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

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

Saturday 2 July 2011

STRICT ADHERENCE TO THIS ARRANGEMENT WILL GREATLY FACILITATE THE PROMPT PUBLICATION OF THE BOUND VOLUMES OF PROCEEDINGS IN GENERAL COMMITTEES
The Committee consisted of the following Members:

Chair: Mr Jim Hood

† 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)
† O’Donnell, Fiona (East Lothian) (Lab)
† Poulter, Dr Daniel (Central Suffolk and North Ipswich) (Con)
† Pugh, John (Southport) (LD)
† Shannon, Jim (Strangford) (DUP)
† Smith, Owen (Pontypridd) (Lab)
† Soubry, Anna (Broxtowe) (Con)
† Sturdy, Julian (York Outer) (Con)
† Thornberry, Emily (Islington South and Finsbury) (Lab)
† Turner, Karl (Kingston upon Hull East) (Lab)
† Wilson, Phil (Sedgefield) (Lab)
Sarah Davies, Mark Etherton Committee Clerks
† attended the Committee

Witnesses

Professor Stephen Field, Chair, NHS Future Forum
Dr Kathy McLean, Clinical Advice and Leadership, NHS Future Forum
Mike Farrar, Chief Executive, NHS Confederation
Professor Chris Ham, Chief Executive, the King’s Fund
Dr Jennifer Dixon, the Nuffield Trust
Dr David Bennett, Chair and Interim Chief Executive, Monitor
Sonia Brown, Chief Economist, Monitor
Sue Slipman, Director, Foundation Trust Network
Cllr Dr Gareth Barnard, Vice Chair, Community Wellbeing Board and member for Bracknell Forest BC, Local Government Group

Andrew Cozens, Strategic Advisor for Children, Families and Health, Local Government Group
Public Bill Committee

Tuesday 28 June 2011

(Morning)

[MR JIM HOOD in the Chair]

Health and Social Care
(Re-committed) Bill

10.30 am

The Chair: Good morning. Before we begin, I have a few preliminary announcements. Members may, if they wish, remove their jackets during Committee meetings. It is pretty warm today, so that is a kind gesture on my part. Would all Members please ensure that their mobile phones, pagers and so on are turned off or switched to silent during Committee meetings? As a general rule, my fellow Chair and I do not intend to call starred amendments that have not been tabled with adequate notice; the required notice period in Public Bill Committees is three working days.

I shall briefly explain how we will proceed. The Committee will first be asked to consider the programme motion on the amendment paper, for which debate is limited to half an hour. We will then proceed to the motion to report written evidence and the motion to permit the Committee to deliberate in private in advance of the oral evidence sessions. Assuming that those three motions are agreed to, the Committee will move into private session. Once the Committee has deliberated, witnesses and members of the public will be invited back into the room and the oral evidence session will begin. If the Committee agrees to the programme motion, we will hear oral evidence this morning—the session with the first set of witnesses must finish at 11.30 am.

The Minister of State, Department of Health (Mr Simon Burns): On a point of order, Mr Hood. Will you confirm that, if we debate the programme motion, up to half an hour will come out of the time allotted for the first set of witnesses?

The Chair: I am afraid so, yes.

Fiona O'Donnell (East Lothian) (Lab): It is difficult to hear the Minister because he is not speaking into his microphone.

The Chair: I was asked, “If we debate the programme motion for half an hour, does the half hour come out of the time allotted for the first set of witnesses?” The answer to that question, unfortunately, is yes.

Motion made, and Question proposed,
That—
(1) the Committee shall (in addition to its first meeting at 10.30 am on Tuesday 28 June) meet—
(a) at 4.00 pm on Tuesday 28 June;
(b) at 9.00 am and 1.00 pm on Thursday 30 June;
(c) at 10.30 am and 4.00 pm on Tuesday 5 July;
(d) at 9.00 am and 1.00 pm on Thursday 7 July;
(e) at 10.30 am and 4.00 pm on Tuesday 12 July;
(f) at 9.00 am and 1.00 pm on Thursday 14 July;
(2) the Committee shall hear oral evidence in accordance with the following Table:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Witness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday 28 June</td>
<td>Until no later than 11.30 am</td>
<td>NHS Future Forum</td>
</tr>
<tr>
<td>Tuesday 28 June</td>
<td>Until no later than 12.15 pm</td>
<td>NHS Confederation; The King's Fund; The Nuffield Trust</td>
</tr>
<tr>
<td>Tuesday 28 June</td>
<td>Until no later than 1.00 pm</td>
<td>Independent Regulator of NHS Foundation Trusts (Monitor); Foundation Trust Network; Local Government Association</td>
</tr>
<tr>
<td>Tuesday 28 June</td>
<td>Until no later than 4.45 pm</td>
<td>British Medical Association; Royal College of Nursing; Royal College of Physicians; Academy of Medical Royal Colleges</td>
</tr>
<tr>
<td>Tuesday 28 June</td>
<td>Until no later than 5.15 pm</td>
<td>Royal College of General Practitioners; NHS Alliance</td>
</tr>
<tr>
<td>Tuesday 28 June</td>
<td>Until no later than 6.15 pm</td>
<td>National Voices; Rethink; MacMillan Cancer Support; Asthma UK; Diabetes UK; Stroke Association</td>
</tr>
<tr>
<td>Tuesday 28 June</td>
<td>Until no later than 6.45 pm</td>
<td>Unite; Unison</td>
</tr>
<tr>
<td>Tuesday 28 June</td>
<td>Until no later than 7.30 pm</td>
<td>Department of Health</td>
</tr>
</tbody>
</table>

The Chair: I have notice of three amendments to the programme motion.

(3) proceedings on consideration of the Bill shall (so far as not previously concluded) be brought to a conclusion at the times specified in the second column of the following Table:

<table>
<thead>
<tr>
<th>Proceedings</th>
<th>Time for conclusion of proceedings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clauses 1 to 5; Schedule 1; Clause 6; Clauses 9 to 11</td>
<td>6.00 pm on Thursday 30 June</td>
</tr>
<tr>
<td>Clauses 19 to 21; Schedule 2; Clauses 22 to 24; Clauses 28 and 29; Schedule 3</td>
<td>8.00 pm on Tuesday 5 July</td>
</tr>
<tr>
<td>Clause 55; Schedule 8; Clause 56; Clauses 58 and 59; Clause 63</td>
<td>6.00 pm on Thursday 7 July</td>
</tr>
<tr>
<td>Clauses 64 to 69; Schedule 9; Clauses 70 to 75; Clauses 100 and 101; Clauses 112 to 117; Clause 147</td>
<td>8.00 pm on Tuesday 12 July</td>
</tr>
<tr>
<td>Clause 149; Clause 156; Clauses 165 and 166; Clause 176; Clauses 178 and 179; Schedule 15; Clause 180; Clauses 189 to 193; Clause 242; Clause 265; Clauses 285 and 286; Clause 295; Clauses 297 and 298; new Clauses; new Schedules; remaining proceedings on the Bill</td>
<td>7.00 pm on Thursday 14 July</td>
</tr>
</tbody>
</table>
The government’s tabling of 180 amendments at 5 o’clock on Thursday evening, allowing two full working days before the Committee’s first sitting, means that there is insufficient time for those amendments to be properly read through and for proper work to be done so that we can scrutinise the Bill in the way that the Bill and the national health service deserve. We should, therefore, amend the programme motion to allow more time for witnesses to read through the amendments, to consult their members and to give proper evidence to this Committee. Our amendments would allocate today, Thursday and next Tuesday for the Committee to hear from witnesses.

In passing, I should say that it is completely inappropriate for there to be only one hour to hear from patient groups. If the national health service is about patients, it is unfair to allow patients one hour to give evidence with two days’ notice of 180 amendments. In reality, patient groups do not have the same resources as, for example, the Government, so it is not possible for them to consult. The Committee may know that the British Medical Association is beginning a conference, and we think that it is important for it to be able to consult its members before giving evidence to the Committee. If we want to scrutinise the Bill properly, we suggest that that should happen.

We agreed with the Prime Minister when he said that it would take about 10 days to scrutinise the amendments, but 10 days have not been granted under the programme motion that the Government tabled. Our solution is to spend three days listening to witnesses, to give them more time to look at the amendments and talk to their members, and then to have many more days of scrutiny with longer hours and without knives at the end, so that we can look at this properly. We also fundamentally disagree with the fact that only part of the Bill is being re-examined in Committee; it is not only a matter of looking at the 180 amendments, but of looking at them in the context of the entire Bill.

We know that we are short of time and we do not want to cut into the time available to witnesses, but we work with the programme that the Government suggest unless we can amend it today. In summary, the kernel of our objections is that the proposed programme is undemocratic, is not in the interests of the NHS and does not allow for proper scrutiny. I urge Members to consider carefully the amendments that I have tabled to the programme motion.

Mr Burns: I, too, will be brief, because I do not want to eat into the time for witnesses, which is probably more beneficial to the Committee.

I urge my hon. Friends and other hon. Members to oppose amending the programme motion. As the Committee is aware, the Government have been extremely anxious from the start to give full scrutiny to the legislation. At the end of the original Bill Committee, the hon. Member for Halton (Derek Twigg), who led for the Opposition, said in his concluding remarks that “every inch of the Bill” had been examined.

As we all know, the Government accepted the core recommendations of the independent NHS Future Forum following its review. To fulfil the changes recommended to strengthen and improve the legislation, it is right to recommit the parts of the Bill that we seek to amend. I will not rehearse the debate on recommittal, but I believe that the timetable we are offering the Committee...
is more than generous. In fact, it is double the time of the Committee stage of the last Government’s Health Act 2009, in that we are offering 12 sessions; for that Act, the Committee was offered six sessions.

Similarly, I believe that the attempt to amend the programme motion is a red herring and part of a delaying process, because the Opposition have made it clear from the outset that they want to delay—their original motion was to stay in Committee until 18 October. We had a full discussion in the Programming Sub-Committee yesterday, where we thrashed out and voted on the issues. The Opposition are seeking to live up to their original line, conveyed at the outset of the proceedings to discuss recommittal through the usual channels, that they would oppose everything.

As the hon. Member for Islington South and Finsbury has said, the Government amendments were tabled on Thursday, but she did not tell the Committee that the Labour party tabled a host of amendments yesterday, three days after the Government. If she does not think that there is enough time to consider the Government’s amendments—I do not share that view—she must think that there is even less time to consider the Opposition amendments. On those grounds, I regard the argument as bogus, and if the hon. Lady decides to divide the Committee on amending the programme motion, I urge my hon. Friends and any other reasonable hon. Member to join us in voting it down.

Emily Thornberry: This Bill is of a completely different nature to the 2009 Act. I challenge Members to list the five most controversial clauses in that legislation. This Bill has had the national health service up in arms. The Government say that they have listened and that they want to put into law the challenges and concerns that have been well expressed by the NHS, but if the Government believe that they are doing that, what are they afraid of? Why will they not give us all sufficient time to scrutinise the Bill properly? I appreciate that the Government might find it inconvenient if the Opposition wish to look at such things, but that is democracy. We are doing our job properly, and we, the national health service and all the groups involved need to be able to scrutinise the Bill.

It is a red herring—again, we are talking about red herrings—to draw any parallels between this Bill and the 2009 Act. In some written evidence that has been submitted—of course, not all organisations have had the opportunity or sufficient time to write evidence—it is clear that various groups, and I pray in aid the Royal College of Nursing and the BMA, have not had enough time to discuss the changes in anything other than generalities. That is wrong.

