round the same table, and actually at the top table in the consortium. Otherwise, in certain areas of the country there will be a turf war between the providers, or a very powerful single provider, and the GP consortia. I prefer, as you say, the teams without walls, which we have written about that, and to get rid of the barrier between primary and secondary care. We call that “commissioning without walls,” where we are all together around the same table and doing that. I hope that very sensible decisions will then be made, as you say, between the balance of secondary care and primary care.

Q331 John Pugh: How do you stop a cosy relationship taking place, where nobody ruffles anybody else’s feathers and there are no strong drivers to reduce hospital admissions?

Sir Richard Thompson: If clinicians and nurses who run all-round social care are all round the same table, it will not be cosy. They will be discussing how we can keep within budget and change services round, and where the evidence is that something could be improved. I see the one positive part of the Bill that that could, in fact, work extremely well. Otherwise, I think there will be areas where there will be a turf war.

John Black: At the Royal College of Surgeons, what we are anxious to see—and would love to see in the Bill—is the necessity in the national commissioning board for clinician advice. By that, we mean practising clinician advice, not people with medical qualifications working in the Department of Health or in public health, but real working clinicians.

We are slightly concerned about the gap between national commissioning and local commissioning by relatively small groups of GPs. National commissioning is fine for rare diseases, where you need two centres in the country, but at present there is an awful lot organised on a regional basis that GPs do not know enough about, because they do not see enough patients. In my area, for example, cardiac surgery, neurosurgery and children’s surgery are organised for a population of about 5 million. No GP collective, unless it is very much bigger, is going to be able to do that. We hope that the national commissioning board, with appropriate clinician advice, will fill that gap on whatever sort of sub-national level is decided.

Q332 John Pugh: On a point that Sir Richard made, another thought has occurred to me. A further problem of the model that you are suggesting is that you would
be sitting alongside the GP as a commissioner, but you would also be sitting at the other end of the process as a provider.

Sir Richard Thompson: And so would the GP.

John Pugh: Not in quite the same way, I think.

The Chair: I think that that is more a debate for the Committee at a later stage.

Q333 John Pugh: You are saying that there is essentially no difference in the situation.

Sir Richard Thompson: There is very little difference. I think that they would get together and improve services together. On the whole, clinicians sitting together produce solutions.

John Black: I have done that before, as a trust medical director talking to fundholding practices, so the model exists.

Dr Carter: We have a better chance of that working if people are in it together, rather than in different areas and competing with one another. I understand the concerns about the conflict of interest. It is a bit of a caricature that people would be self-interested. Most clinicians—and I use “clinicians” in a generic sense—have the interests of patients at heart.

Q334 Owen Smith: I take your point about wanting to see greater integration between primary and secondary care, Sir Richard. Do you think that there is a danger that, once we have introduced a greater degree of competition and competition law in particular, that lawyers might intercede and that that might increase the distance between primary and secondary care?

Sir Richard Thompson: I do. I suspect the private companies are circling around and waiting to get in on the act, both on the management side and in taking clinical services, which will be extremely damaging. I do not believe that that sort of competition works. You can have two tobacco shops working side by side, and one goes under and one goes up, but you cannot do that with hospitals, because you cannot allow a hospital to shrivel. I do not believe that competition works. I always say that the harder you work in the health service, the more money you spend, and the harder you work in Marks and Spencer, the more money you make. Therefore, I do not think that that sort of crude competition, particularly price competition, works.

Q335 Owen Smith: Is there no way that matter can be mitigated, or does it simply need to be struck out of the Bill?

Sir Richard Thompson: I would prefer it to be struck out of the Bill—thank you very much. I presume it will be up to Monitor but, as I read the Bill, we are told that it will encourage competition. I think that that would be wrong.

Q336 The Chair: It is a bit early for that decision to be made, but I am sure it is something that we will come to. Does anybody else want to add anything?

Matt Jameson Evans: I would say that price competition is not acceptable unless you have a good set of quality outcome frameworks. Without that ability to assess the actual outcome of buying something, you cannot really do that effectively. If we are serious about putting outcomes at the centre of the new way that we approach delivering health care, it can work. If we do not have that at the centre, it cannot.

Q337 Mr Barron: I should declare that I am an honorary fellow of the Royal College of Physicians. I want to raise the issue about current gaps in terms of population. There are some services that have a population of 5 million or more. Has there been any discussion at all with the royal college about that?

John Black: Not so far. Anticipating this, we have networks already set up on a regional basis in relation to the appropriate number of patients for this sort of service. It is going to have to be commissioned from somewhere. I do not think that the GPs will feel competent to do it, and we have got the service set up to give them the appropriate specialist advice.

Q338 Mr Barron: If there were acute care clinicians on the GP consortia, would that get over the problem?

John Black: It would be very helpful. They do not have to be on it, but it could perhaps be put in the Bill that they have to take advice from the appropriate secondary care level.

Sir Richard Thompson: The point about who is mandated and who is actually on the commissioning board is important. Otherwise, consultation will involve sending a clot down the road to talk to them about urology. They will then come back and say, “I’ve consulted.”

Q339 The Chair: You are nodding, Peter. Do you want to put something on the record to say whether you agree or not?

Dr Carter: We think it should be mandated, but we also think that one of the problems with the Bill is the lack of detail. How do people get on? Which secondary clinicians will it be? What is the tenure—the term of office? There is also a whole issue to do with conflict of interests. We strongly believe that they should be involved, but we need far more detail about this. The Bill is very light on that kind of detail.

Q340 Mr Barron: That is the issue about commissioning itself. This commission is going to be driven by GPs and not by anybody working in the local secondary sector. A lot of commissioning is being done outside hospitals—without hospital clinicians being involved in it. Do you think we would be able to improve patient pathways and get better quality if it were more integrated at a local level?

Sir Richard Thompson: Absolutely. Then you have both ends of the spectrum working together for patient care pathways. Community and hospital should be one. There should not be a barrier.

Q341 Mr Barron: Do you think there would be a vested interest in saying, “You ought to send all the orthopaedics to my hospital”? 

Sir Richard Thompson: There will always be vested interests, but it depends on whether you have one provider or two or three in the area. If you are all sitting around the table, I would be optimistic that that could be sorted out.
John Black: If the outcomes measurement—the whole thrust of the Bill—was carried out, you could do that on very logical grounds and compete on outcomes not process.

Matt Jameson Evans: The experience of the GP is that they have a huge range of anecdotal experience from their interface with their patients, but there should be some slightly more objective measures of working out those choices.

Q342 Nicky Morgan: How does it work at the moment? Obviously, we have a system at the moment. Are the four of you going to tell me that it is absolutely perfect and does not need to be changed at all? That is not the evidence we have heard either anecdotally as constituency MPs or from previous evidence givers. How does it work at the moment? I sat with a GP on Monday morning who was less than complimentary about other parts of the NHS that he has to work with. Is some of your discomfort a result of the fact that generally care is moving from secondary care into primary care? We heard earlier from patients. If we have better diagnosis at a very early stage—at the GP level—of, for example, cancer, that would improve outcomes for thousands of people.

Sir Richard Thompson: I entirely agree. It is my view that more care should be in secondary care. The diagnosis is not being made in primary care because primary care doctors do not want to refer patients as there is a cost involved in that. The reason that cancer is not being diagnosed is because they are not sending patients up for referral. Andrew Lansley told me that. He has been to the Marsden and the doctor said, “Please send the patients earlier, then we can cure them.”

Q343 Nicky Morgan: Are you saying that GPs cannot make those diagnoses?

Sir Richard Thompson: It is very difficult. In my own hospital, St Thomas’s—your own hospital—I cannot deal with such things, so I would always refer them on to get the best appointment and advice. I do the same to myself—if I am going to see anyone, I see someone who is in that specialty.

Q344 Nicky Morgan: Are you saying that the model of GPs wanting to take on more responsibility is wrong? Do you think that GPs should not have such responsibility, and that more of it should go to secondary care than primary care?

