Public Bill Committee

HEALTH AND SOCIAL CARE (RE-COMMITTED) BILL

Second Sitting
Tuesday 28 June 2011
(Afternoon)

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Examination of witnesses.
Adjourned till Thursday 30 June at Nine o’clock.
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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)
† Smith, Owen (Pontypredd) (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)
† attended the Committee

Sarah Davies, Mark Etherton, Committee Clerks

Witnesses

Dr Hamish Meldrum, Chairman, BMA Council, British Medical Association
Dr Peter Carter, Chief Executive and General Secretary, Royal College of Nursing
Sir Richard Thompson, President, Royal College of Physicians
Professor Sir Neil Douglas, Chairman, Academy of Medical Royal Colleges
Dr Clare Gerada, Chair, Royal College of General Practitioners
Dr David Paynton, Joint Clinical Lead, Royal College of General Practitioners
Dr Mike Dixon, Chairman, NHS Alliance
Michael Sobanja, Chief Executive, NHS Alliance
Paul Jenkins, Chief Executive, Rethink and the Richmond Group
Jeremy Taylor, Chief Executive, National Voices
Ciarán Devane, Chief Executive, Macmillan Cancer Support
Neil Churchill, Chief Executive, Asthma UK
Baroness Barbara Young, Chief Executive, Diabetes UK
Joe Korner, Director of Communications, Stroke Association
Gail Adams, Head of Nursing, UNISON
Rachael Maskell, National Officer, UNITE
 Rt hon. Andrew Lansley MP, Secretary of State for Health
Rt hon. Simon Burns MP, Minister of State for Health
Paul Burstow MP, Minister of State for Care Services
Public Bill Committee

Tuesday 28 June 2011

(Afternoon)

[Mr Jim Hood in the Chair]

Health and Social Care (Re-committed) Bill

4 pm

The Committee deliberated in private.

Examination of Witnesses

Dr Hamish Meldrum, Dr Peter Carter, Sir Richard Thompson and Professor Sir Neil Douglas gave evidence.

4.3 pm

The Chair: Good afternoon, gentlemen. I welcome Dr Hamish Meldrum who is video-linked to us from Cardiff; Dr Peter Carter, chief exec and general secretary of the Royal College of Nursing; Sir Richard Thompson, president of the Royal College of Physicians; and Professor Sir Neil Douglas, chairman of the Academy of Medical Royal Colleges.

We have a video link, but we will run the evidence session as though Dr Meldrum was sitting in his chair, and for all intents and purposes that is exactly where he is sitting.

Emily Thornberry (Islington South and Finsbury) (Lab): It is nice to speak to you, Dr Meldrum. Can you see us?

Dr Meldrum: I can see Mr Hood at the moment. Yes, I can see you now.

Q100 Emily Thornberry: I shall begin with a question to all four witnesses that is similar to the one I asked first thing this morning. Although there might be pressure to get on with the changes and it might be regarded as important for the national health service to be able to move on, do you believe that the timetable that has been set out for all of us, and particularly for you, has been sufficient to enable you to go through the 180 amendments, compare the new document with the original Bill, consider the suggestions from the Future Forum and the Government’s response, and then look at whether the clauses reflect the promised changes? Do you think that you are in a position to represent fully your views and the views of your members in the time you have been given?

Dr Carter: The straight answer is no. We have had two full working days, and by anyone’s standards 180 amendments is a huge quantity. We are working on it, so we have two full working days, and by anyone’s standards 180 amendments is a huge quantity. We are working on it.

Sir Richard Thompson: I think the timetable is very short. The Irish person would say, “I wouldn’t start from here,” but we are here. There are bigger problems outside this room, to do with money and improving care in the health service, and we must get on with that. A senior politician said to me, “We’ve lost a year arguing about these things.”

Professor Sir Neil Douglas: The 48 hours was ridiculous, but there are so many disadvantages in delaying that we have to get on with it to the best of our ability now. We will not be able to give you definitive answers on detailed questions because our members have not had a chance to respond, but we will do our best and we believe that we should be going forward at the moment.

Q101 Emily Thornberry: Dr Meldrum, I think some of us may have received by e-mail about 10 minutes ago some form of response from the BMA, but you will forgive us if not all of us have been able to read it in some detail. We promise that we will. Could you give us a response to whether you feel that you have had a sufficient timetable?

Dr Meldrum: It has certainly been extremely rushed and challenging. I repeat how grateful I am for you allowing me to join via video link because I am at our annual conference in Cardiff. Interestingly enough, we had a very full and quite passionate debate on the Bill this morning. One of the problems that many members pointed out was that they were finding it very difficult to work out how the amendments fit into the current Bill. They feel that the degree of complexity is really quite immense. Any judgment we make at the moment has to be predicated on the view that we will want more time to study the amendments to see how they fit in with the overall situation. I echo what others have said about the uncertainty in the service also causing problems.

Emily Thornberry: Thank you very much.

Q102 John Pugh (Southport) (LD): Can I direct both of my questions to Hamish? I, too, received some communication during the lunch hour on a resolution passed by the BMA, and it would be helpful, Dr Meldrum, if you were able to amplify a little bit on it. Can I just take the resolution in reverse order? I understand that the BMA wants the Bill withdrawn, and three or four reasons are given there. One reason is that it imposes a duty on commissioners to promote choice as a higher priority than tackling fair access and health inequalities. An awful lot of the amendments are about tackling fair access and health inequalities and, indeed, some are about promoting choice. Is your reading of the Bill that it promotes choice as a higher priority than tackling fair access and health inequalities?

Dr Meldrum: Our understanding of the amendments as they are at the moment is that that might well be the case. I have always said that we are not against patient choice but, in a social solidarity model of health care, there always has to be a balance on how much individual choice impacts on the choice of others and the potential destabilisation of other services. First and foremost, we want to ensure that there is comprehensive, fair provision of health services to all. I think the reason that the conference asked for the Bill to be withdrawn is what I said earlier about the increasing complexity and the difficulty people were having finding out what it actually all means. There was another option, which was defeated, that opposed the Bill in its entirety, so there are still aspects of what the Government are trying to do that the BMA would continue to support.

Q103 John Pugh: I can entirely understand your difficulty in getting clear about what all the legislation means in the round. What I am trying to do is clarify
the BMA's present position. The second reason is that you believe that Monitor, the CQC and the NHS commissioning board should have a legal duty to act and to avoid the undermining of existing NHS services. That is something that you would hope that everybody in the NHS would seek to do—avoid undermining services. According to the BMA, what would it involve any of those bodies doing that they do not currently do and are not mandated to do by legislation?

Dr Meldrum: It goes back to my answer about the position of choice and the focus on that rather than, in some cases, there not being enough focus on the provision of stable, integrated services. It is about getting that balance right in allowing appropriate choice but not doing it in a way that undermines the system.

Q104 John Pugh: It is about getting the balance right between integration and choice. I will not go into the issue about the duty of the Secretary of State for Health because we will have him here quite soon. The other reason given is in regard to the function of Monitor to promote competition in the provision of health services. We had an interesting debate this morning as to whether preventing anti-competitive behaviour, which is what the actual amendment states, is the same as promoting competition. Your members are presumably aware that that particular phrase does not occur?

Dr Meldrum: Yes, they are aware of that. There was a very heated and passionate debate.

John Pugh: I do not think passion helps here. Clarity helps.

Dr Meldrum: Yes, but clarity is getting increasingly difficult. This was already quite a complex piece of legislation and it is now being very significantly amended. In many ways, it is being amended in ways that we approve of and have suggested, but we could end up with something that I would call almost a legislative morass, which is quite difficult to find one's way through and work out what it will all mean in practice. Of course there are other areas, such as the relationship with the NHS commissioning board and the role of clinical practitioners which add to the confusion.

Q105 Owen Smith (Pontypridd) (Lab): I will put my question to the people in the room, starting with Sir Richard. When you gave evidence to us previously, you were not sanguine at all about the changes that the Bill was going to introduce into the health service. Are you reassured by the amendments that we have seen, albeit at very late notice?

Sir Richard Thompson: The amendments are improvement. There are still things that I worry about, but the amendments, such as the one about putting a secondary care doctor on each clinical commissioning group, are a step forward. If there is one good thing in the reforms, it is forcing integration between primary and secondary care and getting rid of that barrier—commissioning without walls, we would call it. One thing that we suggested but no one has picked up is that there should also be a GP on the foundation trust board as well, to encourage integration between both sides of the patch.

Q106 Owen Smith: One of the issues that we discussed this morning was the extent to which Monitor's powers remain effectively the same. It has powers to promote competition; it has words relating to integration but no powers to compel or to encourage integration. Are you still concerned that we will see more competition and that that will play against further integration in the NHS?

Sir Richard Thompson: I am worried. I know that the chairman of Monitor has changed what he said previously, when he was interviewed by Mr Timmins. Hopefully, that is a real change and he does not have the same financial competition in mind that he seemed to have then. Clearly, if there is going to be choice, there will be some type of competition. I prefer the word “choice”, as I think Nick Clegg does, so I will stick to that. I am worried about Monitor and it must be watched carefully. I am not technically minded, so I do not know how you can write these things in. You have to leave some flexibility. Yes, though, I am still worried about it.

Q107 Owen Smith: Dr Carter, do you feel that the balance between integration and competition is better struck?

Dr Carter: It is right to say publicly that the listening exercise was a real exercise and we are pleased that many of the things that we asked for have been taken on board, but we have serious reservations about Monitor. Sir Richard has already mentioned some of the comments that were made by David Bennett when he was first appointed— likening the NHS to gas and utilities and saying it was ripe for significant change. Ideologically, we do not believe that getting component parts of the health service to compete with each other is a sensible way forward. We would prefer a model where people are tasked to collaborate with each other and to co-operate, where there is more integration of services, and where services sort out who is best placed to do what. We are worried that Monitor will focus on cost at the expense of quality, which is something we will have to watch in the coming period.

Professor Sir Neil Douglas: I agree entirely with what Richard and Peter have said. I welcome the involvement of a hospital doctor and a nurse on the clinical commissioning groups, although it is unfortunate that there is no firm recommendation that a public health doctor should be there too, because driving down health inequalities is really a public health role. One of the roles of the commissioning group is to drive down inequality, so I would like to see that there.

I also am very disappointed that although the involvement of the medical royal colleges in such things as the NHS commissioning board has been welcomed, recommendation 3.25 in the clinical advice and leadership report of the Future Forum of a requirement on NHS employers to release people to do work for the greater good of the NHS, be that for the colleges and thus the commissioning board, for the National Institute for Health and Clinical Excellence or for any other group, has not been taken up. The fact that foundation trusts do not wish to release people for the greater good of the service is a real problem for the colleges at present, and we would very much like to see that embedded in the Bill.

Sir Richard Thompson: Could I follow on the topic of public health, because that is one of our faculties? We are worried that public health will not be strong enough when it is embedded in local authorities and health and well-being boards. After all, as David Cameron has
suggested, public health must be our future; if public health does not win through, we will be destroyed economically trying to run the health service. I think it should be more prominent not only on the clinical commissioning groups but in advising the NCB and the local clinical commissioning groups.

Q108 Mr Steve Brine (Winchester) (Con): This is a question for any of you, but let us start with Cardiff. Dr Meldrum, thank you very much for joining us. I know that the BMA union has had its run-ins with Government over the years—some would say right from the start—and that has certainly been the case recently. Can I ask you two questions? First, I know that the BMA has made its position clear today, as is being reported, but what do you personally like in the new Health and Social Care Bill?

Secondly—the other gentlemen may be able to answer this as well—I am interested in probing the representative voice a bit. Obviously, the views of your organisations about this Bill have been well reported in recent months, but I am wondering what ongoing surveying of membership takes place. How many members do you have, and how many have answered your calls for responses about the Bill?

Dr Meldrum: I am here to represent the views of members, so in that sense my personal views do not count. That is the honour I have in being chairman of a representative body—

Q109 Mr Brine: Sorry to interrupt you, but let us just be clear. You asked your members not to support the withdrawal of Bill motion today, so presumably you were arguing a slightly different case from them. I tend to be a rather positive person, so I am asking you what you like in the Bill.

Dr Meldrum: I am a positive person, too, and I am a pragmatic person. I like to try to work out and talk out differences, and I did not really feel that suggesting the withdrawal of the Bill—whether that would be practical or not—was the best way to achieve that.

We obviously like the underpinning principles, which are greater clinical involvement in the decisions about how services will be provided, more patient engagement and a focus on quality. However, many of us, myself included, felt that a lot of those could have been achieved without recourse to legislation, or certainly with much simpler legislation than this Bill. Instead, we have this whole additional layer of legislation, which led to the worry that it was actually going to destabilise services and widen the split between primary and secondary care, and that it was not going to encourage collaboration. We wanted to see something that would actually change that position. However, the basic principle is fine. Certain aspects about getting rid of certain elements of bureaucracy are fine, although one wonders whether, with these amendments, we are replacing it with another layer of bureaucracy.

On getting members’ opinions, we have had meetings around the country, we have had our annual meeting, we have had the conference of GPs, and we have done surveys. Even among GPs, whom you might expect to be the most positive, many, even though they are getting quite actively involved in commissioning groups, still have severe reservations about certain aspects of the Bill.

Q110 Liz Kendall (Leicester West) (Lab): Thanks to everyone for joining us, here and from afar. I want to come back to a point made right at the beginning about what is happening now out in the services. The NHS Confederation managed to get us a briefing on the amendments to the Bill. It says:

“The new system could make it more difficult to make urgent decisions about reconfiguring local services when this will improve the quality of care for patients”.

It also stated that

“the reforms do not sufficiently focus on the big challenges facing the NHS: making £20 billion of efficiencies over four years”.

I want to ask each of the four witnesses whether, from what you understand that the Government are now saying, you think that those difficult decisions are going to be easier or harder.

Sir Richard Thompson: I think that improving the quality of care and saving money, which is desperately important, are separate. I came back from Nottingham to be with you today, and I hear that there are tremendous problems in secondary care everywhere, which is obviously my business. I think that that is separate from the reforms, which are altering the structure of the NHS. I see them as two separate things.

Sir Richard Thompson: The only thing that is really good is encouraging integration between primary and secondary care, which may lead—I hope it does—to improvement in the way that patients receive care and possibly to savings. Reconfiguration is a separate matter, and I would not see it as particularly affected by the reforms.

Q112 Liz Kendall: Neither the need to make current savings nor the need to reconfigure services is affected by the reforms?

Sir Richard Thompson: I would need to be convinced.

Q113 Liz Kendall: Thank you. Dr Carter?

Dr Carter: Because we are still not clear about how these various structures are going to work, it is difficult to make an informed comment. I downloaded something just today that is a byzantine maze of structures, and we are hoping to get very quickly from the Government further understanding about how it all wires up and links together, because it is not readily apparent now.

On the £20 billion, it has been said many times before that that on its own would be a huge challenge for the NHS at the best of times. Doing it now, coupled with this major reorganisation, makes it that much more difficult. As we go around the country, we see hugely differing approaches. Some people are applying some intelligent and imaginative thinking, but sadly there are many examples of people carrying out short-term cuts that will soon stack up as problems both financially, because we do not think that they are properly thought through, and, more importantly, for patient care. We are seeing waiting lists go up in a way that I believe will soon become unacceptable. Why are we keen to work with the Government to get this on board? We need to get some coherence and stability in the system. We need
to find a way of getting through the financial crisis that is facing the NHS in a way that does not further destabilize it.

Dr Meldrum: There are two aspects to Liz Kendall’s question. One is whether the reforms themselves will help to achieve the savings and achieve the reconfiguration or better help to do that. We have concerns about the original legislation, for some of the reasons I have mentioned, such as not encouraging co-operation, not encouraging that good partnership working between clinicians of all types and patients, which will be vital if we are to buy into reconfiguration and provide more cost-effective services.

The other aspect of the reforms is the disruption that a major reorganisation creates, with people more interested in looking after their jobs or finding their next job than in doing their day-to-day work. There is no doubt that, even at the moment, we are seeing the destabilisation of primary care trusts and strategic health authorities. That is why there is a real dilemma: do we try to move on more quickly and get over this process of reorganisation or reform, or do we take our time to get it right? Difficult though it may be, we have to do as much of both as we can.

Professor Sir Neil Douglas: One of the deeply disappointing aspects of the Bill is that it does not read like a logical attack, or a logical approach to solving the problems, namely the ageing population, chronic illness, reconfiguration and integration. Having said that, we are where we are, and as I have already said we need to proceed as best we can to come up with some clear answers. I have no doubt that the Bill has been improved to a significant extent during the pause.