There would have been nothing wrong with putting this matter back to 18 October. Unfortunately, we have lost that opportunity, and we are now working within the constraints of the decision that was made. We are prepared, however, to work all hours to get this out of Committee within the time frame that has now been set. To do that, we need more time to hear from the NHS and its representatives, and we then need sufficient time to scrutinise the Bill properly and still get it to Report by Thursday 14 July. It will take a lot of time and a lot of work, but the national health service is worth it.

Phil Wilson (Sedgefield) (Lab): Very quickly, there were no internal knives in the Committee stage of the 2009 Act, so the debate could go on, whereas this has been time-limited. If the Government thought that the time allocated was adequate, why did they include knives? There were none in the previous Committee stage on this Bill, which had 28 sittings. The knives have been included, because the Government want proceedings to end when they say, and because they know that there is insufficient time to discuss all the proposals.

There is no way that this Bill can be compared with the 2009 Act, because it is highly contentious. My hon. Friend the Member for Halton (Derek Twigg), who is not on the Committee today because of ill health, would say that we thoroughly scrutinised this Bill, as it was at the time. However, if he were here, he would also say that this is a completely different Bill, and that we need to go through it all again.

Mr Burns: It is not.

Phil Wilson: The key thing is that adequate time needs to be provided for people to give evidence on proposals that they have had sight of for only two or three days. Secondly, the knives should be removed, so that we can discuss this adequately.

Mr Burns: May I very briefly respond to that point? This is not a completely different Bill. Substantial changes have been made to strengthen and improve the Bill, as a result of the recommendations from the NHS Future Forum. As a Government, we believe that the Committee should have significant and ample time to consider the changes. That is why we have re-committed the relevant clauses and some others to give context, so that the Committee can do its work and fully scrutinise the new parts that are a result of the Government’s amendments. It is palpably absurd to suggest that we are not giving hon. Members enough time to consider those points.

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 11.

Division No. 1]

AYES

Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O’Donnell, Fiona
Smith, Owen
Thornberry, Emily
Turner, Karl
Wilson, Phil

NOES

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick
James, Margot
Poulter, Dr Daniel
Pugh, John
Soubry, Anna
Sturdy, Julian

Question accordingly negatified.

Manuscript amendment 2 proposed.—(Emily Thornberry.)

Question put, That the amendment be made.
The Committee divided: Ayes 9, Noes 11.

Division No. 2

AYES

Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O'Donnell, Fiona

NOES

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick

Question accordingly negatived.

Manuscript amendment 3 proposed. — (Emily Thornberry.)

Question put, That the amendment be made.

The Committee divided: Ayes 9, Noes 11.

Division No. 3

AYES

Barron, rh Mr Kevin
Blenkinsop, Tom
Kendall, Liz
Morris, Grahame M. (Easington)
O'Donnell, Fiona

NOES

Brine, Mr Steve
Burns, rh Mr Simon
Burstow, Paul
Byles, Dan
Crabb, Stephen
de Bois, Nick

Question accordingly negatived.

Main Question put and agreed to.

Resolved,

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

10.49 am

The Committee deliberated in private.

Examination of Witnesses

Professor Stephen Field and Dr Kathy McLean gave evidence.

10.51 am

The Chair: Professor Field and Dr McLean, welcome. We are finally getting down to our evidence session; I am sorry for the delay. I will ask Emily Thornberry to ask the first question.

Q1 Emily Thornberry: Thank you very much, Professor Field, for the work that you have done. During the two working days that you were given, do you think that you had sufficient time to compare your recommendations with the Government's oral and written responses to those recommendations and, perhaps most importantly, to see whether they have been implemented in the 180 amendments that the Government have tabled?

Professor Field: I do not understand the term “working days”, but yes, I do. Despite the fact that I was poorly, I spent the weekend looking through the amendments and cross-checking. This is so important for the NHS that it is worth giving all our waking time to it, which is what we did during the eight or nine weeks of the listening period as well.

Q2 Emily Thornberry: On my question about which of your recommendations had been left out of the amendments, are you able to particularise perhaps the top three that have not been included?

Professor Field: First—off the top of my head—looking at the openness of board meetings, I believe that there should be a level playing field for all providers of health care. I strongly believe that, as a taxpayer, I should know where my money is being spent, and that was the feeling that people gave back to us in the listening period. Open foundation trust board meetings have been accepted, but I believe that private providers of...
NHs services should also be on the same level playing field as foundation trusts. I can understand why that cannot be put in an amendment to the Bill, but it does say that. Communication and whatever, can be explored, so that is really a minor issue. The vast majority of the paper has been accepted in its entirety.

In one particular area about demonstration sites for some integrated care between health and social care, the wording is slightly different from what we suggested. However, as a global answer to your question, it is remarkable how the Government have listened to what we have done. They have come back with more ideas and suggestions in the amendments than we had asked for. We are pleased with that, and Kathy would probably agree.

Q4 Emily Thornberry: That is just two.

Professor Field: We believe that personal health budgets are important, and we wanted a time frame so that they would be pushed forward quickly to give patients more control. There is no mention of the time frame in the paper. There was a lot about public health and establishing Public Health England as an independent organisation. That has been accepted, but the Government have said to us that more work needs to be done looking at public health in the NHS. That has been suggested for us to carry on with during the listening exercise over the next 12 to 16 weeks. Where the Government have not followed what we suggested, I believe it is for legitimate reasons, and extra work has been suggested to help them. If you read the original Bill, which you all know well, it is remarkable how the Government have responded in such a constructive way to what were quite challenging recommendations.

Q5 Liz Kendall (Leicester West) (Lab): Hello and thank you very much for coming. I am sorry that you had to go in and out of the room.

I want to ask Professor Field a question and then Dr McLean. In your report, Professor Field, you recommend the establishment of clinical senates and a stronger role for clinical networks, and the Government have said that they will be run by the NHS commissioning board. Is that a good idea?

Professor Field: It is probably best to defer to Kathy, because she is writing the detail and listened on that area.

Dr McLean: Clinical networks and senates were recommended in response to what we heard about the need to involve a broad range of multi-professional people and clinicians in the advice to commissioners and the design of clinical services. In terms of whether the commissioning board actually leads those, that is around their being both hosted by the commissioning board and supported by the clinical commissioning groups.

Q6 Liz Kendall: I do not really understand the difference between those two things. What would that mean?

Dr McLean: In order to have something that actually functions and exists, it needs some support in terms of somewhere to do administration, someone to make arrangements and so on and so forth, and you obviously need a body that will do that. The commissioning board, spread out into the country, would support the networks. At the moment, the clinical networks are supported as they exist, and the proposal would take things forward and allow them to continue and develop. It is similar for the senates, too.

Q7 Liz Kendall: So there would have to be staff within the NHS board to run them.

Dr McLean: No. That would be for discussion. One thing that has been made clear in the recommendations is that the development of the exact detail needs to happen now, so we need to look at that in detail. I would anticipate a fairly lean approach, so that you have a small number of people supporting a number of networks and senates. We have to agree at what level—

Q8 Liz Kendall: What is the difference between a senate and a network?

Dr McLean: We have a well established system of networks for, say, cancer, stroke, cardiac and so on. They are largely based around either a single disease area or a single client group, such as mental health or children. A senate brings together the different areas into one group, so you might have the leads for various areas such as urgent care networks, end of life or children coming together in a group so they can provide cross-cutting advice.

Q9 Liz Kendall: Who would have the final say about a decision on services?

Dr McLean: As I said, the details need to be sorted out, but the aim is certainly not to make them bureaucratic.

Q10 Liz Kendall: But as you understand it—Professor Field said that he was pleased that the Government had done everything that you said—who has the final say about how services change?

Dr McLean: The commissioning is done by the commissioning groups and in some instances by the commissioning board, because it will be commissioning specialised services. Where the local authority also commissions, it may commission as well. Those are the statutory bodies that commission.

Q11 Liz Kendall: We have argued that there should be lots of other clinical advice put in, and quite a lot of people are confused about how the bodies will run. I wanted to ask you, Dr McLean, about one of the big recommendations in your specific report—something I am very interested in—which is a concern about leads for safeguarding children. As far as I can see, nothing in any of the amendments specifies where that responsibility will lie. Where do you think it should lie? Where should the safeguarding lead be?

Dr McLean: In terms of the overall safeguarding lead, at the moment there are the safeguarding committees that cover the whole area.

Q12 Liz Kendall: Which area?

The Chair: Order. A lot of Members are putting their hands up to ask questions, and that has been four or five already.
Q13 Dan Byles (North Warwickshire) (Con): I will ask two very brief questions, if I may, because I know that time is pressing. They are directed more to Professor Field. First, I want to summarise what I think you said in your opening remarks. Is it fair to say that following the very impressive listening exercise that you and the Future Forum did, you feel that the recommendations that you put forward, which have been predominantly accepted by the Government, address what you consider the legitimate concerns expressed to you during the listening exercise?

Professor Field: Yes.

Q14 Dan Byles: Marvellous. Thank you for that very concise answer. Secondly, I would like briefly to quote one line—I do not know whether they are your words or the forum’s words—from the summary of your document:

“It was right to pause and reflect. It has, however, been a destabilising period for the NHS and an unsettling time for staff and patients. It is time for the pause to end.”

Do you consider that it is quite important that we do not spend too long now chasing our tail over what to do next, and that we get on, get behind these reforms and get moving?

Professor Field: Yes.

Dan Byles: Wonderful. Thank you, Professor Field.

Q15 Owen Smith (Pontypridd) (Lab): Professor Field, in the report you referred to the fact that you no longer wanted Monitor to be an economic regulator, and that you wanted choice to be emphasised and competition to be played down. Are you not disappointed, therefore, that part 3 of the Bill, which relates to competition, is still called “Economic regulation of health and adult social care services”? Are you not also slightly concerned that the shift of emphasis in the wording of the amendments from promoting competition to preventing anti-competition, which I contend is pretty much the same duty, is a very minimal change?

Professor Field: Thank you. Monitor and the role of Monitor probably caused more discussion than any other part of the Bill during our listening exercise. We are pleased with how the Government have responded in the proposed amendments to the Bill. You have read out one part of it. There are a lot more. If you take them all in context, our belief is that competition, as we heard a number of arguments about, is not a bad thing. What we did not want to see was promoting competition being the main role of Monitor. On the one hand we believe that choice is important and through our choice mandate we also believed that creating a market in some circumstances is important as well. So we are satisfied with how the amendments are laid.

Q16 Owen Smith: So perhaps you can help me. What is the difference in your interpretation between promoting competition and preventing anti-competition?

Professor Field: The emphasis on the words is completely the opposite, is it not? Anti-competition—there needs to be choice in the market. There is choice even in Scotland where they profess to have a different health system from us in England. Turning Point provides brilliant services for substance misuse and learning disabilities. It has done that here for many years. We want to encourage patient choices. We do not want to close down competition, but we do not believe that Monitor’s prime aim should be to promote competition. It should be about encouraging the best quality, most efficient, effective health care possible. In some cases that will encourage integrated care between health and social care. In other areas it will be about suggesting that more competition should be there. I think the wording changes completely the emphasis on that and needs protecting.

Q17 Mr Kevin Barron (Rother Valley) (Lab): May I question you further on that? My understanding was that you recommended that Monitor should be stripped of the competition issue altogether and also be stripped of its economic regulator role. Correct me if I am wrong, but it will still remain an economic regulator. Really the question I should be posing to you is this: what is the difference, if any, between a sector regulator and an economic regulator? What does this mean?