Sir Richard Thompson: I do not think that it is wrong, but the argument is one-sided. A lot more patients should come to hospital for diagnosis and then be sent back to primary care. The whole story, as you have said, is that people say it should all be done in the community much more. There is no evidence that I know of—if anything, it is against that—to suggest that that would be cheaper.

Q345 Nicky Morgan: Do you not think that patients want to be treated closer to home, and want to minimise their access to secondary care? In my local area, getting to the hospitals and parking at them is a nuisance. People do not know their consultants, they sit there and wait for hours, and they have to cancel work. If they go to their GP or their community hospital, the chances are that they will know that person, and he or she will know them.

Sir Richard Thompson: I do not believe that. First, I talk to patients who turn up and cannot get to see their GPs, or they do not get to see the same GP—they do not get continuity of care at all. Secondly, patients are quite happy to go to a hospital at which they will get a good opinion. I entirely agree that they should not have to wait, and that the parking and transport should be good. If it were working properly, patients would prefer to see a specialist. In America, people with money go and see a cardiologist; they do not go to see a generalist.

Q346 Nicky Morgan: You just said, “If it were working properly”; the point is that it is not.

Sir Richard Thompson: Yes, but I do not think that these reforms will make the particular hospitals you mentioned—I am not talking about not St Thomas’s—improve.

John Black: In my own area the surgery gets more complex. Primary care is not competing; neurosurgery will not go into primary care.

Nicky Morgan: I do not think that the GPs want it, either.

Dr Carter: In relation to Mrs Morgan’s opening comments, in case I misunderstood, let us be clear: one of the reasons why we support some of the core principles of the Bill is that the current arrangements with PCTs and commissioning have not worked. We think that commissioning has been very poor and it has been a failed experiment. I will not dilate on the issues covered earlier, but that is something that we should bear in mind.

Q347 Mr Brine: Dr Carter, in your written evidence, which is very helpful, you said that you were particularly pleased with the article that was in The Times on the day of the Second Reading, in which the Prime Minister said that nurses will play a vital role and “GP consortia will have a statutory duty to work with nurses and other healthcare professionals”.

I presume that the reference is to proposed new section 140 in clause 22, which states: “Each commissioning consortium must make arrangements with a view to securing that it obtains advice appropriate for enabling it effectively to discharge its functions from persons with professional expertise relating to the physical or mental health of individuals.”

What is your beef with that? What do you want it to say? I appreciate that you do not have a problem with the principles of the Bill, because you have just said so on the record. That is welcome, but presumably you want to make it a bit better, which is what Committee is about.

Dr Carter: One of the major problems with the Bill is that it is full of what I would call hymns to virtue. There is lots of encouraging people to work together. It is a bit like Monitor and the Care Quality Commission: they should co-operate. We feel that nursing and other clinical involvement should be mandated and not left as loose as it is. Otherwise, you will end up with a fragmented patchwork of arrangements and, ultimately, you will be playing catch-up.

Q348 Mr Brine: Only the state can guarantee fairness; is that basically what you are saying?
Dr Carter: Yes.

Q349 Tom Blenkinsop: Going back to that quotation from the Prime Minister, have you found the statutory duty to which he referred? Are you guaranteed a place on the NHS commissioning board or the board of a GP consortium? Do you know what your “vital role” will be?

Dr Carter: No. We are not guaranteed a place, which is why the Bill is much too loose and ambiguous. That is something that we want toughened up through amendments. We want more precision; it is far too loose.

Sir Richard Thompson: That is exactly what secondary care doctors are saying.

Matt Jameson Evans: We are not expecting a position on the commissioning board, but that would be nice. We understand the need for those people in that situation. I am not sure that I agree that that can be prescribed at this stage of the Bill, but we shall see.

Q350 The Chair: Sir Richard, I did not hear your comment; will you say it again for the record?

Sir Richard Thompson: I was supporting Peter Carter. As well as nurses, secondary care conditions should be on the board and the local consortia, as I said earlier.

Q351 Emily Thornberry: I want to take you back to the issue of competition. Let us say that a GP has a long-standing relationship with a local hospital; for example, the GP always sends hernia patients to Mr Thompson, who deals with hernias. They know each other well, and indeed, they have an idea of where you go for care afterwards, and that is the way it has always been. There is a Bupa hospital just as close, but they are not using the Bupa hospital under the new legislation. From your understanding of it, could the Bupa hospital challenge the GP? Although the patient may have some choice, perhaps they take the doctor’s advice, do not question it and do as the doctor suggests. Some might interpret that sort of relationship as co-operative and integrated, and an example of working together. From what you understand, however, can that also be seen as anti-competitive?

Sir Richard Thompson: Under the Bill, as I understand it, that private hospital will be able to get the lawyers involved; you are quite right. I think that that is a risk, because I believe that whatever you may say the standards are in the private hospital, they actually live off the back of the NHS. If something goes wrong, they have to come back into the NHS.

Q352 Emily Thornberry: There is tension between introducing the market and talking about greater integration between primary and secondary care in the Bill. Are you concerned that, actually, of the two, the market will top it?

Sir Richard Thompson: I am fearful that that will happen; you are quite right. Although Andrew Lansley denies that much private provision will come into any willing provider, I think it may do, gradually.

John Black: I am very concerned about that particular point, because of the danger of cherry-picking. The answer that could be in the Bill and would give better services to patients would be that the competition should be on quality, not only on price, and that the service must be comprehensive. If you decide, therefore, to send a bit of surgery or medicine to an alternative provider, that alternative provider would also have to include training, teaching, research, audit, outcome measure and the ability to deal with emergencies arising from those particular conditions. That means that you should only compete if you can give a comprehensive, quality service, if you are prepared to measure your outcomes, and if you are prepared to use your outcomes as they come in to make modifications to provide that the patient gets the best care. That is a pretty demanding schedule for a competitor.

Q353 Emily Thornberry: In the new world, as perceived by the Bill, who will measure quality? We have heard that there may be competition on the basis of quality, but from your understanding, who will measure that?

John Black: I do not know. It should be those who are doing the commissioning, and it should be fed back into, so that the highest-quality areas are the ones commissioners use.

Matt Jameson Evans: As part of an organisation that is very much interested in the standards of training in this country, we are very interested in this point. Clause 54, I think, says that Monitor will look after the standards of training, education, and research in private providers. Clearly, if Monitor has the teeth to do that, that is positive. If it does not and it slips, it is not positive. We will look very closely at the training implications for private providers.

Dr Carter: I have no problem with saying that I genuinely believe that the Secretary of State is clear that quality and cost are equally important. I am sure that the ministerial team and senior civil servants hold that view, too.

My concern goes back to where Mr Morris came in at the beginning. You are running this major reorganisation and—you must have heard this from other people—the NHS has never had such a huge reorganisation in its history, which is happening in parallel with this £20-billion imperative. Our fear is that once this leaves Westminster, and as it chunks down through the echelons, cost will be what people are most concerned with. We are concerned that cost will be at the expense of quality, and we are not quite sure who will hold the ring on that.

Matt Jameson Evans: We risk sounding like a broken record, but it all comes down to whether we can actually deliver the proposed outcomes framework. If we can, there is a counter to that argument. If we cannot, and if we do not have faith in outcomes being delivered following the implementation of the Bill, there is a question. As an organisation, we believe that outcomes collection is changing and can be matched to the implementation of the Bill.

John Black: There is a very simple point: commissioning should insist on appropriate measurement of outcome. That would meet so many objections and, I think, would drive better patient care, which we hope is the point of the Bill.

Q354 The Minister of State, Department of Health (Paul Burstow): On that point, I draw your attention to proposed new section 14L in clause 22, which is all about the improvement in quality of service. Do you think the following subsection would help on that point?

“In discharging its duty under subsection (1),”
which is about “continuous improvement in...quality”, “a commissioning consortium must, in particular, act with a view to securing continuous improvement in the outcomes that are achieved from the provision of the services.”

Do you not think that that addresses that point?

**John Black:** It is a very long Bill, and that is one clause in it, but if that is to be prominent, I think it probably does, yes.