Q114 Dan Byles (North Warwickshire) (Con): I have two questions, one of the entire panel and one of Dr Meldrum. First, you stated that you have perhaps not had as much time as you might have liked to look at the amendments. However, I would suggest that you have had plenty of time to look at the NHS Future Forum report, which this morning Professor Field said he was extremely pleased about, and that it was remarkable how the Government had responded to it in such a positive way. He felt that the vast majority of what had been recommended is reflected in the amendments. [Interruption.] You can read it in Hansard tomorrow. I think you will find that he did. Based on the NHS Future Forum report, which you have had time to read, I am curious to know whether you are satisfied that, if the Government amendments are to reflect accurately the Future Forum recommendations, it is the right move and will take us forward in the right direction.

Dr Meldrum: Certainly, the Future Forum took a significantly better direction than we had been going in previously. We still have some issues with aspects of the Future Forum report, but what counts in practice and will count with the service on the ground is how the recommendations are delivered in legislation. As I said earlier, it was already a very complex piece of legislation; it is now potentially more complicated. Besides Professor Field’s comments that you reported, we still need to study the detail of the legislation, see how it all fits together, and to see whether, in trying to deliver the Future Forum recommendations, it does so and does not have other pernicious consequences.

Sir Richard Thompson: I agree, it was very carefully written. We all met them several times; they tried extremely hard. A lot of the suggestions have been picked up by the Government. We are probably not discussing the work force section, but we are strongly against that. We are very worried about that, but it is probably not being discussed. One thing they did not pick up was the question of allowing NHS doctors to do national work, such as working in colleges—to give them definite time off to do that. Now, with the increased stress as I have found in Derby and Nottingham in the past two days, there is enormous difficulty in getting time off from an increased clinical work load to do work for the colleges, or even to go out and meet GPs, I am told. Yes, I think they have achieved quite a lot and I welcome a lot of their suggestions, but not on the work force.

Dr Carter: We, too, have said that we feel it was a real exercise. Steve Field and his colleagues came down to the RCN, and we had a very good half day. Our members throughout the country participated at a host of events. Many of the things we asked for have been achieved.

In relation to Mr Brine’s question, I hope I will complement what you are asking. We have consistently said that we sign up to the key principles. One thing we had always been concerned about in the NHS was that there were far too many bodies, far too many primary care trusts. In addition, far too many primary care trusts did not do what they were set up to do—that is, commission. They had a provider arm, and that really muddied the waters.

Therefore, when the reforms were first announced, we were encouraged by the fact that we were to see a reduction in some of those structures. We were to get more clinical involvement—and we mean “clinical” in a generic sense. We also felt it was a very healthy and sensible thing to do to put GPs right at the heart of things, because in many respects they had felt alienated and on the periphery. There was lots of good stuff in the reforms.

However, the reforms lacked detail. We put this to the Future Forum. In the meeting that some of us went to with the Prime Minister and others, we made the point that even at this stage in what are now known as clinical commissioning groups, we still do not have the architecture, we do not have the detail and we do not know who will chair those groups, who will appoint them and what their term of office will be. What is the failure regime? It is naïve to think that every group will be a success. When money was being poured into the NHS, trusts still got into financial difficulties. We are kind of being asked to sign a blank cheque, and what we say is that it would not be unreasonable at this stage, nearly a year on, to have had answers to some of those quite elementary questions about the governance of those groups.

I know that was a bit of a walk-around, but I was keen to come back on Mr Brine’s question. I hope that has helped.

Professor Sir Neil Douglas: Broadly, the Future Forum did a very good job, but the devil, as Hamish has said, is in the detail of the Bill. That is where we have had problems. I am the chairman of 16 different colleges, which each have to report back to me their views. However, I am speaking for myself at the moment, largely.
Q115 Dan Byles: Dr Meldrum, picking up on my colleague Mr Brine’s question, I am very interested that the BMA has voted the way it has today, because it seems to be at odds with the way quite a lot of doctors in my constituency whom I speak with say that they feel. Can you tell me what the total membership of the BMA is and how many people are present at the conference and voted today?

Dr Meldrum: The total membership of the BMA is about 145,000. There are about 500 at the conference today. They are representatives.

Q116 Mr Kevin Barron (Rother Valley) (Lab): I declare my interest again as an honorary fellow of the Royal College of Physicians. I have just two questions. One is to Dr Hamish Meldrum. Dr Meldrum, I will quote from your speech yesterday:

“There is a huge difference between adapt and change and slash and burn, between carefully planned reorganisations and knee-jerk closures and redundancies, between partnership working amongst health professionals, managers and patients and imposed, top-down, politically motivated diktat.”

Clearly, you are shy with words, Dr Meldrum, but could you put that quote in some context for the Committee this afternoon?

Dr Meldrum: Thank you for the compliment, Kevin. Obviously, speeches are a time for trying to use words effectively, but we are getting reports from people that they feel that the co-operative working that I talked about earlier, whereby you get all the people together and decide what you will do about difficult situations, is not happening, particularly in the current financial situation. That quote was in relation to the need to make or identify £20 billion of savings, rather than in the context of the Health and Social Care Bill. The need to identify those savings is leading to short-term thinking and immediate, rushed reactions that are having bad effects for staff and, consequently, for patients.

We realise that time and money are tight and that we will not be able to do everything that in an ideal world we would like to do. However, there is a way about the process, which to some extent is a legacy of the way things were in the past, that seems to militate against good-quality planning and decision making. That is unhelpful. Of course, the only aspect of the immediate impact of the Bill is the destabilisation I talked about earlier.

There is an added aspect, although again we are grateful for some of the changes. I do not want to sound like a latter-day Oliver Twist from the BMA, always coming back asking for more. We are grateful for some of the changes that have been made, and one of them was the relaxation of the foundation trust pipeline, but even in relation to that, a lot of managers and people from hospitals who were at the conference were reporting that they still feel a pressure to meet very tight financial deadlines and voted today.

Q117 Mr Barron: One further question to the panel. We had it confirmed from Monitor this morning that mergers between national health service trusts and between NHS trusts and other bodies could become a matter for the Office of Fair Trading and the Competition Commission. I asked to talk all four of you whether you as individuals are happy with that. Do you think your members would be happy with that?

Dr Carter: I have not seen those comments but that concerns us. I assume that it was Mr Bennett who gave that evidence. We would need to understand more what he means by that. We simply do not see that mergers are necessarily something that will take the health service forward, but there needs to be intelligent service redesign and it means making difficult decisions that at times are politically very contentious. We feel that that is the only logical way forward. I would need to study more what Mr Bennett said, but it gives me some concern.

Sir Richard Thompson: I understand that if there were mergers, it might be considered to be anti-competitive and that worries me. We have to move towards fewer and larger hospitals. I am reassured about the European law by Nick Clegg and that that has been sorted out, but I have not seen that in print.

Q118 Mr Barron: I am talking specifically about clause 65, which remains unamended. Professor Douglas?

Professor Sir Neil Douglas: Deeply concerned.

Q119 Mr Barron: Dr Meldrum?

Dr Meldrum: Yes, I also have concerns remaining. Mergers should take place for good clinical reasons. Certainly, you have to consider cost-effectiveness but they should not just be done for financial reasons. I am afraid that I never like to personalise things, but it is another comment from the head of Monitor that has not been exactly helpful in reassuring people that the real purpose behind Monitor has changed and that we are seeing a move much more to collaboration and appropriate choice, rather than focusing on competition as an end in itself and not just one of many means to an end.

Q120 Dr Daniel Poulter (Central Suffolk and North Ipswich) (Con): There has rightly been a focus on integration of services. I know, Dr Thompson, that when you were here last time that was one of your concerns, particularly given our ageing population and the fact that many people now are living with multiple medical co-morbidities. It is obviously a key challenge. This morning we heard from Sonia Brown and David Bennett of Monitor that the key focus of Monitor now would be on promoting integrated care. I want to get your views on that. Monitor would be looking to achieve value for the NHS, and value for the NHS is also value for patients; which meant, from further questions, that it would be better looking after patients in the community to prevent inappropriate hospital admissions, which is good for patients and good financially. Would you welcome that sort of thing in our focus from Monitor?

Sir Richard Thompson: Absolutely. I just hope that the leopard can change its spots. If it does, that is fantastic. I would not entirely say that everything is done out in the community. Obviously, patients like things done at home but it can be done more cheaply. The evidence, as you probably know, is very divided in the studies that have been done. In principle, yes, I support that.

Dr Carter: You need a mixed economy of provision. You do not want to lurch from one extreme to the other. What is undoubtedly the case is that far too many people are coming into hospital with long-term conditions, and if you had adequate community infrastructure you
could prevent those admissions. Equally, you have the challenge of delayed discharges because of a lack of infrastructure out there. That is why we were hoping that these reforms would free up resources, and you would be able to switch to get those sorts of things that prevent unnecessary admissions.

Q121 Dr Poulter: So you very much welcome that Monitor said this morning that it was taking that into account in its involvement in securing provision?

Dr Carter: I am sorry to be awkward, but because we have genuine concerns about the orientation of Monitor, I really do need to study what it is saying. On the face of it that would be a sensible way forward, but we really need to look at the detail.

Professor Sir Neil Douglas: I would be concerned if it was Monitor that was driving this inevitable and desirable movement. It should be driven by the professions together, because that makes logical sense. For Monitor to see itself as driving it would be unfortunate.

Q122 Dr Poulter: I do not think it was saying it was the driver, but that it saw that its role was to help to promote integration, and we heard that very clearly this morning.

Professor Sir Neil Douglas: We are comfortable with “help”.

Q123 Dr Poulter: Indeed. Very good. Do you think that it is none the less a welcome direction of travel for Monitor?

Professor Sir Neil Douglas: It is certainly better than some of the things it has been doing.

Dr Poulter: Fantastic.

Dr Meldrum: I agree. It is a welcome direction. I would like to see the context in which the quote was made. We want to see care appropriately delivered closer to home. It is not always the cheaper option. Of course, the other thing that we do, which we have clearly mentioned, is the administration of health and social care. Again, we hope that there are measures within the legislation that help to achieve that, because that is really going to help with the longer-term management of these long-term conditions.

Q124 Tom Blenkinsop (Middlesbrough South and East Cleveland) (Lab): I address this question directly to Dr Meldrum. You said today that the BMA discussed the Future Forum document and the Government’s proposed amendments, and you said to the BMA conference that the Government response on the issue of competition largely addressed the BMA’s concerns, but members today clearly rejected your view and advice.

Dr Meldrum: Yes, absolutely. Just in case my personal position is being misrepresented here, what I said both yesterday and today is that there has been movement in the right direction. It has not gone as far as we would have wanted it to in many places. What I am anxious to do as the leader—this is one of the reasons I am sitting here—is to still be in a position in which I can negotiate with some credibility, not wanting to sound totally curmudgeonly and negative. Some of the way in which people will interpret some of the notions might not help with that process. I have quite a lot of sympathy with the strength of feeling, and if you had been in the hall, you would have felt the passion behind the statements that were made. I have never said that the changes are absolutely great and that we are completely happy with them all. We still need to work on the detail.

On the question of intelligence, I hope that I am of above-average intelligence, but I have to rely on people who are skilled in parliamentary drafting to tell me exactly what the words mean in practical terms.

Q125 Tom Blenkinsop: Dr Meldrum, I would imagine that your members are of average and above-average intelligence.

Dr Meldrum: Let’s not get into a debate.

Q126 Tom Blenkinsop: Given that there are no amendments to clauses 60, 64 and 65, which are a substantial part of the Bill with regards to competition law, would you not say that that might be one of a few reasons why your members voted against the Bill?

Dr Meldrum: Yes, absolutely. Just in case my personal position is being misrepresented here, what I said both yesterday and today is that there has been movement in the right direction. It has not gone as far as we would have wanted it to in many places. What I am anxious to do as the leader—this is one of the reasons I am sitting here—is to still be in a position in which I can negotiate with some credibility, not wanting to sound totally curmudgeonly and negative. Some of the way in which people will interpret some of the notions might not help with that process. I have quite a lot of sympathy with the strength of feeling, and if you had been in the hall, you would have felt the passion behind the statements that were made. I have never said that the changes are absolutely great and that we are completely happy with them all. We still need to work on the detail.

On the question of intelligence, I hope that I am of above-average intelligence, but I have to rely on people who are skilled in parliamentary drafting to tell me exactly what the words mean in practical terms.

Q127 Liz Kendall: I think everyone supports the idea that commissioning should engage the full range of clinicians, but what do you think of the fact that clinical senates and clinical networks will be run by the national commissioning board and that the legislation gives the board the power to tell commissioning groups how they get their guidance?

The Chair: Order. We had time for the question, but unfortunately we do not have time for the answer. I would like to thank our guests for coming along. It was an interesting video link. [Interruption.] I think it is a first for a Public Bill Committee, but Select Committees may have tried it before.

Examination of Witnesses

Dr Dixon, Dr Gerada, Dr Paynton and Michael Sobanja gave evidence.

4.46 pm

The Chair: I welcome our guests to this evidence session.

Q128 Emily Thornberry: I wonder whether you feel that you have been given sufficient time to read the Future Forum’s report and the Government’s response, to listen to what various people have said, to read
180 amendments and to consult your members in the two working days that have been made available to you. Will you comment on that before giving any further evidence?

Dr Gerada: As you know, I am Clare Gerada. I am a general practitioner and chair of the Royal College of General Practitioners, which has 42,000 members looking after 60 million people across the United Kingdom.

The short answer to your question is, no, we have barely had time to read the Future Forum’s report. We have not had time to look in depth at the Government’s response to that report, and we certainly have not had time to consult on the 160 pages, the 34 amendments and the documents that arrived in our inbox last night.

By the bye, we had a brief consultation with our members over the weekend. A survey went out with my blog, and we have had a number of responses and continue to receive responses. To test the water, because I am giving evidence today, I asked our members to give me a steer. We have our formal structures, but I asked them to give me a steer on what they feel post-Future Forum and what they feel having seen some of the deliberations in the Government’s response. I am happy to share those early responses with you as and when.

Emily Thornberry: I do not believe that any of your organisations have been able to put in a written submission, so, when answering the question, will you confirm whether you will be in a position to give us anything in writing in furtherrance of the evidence that you give today when you have had an opportunity to read through everything?

Dr Gerada: I would be delighted.


I am in a similar position to Dr Gerada, particularly on being able to consult the 216 commissioning groups that the NHS Alliance represents on the detail. We intend to submit written evidence to the Committee.

I would only add that the Bill is one thing; the culture and behaviours of the organisations that are envisaged as operating and applying the Bill are another. With the greatest of respect to the Committee and the parliamentary process, one might be concerned about the level of centralisation that could come about if, for example, the national commissioning board behaved in a particular way, irrespective of the way in which the Bill is written. There are two levels of concern but, no, we have not had the opportunity to consult members fully on every clause.

Dr Paynton: I am Dr David Paynton. I am a practising GP in Southampton. I was a commissioning director in a PCT, and I now work for the centre for commissioning at the RCGP. There have been a number of responses to the survey, as Clare has indicated. It is fair to say that many members are still looking for further assurances from the Government on the direction of the reforms. They are not wholly opposed to them, but it is fair to say that many are still expressing some concern.

Q129 John Pugh: I suggest to you all that it is probably rather hard to consult on something that you understand only imperfectly in a fair or objective way, so it may be a few days or even weeks before you are able to get the full flavour. However, I ask Dr Gerada to tell us about the different nuances of response to the Future Forum, rather than what people have heard about the legislation. Given that everybody agrees that greater integration is the way forward—it is the bottom line for everyone—what are the obstacles, if any, or opportunities, if any, in doing that under the Bill?

Dr Gerada: What a long question. Indeed, there are two questions.

The first is about the Future Forum and what our members feel about it. I shall not address the Future Forum itself because it is important that we say what is the Government’s response to it. We were reassured that the Prime Minister should have spoken so positively about the NHS, and so positively at Guy’s hospital about the values and principles of the NHS. We were particularly reassured by his response to the Future Forum, when he upheld the 2006 duty of the Secretary of State to provide a comprehensive health service, and by his reassurance that it would be in the Bill. We note that it is not in the revisions, but we are not lawyers and I suspect that lawyers will be picking over the exact wording. We have had discussions with the Department of Health, which tells us to be reassured about it, but my simple mind as a GP says that if it does not matter why not resort to the original wording? That is the first thing.