Professor Field: We had long discussions with people out there in the NHS, with Monitor, and with the people who wrote the original part of the Bill, and we discussed the issues of a sector regulator and how that sector regulator’s role should be just about health and not about a broad group of utilities. We felt it was wrong in that the early discussions Monitor was described as a utility regulator like that for water. We felt that set the wrong tone. We felt that there should be a regulator that looked at competition, but also encouraged choice and integration. The wording we suggested there was about sector regulation. It was about removing the initial promoting of competition. It was about inserting words about collaboration and choice. So we wanted to say that we felt Monitor should exist, but should not have promoting competition as its prime aim. It should be there and it would have an important role to play.

Q18 Mr Barron: So the Office of Fair Trading and the Competition Commission should have no role to play in terms of the merger of NHS trusts?

Professor Field: That is a very good question.

Q19 Mr Barron: I have asked it before in this Committee in a previous life and I still have not had an answer as to whether they should or should not.

Professor Field: We heard a number of arguments about the OFT. We had a lot of discussion about European law and we even asked for opinions about what was happening in Holland now over competition, because that might be a precursor to what happens here. Our feeling was that in a way having Monitor as a specific sector regulator protects you from the OFT, because the alternative would be to let the OFT take on responsibility for everything, and perhaps it would never get round to health because it was so busy. We felt that being explicit and tying Monitor down to doing what we wanted it to do was the best course of action.

Q20 Mr Barron: So should the OFT have a role in NHS trust mergers?

Professor Field: I personally believe that it should not and that the sector regulator should predominate, but I am not an expert in how you write the Bill. We were listening to people’s opinions and that is what we reflected in our paper. The amendments follow what we suggested.
Q21 Grahame M. Morris (Easington) (Lab): I would like to follow along on the same theme. The concern on the Opposition side of the Committee has been about Monitor as a potential Trojan horse for introducing competition into the heart of the NHS. One of the NHS Future Forum’s recommendations was about raising concerns about promoting competition as an end in itself, which was set out in the original Bill. You recommended that Monitor be stripped of the competition duties and no longer be an economic regulator. I am surprised that you said that looking at the Government amendments you were not concerned that there is no provision to remove the role of Monitor as the economic regulator.

I want to consider the costs of Monitor because the Minister of State, the right hon. Member for Chelmsford, indicated in evidence to the original Bill Committee that the costs of Monitor would be between £40 million and £130 million a year. It is a huge bureaucratic machine. Given that its powers are being diluted, is there an argument for asking why we need it? Could its powers not be transferred to the Care Quality Commission, Healthwatch England or another organisation in the new architecture that the Bill establishes?

Professor Field: Thank you. On the final point first, some people suggested that we should have one regulator that included the CQC, but the overwhelming number of people we spoke to when that was raised felt that the CQC should do its job properly as its prime directive, rather being merged with Monitor. Merging two organisations certainly would not help now when the CQC has a lot of difficult issues on its plate, so when we discussed it with people the feeling was that Monitor should be separate.

We do not believe that competition is bad; it can be bad, as can integrating a health care service and fossilising it, so that the service quality decreases. Choice can improve quality of care. There needs to be some mechanism for managing those issues, and therefore, from a regulation point of view, there is a role for Monitor. We did not believe that the prime role was about promoting competition. Clearly, it does have a role there.

Q22 Grahame M. Morris: The costs, Mr Hood, are not incidental. Over the lifetime of a Parliament, they equate to the cuts in social care for elderly people, highlighted only yesterday in a report published by Age Concern—it is around £600 million in total.

Could you comment on another recommendation of the NHS Future Forum, which is the system for designation that allows services to close without consultation? My understanding is that the NHS Future Forum indicated that it would like that changed, but as yet that change does not seem to be among the 180 amendments the Government have tabled.

Professor Field: No. Reading through the amendments, I cannot find that area of designation.

Q23 Grahame M. Morris: Is that a matter of concern, given that 20 units have been identified in the press as at risk of closure?

Professor Field: Unfortunately, difficult decisions will have to be made in the NHS and those decisions have been dodged for many years. Those of us who work as GPs understand the difficult nature of reconfiguration of services. Two or three years ago, I chaired a reconfiguration panel in the south of England, and our opinion was overturned nationally. Someone will have to make those difficult decisions. There is enough in the Bill, as it stands, to allow consortia, the commissioning groups or the commissioning board to have a view, and to allow the system to be there to make those decisions. The critical period will be over the next two years, because we have to meet the financial and productivity challenge.

Q24 Fiona O’Donnell: Professor Field, I welcomed your remarks at the beginning when you said that it was worth giving all of our waking time to consideration of the Government’s amendments, and I want to reassure you that at least some of us feel the same way.

Can I ask about the cap on private patients in foundation trust hospitals? What representations and submissions did you receive about that?

Professor Field: We talked about it a little bit, and we did not put as much in our report as perhaps we could have done. In fact, it was one area, having re-read the paper at the end, that we might have been stronger on, but, because the feedback was so mixed, I did not feel that we could actually make a strong recommendation.

On one hand, many of the foundations trusts were saying that the private patient cap was unreasonable. One strong representation was from University hospital Birmingham, which is capped at around 1%, whereas the Royal Marsden is capped at around 30%, so University hospital Birmingham could not bring money in that would actually help its NHS services. On the other hand, if you opened the cap, it made you more likely to be under attack from EU law, competition and Monitor, so when we weighed up the proposals and the problems that might arise, we chose not to go into any great detail.

If you wanted a gut feeling for what was happening in the listening, the feeling was that the private cap should actually stay, because people felt that that would provide a protection. However, it should be reviewed and set at a reasonable level, whereas it is unreasonable in some areas at the moment. We felt that that probably was not worth putting in the document, because it was divided.

Q25 Fiona O’Donnell: Can I ask a quick question about Monitor? I am new to this Bill Committee—I was not part of the previous one—and I am thinking about patients being at the centre of this and about explaining to them the difference in the wording between a positive statement about competition and a double negative one. What could have happened under the previous Bill that cannot now happen under the recommitted Bill? Is there an example that you could give patients today?

Professor Field: Most of the feedback that we had was about fears of competition and of big American companies coming in and taking over the local hospital and stripping it of services and money for profit. We wanted to ensure that Monitor had a role in competition, but that it was not the end in itself.
Q26 Fiona O'Donnell: Is there an example that you could give patients? I am just concerned that it sounds like we do not know what the Government’s amendments will actually do.

Professor Field: When we spoke to the Government and when we spoke to most of the people who were involved—we spoke to a lot of senior staff at the Department of Health—we did not, at any time, pick up any feeling that anyone wanted a free open market where people could come in and privatise the NHS, as some people have said in the press.

Q27 Fiona O’Donnell: Just to press you a third time, can you give us an example for patients of how their experience will be different?

Professor Field: Under the original Bill, we did not feel that there would actually be a free and open market.

Q28 Fiona O’Donnell: So the amendment makes no difference.

Professor Field: No. We believe that it actually makes it clear that the prime role of Monitor is not to pursue competition as an end in itself but rather to be there to encourage collaboration and integration, as well as competition where it is needed. That actually gives a safeguarding. We do not believe that any individual actually believed that there would be an open market, but there was an overwhelming fear that the way that the Bill was written would cause problems.

Q29 Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): The key issue that we have picked up on is about the integration of services, competition and patient choice. We have talked also about reconfiguring services, which you mentioned briefly. Do you now feel that the Bill is well suited to doing that? Obviously, there are different challenges in different parts of the country; perhaps better integrating adult social care with NHS care is a challenge where there are more elderly populations with health and services issues. In the Bill as it now stands, how do you see Monitor’s role in promoting that sort of integrated working?

Professor Field: We saw Monitor as being part of a more complex system. Monitor is described as an economic regulator in the title of part 3, but when you read further down that section the amendments talk about promoting collaboration and so on. It is part of Monitor’s role to make sure that that happens, and if you read some of the other amendments to do with the commissioning board they also talk about integration and services around the patient. We talk about health and well-being boards and their important role, and we talk about pilots locally to try to bring everything together.

What we were trying to do in our paper was to encourage the integration of care around the needs of the individual patient and make sure that the system as a whole encourages that, while not getting rid of the need for competition if that was needed in a particular area. You can still have choice within an integrated pathway. That might be competition between optometrists or between pharmacists, for example, in a more tied-in, integrated system.

Q30 Dr Poulter: Do you see the Bill as promoting a greater community focus with services being provided more around the patient in the community? Do you feel that the Bill supports a move in that direction in health care?

Professor Field: Absolutely. We need to move from a hospital provider-based health care system to a more preventive, community-based system. The original Bill moved in that direction, but we think that our recommendations and the amendments will help that direction of travel.

Q31 Karl Turner (Kingston upon Hull East) (Lab): Professor, Monitor remains an economic regulator with wide pro-competition powers, does it not?

Professor Field: It remains an economic regulator in the title of part 3, but when you read through the amendments, look at the original Bill and put them together with our recommendations, Monitor no longer has a prime directive of pursuing competition. It is not the be-all and end-all, and it is not an end in itself; competition is part of that.

Q32 Karl Turner: But it still has wide powers to promote competition, does it not?

Professor Field: If you read through our recommendations, and you read through—

Q33 Karl Turner: Professor, with respect, it is a fairly simple question. Does Monitor remain an economic regulator with wide pro-competition powers: yes or no?

Professor Field: Monitor is a sector regulator, which also will have a role as the economic regulator within health.

Q34 Karl Turner: Yes, professor; the answer is yes, is it not?

Professor Field: The answer is exactly as I have said to you.

Q35 Karl Turner: The answer, professor, is yes, is it not?

Professor Field: It is exactly as I have stated to you. It is a sector regulator, yes, but there are amendments all the way through around integrated care about improving quality and efficiency. It is unfair to take out just one thing and pursue it, on economic regulation, when Monitor is the sum of the amendments that have been tabled to the original Bill.

Q36 Karl Turner: Professor, did you not recommend that Monitor be stripped of its competition duties? Is that what you recommended?

Professor Field: No, we did not say that it should be stripped; we said—I will try to find the exact wording.

Q37 Karl Turner: I have the wording, I think. You said that the Bill should “clarify that Monitor’s role should support choice, competition and integrated care”.

Professor Field: I said:

“Competition should be used as a tool for supporting choice, promoting integration and improving quality and must never be pursued as an end in itself.”

That is quite clear, I would have thought. I also stated:

“Monitor’s role in relation to competition should be significantly diluted in the bill.”

The amendments, as far as I read them, do that. I also recommended that
“Its primary duty to ‘promote’ competition should be removed and the bill should be amended to require Monitor to support choice, collaboration and integration.”

In the amendments, cherry-picking and tackling abuses are also talked about. As they are written, they adequately answer what we have recommended in our paper.

**Q38 Karl Turner:** Finally, would you accept that Monitor remains an economic regulator with wide pro-competition powers? That is the truth, is it not?

**Professor Field:** I would accept that, yes, Monitor is the sector regulator with economic regulation as part of its wider remit, but that is not exactly what you asked me, so my answer to you is no.

**Q39 John Pugh** (Southport) (LD): Can I take you back to a remark that you made earlier? One thing that you thought had not quite been embodied in the legislation and that was demanded by some contributors to the listening exercise was a demand for greater transparency with regard to private sector providers. The Government have the laudable intention of trying to secure a level playing field, but clearly, without financial transparency, you could get a private provider behaving in a predatory way—trade at a tariff but at a loss for a period of time to remove a hospital unit that is thought to be fragile, or whatever. Is that a problem that people wanted TO be addressed? Were there any obvious solutions coming from the Future Forum, or that have been, as you can see, embodied in the legislation to deal with that issue? It is obviously a tricky problem, because private firms are not very good at letting people know precisely how their finances stack up.