**Paul Burstow:** Thank you.

**Q355 Nick de Bois:** Sir Richard, going back to the point about the possible choice of a Bupa hospital, may I clarify? Looking at it conversely, from the other end of the telescope, are you opposed to that patient having the choice, and the right to go to that Bupa hospital, if it can be done on those tariffs?

**Sir Richard Thompson:** No, I am not. What I am saying is that there are dangers if they go out of the system and into a private hospital.

**Nick de Bois:** Okay. It could be Bupa or a social enterprise but, again, your objection is not to the patient having the choice—

**Sir Richard Thompson:** It is the going out of the system.

**Q356 Mr Barron:** 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.”

We understand that the new economic regulator, Monitor, will apparently address such issues. What are your views on these fair playing field distortions? How might Monitor want to address them?

**Sir Richard Thompson:** Personally, I think it will find that very difficult. I keep looking at that section and trying to work out what is meant. Apparently, it is because the pensions are better in the NHS. However, lots of things are stacked on the people outside the system—as I have already mentioned, a patient who becomes ill while being operated on is transferred to the NHS. A lot of the costs are piled on to the NHS, so it is quite difficult to unravel the finances.

**John Black:** I support that. Clearly, the balance is the other way—it is very much in favour of the private provider. If there are financial biases against it, what about all the things that we have just talked about—audit, research, training? If all the simple cases go to private hospitals, how on earth is the next generation going to be trained? And training has a cost. If that is included, it is not looking good for the private provider, to be fair.

**Matt Jameson Evans:** I agree. We had the hangover of independent sector treatment centres at a huge cost. Cataracts. A poor way to get change is by setting up independent treatment centres. Do you not accept that?

**Sir Richard Thompson:** I certainly accept that it got waiting lists down and day case cataract surgery is a good example. It encouraged the hospital to do what it should have done earlier, I quite agree. However, as you know, the financial structure of the centres was appalling. The process got foreign people coming over. The standards were very low, and it took NHS staff out and actually paid them extra to work in them. To me, that is entirely wrong. What should have happened is that the surgeons in the NHS hospital should have been doing day case cataracts. A poor way to get change is by setting up independent treatment centres at a huge cost.

**John Black:** I agree with everything you say; providing that the private sector provider has to do it to the same standard and provide a full service.

**Matt Jameson Evans:** I agree completely. No cherry-picking.

**Q357 Mr Barron:** Matt, do you think that ISTCs helped to bring down the waiting lists for orthopaedic surgery?

**Matt Jameson Evans:** At what price? I do not think that they were an effective way of doing that.

**Q358 Mr Barron:** You might have to ask patients about that.

**John Black:** They helped to bring down waiting lists, but the way the contracts were written will never be repeated.

**Mr Barron:** We have had that discussion, John.

**Q359 Margot James:** I would add cataract surgery to that last question. The differences were dramatic. Even if you included a component for the costs of training, which I appreciate is a very important point, there has to be a way of the private sector complementing, challenging and innovating to get the NHS hospitals to improve their practice, as has been the case with some independent treatment centres. Do you not accept that?

**Sir Richard Thompson:** I certainly accept that it got waiting lists down and day case cataract surgery is a good example. It encouraged the hospital to do what it should have done earlier, I quite agree. However, as you know, the financial structure of the centres was appalling. The process got foreign people coming over. The standards were very low, and it took NHS staff out and actually paid them extra to work in them. To me, that is entirely wrong. What should have happened is that the surgeons in the NHS hospital should have been doing day case cataracts. A poor way to get change is by setting up independent treatment centres at a huge cost.

**John Black:** I agree with everything you say; providing that the private sector provider has to do it to the same standard and provide a full service.

**Matt Jameson Evans:** I agree completely. No cherry-picking.

**Q360 Margot James:** I accept your premise that, to a certain extent, a comparison between apples and pears is going on. We have talked about private providers, and the example of BUPA hospitals came up, but what about the third sector? We heard evidence earlier this afternoon from third sector and charitable providers. They are quite large concerns with resources and economies of scale, and a volunteer force that keeps the costs down. How do you feel about the Bill’s ability to allow more third sector provision?

**John Black:** From international comparisons, I would support it. If you visit north America or the countries with fairly successful systems in Europe—particularly France—some of the major providers are almost Imperial college-size units that are owned and run by religious orders and independent charities. This is a matter on which, as a college, we would think, “Fine—a gramophone record—if they do the same standard.” They have done exactly what I am asking for, which is fair competition, and good luck to them. The trouble is that they don’t exist in this country at the moment, unfortunately.

**Q361 Owen Smith:** What has not been impenetrable— unlike the Bill, perhaps—is the very clear warning we heard that you think costs might trump quality when push comes to shove. John Black, you said earlier that
you thought that other aspects of quality ought to be defined. The principal problem is that cost is very easy to define, whereas quality, especially in health care, is notoriously difficult to define. The Minister referred to the clause that talks about quality in respect of outcomes, but do you think that there ought to be an attempt to define other aspects of quality in the Bill to make sure that they are observed?

John Black: Indeed, and quality standards are, as you say, very difficult. Outcome measurement can also be very difficult, but there are certain objective quality standards. I am sure that Peter Carter would tell me that proper professional advice from nurses would set nursing staffing at levels that would have stopped some of the much publicised disasters we have seen over the past years. That is an area where proper clinician input into commissioning would set a standard that it is so obvious would benefit patients, and the outcome would then follow.

Dr Carter: Quality costs, but we believe that ultimately it is more cost-effective in the long run.

Going back to what we have touched on a number of times with the £20 billion imperative, we can see erosions of staffing levels and skill mix. We can see throughput faster than it should be, and a whole array of things that will mitigate against quality. We are concerned. As everyone on the Committee will know, when you go through a major reorganisation, there is instability at the best of times. With the size and complexity of this, plus the difficult economic climate, there is a real fear that quality could be compromised much quicker than people realise.

Q362 Liz Kendall: I want to ask a question about a bit of an unfashionable word: “planning”. In a former lifetime, I was involved with ambulance services and one of the big issues was how we improve trauma care. The trauma tsar recommended that there needed to be reorganisation of services at the regional level so that you got to the best place for very serious head injury and so on. Obviously, the strategic health authorities, which are the regional bodies, are going. How do you see that kind of planning happening? Can it happen with GP consortia?

John Black: If I may say so, surely that is a matter for the national commissioning board. The evidence for major, life-threatening trauma to young adults—the average DGH would lose one person a fortnight—is that that should be done with large units covering 3 million. The evidence base is clear; surely that must be done nationally.

Q363 Liz Kendall: So you think it should be the national board that decides all trauma structure in the country—across all England?

John Black: I think there is a national dimension that should be included, and certainly national standards, which have been laid down.

Q364 Liz Kendall: National standards, but who decides which hospital keeps—

John Black: I think it is too big for GP consortia of the size emerging at the moment.

Sir Richard Thompson: I agree. It has to be done on some sort of regional level. For instance, the work force consultation that is out at the moment suggests de-structuring the education and training down and fragmenting locally, but you need some sort of regional or sub-national—I gather that that is the word now—planning.

Q365 Liz Kendall: That was going to be my follow up. There is real concern in relation to the deaneries which, at the moment, work at a regional level, but that is being abolished so nobody knows where the deaneries are going to go.

Sir Richard Thompson: Absolutely agree. I think it is quite wrong to do that.

Q366 Liz Kendall: Do you think there needs to be some kind of regional-level something?

John Black: The function of deaneries can be taken over by other bodies, as it used to be before deaneries existed. The trouble with deaneries is that they have become part of SHAs which, we hear fairly confidently, are going to be abolished. They have become rather bureaucratic. The fact that they hold salaries makes them very complex bodies. There are simpler ways of doing it, which organisations such as all the Royal Colleges will be giving evidence on.

Sir Richard Thompson: But they should not just be swept away.

John Black: I know that a big hole is left, but that can be filled quite easily, and I think it should be simpler.