Secondly, we all talk about integration as if it is some sort of magic bullet, but everybody has different views on what it means. I run a shared-care mental health service that has within it professionals from psychiatry, psychology and the third sector, and GPs and nurses. To me and to GPs, integration is about shared care, where the professionals maintain their professional autonomy, where you work across professional boundaries, ideally with shared budgets and using the GP electronic record that everybody writes in.

That is what integration means to us. We need it absolutely for the big issues that face us, such as end-of-life care, certain mental health services and services for the frail and elderly. That is what we mean by integration, and that is what the Royal College of General Practitioners will be promoting.

Q130 John Pugh: I did ask what obstacles remain in the Bill that would hinder that.

Dr Gerada: I am not a lawyer but a GP, and it takes me enough to read our “British National Formulary”, let alone the Bill and the amendments. The obstacles to integration in the Bill are particularly to do with competition and the fact that we now need to have responsibility for looking after all our patients within a geographical boundary. Questions on purchaser-provider split and the market act as a disincentive and a barrier to that.

John Pugh: These are not in the Bill. They have been in the NHS for quite some time.

Dr Gerada: Yes, I know that, but having looked through the amendments my understanding is that the focus on competition remains.

Dr Paynton: As Clare has indicated, the biggest problems that we face in the NHS are frail, elderly vulnerable adults and long-term conditions. Those conditions require care across a number of organisational pathways. I hope that GPs leading the clinical commissioning groups
can help bring that together and make it work on the ground for local patients, without the fear that they will somehow compromise competition law—or that they will not be able to do it because it might result in their being accused of not following competition law. There is something about the spirit—

Q131 John Pugh: May I press you a little on that, because it was a point made about the initial legislation? Clearly, the initial legislation has been changed—and changed in the direction of making that less rather than more possible, would you agree? Without actually abolishing competition altogether, what further changes to the legislation are you looking for that would do the trick?

Dr Paynton: I think it is about assurance for our members.

Q132 John Pugh: Assurance, not legislation?

Dr Dixon: I think the legislation already supports integration, simply through clinical commissioning groups. As David says, the issue is about how you get front-line primary care clinicians to redesign services for the 80% of patients we see who get a totally unintegrated service at present. Intrinsically, the legislation supports integration.

The changes to the role of Monitor are very welcome, because it should be as concerned about integration as it is about competition—you need both. Therefore, to get this right, we need to ensure that the clinical commissioning groups are themselves sovereign. Our concerns with NHS Alliance are now mainly around the autonomy of those groups to determine the services that their local patients need. Now they are responsible to quite a lot of organisations, from senates to the health and well-being boards and the NHS commissioning board, and we must ensure that these are lean organisations, owned by the local practices, fuelled by the local population and able to make the innovative changes needed. Tying them up in knots will not allow for that.

Michael Sobanja: A thing that the Bill might have addressed is the mechanism of payment by results. PBR does not necessarily promote integration between primary and secondary care, often known as vertical integration, but one thing that we want to promote is integration across primary and secondary care. If your question is, “What is in the existing Bill that could be changed to do that?” I am not sure what the answer is. What might have been in the Bill would be something to address some of the frailties of PBR.

Q133 John Pugh: The role of the Secretary of State and how it is defined in the Bill has been mentioned. I have seen various wordings, some of which has been rather confusing. What operational difference do you see, as far as the NHS is concerned, with one wording rather than another? Do all of you see a big operational difference or is it just an issue for Dr Gerada?

Michael Sobanja: I think there is a difference. The original provisions envisaged that the Secretary of State would be required to secure a comprehensive health service, which is slightly different from how it was a few years ago when they had to provide a comprehensive health service; there is a substantial difference between the two in terms of ideology. The major point is that the Secretary of State is still obliged to secure a comprehensive health service within the resources available. I do not see that as being any different from the 2006 Act or previous legislation in practice.

Q134 Liz Kendall: Thank you all very much for coming today. I did not manage to ask a question at the end of the previous witness session, so I will ask it of you now. The briefing that the NHS Confederation has provided says:

“The role of the NHS Commissioning Board has been extended, which means decision-making and financial control are more centralised than previously anticipated and far more than is the case in our current health system”.

It also says that the NHS commissioning board will commission services on behalf of any clinical groups that are not ready to do so and will run the clinical senates and clinical networks, and have powers to determine how else commissioning groups get their advice, how frequently your governing bodies meet and so on. What do each of you think about those extra powers being given to the commissioning board? Perhaps we can start with Dr Dixon.

Dr Dixon: It is a concern, for the reasons I gave. You can have all sorts of laudable things that en masse can have an erosive effect and straightjacket hopefully innovative clinicians. I am concerned by the move in the language from an assumed responsibility, which the NHS Alliance has always said that there must be. There must be trust in front-line clinicians and people to do these things, rather than earned autonomy, which has a slightly childish feel to it in that it has to be earned.

On the point about the board with its PCT clusters signing off those consortia and being able to commission on their behalf, I suggest that we need to ensure that there is a proper incentive arrangement for those clusters to sign off to commissioning groups in 2012 and make them ready for purpose, and not delay the process and end up with groups that are not ready for all sorts of reasons.

With such things as the senates, we must not return to the Durzi-type scenario, where we had a lot of secondary care input into how services were commissioned. There was, therefore, a linear look at different diseases rather than in the round, which is what clinical commissioning groups need to do—they need to look horizontally and adjust priorities. As far as the senates are concerned, I would suggest that rather than their seeming to hand the tablets to the commissioning groups, they should be co-owned by the groups and by the national board, so that clinical input is not something that seems to be another imposition on clinical groups.

My feeling is that in the Government’s response, it is clear why, for political reasons, more responsibility for governance has been put on commissioning groups, but that could, as a whole, stop the groups from being as free-moving as they need to be.

Dr Gerada: The bureaucracy with the new Bill, post-pause, means that we have gone—we have calculated this—from 163 statutory organisations to a proposed 521, not counting the commissioning support organisations. Clearly, we have massively increased the bureaucracy, if one calls it that, within the new, post-pause NHS. With respect to the national commissioning board and whatever, the current, post-pause Bill seems to be very incoherent. No matter what one felt about the pre-pause Bill, it was coherent. This is not. It is neither liberating nor controlling. It neither allows for GPs to be innovative, nor does it give them tight restraints.
I cannot really answer the question, except to plead that we are talking about the health of our patients and our population. If the national commissioning board sees fit to control vast sums of taxpayers’ and NHS resources until consortia are fit to be able to do it, so be it. This is not unimportant; it is the most important thing for my patients whom I see every day, and it is the most important thing for the 60 million patients whom my members see every year.

**Dr Paynton:** While we obviously support the role of the national commissioning board in holding the ring, there is a danger, particularly with the PCT clusters—this may an operational issue, rather than a legislative one—that if we are not careful and there is no clear plan of shifting authority and autonomy to clinical commissioning groups over a period of time as they are ready, we could see an ossification of the system, rather than a liberation of it.

**Michael Sobanja:** Put simply, the Bill puts too much potential power in the hands of the national commissioning board, to address your issue head on. Clinical commissioning groups should have the right to appeal to the Secretary of State, potentially, or some other body, which I think is suggested in the revised Bill, to avoid the national commissioning board from becoming too directive and to ensure that it focuses on its true role of holding the commissioning groups to account. There is a substantial difference between the two.

**Q135 Fiona O’Donnell** (East Lothian) (Lab): The message we have heard so far today is that the biggest challenge facing the NHS, as you have also said, is an ageing population and the need to meet their care needs through integrated services. Dr Gerada, we had a very clear example of your view of integrated services. My question to each of the panel is whether we need legislation for you to be able to deliver that.

**Dr Gerada:** No. Let me also say that we have to ensure that commissioning is done by the right people with the right skills across the right population. Where we will make phenomenal changes is in provider reform. Where the Royal College of General Practitioners comes in is to ask, “How do we tackle those big challenges?” Where doctors get excited, really excited, is when we start talking about delivering key services, innovation, joining together across federations—integrated care with the model that I mentioned and removing the perverse incentives.

I will give you an example. Hospitals are designed to make money, which means that they increase their activity because that is how they make money. GPs are performance managed. They have to reduce money and therefore stop patients going into hospital. You have two opposing systems working. Somehow, in the second decade of the 21st century, we have to ensure that we do not continue to have those perverse incentives. We need to look at tackling those big issues through provider reforms, and sensible commissioning should enable us to do that.

**Dr Paynton:** There is one other aspect to this. If we are serious about wanting to shift the focus of care into the community, that requires everyone to support that direction of travel. It also requires us to consider, as Clare has said, provider reform and how we can enhance the capabilities of primary and community services to provide the care in the community that our population is looking for.

**Dr Dixon:** I think we need legislation because we have tried to introduce clinical commissioning for the past 15 years and have failed. Each time, we have not changed the environment sufficiently. We have not given them statutory responsibility and we have ended up with fundholding primary care groups and, latterly, practice-based commissioning, which all folded because there has never been that power and responsibility with the front-line clinicians and local people. Without that, it will not happen.

You need to have a means whereby you can say, “These clinical commissioners are leading the health service and, for the first time, the spending decisions that I make in surgery for my patients, in terms of referrals, prescribing and diagnostics, are aligned with my responsibility to the outer world and population. I am no longer responsible just for you—the patient in front of me—but in future for the whole of the population and for the best good of the greatest number.” Unless you bring general practice and other clinicians into that role and responsibility—but you have got to empower them as well—you will not get the integration that you want.

**Dr Gerada:** Can I clarify? The Royal College of General Practitioners has discussed this issue. Our primary responsibility must always be the patient in front of us. I have always said that good commissioning is about the good use and husbandry of resources and that we must never muddy the water between commissioning across a population and the patient in front of us. Once we do that, we stop the trust. It is the trust between the doctor and the patient—the fact I am doing something in their best interests and not to save money—that defines the national health service.

**Dr Dixon:** The NHS Alliance would say that we do, because when I offer a patient in my surgery a choice of different alternatives, that choice will depend on how much money is in the system and what sort of services are available.

**Q136 Fiona O’Donnell:** You are both agreeing that the doctor-patient relationship is so important. What do you think—first in terms of that relationship, but also in terms of the efficiency drive in the NHS—of the power for the national commissioning board to make bonus payments to clinical commissioning groups? How do you think that impacts?

**Dr Gerada:** Clearly, as the representative of a national organisation that represents 42,000 GPs, I can answer that. We are well against making bonus payments to GPs that are predicated on stopping patients going to hospital. By all means use those payments for patients or give them to charity, but we must not be rewarded for preventing people going to hospital. That is a perverse incentive that will backfire on us.

**Michael Sobanja:** I have a slightly different view. The truth here is between those two views. It is entirely justifiable to give an incentive to clinical commissioning groups as long as the caveat is that that money can be spent only on improved patient care. I understand where Dr Gerada is coming from, but somebody has got to take a population view. It is a hard fact of life that doing something for the patient in front of you every time may disadvantage the patient who is not in front of you. So there has to be a balance in this. I would suggest that
it is appropriate to incentivise the groups, not GPs and practices, with the caveat that that money can only be spent on improved patient care.

Dr Paynton: Speaking for the RCGP, we are absolutely clear that decisions by clinical commissioning groups have got to be made with the support of the population and the public they serve. Doctor-patient relationships are very good. The vast majority of patients trust their doctor. I would like to see the same degree of trust being established by the clinical commissioning groups and the local population as exists between the GP and the individual patient. We need to try to ensure that whatever difficult decisions need to be made by the clinical commissioning groups are supported by the public they serve. That way, we will retain the trust.

Dr Dixon: David is absolutely right. We have to be courageous; we have to take on this population role as well as our individual role. After all, when you see me in my consultation, if we have devised a better menu of services that you can have—that are more local and appropriate—and they are more cost-effective, and if we are mutually geared to making sure that they are used cost-effectively, there will be more to go round.

Q137 Fiona O’Donnell: But Dr Dixon, what you and David said was that you were not just thinking about me; you are thinking about the next person to walk through the door. I am alarmed, because I have never sat in front of my GP thinking for one minute that they were not absolutely focused on my needs, but were thinking about the next person to walk through the door. I am living in a different health system.

Dr Dixon: I am sure you make absolutely reasonable demands on the NHS.

Fiona O’Donnell: I could not possibly comment on that.

Dr Paynton: Perhaps there is a misunderstanding. When I see an individual in front of me, that is what I am focused on. If I need to make a commissioning decision collectively and corporately, I would wish to ensure that that decision was respected by the population I serve. It is a challenge for GPs to see themselves in those two different roles, but I think it can be done.

Dr Gerada: Do not conflate the use of evidence-based practice with rationing services. We are all in favour of using evidence-based best practice, and if our patients ask for something that is non-evidence-based, we generally reassure them.

Q138 Owen Smith: Dr Gerada, I have a question about new clause 4. I will read a bit of it to you, because I heard you say earlier about not having enough time to do so. It is a clause in which the Government are trying to alleviate fears that there is a danger that we will see the NHS privatised. They have highlighted this as ruling out privatisation. It says, in effect, that the Secretary of State will no longer in future be able to promote the interests of any one group. He will not be able to promote the interests of a private provider over another group.

It also says, equally, that the new clauses would prevent the Secretary of State from deliberately promoting the growth of state providers over voluntary sector or private ones. Is it your view that that is another perverseness in the Bill? In a tax-funded and still overwhelmingly publicly owned NHS, the Secretary of State would be so hidebound by competition law as to stop him protecting publicly owned bits of the NHS.

Dr Gerada: We have surveyed our members on that. I will give you evidence of why I think you are correct: the Future Forum’s own consultation process on choice and competition. I urge you to look at it. There were more than 800 responses from members of the public, patients and some professionals. Of those 800 responses, and pulling out only the ones that relate to choice, about 597 of them were against choice. They actually used words such as, “We want a good local provider”, “We want our NHS service next door”, “We want to be able to choose the treatment we get in the consultation, but basically we don’t want a multiplicity of providers and choice.” Seventeen of those who expressed a preference were pro-choice, and one of them lived in France, so that can be reduced to 16.

I think, and our members feel, that it is important that the Government are partial to and protect the NHS on behalf of our patients. The NHS is there because it provides a totality of service, universality and services that do not come and go. Our patients with long-term illnesses do not have illnesses that last for three to five years. That is how long contracts are for now, and I run many contracts. We have won, as GPs, many contracts where we run GP practices, and now we are coming to the end of the tender process and we have to go out to tender again. Patients with long-term diseases have them for more than five years. If what you say is the case, I and the college would feel that we are entering a difficult space.

Michael Sobanja: It is true to say that significant parts of the health service are not part of the nationalised industry view of the NHS now. There is community pharmacy, to give you one example. My own view would be that it is actually much more important for those who are providing a service to sign up to NHS values—I absolutely agree with Dr Gerada in that sense—rather than there having to be some form of state provision of which the Secretary of State is the non-executive chairman. Also, rather pointedly, I cannot avoid pointing out that general practice isn’t that anyway.

The Chair: Order. I am afraid I must announce that this brings us to the end of the time allocated to the Committee to ask questions of our witnesses. I thank you on behalf of the Committee.

Examination of Witnesses


5.15 pm

The Chair: Welcome, lady and gentlemen. Can I have a bid for questions? Emily Thornberry?

Q139 Emily Thornberry: I want to begin with a general question to put your evidence in context. Do you feel that you have had sufficient time to look at the 180 Government amendments, the Future Forum report and the Government’s response, and to consult your
members before coming before us to give evidence? I know that not many of you have been able to do written evidence for us, and I wondered whether you were hoping that you may be able to in future.

**Paul Jenkins**: We have not had the greatest time to consider things. It is clearly part of a process, so we have been checking to see whether the commitments made in the response to the Future Forum report are addressed in the amendments. It is very important that, whatever we think and say about the amendments today, there is the opportunity to continue to influence the process as it goes through, so that we get the best legislation. If the deal is that what we have today is what we have today, that is probably not very helpful. If there is the opportunity to refine things as we go through, that is more positive.

**Jeremy Taylor**: We would not want this to be our last word, that’s for sure.

Q140 **Emily Thornberry**: Do any of you have any particular anxieties about the process?

**Joe Korner**: I have not really had a chance to study the amendments in detail at all, but I have just come from a meeting of 200 stroke survivors at the UK stroke assembly in Birmingham. I was giving a talk about the potential reforms to the NHS, and there is an enormous amount of anxiety and confusion. That is compounded because there is already change and some disintegration going on locally in existing health structures, but there is not a lot of clarity about what is going to replace them in the future. There are great concerns, and I was not able to give them much clarity, because we have not had enough time. However, we welcome the chance to give evidence and give our view, such as it is. Our view is maybe more general, rather than about specific parts of the amendments.