**Professor Field:** It was quite complex. The question that we posed was about transparency, and overwhelmingly, the feedback was that foundation trusts should have open board meetings, consortia should have open meetings, and all the minutes should be published. Nurses, doctors and patients also wanted those providing NHS services, which might be the third sector or a hospital, to have more transparency. Many said that open board meetings would be a good thing, because that would create a level playing field with NHS providers. It is difficult legally to make that happen. You might do it through the commissioning process, by writing it into contracts. I can fully understand why the Government did not go as far as we were suggesting, because it is very difficult in law, I gather, to make that happen. There are other parts of the Government’s response that reassured me, and I knew that I was pushing harder than I might get an answer for.

**The Chair:** I am afraid that this will probably have to be the last question.

**Q40 Mr Steve Brine** (Winchester) (Con): I am trying to get to the spirit of the input that the Future Forum received, so this is a general question to finish. Many representations that have been made to me in the past few months regretted the unsightly political football match that had taken place. In the summary to your report, you said that things became polarised; on one hand, the Bill was about all-out privatisation of the NHS—we will call that option A—and on the other, reform was the only way to safeguard the principles of the NHS that we all hold dear. We will call that option B. Were most of the tens of thousands of people who contacted you coming from position A, position B, or somewhere more moderate in between?

**Professor Field:** It was more complex than that. Most of the public face was “Save the NHS from being privatised”. That was in the press. When we met with organisations and individuals, and once you got past the privatisation and talked about the detail, there was a genuine understanding from lots of people that the NHS had to change. When we talked about the reasons for change, such as the ageing population, or the cost of fantastic medical advances that the NHS has brought about, people genuinely felt that the NHS had to move on from where we are now, which is hospital-based, to something more community-based and preventative. When we started to ask questions about the principles underlying the Bill, there was overwhelming support for the principles of clinical leadership, which had not been apparent in many of the PCTs in the past—that led to stagnation and a lack of development of commissioning, and all of that is on record—as well as for more meaningful patient and public engagement, and for the outcomes framework, building on Lord Darzi’s brilliant work on quality. Therefore, it was more complex. It quickly became apparent that those people who were aware of the NHS constitution and its first words owned the NHS almost like a religion and wanted us to safeguard the constitution.

**The Chair:** Order. I am afraid it is 11.30, so the session is over. Thank you.

**Examination of Witnesses**

Mike Farrar, Professor Chris Ham and Dr Jennifer Dixon gave evidence.

11.31 am

**Q41 John Pugh:** May I put a simple question, to which I might know the answer, to Mike Farrar? You represent the people who administer the NHS and most health providers across the UK. What is the feeling apropos the situation we are in? Would you welcome a prolonged legislative bout going into December, or would you like Parliament to make up its mind one way or the other on what it wants to do with this legislation?

**Mike Farrar:** It would be fair to say that our members believe that we are in a better place now than we were before the pause. There was a good deal of concern about that. It is also fair to say that, although we live in a political democracy and we all support and welcome political debate, the NHS is rather worried about the extent to which the real issues it is facing on a day-to-day basis are not going away. In fact, the uncertainty of some of the key players in the system is very distracting.

I have used the phrase that we have been a bit in the woods trying to separate the wood from the trees as the forest fire is burning, and our members can see that. We are looking for real certainty and a real direction of travel, but the amendments raise important issues about how this will work in practice, which needs to be understood properly. The Committee needs to have a sense, perhaps from the evidence it is taking today, of the areas that need to be sorted before the NHS has the degree of certainty that it needs.
Q42 Emily Thornberry: Listening to the evidence, is another way of putting it that the NHS has been directionless for the past year and has been unable to address the fundamental issues? Amended or not, does the Bill address those fundamental issues?

Mike Farrar: The sense we have from our members is that the key decisions that need to be taken in the next two years will be seminal for the future of the national health service. A number of the reforms will have a future impact, but some of them will not take effect until 2013. Our worry is that in the short term some of the people taking decisions are doing so without understanding what their position will be in the future or, indeed, whether those organisations will be around to deal with the consequences of those decisions. We recognise the immediate issue that the NHS faces in managing the financial crisis. Think about re-profiling services, think about where capacity needs to come out of the system and think about where pay deals might need to be done with staff to support job security against the overall costs. There are a lot of immediate issues that have to be tackled. At the moment, many of the people who are in place are uncertain of their accountability for some of those decisions. That is a worry for our members, yes. It is a significant worry.

Q43 Emily Thornberry: I think you have been able to give us written submissions. Do they include an analysis of the amendments?

Mike Farrar: One of our difficulties—and I think that a number of people will say this today—is that the amendments were tabled on Friday. Given their complexity and the huge number of them, plus the fact that we only got the very helpful document from the Department at teatime yesterday, all I can say is that I will give you to the best of my ability today my interpretation of the views of our members on those issues. In the fullness of time, we may start to understand the issues more, particularly as we need to see the whole thing together to understand a number of them.

It is not just about the individual elements—for example, understanding the nature of a regulatory system against the nature of the accountability of the commissioning consortia—as they play together with the commissioning board. Some of that will emerge in the fullness of time. We know that some issues will not be discussed until Report, which is significant in terms of failure. All I would say today is that I can answer to the best of my ability with the time that has been available, but it may be that there should be future opportunities to bring us back and ask us further questions, should you choose to do so, when we have had a chance to consider the measures. This is a very complex set of changes.

Q44 Emily Thornberry: Thank you. May I put a similar question to Professor Ham and Dr Dixon?

Professor Ham: We would echo that. We have had very little time to get our head around the amendments and how far they carry forward both what the Future Forum said and what the Government’s response was. The document that came out yesterday teatime was very helpful. Our briefing on the Bill and the amendments is based on a very fast reading and appreciation of what we had over the weekend, not taking account of yesterday’s document, so I enter the same caveats as Mike.

Dr Dixon: The only thing I would add is that there is legislation and there are the regulations that follow, and to get a full picture and understand what is appropriate, we need a full idea of the full policy. In some areas, the full policy is not apparent.

Q45 Emily Thornberry: Could you give some examples?

Dr Dixon: Yes. An example could be to what extent should the legislation be very specific about surpluses that consortia might keep? Is that more properly something that should go into the regulations? That is a key financial driver for the consortia.

Q46 Emily Thornberry: Doctors paying themselves bonuses.

Dr Dixon: Yes, or, quite apart from the quality premium, if they make savings, as in fund holding, can they keep them? Should that be in the legislation or should it be in the regulations? There is a whole set of other things, which could include governance as well. They are two small examples.

My point is about wider policy making. If a full thought-out policy was put before us, it might be better and easier to look at what was appropriate in legislation and what should be in regulations. It is a question of time and the scope of ambition of any legislation.

Q47 Mr Barron: I have a question to Mike Farrar. You said that you members feel that they are in a better place. Clause 65 of the original Bill said that any merger between NHS trusts or a merger between NHS trusts and another business could be referred to the OFT or the Competition Commission. That provision remains unaltered by the amendments tabled. Do you think your members would be happy with that?

Mike Farrar: When I was referring to the overall perspective, I was taking a general view. We have some questions to raise on elements of the amendments.

On mergers and acquisitions, our sense is that sector-specific oversight is better than general oversight, given that the nature of health is different from that of other industries. Our people would support a more practical approach to supporting relationships between organisations, not just mergers and acquisitions; it is about being able to support organisations working together to become more efficient and to improve and maintain quality standards. Our experience to date in the health service has been that those kinds of processes have been very lengthy, they cost a lot and it takes an awfully long time before you get better value for patients. The general, rather than the specific, point to make is that we need something that is sensitive to the needs of the health service, and effectively to understand that, in some cases, you will have to bring together providers and you should be able to do that swiftly, transparently and clearly so that patients benefit.

Q48 Mr Barron: Does the OFT have a role to play in that?

Mike Farrar: Ultimately, there is a view that if the health sector regulation is invoked, there is always a question whether it could be challenged later at a higher level. I am not certain that this is buttoned in the legislation. It may get tested in the fullness of time, but I
am not entirely certain that the OFT would be a player. I assume—I am aware that this is hypothetical—that the OFT is the backstop if someone feels that the actions of a sector-specific regulator have not dealt with their issues appropriately.

Q49 Mr Barron: Could I put this to the other two witnesses? Your written evidence states that competition has changed in the last few weeks, but this Act remains—clause 65 refers to part 4 of the Enterprise Act 2002. Are you comfortable that this and other clauses related to competition remain in the Bill, or do you think there has been a fundamental change in terms of using competition law in NHS reconfigurations and services?

Professor Ham: There has not been a fundamental change because the law is the law. Economic regulation takes place within the framework of the law. The first question is whether there is a role for competition in health care, particularly in the NHS. If the answer to that in policy terms is yes, inevitably you need to have some way of regulating the market in health care. The next question is: do you expose the NHS to the existing economic regulators, such as the Competition Commission and the OFT, without a sector-specific economic regulator, such as proposed in the Bill, which might, if it works well, have a detailed understanding of the complexities of health care and the need to apply competition principles in a way that is sensitive to those complexities? Given that the policy says, yes, there is a role for competition and you have to some way of regulating the market, our view is that it is better to have Monitor as the economic regulator with concurrent powers with the OFT and the Competition Commission than not to have a sector-specific regulator. People will differ on the answer to the first question, which is whether there is a role for competition.

Dr Dixon: I completely agree with that. The Co-operation and Competition Panel has been applying the principles of the Competition and Enterprise Acts. There has been quite a lot of tranquillity—it has been accepted. I completely agree with that. The Co-operation and Competition Panel has been applying the principles of the Competition and Enterprise Acts. There has been a fundamental change in terms of using competition law in NHS reconfigurations and services.

Q50 Margot James (Stourbridge) (Con): I should like to ask Professor Ham about reconfigurations of hospital services. In the previous session, we heard from Professor Field that the whole Bill is focused on a move from a hospital-based system to a more community-centred, preventive role of delivering health care. He felt that the Bill in its previous incarnation went some way towards achieving that goal and that the Government's amendments had moved that means to that end forward. In its written evidence the King's Fund states that it remains "concerned about the lack of clear responsibility for driving forward major reconfigurations of hospital services." Could you expand on that? It will clearly be a fundamental issue in the coming years.

Professor Ham: Absolutely. We fully endorse what I believe Steve Field said this morning. We need to move as quickly as we can towards less emphasis on services being delivered in acute hospitals to making a reality of prevention, consistently high standards of primary care, and more care closer to home. We have argued that over many years and it remains an aspiration rather than a reality. Inevitably, that means looking at the current organisation of hospital and specialist services and taking some tough, but necessary, decisions about concentrating some of those services in fewer hospitals. First and foremost, that should be done on quality and safety grounds, because that is a better way of getting word-class outcomes, to which I suspect we all subscribe. The debate about paediatric heart surgery is one example of that, and the concentration of specialist stroke services in fewer hospitals to get better results is another example.

Our concern, against a background of generally welcoming what the Future Forum has said and what the Government say in their response about the modifications to the Bill, is that if you add in the changes, particularly in relation to the powers of the health and well-being boards, the as yet ill-defined role of the new clinical senates and the role that clinical networks might have, there are more checks and balances built into the modified Bill than were in the original Bill. That could bring some benefits such as a bigger role for local authorities and community involvement in some of those important and complex decisions, but it is likely to slow down some of those decisions at a time when the NHS needs to move really rapidly to grasp the nettle of how we can improve outcomes by reconfiguring hospital services, in particular, to deliver better care on quality and safety grounds. Our concern would be the risk of too much bureaucracy being built into the process, rather than too little.