Dr Carter: This is another flaw in the concept. There has been a huge underestimation of the need for a body to do overarching strategic planning, and there is a huge distance between the national commissioning board and the consortia. I think that the consortia will have their hands full. Let me give you an example. We in the Royal College of Nursing are supportive in some areas, particularly some of our metropolitan areas, of the reconfiguration of acute hospitals. They are very difficult decisions. They have been difficult decisions for SHAs and PCTs and, if I may say, very difficult decisions for MPs. I cannot see GP consortia getting into that, and I cannot see the commissioning board having the capacity. In recent weeks, this term of “sub-national groups” has emerged. Is that a re-emergence of a health authority by stealth? Someone is going to have to do it. As I say, I just do not think that the consortia will have the capacity.

Q367 Debbie Abrahams: My point relates to a few questions back. To clarify, we are looking at making sure that private providers have a level playing field, but we are also looking at all patients with complex conditions, as well as simple cases. I just wanted that point to be registered. Do you agree?

John Black: I entirely agree. It is not just the complexity of the procedure; it is the complexity of the patient.

Debbie Abrahams: Absolutely. Thank you.

Q368 Jeremy Lefroy: I want to go back to the question of the engagement of clinicians—not so much in consortia, but in trusts and in management generally. The Mid Staffordshire trust is in my constituency and my experience is that there was quite a lot of disengagement over a period of years by clinicians from management—perhaps it was something that they did not particularly want to
get involved in—and I am very concerned about this. Do you have any comments about how this might be rectified, both in the context of the Bill and in general? I think that it is absolutely essential that clinicians are involved in the management of the service.

**Sir Richard Thompson:** I would not use the word “disempowerment”. I think they have been disempowered. We have done visits to Mid Staffordshire and it is clear that clinicians there have tried to change things, as indeed they did in Bristol, but they are disempowered and their views are ignored. I think they should be doing more management. Indeed, we are setting up a faculty of medical management for all types—not only clinicians, but other managers—so that they have a faculty together that will do much better training for medical management. But it is disempowerment—apathy—that stalks the corridors among nurses and doctors because they are not listened to.

**Q369 Jeremy Lefroy:** Is it that the current system has disempowered them?

**Sir Richard Thompson:** It is not so much the system, but the way in which the hospitals are run.

**Q370 Jeremy Lefroy:** What would re-empower them?

**Sir Richard Thompson:** If you had the integrated system, all that would be looked at by clinicians on both sides of the current divide. At the moment, the providers are run as independent financial institutions competing for business, and they run it on financial grounds, as happened in Mid Staffordshire, where they ended up cutting the nurses and other staff in spite of the protests of doctors and nurses. I think, actually, that it would be better.

**John Black:** The best thing to get doctors into management is to make sure that what they recommend will be carried out, because no one will waste time doing things that will be ignored. There are specific reasons in the Mid Staffordshire case as to why they became disengaged, and one of them was a reconfiguration that altered the shape of the hospital. A district general hospital is a house of cards—if you pull out one bit, the consequences are profound. That needs to be taken into account. This goes back to planning.

**Matt Jameson Evans:** There is also often a lack of faith in the whistleblowing process, so doctors who stand up and call attention to clinical risks are often penalised by their colleagues and management. That should be addressed as part of this process.

**Dr Carter:** We all want to see arrangements to prevent what happened in parts of the Mid Staffordshire hospital, but ultimately, irrespective of the architecture and legislation, it is how the Bill is operationalised and managed at a local level. A Bill will never prevent something happening, but it is how the Bill is operationalised and managed at a local level. A Bill will never prevent something happening, but it is how the Bill is operationalised and managed at a local level.

**Q371 Paul Burstow:** I want to ask Sir Richard a quick question. You were just talking about how clinicians in hospitals feel disempowered. On the basis of what you have said so far about commissioning and management within the current structures, are you saying that you want to maintain the status quo, or do you think it is not working?

**Sir Richard Thompson:** In terms of the disempowerment of the hospitals, I want to change that, and I have written to all my fellows, members and physicians about really doing more to bring concerns to the notice of management. Equally, because it is supposed to be directed from the centre, they should be encouraging managers to listen to concerns. To be fair to the Department, it has put out new guidelines to say that people can complain without damage to their careers, but that has not been the experience in the past. Concern should be considered to be a positive thing. In your annual appraisal, you should be asked, “How many concerns have you put in, Dr Thompson? Why haven’t you put some concerns in?” Managers, as in any good business, should be asking for concerns to be raised, as I do in my own institution and the college.

**John Black:** The Department of Health does encourage clinicians to go into management but it has not been that successful. In the same way, all political parties want to get clinicians into Parliament, but it does not seem to happen. The trouble with us is that we all like the job too much.

**The Chair:** We have enough of them; we do not need any more in here.

**Q372 Jeremy Lefroy:** From my personal experience of talking to consultants, they have often been told that they are forbidden even from talking to their Members of Parliament about problems in their trusts. Is that still a problem?

**Sir Richard Thompson:** I have no personal experience of that, but am told that it is.

**The Chair:** I am pleased to say it does not stop them, in my experience.

**Q373 Dr Poulter:** Dr Thompson, the Minister asked you specifically about the status quo and you did not quite answer the question. There is a very real issue that you—and I think everyone on the Committee—acknowledged about the disempowerment of clinicians. As you said, clinicians are probably the best people to advocate their patients’ case. Do you feel that there needs to be a fundamental change in the way the NHS values the role of clinicians?

**Sir Richard Thompson:** Yes. I am absolutely saying I encourage them to do what they can, but at the moment they are disempowered, so I think we should all encourage them to do that.

**Dr Carter:** We should remember that there is a lot of very good management in the NHS, and a lot of trusts have clinicians at the heart of decision making. The trouble is that it is not uniform throughout the NHS. I believe that you get the problems when clinicians feel disengaged, disaffected and disenfranchised. We hope that the reforms will put clinicians—I mean it in the generic sense—right at the heart of decision making.

**Matt Jameson Evans:** We would all agree with that. The generation coming through are very keen that we should be a part of the commission.

**The Chair:** I am afraid, gentlemen, that that concludes our time. On behalf of the Committee, I thank you for the generosity of your time and the spirited way in which you have answered the questions. I am sure you
have provoked a lot more for the Committee to deal with over the next seven or so weeks. Thank you again for coming along.

3.40 pm

The Chair: Good afternoon, Secretary of State. It is nice to have you with us. Your two Ministers have been with us all day, you will be delighted to know. Neither of them has taken a sick note and left the room, even for a few minutes, which is a bit of an exception in Mr Burns’ case because, having been on Committees with him in the past, I know that it was a job to keep him in the room sometimes. Obviously, you are having a good influence on him.

Q374 Emily Thornberry: I think I should ask you the same question that have I asked all the witnesses. I asked them whether they felt that there were risks associated with the changes. We have heard people’s concerns about the fragmentation of training, reforms being too fast, public accountability not being strong enough and competition being directly against the idea of collaboration and integration. We have heard worries about the configuration of services, about who is going to make the decisions, about how is it going to be accountable, about the extent to which the market is going to be involved and so on—I could go on. A whole list of concerns has been raised before us in this Committee, so do you think there are any risks in relation to the Bill? If so, what? If you do not, why do you not just stop for a bit and listen to what people have to say?

Mr Lansley: An open question, then. Apparently, Monitor was asked that question and said that it echoed the view of the shadow Health Secretary, which is that the Bill, and the modernisation of the NHS that is part of it, is coherent, consistent and comprehensive.

Emily Thornberry: And wrong.

Mr Lansley: And to that extent—

Hon. Members: You missed that bit out.

The Chair: Order. Members must let the Secretary of State answer the question.

Mr Lansley: There is a risk if one were to interfere with the consistency of it. If I may say so, Mr Hancock, I am grateful to the members of the Committee for the work that they have done and will do. This is very important—a once in a generation opportunity to get it right. I want to emphasise that we did not arrive at this legislation without a substantial process of consultation. We had the White Paper in July and a 12-week consultation. I will not list them, but you will have seen from the Command Paper that we published before Christmas a series of amendments to the proposals that were originally in the White Paper, which I hope have substantially mitigated any of the concerns that people had.