**Baroness Young**: A particular anxiety is that it was a very complicated set of changes in the first place, and they have now been added to in order to meet the call that the Future Forum gave and also many of the issues that we had raised as a group and individually. It feels slightly churlish to complain that more complexity has been added. On the other hand, however, that means two things. Apart from the point that was made by the Stroke Association about the disintegration of services that we are seeing at the moment, there is an issue of complexity for the future and it being difficult to understand how all these bits fit together.

For me, the biggest challenge is not particularly what we get in the legislation but what comes in secondary legislation—in guidance—and in the various pieces of implementation, because they will be coming thick and furious over the next two years. Are we going to have enough time, as a set of organisations representing patients, really to scrutinise those carefully? There will be tens, if not hundreds, of individual changes that will be subject to consultation; that will have guidance put out; and that will have secondary legislation. The devil will be in the detail of those, and my concern is that we will be on a bit of a treadmill for the next two to three years of trying to keep up with a very broad programme of changes, and a very complex set of issues. There are plenty of slogans around but not yet any clear understanding of how they all fit together.

**Neil Churchill**: It would also be fair to say that the quality of the engagement in the latter part of the discussion has been much better than it was in the earlier part. We are very much hoping that that engagement will continue as we get into the phases of implementation and dealing with secondary legislation and guidance. We see the patient voice as being a real strength in coming up with the right answers about how those things can be done.

**Emily Thornberry**: A fair summary: for those who have not spoken, you have been spoken for. Thank you.

Q141 **Mr Barron**: I have a question for all of you. There has been much talk in the past seven days about how the changes will open up decision making, commissioning and such things to patients. Given the organisations that you represent, do you feel that the concerns of the different charities will get more of a hearing in what happens now than in what was going to happen three weeks ago?

**Ciarán Devane**: We welcome, for example, lay representation on the commissioning groups; that is very important. We welcome some of the strengthening of scrutiny of health and well-being boards. We are still concerned about the engagement of the patient voice at a national, collective level. The national commissioning board can set the example of genuinely putting the patient at the centre of things so that when we look at the national commissioning board, in the same way as we look at the medical director of the board and say, “Yes, we can believe that he represents the medical view,” we can look at the individuals on the board and say that they genuinely get the collective national patient view.

Similarly, as the secondary processes and secondary legislation get through, it is important that it is not just a debate between the professionals of the health service and the clinical professionals, but that the patient view is genuinely involved in designing those processes as well. We absolutely welcome a number of the changes that have been made, and we commend them, but we have that reservation as well.

**Baroness Young**: Our concern is much the same. It is always very churlish of charities that have pressed for changes in legislation to look, when they ostensibly get them, as though they are being a bit dog in the manger-ish about it. That is something I would very much want to guard against. We have to recognise that many changes have been made to the Bill that are in the interests of patients.

For me, the biggest issue in terms of the patient voice is the dichotomy that Ciarán referred to between what individual patients will be saying about patient choice, and collective views about, for example, commissioning integrated pathways of care. I find it quite difficult to understand how those two fit together at the moment. This collective voice for patients about the commissioning processes nationally and locally, and about integration of pathways of care, has got to be predominant. On choice, which is very strongly driven through the Bill—the whole mandate for choice is quite a strong set of amendments—I need somebody to explain how it works with collective views from patients about integrated care.
opposed to the patient in front of you. A lot of the patients whom we are worried about are not well engaged, if at all, with the health service. We feel that engaging them effectively and involving them in the design of services will be important in meeting the challenges that we face in improving outcomes and productivity. There are a few outstanding questions in relation to what the networks and the senates will do and the patient voice in some of those settings, all of which we would like some clarity on as we move forward. There is definitely a strengthening in the service, but we would like to see it reaching out to patients who are quite hard to get to and involving them in the process.

Paul Jenkins: This issue, like others, is undoubtedly a lot more prominent and a lot more recognised in the revised legislation, which is really important because that harnessing of the collective patient view will be essential if we are to design services that are high quality and sustainable for the future. Like others, I would like more scrutiny of the definition of collective involvement as the Bill goes through Committee. There may be two angles to that; either to put patients and carers on the same footing as specialist clinicians in terms of the requirement to seek advice, so the advice of expert patients is as important in some aspects of long-term conditions as that of clinicians; or to change the public involvement stuff, so that there is much greater emphasis on the proactive engagement of the public and patients before decisions are made, rather than follow what has been the typical model of involvement whereby you make a decision and then you test it and consult people to see whether they object too much to what you propose.

Jeremy Taylor: The NHS Future Forum, on which I sat as one of the voluntary sector members, said:

“The declaration of ‘no decision about me, without me’ must be hard-wired into every part of the system—from the legislation through to each and every encounter between”

doctor and patient. That is a really strong and radical vision. The amendments that the Government have put forward takes us further in that direction, and to that extent they are welcome with the greater emphasis on the duty to involve patients and public, greater transparency and lay people on consortia. We probably have still further to go. This is one of the areas in which we need more time to make sense of the amendments and understand what difference they will make. It seems to us that more could be done in defining what patient involvement means, because it is so central not only to improving quality but to meeting the so-called Nicholson challenge, so there is a case for being more explicit about what we mean about engaging people in their care.

The duty of public involvement still reads very much along the lines of the old section 242 template of informing and consulting. That is still the model of public involvement that is expressed in the Bill as amended. Many of us have the feeling that that is a rather old-fashioned way of engaging and involving people, and we would like to see something a bit stronger.

Joe Korner: I agree with my colleagues from the charities. There is a dichotomy in the Bill and that is the involvement of patients in decision making, which has been strengthened, but there is also this idea of patient choice, or patients as consumers. The stroke survivors I have just been talking to are not interested in a choice of providers. They are interested in engaging to make sure that an integrated complete pathway of care is available for them, that there are no gaps in the care and that it is all integrated. To that extent the collective voice and the voice of representative organisations such as ourselves, is very useful because we can express a collective view of people who have experienced stroke services and help to ensure that those services are commissioned properly across the country.

Dr Poulter: There is obviously an issue here about how we have and how we put into legislation effective discussion and engagement with patients. Often, the people with whom we want to engage do not engage. Patients are incredibly accepting, but unfortunately there are sometimes things that are unacceptable: for example, being treated with chemotherapy in a hospital corridor or on mixed sex wards, which, thankfully, are almost a thing of the past now, but they have been going on, and still go on in some cases, and are not very good practice. Nevertheless, the point is that we often see in local LINk organisations, for example, the agenda is hijacked by one or two articulate individuals who have their own agenda, which is not necessarily representative of a wider body of patient opinion and does not necessarily capture the key challenges for patient care either at the local hospital or in local community services and community care. How do you see the Bill improving engagement with patients to make it more effective, as that is a key challenge?

Paul Jenkins: There are plenty of mechanisms in the Bill that could help; it is very much a question of they are enabled to do their jobs. Let me start with an example: we are a group of charities representing a very diverse groups of patients and we could have gone into the exercise around this Bill just concerned, in my case, with people with mental illness, or stroke survivors, or people with asthma, but we have recognised the importance of working together and providing a generic response to the issues in the Bill. We hope that that style of working together among patient groups locally will be one of the things that we can take forward after the Bill is enacted.

There are other key things—the role of healthwatch is very important. We are pleased that the Government recognise the importance of healthwatch having a duty to engage all parts of the community. It is very important that healthwatch is properly funded and resourced to carry out that function. We were disappointed that there was not a commitment to ring-fence the funding and we hope that that is something that can be reconsidered. We also welcome the role of the lay representatives on clinical commissioning groups and one of them having a specific remit on patient involvement. They need to be real leaders in their local community, along with health and well-being boards, to get the right kind of involvement of patients and carers in decision making.

Ciarán Devane: May I elaborate on that? I think the processes that one puts in place to sample the voice of the patient should not rely on one individual. It is why when we look at a commissioning consortium, we need to look at the lay representations and their quality and the skills they bring. We need to look at the processes by which they do the public engagement and the transparency with which what they do is available for scrutiny by ourselves, among others. It is that collective process that
Baroness Young: There are some interesting methodologies arising to make sure that the patient voice is heard, including hard-to-reach sections of patients and the public. We have just completed a pilot study in three PCTs of new ways of involving users in decision making about care, and if you go to our website you can see a toolkit that we have developed for commissioners and providers to enable them to learn from the experience of these three pilot districts. For me it is going to need, first, time; secondly, investment; and thirdly, skills. We are going to need people involved with commissioners, providers, the health and well-being boards, the NHS commissioning board, Monitor and the CQC who are experts in how to develop that patient and public engagement. Otherwise it will be the tokenism of having an individual.

Q142 Liz Kendall: Thank you all for coming today. I want to ask you about your views on HealthWatch and whether you think it is strong enough. Do you think that it will be as powerful a voice for driving change in the system as the Care Quality Commission, Monitor and the national NHS commissioning board, when we now know from the Government’s response to the Future Forum that it remains a sub-committee of the CQC?

Jeremy Taylor: I am not sure that it matters where HealthWatch England sits. What matters is whether it has clout, credibility, independence and sufficient resources. One could have a big debate about whether it should sit as a separate body or as part of the CQC. Colleagues may have different views. My view and the view expressed in the forum is that HealthWatch England will be an important part of the architecture for the patient voice, so we should welcome it.

We would like to see it set up quickly—I hope that you are listening to this, Paul Burstow, because according to current plans the NHS commissioning board will be up and running in shadow form from this October, but HealthWatch England will not be in action until October 2012. Why the delay? Why not get on with it? Even currently, when we are forming the CQC, that body has the potential to set the tone and leadership for the emerging local healthwatch bodies. Timing is important, and there is something about everybody’s duty to deal with and involve HealthWatch England. The Bill, as amended, gives me greater assurance that people will have to treat HealthWatch England as an important part of the architecture for the patient voice, so we should welcome it.

Overall, there are still some concerns about whether the healthwatch system will be powerful enough when compared to the local involvement networks. LINKs have suffered from scarce resources, not many staff and not a great deal of clout; as a result, they have been patchy. Some have been very good and have started to get off the ground and do some fantastic stuff, others have not. It would be a tragedy if healthwatch ended up being incredibly patchy. We have an opportunity to get something that works well everywhere.

Q143 John Pugh: I wonder whether the Government can keep all you guys and girls happy. Clearly, some of you want to provide services for the NHS, and some want to monitor what services the NHS provides. I was struck by the report “Choice and Competition: Delivering Real Choice” by the Future Forum group, whose members included people from Mind, Marie Curie, Turning Point and so on. As part of the framework on choice and competition, it recommended that “Consorcia would apply the policy on choice and the competition model to their local commissioning decisions to ensure they are delivering real choice”—although I am not sure how real choice differs from ordinary choice. There seems to be a paradox here, in that some of you are unhappy with too much choice because it prevents integration, and others want a piece of the action. I am not clear whether the Government can write legislation that would satisfy you all, other than by including a clause saying, “Give only so much choice as would please the charitable sector.” How can they do that?

Joe Korner: As a charity that is a service provider, I do not think that it means that one cannot have a view about the complete pathway of care that the charities that we represent need to deliver. The services that we provide are parts of the pathway that hitherto have not been provided by anyone else. Traditionally, the voluntary sector is good at identifying those needs of our constituents that are not being met. That is why the type of services that we provide do not normally carry a tariff, and in many cases, they are probably not worth enough to go for tender, so we have great concerns about how they are to be commissioned at all in the future. There is no problem with people choosing between providers; the real problem is that in many areas people have no choice at all because those services do not exist—they are not commissioned.

Q144 John Pugh: If you offer choice, to use the BMA’s words, you are not going at any stage to undermine existing NHS facilities?

Joe Korner: We do not try to replicate existing services; that is not our function. Our function is to meet the needs of people that have had a stroke whose needs are not being met in other ways. Certainly, there are some things that we do—for example, providing information—that we believe the NHS should be doing, and rather than provide it free, we decided to start charging for it, because we do not believe we should use voluntary donations to do that. We are clear about what needs should be paid for by health and social care, but that we are in a better position to provide.

Q145 John Pugh: Bearing in mind that the choice and competition section was chaired by the Association of Chief Executives of Voluntary Organisations. He may be off on one and not representative of you as a whole—

Baroness Young: May I say categorically that he was not representing views as a whole? ACEVO is an umbrella body; it is not a body that votes and takes a position. Although many of us are members of ACEVO, he is not mandated by our organisation. That has to be clear.

Ciarán Devane: For me, ultimately it has to be a choice between quality providers. Ultimate ownership is a second-order issue. Where NICE has produced evidence-based outcomes guidance that says, for example, that clinical nurse specialists drive good patient experience and that if you want good outcomes for sarcoma you...
have to do 100 cases a year, otherwise more people die, we have to get that definition of quality in. Whoever is the provider, whether it is one NHS hospital or another, they should meet those standards.

Q146 John Pugh: Do you not think that commissioners will be properly mindful of that, given their knowledge of their patients?

Ciárán Devane: History would suggest that some are and some are not. In the world we are going into, we need to find a way to ensure, encourage, incentivise and mandate that you do not get to do low-volume operations just because you want to have a go. That mechanism should be in place so that the provider, whatever their ownership and shareholding, meets the minimum quality standards, which are evidence-based, but beyond that, they can be innovative and everything else.

Paul Jenkins: It is a matter of the order in which you do things. If you start with the collective patient experience of services, you rapidly identify, as you would in the area of mental health, a number of issues where it really matters to patients whether they get a service or what service they get. That ought to be defining the choice agenda. In mental health, it is about the choice of medication and the choice of whether you have access to psychological therapies, and it defines choices patients might want in terms of realising personal goals, such as getting a job or other things. That is not unfettered choice; it is a defined agenda of choice. I am not uncomfortable with what the Bill in its amended form says about choice, but that is the order of the argument. We use patient and care input to define where the current system is failing, which then defines a choice agenda, and where the existing system cannot provide that choice, it is important to have diversity of supply.

Jeremy Taylor: That is a very sensible way of looking at choice. There is no single voluntary sector view on choice, and I am not sure there needs to be. Choice is a contentious and politicised issue and there are different views on it. The Future Forum has said that it is meaningful choices that matter to patients and individuals—I paraphrase—rather than the choices that politicians may think that people want. You have to start with the patients and understand their needs, which is Paul’s point.

Sometimes people resist the notion of choice because they think too much fuss is being made about it. The evidence is that people care about a number of things: access to services, the quality of services, meaningful choices—an example might be that I choose to die at home rather than in a hospital, which is the example that Stephen Budd used, and it is a good example of a choice that is meaningful to individuals, but that is often denied to them by the services—and a voice in the system. All of those things are important, and choice plays a part in that.

The Chair: Our witnesses are inspiring or inciting Members to think of questions, and Members are indicating to me that they want to come in to ask questions. I have my own waiting list, and I can only call people in order. If Members are able to come in later, they may refer back to the point that inspired or incited them.

Q147 Emily Thornberry: I want briefly to go back to the CQC and HealthWatch, and then I want to ask about choice. If HealthWatch had been up and running during the scandal at Winterbourne View, one of the things we would expect it to do would be to investigate the CQC’s failure properly to watch what was going on. HealthWatch might have decided that we should be looking not only at Winterbourne View but at large locked institutions for people with learning disabilities and that it is important that the CQC does a study of many organisations. That is a real-life situation happening at the moment. Let us think about the impact of that. With HealthWatch being a sub-department or committee of the CQC, would it not be subject to, for example, pressures from the CQC saying, “We’re 300 people short; we simply can’t do that.”? Do we not need the two organisations to be a little more separate, so that the CQC at the very least can be watched by HealthWatch?

Jeremy Taylor: That is a very good challenge. If HealthWatch England is in the CQC, there has to be a satisfactory answer to how you have sufficient separation and independence that HealthWatch England can operate without fear or favour in relation to the CQC. However, it seems to me that the whole regulatory system has to work, and there is a number of critical ingredients in that. We will probably hear more about this when the Francis inquiry reports, but you must have a system whereby people can blow the whistle at local level and are heard and there is a quick response, so that it does not end up being a national regulatory issue.