Q51 Fiona O'Donnell: I have a general question for all three of you. Is the recommitted Bill more complex? Does it involve more reorganisation and bureaucracy than its predecessor?

Mike Farrar: That is one of the concerns, which we raised in our evidence, about the relationships between the players that are now making decisions at local level, and we echo the point that Chris just made about the potential for several organisations effectively to have to agree on a particular course of action. It is not at all clear what the hierarchy is. For example, we do not support, as is currently set out, the notion that clinical senates and clinical networks would effectively be part of the national commissioning board. We think that they should play an advisory role to local consortia, to emphasise the localism of decision making.

We also worry about the default position wherein consortia are not ready to take on budgets and they are being deployed by a national body. Again, there is a risk that, in that organisation trying to have relationships with health and well-being boards and its clinical senate, which, by the way, it also hosts, there is an enormous amount of confusion when it is supposed to be setting the strategic framework and then holding people to account.

Q52 Fiona O'Donnell: Is that a more or a less, then?

Mike Farrar: I think there is potential for significant bureaucracy unless it is clear what the relationships are and there are mechanisms in place—it may well be, coming to Jennifer's point, that they are part of the regulations rather than the Bill—that actually establish how decisions can be taken speedily in the interests of patients.

Professor Ham: To add briefly to what I said before, it is a more complex Bill than the original draft, because it has taken on board many of the recommendations of
the Future Forum. Equally, it will lead to a more complex—you may want to call it more bureaucratic—structure than was originally proposed. Some of that is beneficial, and some of that will have the effects that I was describing and will slow down necessary decision making. Once the dust settles on the recent debates, I hope it will be clear how we can avoid that risk of everything being slowed down, because there are so many players on the pitch, where we need to act quickly to take some really important decisions.

**Dr Dixon:** I take that point. If you look at some of the more successful attempts at reconfiguration, more involvement of local groups was necessary in order to get change. Some of the unsuccessful ones have been those where they have communicated less and involved fewer people, so, paradoxically, it could have the opposite effect.

The only thing that I would add to what was just said is that the Bill is more complex and may therefore cost more. These commissioning groups are operating within a very stringent—too stringent, actually—management resource.

**Q53 Fiona O’Donnell:** Professor Ham, you talked about a slowing-down of the process. Focusing on patients and given the efficiency savings that the NHS is being asked to make, what might be the effect on the delivery of services for patients?

**Professor Ham:** I think that the impact on patients will be much more felt from the Nicholson challenge and finding the £20 billion of efficiency savings in the next year or two, rather than from the effect of the Bill and the reforms in the medium term. We are already seeing the pressures of that on the ground—we are only three months into this financial year, the first of four years of real financial pressure on the NHS—and add to that the pressures that we know about of social care impacting on services for older people, too.

Our reading is that we are moving into a period in which this is bound to impact on patient care. However well managed the NHS is, and whatever scope there is for being more efficient with £105 billion of public money, the likelihood is that over time there will be pressure on maintaining the waiting time improvements that we have seen in the past decade. The Prime Minister has made a clear commitment that that will not happen, but the financial pressures may drive it to happen. We may find, therefore, that patients have to wait longer for their care if we cannot move quickly on some of the reconfigurations that we need to make on quality and safety grounds, particularly those impacting on maternity and A and E services.

These are complex and difficult issues. The challenge will be whether we can really give a copper-bottomed guarantee to the populations we are serving that they will be treated by services that are safe and deliver the quality of care that we expect and that they have a right to expect, too. That is not primarily an issue of money, although money will underpin the quality and safety challenges.

**Q54 Dan Byles:** Mr Farrar, in your opening statement you referred to the fact that people are trying to make decisions in a period of uncertainty. I know that is difficult, and it is a concern that we all share. It is probably inevitable in any large period of managing structural and organisational change. Would you agree that, if anything, that is an argument for not spending too long navel gazing about what we are going to do and for actually saying, “Once you make the decision, the impetus is then to get on and implement the changes quickly to reduce that period of uncertainty”?

**Mike Farrar:** This is the fourth reorganisation of the national health service in the past 12 years, but it is the biggest. The people on the front line who are trying to take decisions feel rather confused, but there is a sense in which they feel they are doing a good job of improving the NHS.

This rather took people by surprise at first. There are some good reasons why you should be reforming health services on an ongoing basis. Many of those reasons are about trying to engage people and requiring primary care to be more engaged. Most of our members support the principle of primary care being responsible, particularly given that when GPs make decisions on referrals and prescribing they are effectively the major spenders of the budget. So that is a sensible move, as is the move on local authorities having more responsibility, alongside the health service, for health improvement. That is the 15 to 20-year type of benefits that you get out of that.

Our members want to find some real clarity and certainty, but they want to find clarity and certainty in a system that works. So this business about pace is very important, but, equally, it is important that the decisions that are taken on the complexity are clear. There is no point in running very fast if you run into systems in which nobody is quite certain whether the clinical senate can second-guess a consortium or whether a health and well-being board can appeal to the NHS commissioning board if a system does not reflect local need.

There are two responsibilities here: one is to move at pace, but the other is that the legislation is as clear as it possibly can be, so that as we enact it everybody understands the decisions that are made. The decisions should not be subject to appeal or somebody saying, “Well, that’s not the way the system should work.” We need real clarity, and we need pace.

**Q55 Dan Byles:** Do the other witnesses have anything to say on that?

**Professor Ham:** Pace needs to be judged according to the ability of the new clinical commissioners to take on the responsibilities being offered to them. I could point you to some parts of the country in which the GPs, because they have been in the pathfinders, are almost ready to go. Why would we hold them back? There are some excellent examples around the country, but there are many others, often next door, where that is not the case. So pace has to be judged in relation to the ability of people to take on the responsibilities being put in their direction.

**Q56 Grahame M. Morris:** In their response, which the Committee only received yesterday tea time as well, the Government identify how they would assuage concerns about cherry-picking of particular services. One of the ways in which they suggest that that might be done is through a more complex tariff system. Both Mr Farrar and Professor Ham have raised concerns about the new
bureaucracy and the complexities that that will bring into the system. Have you given any thought to how commissioners will cope with that, given that their admin costs are capped elsewhere?

Mike Farrar: Cherry-picking is a very complex issue. The current tariff does not reward accurately the costs of care. From the work that we have done with our members, there is quite a wide range of things, such as older people’s care and general surgery, that, generally speaking, are subsidised by some of the more sporadic elective pieces of work, such as cochlear implant, where trusts can often effectively do better under the tariff arrangements.

That is quite a significant set of complex interrelationships, and if you start allowing individual bits of service to be taken away, you can destabilise services. We think that the tariff is the right way to do it, but we know from the tariff to date that a couple of times when it has been road-tested in its current form it has had to be taken back and adjusted. Going for a more sophisticated tariff probably is the right solution, but we do not underestimate the effort that it takes to do that.

We do not think, however, that you can restrict patients to receiving care from a poor-quality provider, and therefore we think that you have to attack this. There are two principles at stake here. One is not destabilising important services that have co-dependencies and relationships. The second is making sure, as far as we possibly can, that patients can always have the option to get the best provider. This is quite technical and difficult, and it is easy to get perverse consequences. We feel that we need to work quite hard on this issue.

We saw in the Government’s document yesterday a statement of how they might tackle that through things such as trying to redesign tariff and go for a more sophisticated tariff, but the devil really is in the detail and it takes a lot of testing and a lot of understanding. The situation in a large teaching hospital regarding what it is subsidising and what it is benefiting from might be different in a district general hospital, in a rural area or in community services. This is quite a complex area, and we would certainly counsel a significant investment in understanding and developing it. We suggest bringing our members in to play rather than doing it in an academic way, because our members can reflect from their current experience where you are getting some of these variations.

Professor Ham: You asked about commissioning groups—their ability and the management cost constraints on them. I would say that it would be totally inefficient and the wrong way to go to expect 200, 300 or however many clinical commissioning groups to find local solutions to refining the tariff to avoid cherry-picking. That needs to be done properly once by the NHS commissioning board to create some national, off-the-shelf solutions that commissioning groups can pick up and adapt.

The second point is the management cost constraints. We do not see why you should set an artificial limit on how much of the commissioning budget commissioning groups should spend on management costs. If they choose to spend more because they see that as a good way of getting the support that they need, why not let them?

Dr Dixon: It is appropriate to have a more sophisticated tariff, but most trusts in the country do not have the information systems to base it on, so it is going to be very slow going and it will not happen any time soon.

Q57 Grahame M. Morris: The dilemma with that, which you have highlighted previously, Dr Dixon, regarding Professor Ham’s question about why we should cap admin costs, is that presumably that money might otherwise go into patient care. You have identified in the north American study, however, that the failure rate was because not enough investment went into that area.

Dr Dixon: Yes. If anything, we are undermanaged in this country.

Q58 Owen Smith: May I pursue the point about tariff with Dr Dixon? In the amendments, the Government are clearly seeking to create a more sophisticated national tariff. In so doing, they are trying to do what they say they want to do, which is to prevent price competition. In a new NHS, where we have this more labyrinthine set of rules about setting tariff, is there anything in the amendments that you have seen that would stop price competition? Is it not actually more likely? The substantive change on the face of the amendments is that commissioners have to publish information when there is a variance from tariff, so is having that new information in the system and in the public domain not more likely to mean that there will be price competition in the NHS, once a whole variety of different prices is out there in the public domain?

Dr Dixon: As far as I can see, the spirit of the Bill is that there should not be price competition. There is still the option in there for price flexibility under certain circumstances, and that is probably as far as can be gone with this issue. I am clear that the spirit is not to have price competition, but there is scope for price flexibility.

Q59 Owen Smith: What is the difference?

Dr Dixon: Apparently, there is price flexibility below a tariff, but if that is the case, providers have to make more information available about the outcomes and quality of that service, and I think David Nicholson was clear about that in his evidence to one of the Committees. That is broadly the intention, but it would have to be assessed regularly to make sure that it was not being abused, which is another reason to have a sectoral regulator that would monitor that issue.

Professor Ham: It is not as though we are starting from a position where there is one uniform set of prices for a certain range of services all over the country. Mike can comment on this in far greater detail, with more authority than I can, but at the moment, PCTs and, to some extent, practice-based commissioners negotiate on price and the cost of services locally. They do not call it price competition, but they do deals with their local providers, which may well be below the national tariff or about services that are not currently included in the tariff.

Q60 Owen Smith: But at the moment, they are not obligated to publish the prices that they have struck with the provider. The Bill envisages a world in which they will have to publish what that varied price is and why it is a different price. Is that not more likely to lead to price competition across the NHS, as people chase the lower price?
Dr Dixon: It may do, but it also may provide greater safeguards, so that you can actually see where it is happening and monitor the quality of care more closely.

Q61 Liz Kendall: We know that long-term conditions are obviously the biggest challenge that the NHS faces, and that about 80% of patient contact is in primary care. I want to ask each of the witnesses what the Bill does to improve primary care. Dr Dixon, perhaps you could go first.

Dr Dixon: More broadly speaking, the idea of the clinical commissioning groups taking on responsibility for the quality of primary care is a very positive move. In scrutinising expenditure on the budget for hospital care, they will have an incentive to be looking at out-of-hospital care provided by practices that are on their patch. For the first time, that creates a really nice mechanism for proper peer review of the quality of primary care locally.