Are there risks? I think there is a risk if the transition is too prolonged and, as a consequence, it threatens the underlying necessity, which is not really occasioned by the modernisation reforms themselves, for us to achieve greater quality and an improvement of outcomes and efficiency in the next three years. If the transition were too long, that would be threatened.

There is a risk involving the institutions inside the NHS and some of the vested interests, which frankly will find this difficult—change is difficult. As I have said many times over a number of years, power is a zero-sum game. If we give more power to patients and clinician, and if more power shifts towards the front line, there is a disempowering of intermediate tiers of managers and bureaucracies. Many national organisations, strategic health authorities and primary care trusts have good managers who will play an important part in the new system, but who, institutionally, sometimes find change difficult. There is a risk if they try to use the new system simply to recreate themselves, which is exactly why some of the safeguards have been built in and why some of the statutory duties are here to provide against precisely that.

Beyond the Bill, since we came into office last May, we have identified the running costs of the system, which had previously never happened. We are clear that we will reduce those running costs and ensure that there is a financial control that is geared to containing those running costs in the future.

The third thing is about the passage of the Bill itself. If one focuses on the Bill to the exclusion of the modernisation of the NHS as a whole, it would be a mistake and a risk. The Bill is not the whole story. The story is in the White Paper, and it is about putting the patients at the heart of decision making. They should feel that there is no decision about me without me. It is the focus on results and the outcomes framework that we published before Christmas. It is the empowerment of patients through the information consultation that we published.

There are references in the Bill to the mandate to the NHS commissioning board—and, through it, to the commissioners—to improve outcomes. It is there, but to think that the Bill tells you the outcomes we are looking for and the shape of those outcomes is wrong—it does not do all that. The cultural change in the national health service, which is about shifting responsibility towards the front line and giving patients real control over their health care, will not be achieved by legislation.

Legislation—and I have been involved in quite a bit of it, including writing it—is like a lawyer writing a contract. It is very important to get it right if things go wrong. There will be many occasions in your discussions when you will think, “Okay, if something goes wrong, how does the Bill impact upon that?” However, it is not the means by which you make things go right. We are intending to make things go right in the national health service by the White Paper modernisation as a whole, not least by the empowerment of patients and the focus on responsibility on the part of clinicians.

The Chair: Thank you for that answer. I have a very long list of people who want to take part. We have just over 40 minutes. Once again, I urge Members to ask short, sharp questions and if the Secretary of State and his ministerial colleagues could respond in the same way, that will allow people to feel that they have done justice to this Bill this afternoon.

Q375 Emily Thornberry: You referred more than once to a shift of power, with patients suddenly being at the centre of things—no decision about me without me. The rhetoric is very strong, but does patient power not
simply mean that patients, with additional information, may be able to discuss with their doctor effectively buying certain procedures and access to certain things. This by itself—

Mr Lansley: First, the NHS is not a democracy now. It will be more democratically accountable in the future. As a patient, the influence that you exercise in the NHS in future will be enhanced in a wide variety of ways, and not just through choice or through information—important as that is. We will give patients greater opportunity to have a voice through local health watch, which will have additional powers and Health Watch England, which connects directly to the Care Quality Commission. Patients have a direct input into how safety and quality are secured, and can participate in the scrutiny function—at the moment they cannot—democratically through local authorities, through the health and well-being board, which is a system leader in terms of the strategic design of health and social care in this area.

Coming to your point, if the commissioners sought to designate services then those services would be maintained, and that would be secured through the role of Monitor. If, however, it was intended that there should be a major service change in an area, in the first instance, I would expect and the Bill would require that that was part of the discussion between the commissioning group, and the health and well-being board, because that is where one discusses proactively the strategic needs through the JSNA and translates them into commissioning plans.

If there is a specific service change and the public are concerned, the overview and scrutiny function of the local authority is separate from the health and well-being board—it is required to be separate. Those responsible for overview and scrutiny in the local authority can refer it on behalf of local people, in the first instance, to the NHS commissioning board and, if they are not satisfied with the response they get, in the second instance to me as Secretary of State. Then I can ask the independent reconfiguration panel to advise me on the conclusions.

Q376 Emily Thornberry: Why is that different?

Mr Lansley: It is different in the sense that it engages the NHS commissioning board as an intermediate process. But you are right; in that sense, we are not removing the right of the public to have a major service change referred if they are unhappy with it, and the system is democratically accountable at the end of the day.

Q377 Nick de Bois: Secretary of State, some evidence has suggested that in fact there is no evidence to back up some of the reforms. Turning to GP consortia particularly, can you give some examples of improvements in services that have resulted when other GPs have been free or gained some of the freedoms and new responsibilities that we are talking about?

Mr Lansley: Yes. I am sure that the Committee will have access to the evidence that we supplied separately to the Health Committee, specifically on the evidence base for physician-led commissioning. However, the practical thing is to say—this demonstrates also that the system is evolutionary and is not being introduced in the absence of precedent or experience—that practice-based commissioning groups have used the limited freedoms available under existing delegated powers from primary care trusts to show that they can do that and do it well.

I know that the Bexley clinical commissioning group, for example, took cardiology and looked for new ways to deliver improving services for its patients who required cardiology interventions. That was extremely successful. I have been to visit Northamptonshire, which has put together an integrated service, drawing together a range of providers, to look after patients who have long-term conditions. It identified patients who were having large numbers of emergency admissions and substantially reduced those. People who know Cumbria will know well that the acute trust and primary care trust were pretty much at loggerheads. It took the GPs to step in. They stepped in, started to reconfigure services and took responsibility, and they are turning around the whole health system in Cumbria, which was under threat, but is now demonstrating how services can be designed successfully from a community point of view. GPs in Redbridge came together in a commissioning group and are transferring dermatology and ophthalmology services into the community and leading it.

There are risks in not making enough progress with this. My predecessors, including Labour Secretaries of State, have said time and again over years, “It would be better if we could deliver more services more accessibly to patients, maintaining quality but doing it in a way that reduces the extent to which people have to be admitted to hospital, particularly as emergencies.” If we can do that, it is better for patients, the quality is better and the efficiency is better.

There are implications for hospitals, of course, but what hon. Members of all political parties have objected to many times in recent years is the idea that service provision is written down in a primary care trust business plan. Then, in order to transfer patients into the community, the hospital budget is cut, but patients still arrive at the hospital. That is not an effective process of service transformation, which is why at the heart of this is the principle that those who are most responsible for the care of patients—not just GPs but the teams who work with them, in the community and in general practice—should also be directly responsible for using resources best to deliver that care. Then, if we transform services successfully in the community, there will be changes in the pattern of services, but the public will understand, justify and accept them.

Q378 Nick de Bois: Thank you. We heard from the director of the finance of the NHS—if I have got his title right—that he was very confident that GP consortia would manage and respond well to the budgets for managing themselves—their management costs, if you like. Do you think that if they manage those budgets extremely well and come in under the targets for the cost of managing themselves, we might even consider having an incentive for them to take some of that money and put it back into front-line services? There could be an extra incentive, perhaps, on the management costs.

Mr Lansley: We set out in the Command Paper before Christmas our estimate that in 2014 the running costs of GP commissioning consortia would be between £25 and £35 per head. Richard may well have said to you that GP commissioning groups thought that that was an entirely reasonable basis on which to plan.
Let us say, for the sake of argument, that we have a running cost limit, but a consortium spends less than that. That money would then be available for patient care. There is no question about that. In the design of the structure of GP-led commissioning, we have taken account of past experience. One of the flaws in fundholding was that, if fundholders saved money on their practice budget on behalf of their patients, it was too easy for them simply to spend it on themselves. The current design will not allow that. The budget for patients and for management costs is completely separate from the budget for individual practices and for the consortium itself, and the reward to general practices collectively, like the quality and outcomes framework that is set out in the quality premium here, is for delivering improving quality and results for patients. It is not the case that they save money and they somehow get additional compensation as a result.