We have learned about the failings of Winterbourne View. One of the failings is that nobody picked up on that at an earlier stage, when there were plenty of opportunities to do so. Having mechanisms for understanding and measuring people’s response to the services and allowing them to voice that is critical and may, in fact, be more important than the machinery you have at national level, because the national regulators will never be able to cover everything. They need good intelligence and the willingness to respond quickly when they get it.

Q148 Emily Thornberry: May I move on to choice? In a way, perhaps that has been investigated sufficiently, but I want to take this opportunity to underline it. For most patients, choice is not, “I’m going to this hospital instead of that hospital.” As you explained, it is about sitting down with your doctor and saying, “My daughter comes to me three days a week. I have diabetes. I also have this condition and that condition. What are the different ways in which we can work together to give me the support that I need to keep me out of hospital?” That is choice in the modern context, isn’t it?

Baroness Young: The problem is that we have the wrong word. I do not think that it is choice that patients want. They do not want to go shopping, particularly when they are ill, or old, or perhaps have a touch of dementia, or are very depressed about their condition, or have other really horrible pressures in their lives. They want to sit down with their professional and understand what the options are for them and how they can put together a pathway of care that will last for the duration of their condition, which for some can be 30, 40 or 50 years. They want to be confident that they will play a role in selecting those options and that the options will have some way of being met—that the services will be there.

One of the problems at the moment with many long-term conditions is that it is not about choice. If you are a patient with diabetes, it is not a matter of
which podiatrist you want to choose to go to; it is whether you will be one of the 80% who do not get a service or one of the 20% who do get a service. The point was made that the first step must be getting integrated pathways of care commissioned, because that is what people with diabetes and people with long-term conditions are telling our organisations that they want. They want options, not shopping.

Q149 Margot James (Stourbridge) (Con): I would like to keep the focus on clinical pathways, because there are various roles for the patient voice in the health service, but one of the most important is in the devising of the clinical pathway. Do you not feel that under the amended legislation, there is even more scope for patient organisations to have an input into commissioning plans, not from the general LINks-type approach, but more from the specialist patient organisations such as yours, whereby you have input into the commissioning of diabetes or asthma services at local level. We heard this morning that the push to more community involvement and greater input into commissioning plans would be extended. Do you not see that as an opportunity?

Paul Jenkins: Very much so. There is a lot more in the amended legislation that provides a lot more levers to push not only the best performers. We always believe that motivated GPs and other clinicians will involve patients. Our concern was with the bottom quartile, with the people who do not get that and do not get the value of it and who have more paternalistic attitudes towards patients. Undoubtedly there is opportunity and it is better.

Going back to the point we raised earlier, I think that as you consider the detail, there is a little more strengthening around the collective patient voice, particularly to direct it in exactly the area that you have just highlighted in terms of involvement in the proactive design of clinical pathways and getting patients and carers in right at the beginning, rather than when decisions are already being taken by clinicians or managers.

Joe Korner: There is an opportunity, but commissioning a complete pathway for stroke involves a lot of different levels, so you might need to reconfigure your acute hospitals, and you might need to do that across your commissioning boundaries. London is a perfect example, and the Prime Minister was at University college hospital praising London’s stroke care two or three weeks ago. What delivered that was bringing together the 30 PCTs in London and the four stroke networks under the direction of the strategic health authority, with patient involvement through the networks and through the Stroke Association being involved. It was a top-down, strategically planned reconfiguration of a part of the pathway. That is going to need to happen in the areas of the country where stroke services have not reached the level you have just highlighted, and we need to get access to emergency care and stroke unit care. At that level you can have involvement, but it is not clear from the legislation how that strategic input will take place.

There might be other parts of the pathway that can be done locally, but we want to see integrated commissioning across the whole pathway, so that will need to be a way in which patients can be involved with different levels and some way of integrating—bundling up—commissioning groups, with the stroke networks involved.

I would have also thought that the national commissioning board would need to impose some of those things strategically, because the strategic health authorities will not be there to do those things in the future.

Baroness Young: Diabetes UK represents professionals as well as patients, and the most powerful thing in designing an integrated pathway is a grouping of doctors, nurses and other professionals in clinical networks with patients, designing that network. That, I hope, is something that will be taken account of in the way in which the Bill is implemented. Those clinical networks operating not just at national level but at local level will be incredibly important, but they must include the patient voice, because that is the most powerful thing for getting the options that patients are looking for built into the process of commissioning and indeed delivering those integrated networks. They are not just about commissioners; they are about deliverers—providers.

Ciarán Devane: May I add one small comment? When that happens, the reinvention of pathways is more radical, produces higher quality and is more cost-effective. Accessing the money that we all recognise needs to be accessed to have a sustainable health service is more achievable when that patient voice is embedded in the pathway redesign, because you get something that is less conservative and more prone to bringing choice and to bringing care closer to the home, into the community and out of the expensive hospital bed.

Q150 Margot James: Can I add a rider to that? The challenge to you is to operate at the local level, which the Bill gives you the opportunity to do, but also to operate at the national level on the evidence base through your channels into NICE, so that the evidence on which clinical pathways should be based has your input at that level as well, and that that is also facilitated. Do you agree?

Ciarán Devane: From a legislative point of point, I absolutely accept that there could be mechanisms. There is the institutional issue as well: without being unkind to NICE, it is not always known to have the most patient-centred view of life, and we need to apply the same principles to the substructures of the health system as we apply to commissioning consortia and so on.

Neil Churchill: I echo that. This is where we are not aligned in the system, and there is plenty of good evidence that is well accepted by clinicians but is not accepted by NICE. We see that, for example, with the quality standard on chronic obstructive pulmonary disease, which did not take into account the considerable evidence that exists on smoking cessation and prevention of COPD, and we are getting the same thing at the moment with a reluctance to accept the evidence supplied by organisations such as the British Thoracic Society. For us, it is an area where further integration is needed to align incentives to make things that we want to happen, happen. That is not currently there.

Q151 Owen Smith: My question is specifically for Mr Korner and Mr Devane. It is about the level at which services might be commissioned. I am asking you specifically because of the interest groups that you represent. There has obviously been a concern that, with the national commissioning board commissioning some things nationally, specialist services, and with
consortia commissioning things locally, will consortia at the local level have the requisite expertise, and will the national commissioning board have the insight into local conditions to be able adequately to commission across the country? Do you think those concerns have been addressed by the changes in the Bill, notably the creation of senates and networks?

**Joe Korner:** At the moment we have the stroke improvement programme and stroke and cardiac networks across the country. Those bodies are extremely good at promoting good practice and collaboration, but they have no teeth. I do not think we are suggesting that there should be national commissioning of stroke services, but certainly in acute care you do need a critical mass of patients if you want to commission really good acute care. As with Ciarán’s example in cancer, you need doctors to see enough patients to get good enough to provide clot-busting treatments safely. The evidence is clear that the more experienced they are, the better they are at making decisions about thrombolysis.

We feel that there are reconfiguration issues, which are commissioning issues, that need to be considered at a regional level, but there is nothing in the Bill that says that there will be any structures to do that. We have heard that the national commissioning board may have sub-national structures, but until they are in existence and we know they are and what powers they have, and whether they will be able to do more than encourage and advise commissioning groups to get together, we are going to be very concerned. There are areas of the country where services will fall behind the best. If you look at London again as an example, we probably now have there the best acute stroke services in the world. I want to see that for everybody throughout the country. I worry that we have not got the mechanisms in the Bill to guarantee that we can enforce the type of change that is needed.

Many aspects of stroke services should be done locally, such as the ones we provide of community rehab. However, there is a danger that in trying to save money, people are going to start commissioning generic physiotherapy or generic services, when actually we know that it is the specialist services—specialist stroke physiotherapists, for example—who are going to make the difference. It may be that we do need to get those consortia to work together, so that there is a critical mass of patients to make it economically viable to do so.

**Ciarán Devane:** I absolutely welcome what is in the legislation to ensure that networks exist, and the message that they will be hosted by the commissioning board. When it gets to their application, there are a number of things that we have to get right. Let us say that one GP consortium does not want to play when the network is needed. That there will be any structures to do that. We have heard that the national commissioning board may have sub-national structures, but until they are in existence and we know they are and what powers they have, and whether they will be able to do more than encourage and advise commissioning groups to get together, we are going to be very concerned. There are areas of the country where services will fall behind the best. If you look at London again as an example, we probably now have there the best acute stroke services in the world. I want to see that for everybody throughout the country. I worry that we have not got the mechanisms in the Bill to guarantee that we can enforce the type of change that is needed.

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The preservation of the networks was one of the most important things from our point of view, because, with the best will in the world, a GP consortium will not see a childhood leukaemia more often than one in 10,000. They will not have the expertise. We have to bring that up to a collective view, but give them more teeth to ensure that they are unlike some of the existing networks, where people opt out, they do not play, they do not conform, they go around the back and do these operations. I hope that hosting them in the commissioning board will do that. That would be huge step forward.

**Q152 The Minister of State, Department of Health (Paul Burstow):** I want to pick up on Mr Korner’s comment. He posited the notion that the Bill does not provide the changes that will deliver the stroke care that he and every member of the Committee want to see. If we maintained the status quo, would the current system do that?

**Joe Korner:** The current system has succeeded in some areas, such as Manchester and London—

**Paul Burstow:** Manchester and London?

**Joe Korner:** Those are two examples off the top of my head. The current system has delivered across the country a dramatic improvement in stroke care since the stroke strategy was published in 2007. We have seen, for example, that the proportion of people being treated for the majority of their stay on a stroke unit, which is the strongest evidence base for good care and better outcomes, has increased dramatically since 2007, when the strategy was brought in. It has been disappointing that some areas of the country, some stroke networks and some strategic health authorities have not taken the quality markers that were in the stroke strategy and used them to drive improvement in services, so the improvement that is going on is patchy.

The national sentinel audit for stroke, which audits all the hospitals in England and Wales, shows that there has been a dramatic improvement. The audits take place every two years, and the two most recent audits have shown that dramatic improvement. They have also shown where we are failing to make as much improvement as we should. I am not suggesting that the current system is delivering everything that we want, but I am concerned that the legislation as it sits does not provide for the type of strategic planning to improve services that, as we have seen, has made a dramatic change in certain areas of the country.

**Q153 Paul Burstow:** I want to pursue something that was said earlier about choice, to make sure that I understand; it was the point made by Baroness Young regarding the use of the word and what it encapsulates. To be absolutely clear whether we are talking about the word and its application or what it means, I will refer to the Future Forum and the report on choice and competition. The report mentions some work that was done at the seminar co-ordinated by the Health Foundation, which suggested that choice includes:

> “Choices to support healthy living; choice of provider and the way in which care is provided; and choice of treatment including self-management support.”

I thought that really echoed the point that you were making, Baroness Young.

**Baroness Young:** I absolutely support the first and the last of those two. Patients are very interested in those as options because they are about the mix of care that they receive as part of the care pathway. I think that they are not particularly interested in choosing between providers, because I do not think that they have that luxury in many cases. Most of them are anxious to get an integrated
service that gives them, for example, the nine health checks every year that they need. We are just about to launch the national diabetes audit tomorrow, which will demonstrate that very many patients do not get those checks.

Most patients are not interested in selecting their provider; they are interested in having someone bring together that pathway of care and discussing with them what that pathway might look like for them. That might include whether they want to go for healthy walks or would rather have a gym subscription, or whether they would rather have their foot care done in the community, in their own home or in some other way. It would not include the idea that somehow they will select a provider on the basis of information about quality of services, because in many cases people who are in that position will find that their condition makes it very difficult for them to expend that amount of time, effort and energy. Indeed, they may not be in a place where they can easily tackle the assimilation of a huge amount of information about the quality of competing services, for example if they are older; if their first language is not English; if they are very sick; if they are in some sort of emergency situation; if they have dementia; or if they are struggling with other aspects of their life.

Q154 Paul Burstow: But you would agree that choice is a far richer thing than just choice of provider.

Baroness Young: I think that is why I prefer the word “options” rather than choice.

Q155 Margot James: I take your point, Baroness Young, about options in cases where care is inadequate. I understand your point. Surely, however, a lot of patients with diabetes would like to have the choice between going to hospital for various ongoing needs, or having a facility that perhaps GP practices have negotiated that provides the necessary care within the community, where they do not have to wait so long and they do not have to worry about parking their car. Surely, that is an element of choice; are we not rather playing with words in talking about options? Having option A or option B is a choice, really, is it not?

Baroness Young: Absolutely. But the point at which that needs to be expressed is collectively when the pathway is designed, with groups of patients being involved with the clinical networks. To be honest, I do not think there is enough resource in the health service to have the luxury of having a service both in the hospital and in the community, without there being a considerable amount of waste involved. We are very, very thin on specialist staff with diabetes skills. To have them duplicated both in a community and a hospital setting for the same service is very wasteful.

Ciaran Devane: May I bring the word “transparency” into this? Publishing the 30-day mortality rate of a cancer surgical team is a good thing because of the peer pressure it puts on one team to say, “Well actually we think we’re better than Fred and his pals down the road, but maybe not quite as good as Mary. How come we’re here in the data?” That mechanism of transparency and of showing performance will drive some people to make different choices. It will have a salutary effect that will improve standards, even when some people do not make choices.

One of things that the national bit of the national health service needs to ensure it does is to publish data that are measured in a consistent way and that are available for all of us to scrutinise. That can be used as a way of driving up standards. Yes, some people will exercise choice. If I know that the mortality in one place is higher than another, I will do what I can to make sure I do not go there. I completely accept what Barbara is saying that there are no options and no choices and you have to go in and do something, but publishing performance data that will drive some people to make different choices will have an absolutely salutary effect. We welcome that hugely.

Q156 Fiona O’Donnell: People really trust the voluntary sector. Part of the reason is because often the service that people such as you provide is not to say to the patient, “This is what we offer,” but to say, “What do you need?” There is more flexibility. You would never compromise on quality so, in this new market, do you have concerns about the tendering process and whether or not your services will be commissioned, given some of the issues regarding price and tariffs?

Jeremy Taylor: May I offer an overview because National Voices is an umbrella organisation for health charities—big and small? Not all voluntary sector organisations are providers of services. Even those that are, which are a minority, do a lot of other things, too. They are about championing people with particular conditions or needs and influencing the commissioning process. They may be about providing a service, but there are a rich mix of things that the voluntary sector does that are not just about being another service provider. It is about really caring about your beneficiaries. That is a really important part of the mix and I wanted to get that out in the open. There are some more detailed questions about tendering and procurement that colleagues can answer.

Joe Korner: We are not concerned about the tendering process. We go through tenders and we believe that it is very good that we are tested on the quality of our services to make sure that they are cost-effective. We welcome the idea in the outcomes framework of patient reported outcomes because our services are really about the well-being of people, rather than about health outcomes. So, patient reported outcomes are extremely important.

Where we have a concern is, first of all, in the transition because, at the moment, we are finding that, locally, health economies are disintegrating in some places. Primary care trusts only want to commission services for a six-month period or a year, which is very difficult for us. We have staff who we may have to put on notice. In terms of continuity of care for our service users, that is terribly destabilising and upsetting. There is a real worry about what is happening locally. Perhaps less for us, but certainly for smaller organisations, there is a real concern about whether they have the resources to do all the work that is involved in tendering all the other things.

I was speaking to someone who runs a smallish stroke charity in the north-west called Speakeasy, which has just been denied its £35,000 annual grant from the PCT. It has 20 years of experience and does brilliant work around user involvement. It is doing work with the Department of Health and with the stroke improvement programme. All that expertise will be lost for the want
of £35,000. It ticked all the boxes and spent a lot of time doing this, but in a climate of need to make efficiency gains, one “efficiency gain” is actually losing effectiveness, and all of that work. For me, it is not necessarily about what is happening in the future; it is about what is happening now. What is happening now is that we have a real blight in many areas of the country in terms of committing to the types of services that we provide, and that is a real worry.

On the commissioning process, again, it is rather unclear how it might work for us, because, as I said earlier, our services do not carry a tariff at the moment, and it would perhaps be good if there was a tariff for them. Many of them are not worth enough to be part of a tendering process. From the pilot work that we have done, we know that if it is actually about patients’ own health budgets, people do not find their way to the types of services we provide. We are very concerned about where we fit in. That may shake out in the future, but the uncertainty is terrible for our service users, and it may be that we will have to issue redundancy notices to our staff, even though we may be getting contracts in the future, because we just cannot guarantee that. We are responsible for letting them know as far in advance as possible. At the moment, we are holding it all together, but we just do not know what the future holds.