May I just add that the biggest issue facing the service is provision? It is not directly addressed in the legislation—nor should it be, probably—but the quality of primary care and the administration around that is at least addressed indirectly through the commissioning consortia.

Professor Ham: We have always been concerned about the proposal—as far as I understand it, this has not changed—that responsibility for commissioning primary care provision should rest with the NHS commissioning board. It would probably be done through the regional offices—clusters, or whatever they are to be called in future—and the concern is that they would not have the depth of understanding of current standards of primary medical care provision to be able to exercise that power effectively.

That is not to say that PCTs in the current system have done a fantastic job. However, there are some notable exceptions, where PCTs have used the levers available—Tower Hamlets is a really good example—and have got in there among the practices to improve quality and reduce the variability of primary medical care provision. We do not see why that should not be a clear responsibility of the clinical commissioning groups, working in association with the NHS commissioning board, because they will be much better placed to understand what is currently delivered, where the weaknesses are, and they have the right kind of expertise to exert peer pressure on poorly performing practices to improve. That has to be a key part of the future.

Mike Farrar: Our sense is that there are some very positive things for the development of primary care, but some things to watch out for. A positive development around primary care is effectively giving clinical commissioning groups the resource to deploy around secondary care; the way in which they will become managers of demand is largely by developing alternatives to secondary care. In our view, there are some issues about supply-induced demand that can be tackled, but an awful lot of the way that we can deflect work from secondary care is by having an alternative available. In fact, a lot ends up in hospital because there is not primary care.

I very much agree with the point about peer review of primary care. There has been data available to help us look at primary care and we have probably not exploited that to its full potential. We could do more and should do more. We very much support the view that Chris just expressed. It is very important that the clinical commissioning groups have a relationship with their practices. If primary care contracting is too remote from them, first, you will not get the local understanding that you need; and secondly, you will not have the leverage over practices that are behaving in an aberrant way in the sense of not complying with some of the things that the commissioning group might think are sensible. They are all potential positives if we can do the latter.

The downside, and one of the things that was a significant concern to me in my previous role in the north-west, is that we were struggling to have primary care capacity sufficient to do the work that could and should have been done in primary care. Clearly, taking some of that capacity away from primary care provision into the commissioning arrangement could detract from your key principle. Therefore one of the things that is worth giving due consideration to in the implementation of this is where will that capacity be sourced and is it a catalyst for bringing more multi-disciplinary work into primary care? Are there things that we can do to deflect work away from primary care? But that resource is very precious at the moment in terms of providing high-quality primary care, particularly in deprived areas with high health need.

Q62 Liz Kendall: As a quick follow-up, going back to the point that you all made earlier about the need to take difficult decisions about hospital services, do you think the Bill makes that harder or easier?

Dr Dixon: To reconfigure hospital services?

Liz Kendall: Yes.

Dr Dixon: I think it is a fine balance. On the one hand there is more complexity, but on the other hand complexity is needed locally in order to get the decisions through and communicated properly to a wide group of stakeholders. So I am agnostic.

Professor Ham: I think it will be more difficult to achieve reconfigurations at the necessary speed because there are more checks and balances that, for good reason, have been built into the modifications to the Bill. So I think that will slow down. I take what Jennifer said earlier. Sometimes that may result in better decisions, but frankly we do not have the luxury of time and many of these decisions that are around on reconfiguration have been around for a long time.

Mike Farrar: I do not believe that the Bill will fundamentally change the way in which this operates at the moment. The big issue on reconfiguration of services is largely about the extent to which we communicate with the public about change. One of the silver linings to the cloud of the big political debate, if I can put it that way, has been that at a political level there is more engagement with some of the difficulties around the health service and making changes.

I have talked to some MPs who understand in private the case for change, but feel compelled later on to take a rather different public stance. That does not help any of us. It would be enormously helpful if, on the back of this debate about health services, we could have a significantly more mature conversation, with political leadership and the NHS working together to put the case for change.
Q63 Dr Poulter: To follow up on that, the King’s Fund put out a good report recently on incentives in the NHS. It found that the current system of incentives does not really incentivise dealing with health care inequalities, as set up around the QOF payment, or with the big challenge of supporting people living longer with many medical co-morbidities. The focus is now on commissioning boards, so, to start with Professor Ham, do you think that it is a good way to tackle some of the key issues around health care inequalities and to deal better with looking after people in the community and preventing unnecessary acute hospital admissions?

Professor Ham: Yes, if two conditions are fulfilled. First, the commissioning outcomes framework, which has not been mentioned so far, will reward clinical commissioning groups depending on how well they perform, and it could create the right kind of incentives for clinical commissioning groups to focus exactly on tackling health inequalities and avoiding avoidable hospital admissions. We do not yet know what will be in the commissioning outcomes framework, so we, and I am sure you, will follow that very closely to see what the groups will be rewarded for. What gets measured gets managed, and clinical commissioning groups will be no different.

Secondly, the relationship between the new public health function located in local government and the clinical commissioning groups will be critical. Primary care teams are in many ways the foot soldiers of public health and prevention. Putting public health into local government could bring some real benefits, but we must ensure that it does not detach public health from primary care, because we need the two to work together to address the agenda you have identified.

Dr Dixon: On whether the Bill helps, there is a risk on the commissioning side that CCGs will be pretty inert, apart from in one or two go-ahead areas. Remember the phrase about practice-based commissioning—it is a corpse in need of resuscitation, or not. The big risk is that commissioning will not fire, so what is in the Bill to fire up the provider side, which should be integrating to provide the seamless care we all want? There is the promise of integration—the promotion of it—but not much else. It probably rests with the payment mechanism that is constructed around the providers to help fire up and motivate them to provide more out of hospital care. To return to the red tape and the complexity on the commissioning side, there is a risk of inertia on the CCG side that will not act to promote the integration we want.

The Chair: We are coming to the end of our evidence session. This will probably be the last question.

Q64 Fiona O’Donnell: I want to ask about the voluntary sector, following the questions Mr Smith asked about price competition. With the Government’s Work programme, the voluntary sector has had problems getting its services commissioned. Obviously, it plays a vital role in the provision of high quality social care services, so are you concerned that it could face similar challenges in bidding to provide services from this Bill?

Professor Ham: We have just produced a report with the National Council for Voluntary Organisations on precisely that issue, which we will be happy to send the Committee. It raises not only the opportunities from the Bill and the reform programme for the voluntary sector to play a much bigger part, but the risks. It will come down to how clinical commissioning groups see the voluntary sector. If they want to use their resources to bring in the voluntary sector more significantly, I think that will happen at a local level. It is about how the groups operate, rather than how the Bill is framed.

Mike Farrar: There is a hugely important role for the voluntary sector. It has a way of engaging people that should be part of the transformation of the service, so that it can deal with the long-term financial challenges by engaging people more in thinking about their own health and use of resources. Through the process of implementation, we should ensure that we support the voluntary sector to be a bigger provider of services over time to the health service. I do not think that it is necessarily supported or otherwise by the legislation at the moment. The biggest challenge for the voluntary sector is the short-term contracting and financial pressures on the system. We should try very, very hard to secure a long-term position for the voluntary sector as a provider of health and social care.

The Chair: That brings us to the end of our allotted time for the Committee to ask questions to these witnesses. I thank them very much for giving their evidence this morning. We now move on to hear evidence from Monitor, the Foundation Trust Network and the Local Government Association.

12.16 pm

Examination of Witnesses

Councillor Dr Barnard, Dr Bennett, Sue Slipman, Andrew Cozens and Sonia Brown gave evidence.

The Chair: Welcome to our meeting. We will move straight into questions, if that is okay. When you answer your first question, you can give us a brief description of who you are—it saves time if we let you do that when you answer your first question.

Q65 Emily Thornberry: I do not think, looking through the paperwork, that any of you have yet had an opportunity to submit any written evidence. I shall ask the obvious question: presumably that is because you have not had sufficient time? Do you all intend to submit written evidence at a later stage and have you, before giving evidence today, had sufficient time to closely examine the 180 amendments, compare them with the Bill and cross-reference them with the Future Forum report and the Government’s response?

Councillor Dr Barnard: I am Councillor Dr Gareth Barnard, vice-chair of the Community Wellbeing Board. In answer to your question, first, yes the Local Government Association will be submitting written evidence. I believe that the deadline is around 14 July. In the meantime, rather than scanning through every single amendment, we have looked at those where we feel there is a key local government interest. We feel confident that we are able, at this point, to assess where things have gone.

Sue Slipman: I represent the Foundation Trust Network. We have taken a similar approach to that of the Local Government Association, which was the only thing one could do in the time and circumstances. We have a reasonable understanding of how the changes in the Bill will impact on the key issues of foundation trusts going forward.
Dr Bennett: I represent Monitor. Similarly, first, yes we will submit written evidence in due course. We have not had time to do that yet. We have done our best to understand the implications of all the changes. We have, of course, focused on those changes that apply to Monitor. But, rather a lot of them do, so we have just done our very best.

Q66 Emily Thornberry: I wonder, then, whether you feel confident that you will be able to answer questions fully. If there were one further amendment—perhaps with reference to the Future Forum or to your own particular interest—that you think the Bill should have that it may have missed out, what might that be?

Andrew Cozens: I am strategic adviser to the Local Government Group. We have three, but I will choose one if that is okay. We have particular concerns about the extent to which the Bill promotes the integration of health and social care. We are concerned that the proposals promote the integration of the health service, but not necessarily the integration of health and well-being. It misses the concerns that we raised in evidence to you before about Cinderella services, particularly in relation to amendment 59. That amendment talks about the responsibilities of commissioning groups for emergency care, but we feel that it misses wider responsibilities in relation to things like safeguarding emergency mental health services or services for homeless people, for example. That is one suggestion.

Sue Slipman: We have two areas that we are concerned about. The first is the slowing down of the progress to a whole foundation trust sector. The Bill, as a whole, is a real endorsement of the foundation trust model as the way forward for public provision within the NHS. We are concerned that the proposals towards foundation trust establishment, so we were pleased to see that the Bill, as a format, in future is to be retained in the Bill. We think that that will help to keep the momentum and the impetus. We are concerned that, because of the financial challenges—the Nicholson challenge—of needing to get £20 billion out of the system, driving towards more efficient provision is going to be enormously important.

The other area where we have some major concerns is with what is missing from the Bill at this stage, which means the failure regime and how services will be protected, and the implications of that, particularly for foundation trusts, for access to affordable capital. That would be our real concern.

Dr Bennett: I echo that. The biggest gap at the moment is the replacement for the original proposals on the failure regime. That definitely needs to be set out.

Q67 Owen Smith: I have a specific question for Dr Bennett. In your understanding, was it ever a primary duty of Monitor to promote competition as an end in itself?

Dr Bennett: No.

Q68 Owen Smith: Which is obviously the way in which the Government have chosen to characterise repeatedly—notably in the notes that came out yesterday—what they have changed about you, because they are talking about you having hitherto had this duty to promote competition as an end in itself. You never thought that was the case, and I didn’t either. Given that we agree that it was never your job, could you explain to us what exactly has changed in respect of your duty with regard to competition? What is the difference between promoting competition and preventing anti-competitive behaviours, which the notes describe as preventing anti-competition?

Dr Bennett: First, although that we should be promoting competition as an end in itself was never my interpretation of what the Bill originally said, there were people who were concerned that we could be interpreted as having a duty to promote competition. One thing that has changed, therefore, is that it has been made clear that that is not what we should do, and it never should have been.