Mr Burns: I just wanted to help Mr de Bois by drawing his attention to an unbiased third-party endorsement of what the Secretary of State said in the first part of his answer. You will not remember, Mr de Bois, as you were not here, but in the last Parliament there was only one serving GP, Dr Howard Stoate, who was the Labour MP for Dartford. He recently wrote an article in The Guardian about GP consortia and commissioning. He said: “GPs...reveal overwhelming enthusiasm for the chance to help shape services for the patients they see daily... GP commissioning can free them to operate more effectively” on behalf of their patients.

The Chair: I think that you have made your point, Simon, but I am not altogether sure that I understood the relevance of making it at this stage.

Mr Burns: It was to get a third-party endorsement of what the Secretary of State had said.

The Chair: That is the sort of intervention to make during the debate in Committee.

Mr Lansley: I thought that it was rather helpful, actually. Howard Stoate is now the chair of the Bexley clinical cabinet.

The Chair: We remember him with great affection, Mr Burns. I thought that it was rather helpful, actually. Howard Stoate is now the chair of the Bexley clinical cabinet.

Mr Lansley: I thought that it was rather helpful, actually. Howard Stoate is now the chair of the Bexley clinical cabinet.

The Chair: We remember him with great affection, Mr Burns. I thought that it was rather helpful, actually. Howard Stoate is now the chair of the Bexley clinical cabinet.

Mr Lansley: I thought that it was rather helpful, actually. Howard Stoate is now the chair of the Bexley clinical cabinet.

Q381 Mr Barron: So by any accusation that this commissioning change was done in haste, you would say no.

Mr Lansley: Not at all. No.

Mr Burn: I have one more area of questioning. Would you say that the Bill is not creating top-down change? You said in the Conservative manifesto that there would be no more top-down changes in the national health service.

Mr Lansley: No. The Bill gives effect to the opportunity for serious decentralisation of decision making in the NHS, and for the future of the NHS to be designed from the front line upwards. I do not like the phrase “bottom up” because it implies top and bottom—who is in charge. The people in charge are going to be at the front line.

Mr Lansley: We were very clear at the outset that we wanted to ensure two things: decision making that was close to patients and in the hands of front-line clinicians, and democratic accountability. When we actually looked at the question, we made part of the overall process of reform, the transfer of public health responsibilities to local authorities. Local authorities' social care departments and the NHS need to work increasingly closely together. In terms of service design, the essential relationship was between general practice leading local commissioning, and local authorities running those services and providing democratic accountability. To that extent, there was not a role for primary care trusts. The principle we applied was that form follows function. If there is not a function, there is no need simply to retain management resources.

Q382 Mr Barron: But why were PCTs referred to in the coalition agreement?

Mr Lansley: Because we had not made that decision.

Paul Burstow: To add to that. In the period between the publication of the coalition programme for government and the publication of the White Paper, as Andrew just said, we spent time looking at the functions and where they could most appropriately be discharged. One conclusion we came to early on was that it would make much more sense to locate public health within local government, because that would present many opportunities to drive a health agenda. It would also allow us to look at the role of local government as an actor in the commissioning functions of the NHS; we actually see the opportunity to integrate health and social care through the formation of health and well-being boards.

Q383 Mr Barron: So by any accusation that this commissioning change was done in haste, you would say no.

Mr Lansley: Not at all. No.

Q384 Mr Barron: I have one more area of questioning. Would you say that the Bill is not creating top-down change? You said in the Conservative manifesto that there would be no more top-down changes in the national health service.

Mr Lansley: No. The Bill gives effect to the opportunity for serious decentralisation of decision making in the NHS, and for the future of the NHS to be designed from the front line upwards. I do not like the phrase “bottom up” because it implies top and bottom—who is in charge. The people in charge are going to be at the front line.

Q385 Mr Barron: I want to refer to the evidence that the Committee took on Tuesday from the chief executive of the National Health Service. When he was asked by my colleague Owen Smith about whether or not these changes would result in a less homogeneous and perhaps less equitable NHS across England, he said—I will not read it all out:

“NICE was given the responsibility for developing quality standards and that is what it has started to do. It has done stroke; it has done a few—it has 150 quality standards to develop across all of the major services. In those quality standards, the NHS will set out for the first time for commissioners, providers and the public what a really good neonatal intensive care service or a really good diabetes service looks like and all of those things. That will then be translated by the commissioning board into local commissioning guidelines. It will all be translated into a
national framework contract for providers.”—[Official Report, Health and Social Care Bill Public Bill Committee, 8 February 2011; c. 14, Q30.]

Would Joseph Stalin not have been happy with a system like that?

Mr Lansley: I have no idea what Joe Stalin would have thought.

Q386 Mr Barron: You are saying that it is not top-down.

Mr Lansley: No, it is not. The question is whether under the current system primary care trusts have an idea, individually—151 separate organisations—what quality looks like? Often they do not; that is why the weaknesses in commissioning at the moment are as great as they are. We need commissioning to be based on quality. For decisions to be made on the basis of care of patients, at a local level, we should design services to meet those quality standards. There is the idea that what the evidence base tells us constitutes quality. Ten or 11 years ago under a Labour Government, it was decided there was a need through NICE for a good evidence base for what quality looks like. It has not happened.

I published a quality standard produced by NICE in June last year. We need to have quality standards; we need to have high-quality evidence to back up commissioning, but the people who make the decisions are the people whom the public trust to make those decisions—the doctors, the nurses, the health professionals who are in charge of them, exercising their clinical judgment on the basis of high-quality evidence.

Q387 Mr Barron: Does the national commissioning board—

The Chair: Kevin, to be fair, we have at least 10 colleagues wanting to get in. If there is time we will come back.

Q388 John Pugh: We all agree that the status quo is not perfect. Anybody can make a fair case for reform. The type of reform can obviously vary. There was another option on the table, which was to take the existing PCT structure and slim it down by 30%, as I think the chief executive of the NHS was intending to do; bring in clinicians to dominate the board, if you want; build or bolt on democratic accountability, and add outcome measures. They are all laudable aims of the legislation. That way you could keep institutional memory, acquired skills and coterminosity with local authorities. Theoretically, you would have less upheaval and risk, and save money while creating very few new organisations. With that as the alternative, why was it not chosen? I am sure there is a reason.

Mr Lansley: It was not chosen because it did not achieve the purposes we were looking for. Several things that you describe as being available now have not really happened. Coterminosity does not happen with primary care trusts in many instances across the country. That is not the objective. The objective is not to have organisations that simply coincide in bureaucratic terms; the objective is to have organisations that respond to the purposes of the White Paper.

Q389 John Pugh: I do not want to stop you mid-stride but one objective is obviously to merge health and social care. There, I think it has to be acknowledged that coterminosity with first-tier authorities is an asset, is it not?

Mr Lansley: That is perfectly possible. Health and well-being boards will bring the relevant commissioning consortia—there may be one or more—in their areas together to secure that. From the point of view of joint working, most upper-tier local authorities do not manage social services as a single function, but tend to devolve it to a range of localities. It is perfectly possible to make these things work effectively.

The essence of it is that we had far too many organisations spending too much. You cannot get around that. When we came into office, there were 909 practice-based commissioning groups, 151 primary care trusts, 10 strategic health authorities and about 57 varieties of arm’s length bodies, and the Department of Health. Coming to my point about power being a zero-sum game, most of those organisations did not make their own decisions anyway. Most of them just looked and waited for the Department of Health.

Mr Barron talked about stroke care—he knows. He and I have been involved in this for years. Most of the commissioning organisations out there, and many of the providers, did not even begin to do the things that they should have done on improving acute stroke care until the Department of Health published a document telling them that they should. That is not the kind of health service I am looking for in future. When it becomes obvious, as it did more than a decade ago, that you can change the design of services for acute care of stroke and secure for a significant minority of patients an overwhelmingly better outcome with fewer resources, I am looking for a health service where people simply change the design because it is the logical thing to do. That requires clinical judgment and clinical leadership.

With respect, Mr Pugh, when you come back to the idea of simply doing it through primary care trusts, I say that we have been there and we have tried. Practice-based commissioning was the previous Government’s effort to make that happen, and it did not happen. Why? Because it was still managers on top and clinicians on tap. It has to be the other way round.