Paul Jenkins: We all know that we are living in hard times, and those of us who provide services know that we have to engage with the debate about how we meet patients’ needs and deliver better value. Our experience has been that there are two very marked ways of doing it. Where commissioners have engaged with us as an organisation, shared their problem and involved us and the service users and carers we represent in redesigning services, we have sometimes come out with services that may be better in some ways than what we were doing before. In other places, we have just been told, “We’re taking 10% or 15% off your budget.” That is not the way to do it. Again, this proactive engagement with our sort of organisations, to understand how you can address issues of quality and how you get better value for money, is crucial.

Going back to the word “choice”, choice is not always about what you want; it may also be about things you do not want. Patients see some of the needless waste of resources in assessment by service x, assessment by service b, assessment by service c, none of which actually meets their needs or necessarily offers them anything as a result. Patients prefer sometimes to get a different service or a different provider. It is about the service that meets their needs or necessarily offers them anything as a result. Patients tell us that it is about genuinely informed consent, such as knowing what the side-effects or the real implications are, and the ability to make the right decisions. So, absolutely, but let us make sure that there is genuinely informed consent around it.

Baroness Young: Could we extend it from research to clinical audit? If we are going to have a more diverse market of providers, it is absolutely vital that they all take part in clinical audit. That is how we will get the information about the quality of services that patients want to see and to understand and that commissioners will absolutely need to see. We would like to see clinical audit being made mandatory across the board for providers, whichever sector they come from.

Neil Churchill: We may need to see more information about how this is going to work, because there is a huge opportunity here, and I am not sure that as much support as is needed has gone into the knowledge transfer that might be needed. There are some questions. Where are the quality observatories going to go? How will what they have started to do, in helping to equip patient organisations to use some of this data, interpret it and communicate it to patients, be continued and ramped up over the next period? We have not yet discussed how that will work, but it is actually quite exciting.

The Chair: That brings us to the end of our evidence session. I thank our witnesses for being with us.

Fiona O’Donnell: On a point of order, Mr Hood. May I seek your advice? If a vote takes place during these proceedings, is time added on?

The Chair: No. If there is a Division during an evidence session, no time is given.

Examination of Witnesses

Gail Adams and Rachael Maskell gave evidence

6.15 pm

The Chair: I welcome our witnesses to this sitting.

Q158 Grahame M. Morris (Easington) (Lab): I want some clarification in relation to the evidence that we received from a witness earlier today. The chairman of the Future Forum, Professor Steve Field, recently told the Health Committee, of which I am a member, that the trade unions had not raised any concerns regarding national pay and conditions in relation to the Bill. He characterised your meeting with him as constructive and useful. Can you confirm whether you or your members have raised any concerns in relation to the Bill with Professor Steve Field and whether you feel that your concerns are being listened to?

Gail Adams: One of our fundamental areas of concern in relation to staff is with the commissioning boards and the commissioning groups as they are established. There is a concern that the transfer of undertakings will be undermined. We fundamentally believe in national pay bargaining and working collaboratively with employers to try to find solutions, which is perhaps what Professor Field was echoing. I was not at the meeting when he met with colleagues in the Social Partnership Forum.
We have, for at least the last 10 years, tried to work co-operatively with Government and employers and we have, during that time, introduced national pay bargaining, got rid of outdated pay scales that were 40 years old and brought in a system that delivers equal pay for work of equal value. We have undertaken an equality impact assessment in which we looked at the pay records, prior to and post the implementation of “Agenda for Change”, of 500,000 staff and there was not a detrimental impact in terms of either gender or race. Therefore, we firmly believe in national pay bargaining.

As the consortia boards will be individual employers, there is a concern that national terms and conditions could be undermined, and that is something with which we would be deeply uncomfortable. I think concerns have been raised with the Department of Health.

[Interruption.]

The Chair: May I ask Mr Morris to speak into the microphone?

Rachael Maskell: Can I come in on the back of that? I was at the Future Forum with Professor Steven Field. I am glad that he found the meeting with the trade unions a fruitful process. We expressed our concern about the process of the Future Forum. In particular, we were concerned about the poor access our members have had in engaging with the process. There was poor information about when Future Forum meetings were held and members were refused access to such meetings. The feedback from discussion groups was very different from the feedback presented at the Future Forum meeting, so there seems to have been many misinterpretations as a result.

At the Social Partnership Forum, we were concerned when we were told by one member who was chairing one of the groups that he was not listening to us because he did not agree with the views of the trade unions. We were certainly very disheartened about that particular comment, especially as we were highlighting some very pertinent and important points about the Bill that were raised by our members.

On terms and conditions, of course the unions expressed our concerns at the Future Forum, in particular as the NHS employers had told us of concerns about their skills deficit and being able to negotiate on terms and conditions locally. We see the fragmentation of the recognisable “Agenda for Change” package, with its quality proofing and rigour, as a huge detriment to the NHS and a huge distraction from delivering front-line services, in particular in taking clinical staff away from their work to negotiate on local conditions. Therefore, we believe that “Agenda for Change” should be upheld and remain the focus of terms and conditions in the NHS.

Q159 Grahame M. Morris: May I ask a supplementary question? Rachael Maskell gave evidence to the original Bill Committee, of which I was also a member, and the trade unions expressed some concern about the level playing field and—arising from the impact study of the Bill—whether the private sector would in some way be playing field and—arising from the impact study of the trade unions expressed some concern about the level of competition. Does anything in the Bill reassure you that that competition could take place under the amendments proposed. We think that some of the wording on the role of Monitor—if I can just pull out that wording—as being to deal with “preventing anti-competitive behaviour” sounds like another way of saying “supporting competition”, so we are concerned about the drive for competition remaining in the Bill.

At the local consortia level, we are very concerned about the role of consortia—now, obviously, expanded but still, essentially, GP consortia once you remove the interests of the provider organisations, i.e. doctors and nurses—in that procurement process. It seems that you can take doctors and nurses out of direct involvement in commissioning, because they might well come from provider organisations, but some GPs might still have extended interests in other providers, and that is not safeguarded in the amendments provided to date that we have read through.

Q160 Grahame M. Morris: May I have one more supplementary, Mr Hood, then I will give someone else a chance?

We have heard from the BMA and the royal colleges such as the RCN—the doctors and nurses—but this is the first opportunity we have had to hear from the rest of the staff. I think that you represent some of the professions allied to medicine. I suspect that the group of staff that you represent could be in the first wave of community services that might well be subject to being opened to competition. The way I am reading clause 9, which is not changed, is that duties are being passed from the Secretary of State to the consortia; the areas impacted upon would be health visitors, issues around prevention of illness and after care for people suffering from illness—all at the discretion of the consortia. Do you have any concerns or views on that?

Gail Adams: In relation to the changes in clause 9 and other parts of the Bill on the relationship of responsibility between the Secretary of State and the commissioning board nationally and commissioning groups locally, there are concerns. Certainly from my reading of the amendments, albeit we have had limited time to look at them, there is a perception that some of the changes are cosmetic. A lot of the decisions will be made at arm’s length which could still, in terms of public confidence in the Bill and in the service—in the confidence of work force—lead to a further undermining of the process. There is no safety net. For example, if one of the organisations goes bankrupt or into receivership, or we have Southern Cross 1,000 times over in the NHS, there is no safety net in the amendments or clauses I have seen, or in the guidance published yesterday afternoon, to give me that level of confidence. As a nurse, that is deeply worrying.

Rachael Maskell: I can add to that. For instance, we are particularly concerned that a consortia choice could be that NHS provision for pregnant women or young people is not essential, and that they will not provide such services—obviously, it will no longer be mandatory for the Secretary of State to do so. It also means that the Secretary of State will have limited accountability for such issues. The commissioning consortia are there to consider the extent to which a service is necessary to
meet reasonable requirements, so that could mean that they consider those services not necessary to meet reasonable requirements, which would mean that the Secretary of State before Parliament would not be accountable for the non-provision of particular services. As the amendments read to date, that is of concern.

Q161 John Pugh: I want to ask you about competition again. Some people get very excited about it, some people get much more excited about prospects for collaboration, and most people are, I suppose, fairly pragmatic about it. Regarding the Government's treatment of competition in the legislation, and the union's stance, what is your general view as a union about whether there should be competition in the NHS? I would not expect the union necessarily to be up in the air about it, or very excited about it and encouraging to the Government. Is it the case that there are no circumstances in which competition is acceptable? Is competition acceptable if someone is trying to provide a service to the NHS from the voluntary sector but not from the private sector, or is competition acceptable from both but under certain circumstances? What is the union line here?

Gail Adams: In relation to the role of competition, I would first say that competition has existed in the NHS since time immemorial. You are over the river from Guy's and Tommy's, and Tommy's used to think that it was the best thing since sliced bread and that Guy's was not as good at it; now they both think that they are better than the Royal Marsden. There has always been a healthy level of competition, but the Bill introduces a completely different concept, and to be truthful I am not sure that I understand the difference between anti-competitive behaviour and competition.

Some of the proposals about Monitor's role and the opening of the door further to private sector provision are deeply alarming. We have recently seen concerns about social care provision, with Southern Cross and Winterbourne View, and in our experience when private sector providers account to their shareholders rather than to the most vulnerable in their care it can bring different analogies. I have not seen in the guidance anything that clearly explains to me what the difference in anti-competitive behaviour is. The challenge with the whole process—the introduction of different providers and the further opening up—is that we will face increasing competition on an EU basis, and the only people who will benefit from that are lawyers who deal in contracts and the EU.

Q162 John Pugh: We have been told that it is better to have a sector regulator because without one we might find greater exposure to EU competition law. That is an argument being mounted. Do you accept it?

Gail Adams: My biggest concern about Monitor and about the legislation as it is currently framed is that it is exactly the same architecture that was in place at Mid Staffordshire. Unless the safety nets are addressed, there could be further problems—

John Pugh: Would you still—

Gail Adams: Sorry. May I just finish this point please, sir? I do not see a need for an economic regulator. I have worked in the service for more than 20 years, and I think that it has always been effective in working collaboratively and responding to change, and almost, in a way, policing itself. We need time to look at the detail of the amendments—they were published only last week—but I have not seen anything in relation to Monitor that reassures me that the fundamental architecture has changed, and it appears, with the greatest respect, to be slightly superficial. On the EU issues, Mr Burns in answer to a parliamentary question also acknowledged that the service would be opened up to more competition law, and once you open Pandora's box you cannot shut the lid.

Q163 John Pugh: But we already have a competition and collaboration power, do we not?

Gail Adams: It is not in the same context though, sir. The competition that we have at this moment, and which we had under the previous Administration, is with the NHS as the preferred provider. Patients inherently want to make choices, and as a patient with a long-term condition, I want to know that if I go to my local hospital, I will receive high-quality care. I do not necessarily want to go to BUPA, nor would I ever wish to use a private sector provider. Patients want to go to local hospitals, and they want to know that they will receive quality care, whether that is in their home, in an emergency care setting, in a hospital, or in a residential home. That is completely different from the principle of opening it up.

Q164 John Pugh: But presumably you are not against a competition and collaboration panel of sorts, if you are comfortable with that—and you have not said that you are not. You already have some sort of sectoral regulator.

Gail Adams: It is fundamentally different to what is proposed in the Bill, with the greatest respect. In the time that my colleagues and I have had to read the amendments, I do not think that any of them have given us any level of reassurance. Having spent days in Mid Staffordshire talking to staff and service users, this is about fundamentally changing the architecture. It may well be that when Robert Francis publishes his final report, we can learn other valuable lessons for patient safety relating to quality of care, but we are not at that stage yet. From my reading, I do not think that the amendments change that.

Q165 John Pugh: To be very precise—my question was narrower than you interpreted—I agree that there are all sorts of arguments about the architecture and what other facets of the Bill may or may not do, but I was trying to press you about whether you would rather that there was some sectoral regulator instead of none. You have the competition and collaboration panel, which was set up largely to deal with some of these issues of competition law and other things being decided by the courts. Are you comfortable with that?

Gail Adams: I do not feel that the amendments go far enough to ensure that the regulator that we would have in place is the regulator that is needed for the service.

Q166 John Pugh: But you want a regulator.

Gail Adams: Well, we have a regulator. We have not called for the abolition of Monitor in our evidence or in anything else. What we have said is that there are problems.

Q167 John Pugh: You have a competition regulator—

Gail Adams: With that competition regulator, in all the clauses that I have seen, there is nothing about a duty for co-operation being inherent in the role that
Monitor will play. There is talk about integration, but no description of what integration is, with the greatest respect.

Q168 Emily Thornberry: Just for the record, I believe that one of your unions—I do not know which one—wrote in response to your invitation here to say that it did not feel that there was sufficient time for you to prepare full answers to the questions that you were likely to be asked, because you had not had enough time to look through the amendments, what the Future Forum has done and so on. We do not know which union it was and the Clerk was not able to help me. Do either of you know?

Gail Adams: I do not know who wrote, but the amendments were published last week and the guidance on them was published yesterday, so clearly there has not been sufficient time to go through the amendments and cross-reference them against the Bill to see the true meaning of the process, and also to complement them with the guidance. Most definitely, even if we did not write in, we would have welcomed more time, and I am sure that colleagues on the Committee feel the same way. There is a huge amount of amendments to go through in a limited space of time, and it is not as though you do not have a day job as well.

Q169 Emily Thornberry: Thank you; that was very well put. Will you be submitting written evidence, too, when you get the opportunity?

Gail Adams: We will. The focus has been to try and read through the amendments and prepare something so that we could help you as much as possible today.

Q170 Emily Thornberry: Since you have been able to do that, on your first reading—I appreciate that you do not have sufficient time to look at this properly—have you been able to see where there may still be changes that definitely need to be made to the Bill?

Rachel Maskell: Absolutely. We have gone through the amendments in as much detail as time has allowed. Our fear is that a lot of the changes seem to be cosmetic rather than fundamental to the writing of the Bill, and that is a real concern of our members. If we look at many of the issues around the any qualified provider role, we find that there is still an opportunity under the Bill for cherry-picking services, for instance. The safeguarding in the Bill is not rigorous enough to prevent certain providers from looking at delivering low-cost, low-risk, high-volume services, such as cold orthopaedics or something in that stream. They would not combine that work with acute renal care or ITU provision, which are obviously high-cost services. Therefore, from our reading of the amendments, cherry-picking can certainly still take place as the Bill is set out, and that is obviously one of the key concerns that has been raised. The Health Committee and even the Future Forum have raised that particular issue, and yet we still can see that process. We still do not believe that the amendments go far enough to reassure the Future Forum and to address the concerns raised by the Select Committee and, of course, by clinicians on the ground, who know the health service better than anyone.

Q171 Emily Thornberry: Are you aware that the Bill will lift the cap on the proportion of private patients who can be looked after in hospitals?

Gail Adams: Yes.

Rachel Maskell: Absolutely. That is clearly going to produce a two-tier system in the health service. It will mean that people who cannot afford to accelerate their treatment will either wait in pain or try to find some other source—who knows? Maybe they may even remortgage their homes—to be able to get crucial surgery, as private patients can buy their way through the health service. That is something that the NHS was set up to mitigate against, but sadly, the Bill will open the door for a two-tier provision for the rich to be able to march their way through the service.

Gail Adams: Just to support Raehael on that, from the time that we have had to look at the amendments, one of the things that I found was interesting in relation to the fact that there was no amendment to that part of the Bill is that the private patients alliance, a private company, is supportive of our concern about lifting the cap. The reason for that is that it is worried that the NHS will pour more money into private patient provision and become a challenge to it as a provider.

The other dimension that we saw in the guidance notes, but which I have not seen in the amendments—I have not had the chance to cross-reference them—is that the Secretary of State, in the Department of Health’s report published last week, talked about separate accounts being produced so that organisations would be transparent in the amount of money that they receive and spend on private patients in the same way as the NHS. I cannot see an amendment for that.

It is difficult. I have no idea how you do it yourselves, looking at all the amendments and cross-referencing them. They need to be looked at forensically because I am sure that if the Government say that they want to do something and make a positive step regarding separate accounts, they would wish to table an amendment. They would not wish to have people say to them subsequently, “You said that you would do it, but you didn’t,” because no one wants to be put in that embarrassing position. However, I have not yet seen an amendment of that nature.

Q172 Julian Sturdy (York Outer) (Con): We have heard a number of times today from witnesses about the need to move away from a hospital-provided health care system to a more preventative system. A number of witnesses have said that they believe the Bill moves towards that. Do you think that is a right step forward?