The Chair: Order. There is a bit of chuntering going on to my right hand side. Please give the witness some order.

Dr Bennett: On the specifics, taking that out makes it clear that that is not what we should be doing. Secondly, it significantly raises the burden of proof on us. If we feel—normally working alongside the commissioning board—that the use of competition is a way of furthering the interests of patients, the burden of proof that that, rather than other ways of furthering such interests, is the right way to go is significantly higher. That is the other key thing that has changed.

Q69 Owen Smith: Can you point to anywhere else in the Bill where your fundamental core powers are altered by the amendments that were tabled last weekend?

Sonia Brown: The most significant change is the focus on integrated care. People were concerned that the duty to promote competition might have led to many fragmented services, so one of the big changes is in the development of amendments in order to make it clear to Monitor that we should work to enable, where possible, integrated care. That is a very big area.

Q70 Owen Smith: Do you have a specific power in relation to integrating care or encouraging the integration of care in the same way as you obviously have powers to promote competition?

Sonia Brown: The primary area where we will be helping integrated care is in price setting, where it will be for the NHS commissioning board to actually develop proposals. The Bill is asking Monitor to take notice of how valuable integrated care offerings are to patients. When the board is established, we should prioritise enabling the delivery of that integrated care.

Q71 Owen Smith: You mentioned pricing. One of the substantive changes that I can see in the amendments is that commissioners will now be obligated to publish prices when they vary from tariff. This will be the first time we have seen that applied across the board in the NHS. Is that not likely to make price competition more prevalent, as there will be more prices and more information in the market?

Sonia Brown: That provision needs to be read alongside some of the other provisions in the Bill that encourage the commissioning board to expand the scope of a tariff. In the Government’s response document, we have also seen that the introduction of any qualified provider
will be limited to services in which there is a tariff to support the introduction of AQP. Read together, the provisions should not see the introduction of more widespread price competition.

Q72 Owen Smith: Among prices that are off-tariff, are you suggesting that there might be more price competition?

Sonia Brown: The Government's response makes it clear that commissioners should not be competing on price when there is no tariff. Instead they should be competing on value and seeking to achieve value from the offerings that different providers deliver. Obviously, there is a lot of work to be done to develop the rules that will underpin how that operates.

Q73 Fiona O'Donnell: Although it did not form part of the Future Forum report, Professor Field said in his evidence that he favoured retaining a cap on the number of private patients treated in foundation trust hospitals. This is possibly one for Sue Slipman, but I am happy to hear from others. Do you support Professor Field's view?

Sue Slipman: No. We welcome the removal of the private patient cap, although we recognise, as we have all along, that there will need to be a great deal of transparency to indicate where NHS patients have benefited from bringing more money into the system.

Our view is that for most organisations it is not about treating private patients at all, although it will be for some. Particularly in services in which there is short NHS supply, such as fertility treatments and so on, there may be a market for services to private patients. Mostly this is about being able to use the intellectual property that is developed within member organisations, in terms of product development and new drugs and methodologies, to bring money into the NHS, which is becoming more and more cash-strapped.

Q74 Fiona O'Donnell: They want to be able to treat more private patients to fill funding gaps, but how can you increase capacity for private patients without lessening the service you give NHS patients?

Sue Slipman: As I said, most of this is not about treating private patients; it is about using intellectual property in the NHS to bring money into the system, which will often be done in joint venture with other partners. It will, therefore, be an overall benefit to NHS patients. Those organisations that have capacity to increase treatment of private patients will often be in areas in which commissioners are restricting access to services for NHS patients.

Q75 Emily Thornberry: I am sorry, but I do not understand that answer. Are you in favour of raising the cap on the number of private patients treated in NHS hospitals?

Sue Slipman: Depending on a range of patient choices, there will not necessarily be fewer NHS patients if you expand the facilities as a result of the money that you bring in. It depends where you invest that money. The term “private patient cap” is a misnomer because it covers all money that is brought into the system from any service that may derive from private patients. For example, if you run a laundry in your hospital and any of that laundry is used by those who supply services to private patients, it counts against the cap.

Q76 Emily Thornberry: So you support the Bill, which allows the cap to be lifted.

Sue Slipman: We believe that the lifting of the private patient cap will enable public providers to bring more money into the NHS, to benefit NHS patients.

Q77 Grahame M. Morris: I want to move on, in particular to the issue of European competition rules. I am afraid that I have not seen the most recent evidence from Monitor, but I refer to an article in the Health Service Journal, which is an interview that Dr Bennett gave in response to the Government's acceptance of the Future Forum's recommendations on diluting the role of Monitor as an economic regulator driving forward competition. Your response, Dr Bennett, was:

“The policy statement makes clear Monitor will still be given enforcement powers concurrent with the Office of Fair Trading and the Commissioning Board will have to consult with Monitor on its competition guidance.”

I am not sure how the powers have been watered down, but can you comment on that in relation to European competition law? A spokesman for the private sector, a gentleman called David Worskett from the NHS Partners Network, suggested that the NHS market would now be opened up through legal challenges and case law, and he predicted that it would still happen but over a longer time frame. How do you respond to that?

Dr Bennett: On the first point about concurrency, that has not changed. I think that the proposals in the revisions are the same as they were originally. What has changed is that in addition to the Competition Act there are the sector-specific regimes. There is one today, the principles and rules for co-operation and competition, as looked at by the co-operation and competition panel. The proposal is that they continue to form the foundation of the new sector regime. The original intention was that there would be a sector regime, and this makes it clearer that it is a continuation of the current regime. But in the application of that regime now, we will be subject to tougher requirements in terms of burden of proof, for example, when we think that it might be appropriate to introduce further competition. Those are the changes, but the concurrency with the Competition Act remains as it was.

Q78 Grahame M. Morris: I note what you said, but the implication is that there is no change. Is not the change that the architecture envisaged by the Bill itself exposes the NHS to greater competition, particularly using EU competition laws?

Dr Bennett: This is a complex area, but fundamentally the original proposals did not extend the application of EU, or indeed UK, competition law to the health sector. UK, and therefore EU, competition law applies across the whole of the UK economy; it does so today, and it will in the future. Giving Monitor concurrency means that as competition regulations, whether sector specific or the Competition Act, are applied to the sector, they are being applied by a body that has sector-specific knowledge today; the Office of Fair Trading oversees
the application of the Competition Act and is able to look at the health sector today. That would give us a role in looking at the health sector.

Q79 Grahame M. Morris: Is it not the case that the private sector sees European competition law as a mechanism that would allow it entry to the market?

Dr Bennett: Again, I will pass this on in a moment because the technicalities will get very complex. Today, if the private sector wanted to go to the OFT and make a complaint under the Competition Act, which embodies European competition law, it could, and the OFT is indeed dealing with a complaint today. What is proposed is that in addition to the OFT having that power—its normal power—we would have concurrent powers under the Competition Act. What that should mean is that if someone wanted to make a complaint under the Act they would come to us first. The advantage of that is twofold. First, it means that it has been looked at from the point of view of a sector-specific regulator, which has, I hope, an in-depth understanding of the sector, rather than being looked at by a general regulator. Secondly, it means that we are looking at it alongside the sector-specific regime, the principles and rules for co-operation and competition, which is being continued. If you were fearful that the Competition Act might be applied in an undesirable way to the health sector—we do not really know the extent to which it is applicable because it has not been tested; in the way these things work, until you have had cases in the courts to determine exactly what applies where, you cannot be sure—the fact that you have a sector regulator with concurrent powers able to look at those issues means that the Competition Act is more likely to be looked at through a sector-specific lens than applied in the same way as it would be to any other sector.

Q80 Dr Poulter: I have two questions, the first to Dr Bennett and Sonia Brown. You said that the focus was going to be on achieving value for the NHS and promoting integrated care. There are, obviously, considerable health care economic arguments as well as patient arguments for supporting integrated care and preventing unnecessary hospital admissions, as we heard earlier on. In Monitor’s role as part of integrated care, would you be looking specifically at community-focused care and providing more joined-up thinking in that part of health care?

Sonia Brown: Absolutely. The Bill is clear in asking Monitor to do two things. The first is to think, from a patient perspective, about having no boundaries in care in the integration across care setting boundaries for Monitor. The second is to think very hard about the efficiency arguments. Of course, sometimes the two things can actually work together and they are not necessarily in trade-off with each other.

Q81 Dr Poulter: You are saying that value for money for the NHS is the same as value for money for the patient, in terms of providing good care and joined-up care.

Sonia Brown: Yes.

Q82 Dr Poulter: My second question is to our colleagues from local government. On the idea of integrated care, in my experience there is often a lot of silo working between social services and the NHS. At the moment, we do not always see enough integrated care, in my view. For example, someone may have an acute event—a stroke—that will require NHS care for some of the time and social services care later on. One of the key challenges is for funding and support to follow the patient rather than the institution. How do you see this Bill supporting that objective?

Councillor Dr Barnard: First, it builds on some existing very good work that has taken place. Admittedly, in some places that has been better than others, but overall the journey has been in the right direction. A number of things in the Bill really help from the perspective of local government, particularly in the amendments that have been tabled. The first is the recognition of coterminosity, because you are starting to work on an approach that has common boundaries and therefore a common population and understanding, so you can use local information to plan the services more effectively. That fits very well with the role of the health and well-being board, which has been further explored. That is something that we felt was very positive about the Future Forum and it helped feed into that.

We also need to strengthen the transparency and the public accountability of NHS bodies, because if there is greater openness and understanding it will be easier for patients and the public as a whole to understand what is going on. When you link that not only to significant major events but to whole population planning—putting in preventive services for those in your local community who are more vulnerable and in most need of those services—it works very well.

What we find very helpful about the changes that have been made is the golden thread that now goes right through the Bill in terms of public and patient engagement. That is very important, because it helps in various situations by opening up dialogue. In practical terms, we see the role of the health and well-being board, and the commissioning groups, as absolutely core to that. Preventive work goes on; a very small example is work to prevent falls, which can be done very locally in the community and which involves, for example, making sure that older people wear the right sort of footwear so that they do not slip over. Things like that help. That is at a very local level, but the Bill really has helped in beefing up the health and well-being board. Can I link that with scrutiny, which is something that local government is quite passionate about these days? The strong reference to the independent health scrutiny that will take place is the sort of forum where the very question that you posed will be examined in a local setting. It opens it all up.

Andrew Cozens: The proposals for a clinical senate—we do not like the word “clinical” in the title—provide opportunities at regional and sub-regional level to look at not just health pathways but health and social care pathways, so the input of social care and local government at that level is also important.

Sue Sipman: I agree with what we have heard from colleagues on both sides. However, there is one bit that is missing. We are saying that it is in the interests of patients to have integrated care that begins to take people out of hospitals and gets them into the right place at the right time with more control and empowerment over the management of their own conditions, and that
there is now a clinical driver towards that. There is an efficiency driver as well and, as Sonia said, those two things can work hand in hand. However, they only work hand in hand if we then allow the reconfiguration of services in the secondary sector. If we do not recognise that that will mean the closure of some things—whether it be services or whole organisations—and we do not allow that or enable it to happen, we will drive the secondary organisations to failure themselves because they will not be sustainable unless they can reconfigure.

Q83 Emily Thornberry: During the first appearance of this Committee, the Local Government Group gave us some evidence about care trusts in which the chief executive from the primary care trust and the chief executive of the local authority had merged. Local authorities and the primary care trusts were trying to work closely together to provide health and social care at local level and there was great concern that the Bill was driving a coach and horses through that. Will you give us an update on what has happened to the care trusts?