Q390 John Pugh: The suggestion I made and asked you to consider was that the primary care trusts should have clinicians on top. I have to say that suggesting that we will have fewer organisations is arguable given that, presumably, GP consortia heavily outnumber PCTs.

May I go on to another issue, which is patient involvement? The Patients Association has done some research into the pathfinder groups, and it asked them what their strategies for involving and engagement are. In most cases, the answers were very limited, but they said that the Department of Health has not asked them what strategies they have for patient engagement. The Secretary of State may wish to confirm that. Is it correct?

Mr Lansley: We invited GP commissioning groups to put themselves forward as pathfinders in mid-October. It is now 10 February. What is rather astonishing is that they have made as much progress as they have. The idea that the first thing we do to the pathfinder consortia as they come together is require them to fill in questionnaires from the Department of Health is what we are trying to get away from. There is a process of transition. They will be establishing themselves over the coming months. They have a year in 2011-12 to establish their role.
In so far as they have developed, the clustering of primary care trusts, which the chief executive will have told you about, is creating space and room for them to take on more responsibilities and to shape how they do their job. There is then another year where they still do not have the legal or financial responsibility.

They should use that time—they know this, because this is how they want to do it—to start to take responsibility for the clinical design of services. Patient involvement and multidisciplinary and integrated working will be the essence of that. There are duties in the legislation that require them to do it in that way, including consultation with patients and the establishment of health and well-being boards. We have only just—in the last few days—invited local authorities to put themselves forward if they wish to be early implementers of health and well-being boards. We will see, over the course of the next year, how these organisations best manage themselves together to deliver the way of working which I suspect you and I would entirely support.

**Q391 Owen Smith:** Clearly, Secretary of State, introducing competition is one of the Bill’s key themes. Is that competition going to be principally on price, cost or quality?

**Mr Lansley:** On quality.

**Q392 Owen Smith:** Okay. If it will be on quality, which is a theme that we have heard from many people during the evidence, why does the Bill take 100 clauses—a third of it—to introduce a competition law framework and an economic regulator, if the competition will be on quality? There are no clinicians in Monitor.

**Mr Lansley:** That is not the issue. Quality is the basis of competition, because those who make the choice—the patients—will be choosing on the basis of quality. Why would they do otherwise, since the service will be free to them? The information that is provided to them will be entirely about the quality of the service available to them. The commissioners will be focused on quality, because they will have a duty to improve the standards and quality of the service they provide. They will be incentivised through the quality premium to do so. The design of the structure of commissioning is between the commissioning consortia and the NHS commissioning board. Monitor’s job is to ensure that those who are engaged in providing those services do so on a level playing field and that we maximise the opportunity for those commissioning services, or those choosing the services that they go to, to get access to a range of quality providers, who meet the standards of quality, and so far as possible, exceed them.

**Q393 Owen Smith:** I will take you, if I may, to clause 52—the first-principle clause relating to Monitor’s duties—which states that its duty is to promote competition where appropriate. My question is: what capacity does Monitor have as an economic regulator, full of economists, to promote competition that you say will be principally based on quality? How can it determine what quality is?

**Mr Lansley:** It does not determine what quality is, because you have to see the Bill in the context of the responsibilities of the commissioners and the responsibilities of the Care Quality Commission. The licensing process of health care and social care providers is based on a joint approach by Monitor and the CQC. To say that Monitor does not do quality in the context of the Bill is a truism. Of course it does not, because it is the CQC’s job to license for quality purposes.

**Q394 Owen Smith:** One of the key issues that we have been debating is whether competition on price and cost necessarily drives down quality in health care. There seems to be a lot of agreement on that. Can you think of any areas of the NHS where there ought to be greater competition on price, be it services or procedures?

**Mr Lansley:** I know it is my job to answer the questions, but I wonder whether you know what proportion of the NHS is subject to price competition now.

**Q395 Owen Smith:** I think it is your job to answer the questions. My view is wholly irrelevant.

**Mr Lansley:** I will tell you the answer. The tariff applies to some 60% of hospital activity, which, in itself, is just over half of total activity. More than half of what happens in the NHS is subject to price competition now. I do not think that the quality safeguards are as good as they should be, because we do not have quality standards. We are only now at the outset of getting essential standards of safety and quality registered and enforced by the CQC.

Price competition in mental health services is an interesting case. Talking of former MPs, I spent Friday afternoon with the senior management of my local mental health trust, Cambridge and Peterborough mental health trust. In mental health services at the moment, there is effectively a kind of price competition. It is run through a block contracting system. They are currently in a situation in which, effectively, the primary care trust does not commission for quality; it commissions simply for price and volume. Cost and volume commissioning—Mr Barron will not doubt confirm this—was the overwhelming character of commissioning by primary care trusts that the previous Select Committee found when it investigated commissioning. I am determined that we move away from cost and volume commissioning.

On mental health trusts, the chair of that trust is Anne Campbell who used to be a Labour MP for Cambridge. She wants to see the extension of the tariff to mental health as fast as possible. Why? Because then money follows the patient. The quality that is related to the price is absolutely explicit in the tariff. Consequently, if they do a better job, they will get the resources to go with it, rather than constantly being treated on a cost and volume basis alone.

**The Chair:** Sorry, Secretary of State, but we are going to have to move on because a lot of Members have questions.

**Q396 Margot James:** I want to move to some of the evidence we have heard over the two days we have been sitting from people who have been very supportive of the changes, people who have been not so supportive and people who have been dead against it. They are all agreed on one thing, which is that it is very challenging to deliver the reforms set out in the Bill at the same time as delivering 4% savings per year, leading to a £20 billion efficiency gain. It strikes me that what they have all misunderstood is that the reforms in the Bill are an
enabler of those efficiency gains. It is two sides of one coin, but that message does not seem to have got across to anybody.

*Mr Lansley:* If I may say so, it is because there is a disconnect in political discourse between local and national. The moment you go and talk to people who run acute hospital trusts and ask them whether they think, given greater freedoms as foundation trusts, that they have been able to deliver improving efficiency, the answer is almost always yes. This is the principle we have applied to local government. It is tough but, in local government, if you give local authorities greater freedoms and flexibilities, they are better able to manage under the financial circumstances we have.

If you say that to general practices coming together into the local commissioning groups and meet them locally, they almost always say, “We can redesign services and deliver greater efficiency.” I make no bones about it: from their point of view, this is one of the reasons why many GP groups are keen to get involved. It is because they know that the alternative would be traditional salami slicing by primary care trusts—rationing, salami slicing and saying, “You can’t do this.” They do not want systems of referral management where the clinical judgments of general practices are overridden by a PCT-led referral management scheme to try to deliver a budget without regard to the implications for their patients. They want to redesign services.

The truth of the matter is, even if we were increasing the resources to the NHS not by 3% in cash next year but by 10%, we would still do this. We are not doing it to deliver the efficiency savings; we are necessarily doing it in the context of having to deliver efficiency savings. I remind everybody that every penny saved is a penny available for reinvestment in health care services. There are people the length and breadth of the health service who have had previous pressures on efficiencies. The last time it happened on this scale was in 2005-06. There was a massive constraint. People across the NHS were angry and frustrated because they did not feel that they took ownership of that. When you go into productive care services—the new productive care approaches in hospitals—the essence of it, like lean management in industry, is to transfer the ownership of what you do into the hands of the people on the front line who have to deliver it. They redesign the services and they capture the benefits. They can reinvest the benefits to improve services for those they look after.

Q397 Tom Blenkinsop: Secretary of State, do you foresee any potential problems with the GPs or their consortia commissioning firms in which they have a financial interest?

*Mr Lansley:* I think there is a potential for conflict of interest. As I was saying about fundholding, one of the things we have done in designing this new system is to realise where things went wrong in the past. I mentioned one issue in relation to fundholding. Another issue is the potential for conflicts of interest, which, I am afraid, were too many in the past. We are designing to escape from that. It is one of the reasons why Mr Smith says there is an awful lot here about the introduction of competition rules. You know what competition rules give you inside the NHS? It happens at the moment technically when public procurement rules are applied, as they already are. It gives you the opportunity to combat abuse.