Rachel Maskell: Unite has raised this as a major part of our response about how that is brought about. Certainly, everything that happens within the health service is evidence-based. Unfortunately, the processes that have brought about the Bill and even the Future Forum have been about subjective comment as opposed to being rigorously based on evidence and research.

We have said that some of the key concerns are absolutely right to be raised—longevity, the cost of drugs and technology and how to manage chronic illness in old age and deal with complex needs. It is absolutely right to raise those concerns, but the way to do that is to set up a proper commissioning process to review the evidence about how best to manage each patient according to the different aetiology and pathways, and then bring that to a conclusion about the future of the health service.
Prevention is of course a major issue, and we have heard from the Department about how a process that is all about cost saving is meant to be cost saving through ensuring that there is prevention in the future. Unfortunately, prevention is not featured anywhere. We and our members, who are at the forefront of delivering health services, are absolutely at the forefront of wanting to see prevention at the top of the agenda. Unfortunately, this is not the way to achieve it. This is about an illness factory that has been created, as opposed to setting out on an evidence base how we get around the long-term needs of our nation’s health.

Gail Adams: From a work force perspective, one of the challenges in community provision is the ageing profile of the work force providing that service. From a nursing point of view, the overwhelming majority are in the last 10 to 15 years of their service. Between 2010 and the academic year of 2011, the Government will be commissioning 20% fewer student nurse places. We are talking about a 20% drop in the work force that will graduate in 2015.

In order to achieve community provision, we need to make sure that we have a work force that is able to work in the community and across other services to care for people in their own homes. There are concerns around robust, effective work force planning. We hope that the commitment in the guidance notes to producing further information around education will emerge in the autumn, but certainly a numbers problem will emerge in the next three to four years if we do not address the commission rates.

Q173 Tom Blenkinsop: Turning back to competition, I am looking at clause 75, where it says in relation to co-operation with the Office of Fair Trading: “Monitor and the Office of Fair Trading must co-operate with each other in the exercise of their respective functions under the Competition Act 1998 and the Enterprise Act 2002.” What is your interpretation of that sentence?

Gail Adams: In terms of the competition rules—I am not as familiar with that clause as you clearly are—one of the challenges around it is making sure that services are commissioned comprehensively, in an integrated way and across services. If your mother falls over tomorrow and fractures her neck or femur, you want to know that there is a continuous care pathway from the point when she is picked up by the ambulance to the point when she is discharged into her own home.

One problem with Monitor, as I said earlier in relation to competition, is that of the 10 clauses that I am aware of, eight relate to business. That does not seem very integrated or co-operative, from my reading. What I do know is that now, if I were discharging that 89-year-old woman, I would pick up the phone, speak to the district nurse and GP and make sure that there was a care programme in place, but I am not reassured by the amendments that I have seen today that that will actually happen.

Q174 Tom Blenkinsop: In relation to the NHS training system, where you have a diverse and complex market of competitive providers tendering for contracts with the ability to opt out of training and work force development, what do you see as the complications for the NHS service in the future?

Rachael Maskell: This issue is starting to hit home already, with the abolition of the strategic health authorities. I was talking this morning to biomedical scientists who were saying that they were not getting students through for next year because the strategic health authority is not there to release the funding for it. So it is already becoming a problem.

A lot of training within the NHS is borne out through clinical placements, student placements or continuing professional development. Without an obligation on providers to provide that education—we will wait and see what proposals come out on education and training—it will seriously impede work force development and training.

One thing that we are particularly concerned about with the fragmentation is some of the talk around the way that services will be commissioned: that is, along care pathways.

If that is the case, how people get supervision from within their own discipline and their own profession is of huge concern. It just will not happen. We already have examples of speech and language therapists, for instance, who have been singly employed to deliver service around a particular pathway not getting supervision, running into trouble and ending up before the Health Professions Council in their first year of practice. That should not be the health service being created for the future. They need an opportunity to learn on the job with supervision and advanced practitioners around them.

I can draw another example. It is about engagement with the third sector at the moment and one particular organisation. Services are transferring from mental health trusts into this charity. The charity is not taking on board some of the higher band clinicians in bands 7 and 8 and is focusing on bands 5 and 6. As a result, the expertise and experience are not transferring over to the third sector organisation. As a result of that, people are not having that learning experience and that supervision at a higher level in order to deliver the best clinical practice in regard to those patients. So there are already real concerns coming through the system on that front as well.

Gail Adams: I would like to make one point about the work force; I think that earlier colleagues alluded to it in their evidence. One of the big problems that we have at the moment is that the people with work force expertise are voting with their feet, because they are worried about whether they will have jobs at the end of it. So you have—

The Chair: Order. That brings us to the end of the time that was allocated for the evidence session. I thank the witnesses for coming along today.

We will now hear evidence from the Department of Health.

Examination of Witnesses

Andrew Lansley MP, Simon Burns MP and Paul Burstow MP gave evidence.

6.45 pm

The Chair: Welcome, Secretary of State, to this evidence session, along with your two Ministers, who are members of our Committee. I welcome them, but I give a special welcome to your good self.
Mr Lansley: Thank you, Mr Hood. It is a pleasure to be here.

The Chair: You seem to be very popular, Secretary of State, as all the members of the Committee are putting their hands in the air.

Mr Lansley: It is not a Mexican wave, is it?

Q175 Emily Thornberry: I want to ask you, Secretary of State, about clause 1 and about the new clause—new clause 1—that I understand your Government want to amend the Bill with. I want to understand why you are doing that and the reasoning behind it. I am obviously particularly interested in new clause 1(2), which says:

“For that purpose, the Secretary of State must exercise the functions conferred by this Act so as to secure that services are provided in accordance with this Act”—

the Act being the National Health Service Act 2006. The difference that you seem to want is that you want to “exercise the functions conferred by this Act” rather than state that you must provide and secure services. That is the difference, is it not?

Mr Lansley: Act so as to secure the provision of services—I am not quoting, but that is the purpose.

Q176 Emily Thornberry: If you are going to “exercise functions conferred by this Act” instead of having to provide and secure services, would you be kind enough to give us a comprehensive list of the functions that would be “conferred by this Act” as you want to amend it, so that we have a better understanding of what you are trying to do?

Mr Lansley: By all means. I am sure that if the Committee asks for a note setting out the Secretary of State’s functions under the Act, we will be glad to provide one. You asked why we are doing it—

Q177 Emily Thornberry: I will not interrupt again, but I just want to ask something else. If you are not able to provide a comprehensive list today, and I fully understand why, we are to examine this on Thursday, so could we please have the comprehensive list tomorrow, so that we understand what functions you will be exercising in order to secure services under the Act?

Mr Lansley: All of the functions in the Act are carried out in order to achieve that purpose. The functions of the Secretary of State, of course, are to ensure that—for example, through the mandate that is issued to the NHS commissioning board. That is the most important of these purposes: to ensure through the mandate that the NHS commissioning board does indeed secure the provision of a comprehensive health service.

You will recall from our previous discussions that it was always in the legislation—the continuation of the duty of the Secretary of State to promote a comprehensive health service for the provision of health care services and health improvement. What people said to us, and the reason why we are making the change, is that the legislation went on in the previous form, under the 2006 Act, to require the Secretary of State to provide—

Q178 Emily Thornberry: It said you must provide and secure.

Mr Lansley: Provide and secure. The distinction, which we explained previously, was that because the Secretary of State, under the structure of this Bill, was not directly providing but securing the provision, it was inappropriate to say “provide”, because it would not necessarily be provided by the Secretary of State; it would be provided through the responsibilities of the NHS commissioning board and the other commissioning organisations. However, people said, “We want to know that the Secretary of State, in addition to having a duty to promote a comprehensive health service, also has a duty to secure the provision of it.” We have therefore changed the legislation—or we propose changing it, with your consent—to make that absolutely clear, although I think that it was always clear that the Secretary of State’s duty to promote a comprehensive health service and for it to be provided was enshrined in the Act.

Q179 Emily Thornberry: Part of the confusion is the result of what the Future Forum has asked for; and, secondly, it is because of what the Prime Minister said. I understand that he said that the 2006 Act wording would be reinstated, but section 2 of the 2006 Act has not been reinstated, and has been edited as I have said, so that instead of saying that the Secretary of State must provide and secure services it now says that the Secretary of State “must exercise the functions conferred by this Act so as to secure” those services. That is why, in order to scrutinise the Bill properly, we want the full list of functions that will be conferred by the Act.

Mr Lansley: As I said, if you want a note about all the functions, I am afraid that it might be quite a long one—

Q180 Emily Thornberry: By tomorrow, please? We will deal with that clause on Thursday under the Committee timetable.

Mr Burns: You did say that you were not going to interrupt.

Mr Lansley: I have to say that it would be a lot simpler to read the Bill, because to all intents and purposes it is a description of the responsibilities.

Q181 Emily Thornberry: I have had a look at your briefing notes on the amendments, and on pages 4 and 5 you talk about securing provision of services, but it confuses me even more. The note on new clause 2 says that you will have a duty to keep an eye on various bodies and that you will have “extensive powers to intervene in the event of significant failure.” I have searched the Bill, and I cannot find where it says that you will have the power to intervene in the event of a significant failure. Will you be kind enough to point out where in the Bill—we have had only two days to look at it—you are given the power to intervene in the event of significant failure in one of the bodies that are to provide the services in accordance with the Act.

Mr Lansley: I will, by all means, provide in the note an additional reference to this. As we set out in our response to the Future Forum, our intention is not only that the Secretary of State should be responsible for securing the provision of a comprehensive health service and will do so through mechanisms such as the mandate, but that there will be powers of direction in the event of a national emergency and powers of intervention in relation to a significant failure. If I recall correctly—I do not have the list with me—a number of the amendments that we wish the Committee to consider were meant precisely to achieve that effect.
Q182 Emily Thornberry: The difficulty is that we have had the Bill for only two working days. I was hoping that, if anyone could, you would be able to answer these questions, so it is disappointing that you are not able to do so, but I would appreciate it if we could have a full list and a full answer to that question tomorrow.

Q183 Nick de Bois (Enfield North) (Con): Secretary of State, we have heard an awful lot of support for the process of the Future Forum, including this morning, with Peter Carter, for example, saying that they have bought into the process and accepted it as genuine. How much did you rely on Future Forum to drive the reforms? Is its report the main driver of the amendments that have been tabled?

Mr Lansley: We wanted, as we made clear when we took the decision to pause, listen, reflect and improve the Bill, that we would do so through the mechanism of the NHS Future Forum but not exclusively so. You may have found that many of the organisations and stakeholders you talked to have been engaged both with Future Forum and directly with us.

As you may recall, Future Forum was engaged in a process of looking at four specific areas: choice and competition; patient and public involvement; education and training; and clinical advice and leadership. Although the Future Forum was engaged on those issues, we did not say that others were inappropriate, and the fact that there was no direct representation on the Future Forum was not in itself a bar to others bringing forward a range of issues of their own. We talked directly to, for example, the Richmond Group, the BMA, the royal colleges, the Academy of Medical Royal Colleges and a range of other organisations with the objective of ensuring that in so far as people had worries, we provided reassurance, and in so far as they had concerns, we understood whether we could deal with them by amending the legislation. That is the result at which we have arrived. I think that it is providing a lot of reassurance, and for some people we have been able to deal with genuine concerns.

Just as in the previous question, from our point of view there is no change of intention: the intention was always for the Secretary of State to continue to have an enduring duty to secure a comprehensive health service in England. That did not change, but people expressed concerns and it seemed to us perfectly reasonable that we should change the Bill if we could, in order to give people that greater confidence.

Q184 Nick de Bois: One recommendation was that, where necessary, some of the clinical commissioning groups would be able to come on board a little later. My understanding is that that was always anticipated. Given the current coverage over the country and the pathfinder groups, do you have a view on what we may expect by April 2012? 

Mr Lansley: Given where we are, with something approaching 90% of the country covered—88% is already comprised within pathfinder commissioning groups that have come forward—we can be reasonably confident of realising the intention that we set out to establish clinical commissioning groups covering the whole of England before 1 April 2013; but establishing them does not necessarily mean that they will be authorised to take over the whole of their commissioning responsibility. It would be premature on my part to say to what extent across England they will be authorised with full commissioning responsibilities. That must be a process that we understand through authorisation.

The Future Forum asked us to establish the NHS commissioning board quickly, at least in special health authority form. I hope we can do that in October, but it will probably be well into next year—later next year—with the benefit of legislation, until it will be in a position formally to start an authorisation process. That will tell us, at that point, whether the clinical commissioning groups that have been established should take full responsibility or partial responsibility, or are not in a position to be authorised and will be, as we express it, shadow clinical commissioning groups, with the NHS commissioning board taking the responsibility pro tem.

Nick de Bois: Thank you. I apologise; I gave you a tough deadline of 2012 in my question, but it was always 2013.

Q185 Owen Smith: Secretary of State, will you help me out with a definition of terms? Language in the Bill is very important, and one of the much trumpeted changes is the shift in the responsibility on Monitor to move from the previous situation where it had a duty to promote competition, to having a new duty to prevent anti-competitive behaviour. That is described in new clause 5 as “behaviour which would...prevent, restrict or distort competition.” Will you tell me what the difference is between promoting competition and preventing anti-competitive behaviour?

Mr Lansley: Yes. From my point of view, this is very clear. On the one hand, people were very concerned; they felt that if, for example, NHS commissioners were to set out to integrate services, Monitor’s responsibility as previously expressed, which was to secure the best interests of patients
by promoting competition where appropriate, and...through regulation where necessary”—you are right: language in legislation does matter—and putting competition as a primary duty in that way might lead Monitor to use that power to interfere with the structure of integrated service provision and seek to fragment it. That is essentially the proposition that was put to us. We wanted to be clear that that was not Monitor’s job and that its job is to support NHS commissioners in accessing the services that they should. There are related changes about that, so that where commissioners are establishing a structure of commissioned services, that should not be interfered with by Monitor on that basis.

The shift for Monitor is to continue to exercise the extent of competition law within the NHS but, as we have made clear, to do it through the Co-operation and Competition Panel that was previously established using the same principles and rules. The intention is to secure, where that is necessary, the best interests of patients by dealing with any anti-competitive practices that would prejudice the interests of patients. You are right, language is very important. We are talking about shifting from an ex ante intervention to one that is, as it were, an ex post examination of where there might be clear evidence of damage to patients interests.
Q186 Owen Smith: You agree, I take it, with David Bennett, who told us earlier on today that the powers Monitor will have have not changed as a result of the amendments that you have tabled. It still has precisely the same set of powers concurrent with those of the OFT.

Mr Lansley: I did not sit and listen to David Bennett, but I am very clear, and I am sure that David Bennett will be equally clear, that the way in which the duties of any regulator are expressed in their founding legislation has a direct impact on the manner in which those duties and powers are exercised. I think that what I have just described is clear and significantly different in the way I have expressed it.

Q187 Owen Smith: Do you agree with your Minister, who said a couple of weeks ago that competition had now been well and truly put back in its box in this Bill?

Mr Lansley: I think we were both very clear that competition is entirely a means to an end. I do not know what David Bennett said earlier, but he may well have been referring to the fact that, strictly speaking, the legislation does not extend the application of competition rules and law in the NHS. To that extent, the legislation does not change because it does not change competition law. What we need to be clear about is that it is in that box—that we know what the extent of competition rules are. They were introduced into the NHS under the Competition Act 1998 under the previous Labour Government. They were given specific clarity in the principles and rules in January 2009 that were written to accompany the establishment of the Co-operation and Competition Panel. To that extent, we are not changing the boundaries of competition law, and it is in that box.

Q188 John Pugh: I have heard quite a number of discussions, Secretary of State, about procurement roles and at times I have lost the will to live—it is almost like the sketch in “Life of Brian” between the People’s Movement for the Liberation of Judea and the Judean People’s Liberation Movement, because some very fine distinctions are being played out here. The discussion could just be about the most elegant description of your role and function. I suggest that in those circumstances, you would go for the one that gave you least grief and that most people seemed to like best. But I suppose that riding behind it is that people really want to know the difference between one amendment and the other.

I notice that the Government amendment uses “secure” twice, and the Opposition amendment uses the word in a slightly different context. I suppose what people really want to know is, if you have one description rather than another, what do you do differently? For example, if “promote” is used, do you simply say, “Well, I have done my best with the health service, it hasn’t worked, I stop there”? I suspect that it does not mean that.

This is what I really want to know in relation to the behavioural impact. Suppose you found yourself tomorrow with one wording rather than another, what behavioural difference would it make to what the Secretary of State gets up to every day and does, either in directing the NHS or in acting when the NHS fails to deliver what we suppose it ought to deliver?