Andrew Cozens: We were concerned about an inflexibility that did not have sufficient regard to the progress that local government had made with the health service in local areas. To a certain extent, some of the issues have already happened as a result of the clustering issues, but we are more reassured by the messages in the Government’s response to the Future Forum and by some of the representations in direct communication between the Secretary of State and the chairman of the Local Government Association. They talked about there being scope for greater local flexibility and about a general presumption in the amendments to promote integration between health and social care. A lot of the detail that underlies this will be not in the Bill but in subsequent guidance. We are encouraged but we remain generally concerned.

Q84 Mr Barron: First, a question for David Bennett. You have said—please tell me if this is a misinterpretation—that competition law in the national health service is covered at the moment. We have more than 80 clauses in this Bill bringing in competition law. One of those clauses, which remains unamended at the moment, gives you the power under part 4 of the Enterprise Act 2002 to refer any mergers between NHS trusts or mergers between NHS trusts and other businesses to the Office of Fair Trading or the Competition Commission. Under what circumstances do you think that you would use those powers? Could you give us an example of how you think that they will be used by Monitor in future?

Dr Bennett: I might pass the merger question to Sonia. Let me take the first bit. The NHS today is covered by competition rules in two fundamental ways. First, the UK Competition Act, which embodies EU competition law, applies across the whole of the UK economy. The extent to which it applies is untested because no one has actually tried to apply it in detail. In principle, it is there today. The second way in which there is already a competition regime in the NHS is through the principles and rules of co-operation and competition established by the previous Government. Those set out rules that determine, among other things, how competition should be applied in the health sector. The Co-operation and Competition Panel today looks at the application of those rules, hears complaints if people are concerned that they are not being followed, and will take a view. Today it advises either us, as the foundation trust regulator, or the Department of Health if it falls in its area, where it sees an infringement of the rules. Then we or the Department decide what to do about it. Those things are true today and, in principle, they do not change under the new proposals.

The Chair: Liz Kendall.

Mr Barron: Can I just finish, Mr Hood?

The Chair: If it’s just one more.

Q85 Mr Barron: If it is just one more, I’ll leave the need of clauses alone. I wanted to ask Dr Barnard just one question, but did you have a view on that first question?

Sonia Brown: On the mergers? The intention under the Bill is that foundation trusts will be subject to merger control by the Office of Fair Trading and, if necessary, by the Competition Commission. That is the idea that sits behind the Bill.

Q86 Mr Barron: And that remains?

Sonia Brown: Yes.

Q87 Mr Barron: Just one quick question, Dr Barnard. The changes proposed in the amendments, we are told, give more power to health and well-being boards, inasmuch as you have to be consulted about commissioning plans. It says that on an ongoing basis, not just that this is the commissioning plan—and then go away for the next 12 months. Commissioning bodies will have limited money. One of the matters raised is, do you think that health and well-being boards, given that they are looking at the wider strategy of health and well-being in communities, should have the power to veto commissioning groups’ plans?

Councillor Dr Barnard: I do not like the word “veto”.

If you look at the way that health and well-being boards will work, I would like to base it on the experience of children’s trusts, for example—the idea that when you come together to commission services, if you start with the established health needs of the area, you have the joint strategic needs assessment, which will clearly set out the key determinants of health in the area. If you cannot come to an understanding and agree at that point—on the health and well-being board and then look at the commissioning plans—if they don’t tie in, rather than veto something, you need to go back and review where you have got to.

The co-operation and collaboration go back to the question around care trusts. Where they have worked, it is because at below chief executive level, everyone has worked together. That is far more important. If you start putting that level of power and authority into a board to do that, you rather move away from the core function, which is to agree a local plan within the available resources and meet the needs of the whole population. That is clearly going to mean that you have regard, if you are doing population planning, for what...
some people refer to as umbrella services, the services that target other groups, which is more important. They will have to be included. I am not convinced at this point. The way it is set out and how the Bill will make it happen, with the guidance that is in place—the good practice guidance which is equally as important as the statutory guidance—will be very important. So, I am not persuaded.

Q88 Liz Kendall: That you all for coming. Dr Bennett and Sue Slipman said that the biggest gap in the Bill was now a lack of a failure regime. I would like to ask you both, approximately how many NHS trusts will currently find it impossible to become a foundation trust because of their financial problems?

Dr Bennett: I will give you a simple answer. It is outside our remit. It is the Department’s role, of course, to get the non-FTs to FT status. We don’t have a direct insight into the challenges that those trusts face, until they come to us, at which point they should be ready. The simple answer is that I am not in a position to be able to tell you.

Sue Slipman: I, too, am not in a position to be able to tell anyone the answer. The number that has been generally understood to be the case is around 20. I haven’t heard that changing over the past few years that we have had these debates. However, it is a question for the Department, because the section of the Department that is overseeing this clearly now has a business arrangement with each of those organisations coming forward, hopefully, for authorisation over time, and therefore should have a much more detailed, forensic analysis of the position.

Q89 Liz Kendall: We will certainly ask the Ministers the question again later. What does a lack of a failure regime—that is a very technical term for some people—mean for patients? Again, I would like to ask Dr Bennett and Sue Slipman.

Dr Bennett: The most important thing for patients is that where an organisation is providing a service that is essential for those patients—of course, it may be many services in certain circumstances—we need to be sure that if those providers get into financial difficulty, there is a way of dealing with that while the service continues to be provided. The most important thing from a patient’s point of view is that they are reassured that even if their providers get into financial difficulty, the service will still be there.

Q90 Liz Kendall: Does that mean that someone has to bail them out?

Dr Bennett: Not necessarily. Indeed, you could say that “bailing out”, which is quite an emotive phrase, is exactly what should not be happening.

Q91 Liz Kendall: It is used in the Government’s response to the Future Forum; those are not my words.

Dr Bennett: I seem to remember they said they did not want it to be happening. I think by “bail out”, people mean something that happens in a rather opaque way in relation to providers of services where the services may be essential but the providers, frankly, may not be doing a very good job. They may be inefficient. Sometimes there are even questions about the quality of the service. Today, in certain circumstances, those providers can be kept going through hidden bail-outs. No one really knows how much that is costing. It never really puts proper incentives on the people managing those services to sort out the problems. An effective failure regime also needs to stop those hidden bail-outs and ensure that everything that is done is done transparently.

If a service needs to be subsidised in some way because it is an essential service—and, perhaps because it is in a rural location, it cannot be provided at the normal NHS tariff—that should be looked at in an objective and transparent way and a subsidy should be agreed, by the commissioners, of course, because they are the ones who have to pay it. Then the service is protected in that way. That is another key element.

Sue Slipman: I think David has said almost everything that needs to be said. The immediate issue is about protecting services for patients without protecting the provider, because the whole point of the new system is to drive efficiency so that we get good-quality patient services at the best price that can be managed for that. That is the whole drive of this, and we will support that.

That is the immediate issue. The longer-term question is where we will get the investment for good-quality NHS services in the future. If we do not have a provider regime—a failure regime—that understands where that capital will come from in the future, we starve ourselves of investment in new plant and machinery in the health service in the longer term. The short term—the immediate term—is about the protection of patient services. The longer term is about the impact that the lack of a failure regime is likely to have on getting capital into the NHS as a public service, when we know that public capital will be in short supply.

Q92 Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): Dr Bennett, do you believe that the statement that the Minister, Paul Burstow, gave—that competition has been put back in its box—is correct when we have no substantive amendments to clauses 60, 64 and 65, which hold the real power in terms of competition law and the implications for the health service, and Monitor’s core function and role in the original Bill?

Dr Bennett: What I presume the Minister meant was this. There is no doubt that a lot of people were concerned that the original proposals created the potential for a market free-for-all, as people like to describe it. These changes, I think, guarantee that that cannot happen. I presume that is what putting competition back in its box means.

Q93 Fiona O’Donnell: I am grateful to have the opportunity to ask a couple more questions of Ms Slipman about the cap on private patients. I do not think that patients are worried that laundry facilities will be used by private patients; they are worried that they may have to wait longer for treatment as a result of private patients being treated before them. Where are the safeguards in the Bill that will ensure we do not end up with a two-tier health service in which someone can pay to have a hip replacement and jump the queue? Not that you can jump when you need a hip replacement.

Sue Slipman: Well, you can try, although you are unlikely to be successful.

The safeguards are in the system itself. The first safeguard is the primary purpose of a foundation trust, which is to serve its NHS patients. That is covered under the terms of authorisation by Monitor, so there is
a regulatory interest. If patients were not being served under the terms of authorisation, there would be a whole range of scrutiny and overview for the kinds of activities that hospital organisations undertake at local level. But perhaps the most important safeguard is the elected governors of a foundation trust, who are there to represent patients. They will take a pretty dim view if their organisation is not serving NHS patients.

Q94 Fiona O’Donnell: You are saying that those safeguards are in place. I do not buy the idea that all this income will be generated to treat NHS patients simply through intellectual property, so you will have to develop new capacity to treat more private patients. Where does the capital come from to do that?

Sue Slipman: You have to recognise that the more successful the NHS is in cutting waiting lists, the more we cut the market.

Q95 Fiona O’Donnell: Where does the capital come from?

Sue Slipman: The capital may well come from surpluses earned. It may well come from joint ventures or a whole range of—

Q96 Fiona O’Donnell: Surpluses earned? So existing public funds would be diverted?

Sue Slipman: Those funds have to be reinvested to benefit NHS patients. If, in the longer term, as a result of product development for using intellectual property you are going to generate more funds to come back into the NHS, that is a business case way of ensuring that you maximise the funds available for NHS patients in the end.

Q97 Fiona O’Donnell: Sorry, it is really important. Can I just clarify that the capital may come from public funds?

Sue Slipman: No, not necessarily. You would have to recognise that if you are going to invest in a product that is going to bring in a lot of money, there is a business case. If you are meeting your terms of authorisation while you are developing those new business ideas—innovation of all kinds—for the benefit of NHS patients, that seems to me to be a reasonable thing, provided you are at all times meeting your terms of authorisation and your responsibilities to NHS patients.

The Chair: We have two more minutes. Are there any other questions for our witnesses?

Q98 Owen Smith: Dr Bennett, you have referred several times to the higher burden of proof that you are going to have to meet when you determine whether you will apply measures to increase competition. I presume that is in the changes to clause 56, which are about your needing to be mindful of whether you will apply measures to improve patient outcomes and standards—clinical judgments, basically. Are you confident that Monitor has the expertise to exercise what are going to be clinical judgments, given that you are economists?

Dr Bennett: The part of Monitor that is going to do all of that does not exist today. Monitor today is fundamentally the regulator of the foundation trusts, so we have to build a new organisation to do that. With absolute certainty, we need to have people with the ability, among other skills, to understand the clinical aspects. Quite how we do that, we need to work out. Helpfully, among the new amendments is a duty on us to draw on clinical expertise, which is entirely sensible. There is a duty on us to make sure that we get appropriate input on what patients want, which also makes perfect sense. We have to make sure that we do that.

Q99 Emily Thornberry: At the beginning of your evidence, Mr Cozens, you told us you had three concerns. Have you told us what the other two are?

Andrew Cozens: We have a general concern about the concept and composition of the clinical commissioning groups. We do not like the title; something more like local health groups would be appropriate, largely because there is a danger that it waters down the concept of GP-led commissioning. Our concern is that—

The Chair: Order. I am afraid that that brings us to the end of the time allotted for the Committee to ask questions of the witnesses.

1 pm

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

Adjourned till this day at Four o’clock.