I think that is what happens when we do this properly: the application of competition rules does not stop people commissioning the service they look for. It does not require them to put it out to competitive tender all the time. They can specify the service they are looking for. It is transparent in the legislation that we allow them, for example, to create more integrated services and to commission on that basis but it does not allow them to engage in an abuse.

Q398 Tom Blenkinsop: How?

*Mr Lansley:* Because the moment you start buying services from yourself, for example, by definition you have created an abuse and the competition rules would say that you can step in or somebody else who has been closed out by that can step in and bring a complaint. The same would be true if there was cartels on the part of providers of if there was a very large provider that was engaging in an abusive relationship with the commissioners and saying, “I’m going to push up the price of this service and there is nothing you can do about it because you can’t go anywhere else.” That is why you need Monitor for this purpose and why you need the people in Monitor to have the appropriate expertise, which is in competition rules and economic judgments. It is a specific task. But it is not a task that gets in the way of delivering the best possible care and even of commissioning the services you are looking for.

The Chair: I am going to have to limit it now to just a question and no supplementary and then maybe everyone will get a chance to ask their question.

Q399 Nicky Morgan: I wanted to return to the question of patient and public involvement. Earlier we heard from a number of patients’ representatives. The comments from the lady from Target Ovarian Cancer struck me. She said that when the White Paper was published it was very exciting. There were lots of patients wanting to participate, but they were just waiting to find out how. There is an appetite for engagement among patients. The word “involvement” has been used a lot. Some people are concerned that that is more than consultation. Would you agree that the involvement of patients in consortia, health boards and so on is critical to how we intend to change the NHS?

*Mr Lansley:* Yes, I would. We are trying to increase the engagement and the control that patients have over the system in a lot of different respects. Shared decision making is not achieved simply by one method alone. We are trying to ensure that it is a cultural change in the NHS. We are trying to buttress it by giving appropriate people with long-term conditions greater control over the care that is provided to them, including, in some circumstances, direct access to health budgets alongside their social care budgets. We are trying to make sure that there is greater choice and the consultation on choice is one that we have yet to conclude. When we have concluded it I hope that we will be able to extend choice rapidly.

We are going to give people much greater voice in the system through healthwatch, through democratic accountability and through their direct relationship with commissioners through the requirement on commissioning consortia to involve patients in what they do. It is a very wide range of activity. When you look at it across the board, it is far beyond the limited extent of patient
engagement we have seen in recent years. In particular respect of healthwatch, relative to LINks. I think LINks are a weak vehicle. They were intended by the last Government to be a weak vehicle, because they abolished community health councils. They did not even like patients forums and they kept whittling them down.

The Chair: I have to interrupt you because I want people to feel that they have had value out of you coming here this afternoon, so can we have shorter answers, please?

Q400 Liz Kendall: You said that decisions would be made by clinicians and would not be top-down, and that no one will be required to put anything out to competitive tender. But clause 63 refers to regulations which

"may impose requirements on the National Health Service Commissioning Board and commissioning consortia"

and subsection (3) states:

"Regulations under this section may, in particular, impose requirements relating to… competitive tendering for the provision of services”.

Mr Lansley: The record will show that I did not say that they would never be required to put it out to competitive tender. There are specific circumstances. The urban myth was that the introduction of competition rules in the NHS would require everything to be put out to competitive tender. Myth one—competition rules already apply and the ones that really apply are EU public procurement rules. They already apply to primary care trusts, so there is no change there. The second myth is, actually, the only circumstances in which competition law bites is if you are trying to restrict provider access to commissioning services. For example, if you wanted to give a volume guarantee to a provider, you have to go through competitive tender in order to do that. If, however, you want to specify a service and there is the NHS tariff price, the any willing provider approach would be that you have a range of providers available to you as commissioners and to your patients exercising choice. You do not have to have a competitive tender for that purpose because if they meet the standard and the price, they can offer the service.

Q401 Mr Brine: May I ask about GPs and their enthusiasm for this? GPs are at the heart of these reports. There were mumblings that I had misquoted him earlier in the week, so I will quote directly from Hansard. You will be aware that 55% of the population of England are covered by GP pathfinders. However, when asked about GPs, Dr Meldrum from the British Medical Association said:

"I would reject the idea that there is an overwhelming enthusiasm for this just because a lot of people have put themselves forward as pathfinders.”—Official Report, Health and Social Care Public Bill Committee, 9 February 2011; c. 35, Q78]

You have met a lot of GPs since becoming Secretary of State. I know that you held a meeting in the north-west with several hundred GPs. In your experience, do you find them to be a reluctant group, trudging along to this?

Mr Lansley: No, I do not. You are quite right, it is a case in point. I did not set up that meeting in Widnes. That was set up by the local medical council. I thought, I have to say, that I would meet the GPs in Widnes, and that about 10 or 15 would come. There were 330 from Widnes, St Helens, Knowsley, Kirby and all over that part of north-west England. There were about 10 practice-based commissioning groups, and they each made enthusiastic presentations about how they wanted to develop commissioning. Eight out of 10 wanted to be pathfinder consortia.

Q402 Debbie Abrahams: Could you explain to the Committee why you decided to repeal the duty of the Secretary of State to provide comprehensive health service?

Mr Lansley: I have not.

Q403 Debbie Abrahams: I think that is under clause 1.

Mr Lansley: Clause 1 effectively reproduces the 1948 duty on the Secretary of State and it applies it to the other organisations through the rest of the Bill.

Q404 Debbie Abrahams: The way it is couched, I think you will agree, is not in the original language. It is not a direct provision.

Mr Lansley: It is in the original language. It is reproduced the same way.

The Chair: I think that is a question we can take up at a different stage.

Mr Lansley: I promise you that it is reintroduced the same. We do not amend the underlying duty of the Secretary of State. The Bill applies it to other bodies, including Monitor.

Q405 Debbie Abrahams: It appears that the Bill gives the consortia the power to charge and to define what is chargeable. Would you like to comment on that?

Mr Lansley: The Bill reproduces the existing legislative prohibition on charging that is not otherwise expressly provided for in statute.

Q406 Dr Poulter: The key challenge for the NHS and for social care is looking after the ageing population, both financially and in human terms. Can you briefly outline—perhaps Mr Burstow as well—how the Bill will help get some joined-up thinking on that and drive in better care and cost savings?

Mr Lansley: Paul has been working so hard on this subject, it would be a shame to deprive him of the opportunity to explain it.

Paul Burstow: The important thing to say about the Bill is that if you look only at health and well-being boards in isolation, that is not the totality of what the Bill is trying to do. It seeks to drive an agenda for more collaborative working across health and social care and integration of services. We have set out in the Bill the requirement for NICE to take on a new responsibility for social care where it will set quality standards. It will place additional duties on the NHS Commissioning Board to drive the use of the various flexibilities for joint commissioning and collaborative operations. At every stage, we have looked at how we can make the system have incentives to ensure greater collaboration.
The Chair: Can you end it there Paul? We have one more question. We have two former Whips giving evidence, and a Whip wants to ask a question.

Q407 Phil Wilson (Sedgefield) (Lab): Secretary of State, in November the Commonwealth Fund published an international health policy survey. It contained a question on overall views on the health care system in 2010. To the question about whether only minor changes needed in the health service in your country, two-thirds of people in the UK agreed that only minor changes were needed. That was by far the highest proportion of any country in the industrialised world. Only a third said that it needed fundamental change. Why are you out of step with the British people on the NHS?

Mr Lansley: The 30-second answer is that Commonwealth Fund report is quite interesting. It demonstrates the public’s belief in the NHS and that there should be comprehensive access to a health care service free at the point of need, based on people’s need and not their ability to pay. That is protected absolutely in the legislation and modernisation reform. The moment you begin to look elsewhere in the report, there are things about what results we are achieving and how responsive the service is to patients. We find that in those respects we lag behind other countries. We are trying to do equity and excellence.

The Chair: If only we had more time, it would be a wonderful experience.

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

4.30 pm

Adjourned till Tuesday 15 February at half-past Ten o’clock.