Mr Lansley: The last thing that I want to do is engage in some kind of theological exposition. I think that it is dead simple. Our intention has always been that the Secretary of State should have a continuing duty, as has been the case since the 1948 legislation, for the promotion of a comprehensive health service in England, and, through the Bill, to be able to secure that provision. In the past, legislation was structured around the proposition that the Secretary of State directly provided such a service; in future, that will not necessarily be the case, but the duty of the Secretary of State must be clear.

Q189 John Pugh: But, to be fair, the Secretary of State never provided all the NHS, did he?

Mr Lansley: On the contrary, the Secretary of State generally has provided much of the NHS.

Q190 John Pugh: Well, certain services were provided through a range of things.

Mr Lansley: No, strictly speaking, the Secretary of State for a long time provided, and in many respects now provides, the service. The intention is to create a structure of legislation around the proposition that the NHS commissioning board is actually responsible, through commissioning, for provision, but that the Secretary of State has a duty—not just a power, but a duty—to secure that provision. If, in any way, the NHS commissioning board or the other commissioning bodies were to fail in their duty, the Secretary of State would have a duty, and the power, to intervene to make the provision happen.

The Chair: I have a long list here. I call Kevin Barron.

Q191 Mr Barron: Just two quick questions, Secretary of State. First, you have just said that strictly speaking the Bill does not change competition law. Will you briefly explain why about 80 clauses in it are introducing competition law on statute that you say has been around in health care for a long time? I do not think that it has.

Secondly, in relation to the issue of the change, pointed out by my hon. Friend the Member for Islington South and Finsbury, between “promote competition out and prevent anti-competitive behaviour in”, clause 65 remains unchanged by any of the amendments. It gives Monitor the power to refer any mergers between NHS trusts, or between an NHS trust and a business, to the Office of Fair Trading or the Competition Commission. Why does that remain if, as you said in answer to my hon. Friend, you do not want competition to interfere with integrated services?

Mr Lansley: On the first point, the intention is that Monitor should take responsibility as a health sector regulator for the application of competition law in health and social care services. To that extent, the NHS Future Forum has helpfully looked at precisely that question. It agreed that the NHS was given greater reassurance by that, because otherwise exactly the same competition law would be applied by a competition authority that did not necessarily understand and appreciate how the health service worked, which is what Monitor is charged to do.

In so far as Monitor will have licensing responsibilities, it will be able to exercise ex ante licensing provisions, the purpose of which is to support the NHS. As a consequence, that will make less likely the intervention of any competition provisions, which tend to fragment and distort what would otherwise be the NHS’s approach.
On mergers, it is now the case that the Co-operation and Competition Panel examines mergers, but it does so in a more intrusive way than the way that will result from the Bill. We are looking to legislation that—as would in any case apply if mergers relate to enterprises under it—will relate simply, as I am sure you know, to where the boundary of an enterprise or an undertaking cannot be established in the Bill.

Q192 Mr Barron: And not just have the OFT and the Competition Commission.

Mr Lansley: Exactly, but in so far as that is already the case, the OFT and the Competition Commission can look at such mergers.

Q193 Mr Barron: Do they?

Mr Lansley: They could do. They have not. Actually, there is no reason for us to suppose that they are likely to because—

Q194 Mr Barron: Why put it in the Bill?

Mr Lansley: The threshold for such mergers would be very substantial—

Q195 Mr Barron: Why put it in the Bill?

Mr Lansley: Because the structure of the legislation in creating concurrency has to be clear where the boundary of concurrency lies. It is something that the OFT and the Competition Commission can do now and will be able to do in future.

The Chair: Before I call the next Member, could I make the point that once Members have asked a question, they should wait for the reply before coming back? It is not right that hon. Members are interrupting our witnesses when they are replying to their questions.

Q196 Liz Kendall: I thought I would ask Simon Burns a question to share this out a bit. On page 49 of the Government’s response to the Future Forum, you say that you will withdraw your proposal for commissioners to apply to Monitor to designate in advance which services will and will not be allowed to fail. Why have you not withdrawn the clauses from the Bill?

Mr Burns: We certainly have said that. That is our intention and we will do so.

Q197 Liz Kendall: When will you table those amendments?

Mr Burns: We will certainly deal with it in the appropriate way to ensure that we achieve the objective.

Q198 Liz Kendall: If you have not yet developed your failure regime policy, you could just withdraw that bit of the Bill because you said that you think it is not right. Why do you not just delete the clauses?

Mr Burns: If you want, first of all, to talk about the failure regime—

Liz Kendall: No, I just want to know if you—

Mr Burns: Then—

Liz Kendall: I am so sorry, please finish your sentence

Mr Burns: On the question of the failure regime amendments, as you know it is a significant, complex issue, and we will bring forward the relevant amendments for that aspect of the changes as a result of the Future Forum in due course at a later stage.

Q199 Liz Kendall: So the Bill will be amended with a new failure regime.

Mr Burns: Yes, the clauses dealing with the failure regime as per what has flown from the Future Forum will be brought forward when they have been drafted, but at a later stage. It will not be during the course of the recommittal Committee because they will not be ready in time.

Q200 Liz Kendall: So you are saying that you are not going to put before the House issues which could affect the closure of hospitals in the constituencies of every Member of Parliament.

Mr Burns: If you are talking about the failure regime and what may or may not flow from that—

Liz Kendall: That means hospitals that may fail—

Mr Burns: What I have said, which is I think is quite clear, is that the amendments dealing with the failure regime are very complex; they are being drafted. We are not going to rush it because we have to get it right, and it would be irresponsible to rush. We have a number of sequences during the legislative programme where we can deal with them. They will not be dealt with during the recommittal of the Bill to Committee because they will not be ready, which gives us the alternative of dealing with them either on Report or in another place. I think you will be the first to accept that you would not want them rushed. You would certainly be the first to criticise us if we rushed them simply for this recommittal. There are other times in the legislative programme when we can do it and we will do it.

Mr Lansley: It is reasonable just to make the point that we have been clear, now and in response to the NHS Future Forum, that in so far as there are reconfigurations—the great majority will happen not in the context of any failure of an organisation, but including in the event of the failure of an organisation in providing health care—we will continue to apply the four tests. You will recall the four tests of respecting patient choice, respecting the decisions of clinical commissioners, respecting the democratic view of local authorities and securing safe clinical care. At the moment the public can be absolutely clear about the kind of test that will be applied.

Q201 Liz Kendall: With respect, that is reconfiguration, not a failure regime.

Mr Lansley: The same will apply in relation to any failure regime.

Q202 Liz Kendall: There are two days for Report stage, and you are saying that that will be the only time that MPs can scrutinise how we are supposed to deal with failed hospitals.

Mr Burns: No, I am sorry, but you are falling into the trap that we had to put up with during the Committee: a Minister says something, and you then reinterpret it to suit your argument and throw it back at us. I did not say simply that the failure regime amendments would
be dealt with on Report. I said—you can read it tomorrow when the report of the proceedings is published—that it is a very complex situation. We will not get it wrong. So that we get this right, we will not draft it in haste. I said that there would be—this is the crucial thing—other opportunities in the legislative process in which the measures could be fully considered. There is no point you nodding in a negative way.

Liz Kendall: For the record, it was a shake, not a nod.

Mr Burns: Or moving your head in a negative way. I said that the amendments could be dealt with either on Report or in another place.

Q203 Liz Kendall: Will they come back on Report so that the House of Commons can consider them? [Interruption.]

The Chair: Order.

Mr Lansley: Mr Burns and I served together, if I recall correctly, on the Committee considering the Health and Social Care (Community Health and Standards) Act 2003, which established foundation trusts. The last Labour Government put into that legislation a provision that said that there should be a failure regime, but they did not say what it would be. They said that it would be specified subsequently in regulations, but do you know what? They did not publish any regulations. There was never a transparent failure regime that provided any of the protections that we—

Emily Thornberry: But this is your Bill.

The Chair: Order.

Mr Lansley: As Simon says, when we have a clear and transparent failure regime that provides the protections that we are looking for, we will subject it to scrutiny, as we have done in every other respect with the Bill.

Q204 Dr Poulter: I want to change the subject slightly and talk about patients a little more and the key health care challenges that will face the country over the next few years. I have two questions. The first focuses on the first issue, which we have talked a lot about today, of looking after an ageing population and people with multiple medical co-morbidities. It is a key health care challenge in both human and financial terms, and one that is coupled with the fact that a lot of resources are diverted at the moment into looking after the worried well. That is appropriate in areas such as obstetrics, but not necessarily as appropriate in other areas. Can the Secretary of State outline how the pause and reflection means that the Bill better addresses the problems of delivering services, and integrated services, that will look after people with many medical conditions and the ageing population?

Mr Lansley: It was very clear in many of the representations made to us and to the Future Forum that commissioning and the strengthening of it through clinical leadership, which we proposed through the legislation in any case, is integral to delivering services that are better integrated around the needs of patients. Obviously, from the point of view of patients with a range of co-morbidities and chronic conditions, it is particularly important that the building block for that is the relationship that general practice has with patients. Other than in the community context, it is very difficult to see the range of chronic conditions together, but if you are going to do that, it is very clear that you will also want to be able to bring the range of professionals into the commissioning context and, particularly, entrench health and social care together in doing so, in the way that we are doing in the legislation.

For many of the patients whom you quite rightly describe, care in this context is both health care and social care, and to see the two separated is, from their point of view, very unwelcome. We are creating all that. The Future Forum report was very clear that through clinical commissioning groups we wanted to create something that is not only rooted in the unique population perspective of general practice, but allied with the views of other professions. I think the legislation does that.

From our point of view, because of the role of health and well-being boards, the legislation will also enable many of the functions of prevention through health improvement plans and public health responsibilities, plus social care and NHS provision, to be seen in the context of broader strategic needs in an area. Hopefully the further strengthening in the legislation of the duty on commissioners and the health and well-being boards to work together on establishing how those respective commissioning plans meet the joint strategic needs assessment should give rise to that kind of better, more joined-up response.

Q205 Dr Poulter: Thank you. For me, one of the key challenges and key problems is that we have historically had a lot of silo working in our different organisations. Primary care is rewarded and paid in a certain way, the hospital sector is paid in a certain way and social services are paid in a certain way, but what really matters is the patient and focusing on that. So, effectively, what you are saying is that by having community-based commissioning or primary care-based commissioning, albeit integrated with doctors from secondary care and other health care professionals, it will help to break down some of the silos and focus the money and the attention much more on the patient.

Mr Lansley: Yes, you are quite right. I would not disagree with any of that, but I would not want to leave out the extent to which we are also seeking to involve patients directly both as participants in the governing bodies of clinical commissioning groups and as part of, for example, clinical networks and their role through HealthWatch. That will all strengthen it.

It was also important to hear from the Future Forum about its feeling that it would be good on our part to make further progress, not only with the personal social care budgets—as you know, we intend to secure personal social care budgets for all those who want them by 1 April 2013—but with personal health budgets. I will not disguise the fact that there are many practical issues about the scope of that and how it will work, but if we really are going to break down all these silos, the most effective way of doing it is from the perspective of the patients themselves. If they can say, “I want to see joined-up services and to have direct influence and control over it,” either through personal budgets or other means by which we give patients information and control, that is likely to be the most effective way of taking out the silo effect.
Q206 Debbie Abrahams (Oldham East and Saddleworth) (Lab): I welcome the Secretary of State and the Ministers. Secretary of State, will you confirm your duty in relation to reducing health inequalities in the recommitted Bill? How do you think your amendments will achieve that?

Mr Lansley: Actually, if I recall correctly, right through the Bill there is an intention that the NHS, the Secretary of State and NHS bodies should have not only an obligation to secure continuous improvement in the quality of services being provided and a focus on outcomes, but specific responsibilities on the reduction of health inequalities. If I recall correctly, that is particularly extended into the responsibilities of clinical commissioning groups through a new clause that specifically sets out to do that for the first time ever.

Mr Burns: As you will remember from our previous Committee proceedings, this is the first time there has ever been such a requirement by a Government in primary legislation.

Q207 Debbie Abrahams: Would you care to expand a bit more, specifically on the amendments and how they will help?

Mr Lansley: It will help if we strengthen the duties on organisations. The point of legislation is, in part, to make it absolutely clear to all the bodies that have duties and powers under the legislation how they are to exercise those duties and powers. As you know, from the very outset we have set out our intention to secure improvements in the health of the population and to secure improvements in the health of those who are poorest fastest. That is at the heart of what we are setting out to do. This has given us an opportunity to amend the legislation for the first time to put that duty relating to the reduction of health inequalities directly into the responsibilities of all NHS organisations.

Paul Burstow: If I recall rightly, when we debated this in the original Committee one of the concerns was that we had not applied the duty equally across all of the relevant bodies. In the amendments that we have tabled, we have sought to do just that and to separate it out from the duties around patient involvement. In two ways, we have addressed concerns that Members on both sides of the Committee raised at the earlier stage.

Q208 Jeremy Lefroy: The Future Forum report states that “the boundaries of local commissioning consortia should not normally cross those of local authorities, with any departure needing to be clearly justified.”

I wonder if you could comment on that, particularly in light of the fact that quite a number of existing consortia will, I think, be crossing those boundaries.

Mr Lansley: From memory, we have 216 pathway commissioning groups—clearly, they can change their boundaries and make different proposals if they wish—but of those I think only 16 cross relevant local authority boundaries. To that extent, what we are setting out to do is consistent in practice with the way in which the commissioning groups view their role.

The point is that through the authorisation process, those 16—and others, if they wish to have a boundary that crosses the unitary or upper-tier authority’s boundaries—will need to show that if they do that, they have got clear mechanisms in place to secure continuing integration between health and social care.

Q209 Tom Blenkinsop: I wonder whether the two Ministers and the Secretary of State can reply to this. I am going to read out a statement and see whether you agree with it:

“having prevented the marketisation and promoting of competition via Monitor we now face exactly the same via the NHS Commissioning Board being given a mandate by the Secretary of State to promote competition. In other words we put Monitor back in its box but not the driving of competition.”

What is the opinion of each of you?

Mr Lansley: What I will do is express my view in response to questions, not pass a running commentary on other people’s views.

Tom Blenkinsop: That was my question.

Mr Burns: Well, that was the answer.

Q210 Tom Blenkinsop: What is the Ministers’ response?

Mr Lansley: They agree.

Mr Burns: Don’t be too clever by half.

Q211 Tom Blenkinsop: All right. If that is not the case, would you say that the Bill we have been presented with in this Committee is a completely different one or not?

Mr Lansley: I think we have been clear that there are substantial and significant changes and improvements to the legislation. That was always our intention, and that is not unusual; many pieces of legislation have had significant changes between Committee and Report. What I think is unusual here is that, while we are making significant changes and improvements, we are exposing those changes to heightened scrutiny through recommittal.

Q212 Tom Blenkinsop: So you would not agree with the response of Dr Evan Harris, who said it was bad.

Mr Lansley: He said what was bad?

Tom Blenkinsop: This amended Bill.

Mr Lansley: Funnily enough, I do not agree with him.

Mr Burns: Tom, it might surprise you, but nor, I suspect, do many others. May I make a point, Mr Hood?

The Chair: Witnesses do not make points of order.

Mr Burns: It is not a point of order. It is a point of correction. Given that we are being live tweeted while we are here, would it be fair—if only to myself—if I said that I have not at any time during these proceedings said that amendments will not be tabled in time for MPs to scrutinise them? I said quite clearly that they could be scrutinised either on Report or in another place, so that seems a little unfair.

The Chair: I am sure that this Committee is not the place to correct Twitter. I am afraid the Minister has just taken time from his colleague who is going to get the last question, with only a minute to go.

Q213 Julian Sturdy: Through the Future Forum, we heard about the need to improve access to services, reduce variations, improve quality and, ultimately, keep people out of hospital, moving from hospital-provided
health care to a preventive health care. Following on from what Dr Poulter asked, how important is it to get rid of the barriers between primary and secondary care to deliver that?

Mr Lansley: It is an interesting point, because in this country we have what is internationally recognised to be a strong structure of general practice: a family doctor service of generalists in the community. At the same time we have internationally among the highest levels of health activity in the acute hospital context.

The Chair: Order. I am afraid that brings an end to our business today. The Committee will sit again on Thursday to begin line-by-line consideration of the clauses and schedules.

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

7.30 pm

Adjourned till Thursday 30 June at Nine o’clock.