House of Commons
Health Committee

Commissioning: further issues

Fifth Report of Session 2010–11

Volume II
Oral and written evidence

Additional written evidence is contained in Volume III, available on the Committee website at www.parliament.uk/healthcom

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

Membership

Rt Hon Stephen Dorrell MP (Conservative, Charnwood) (Chair)¹
Rosie Cooper MP (Labour, West Lancashire)
Nadine Dorries MP (Conservative, Mid Bedfordshire)
Yvonne Fovargue MP (Labour, Makerfield)
Andrew George MP (Liberal Democrat, St Ives)
Grahame M. Morris MP (Labour, Easington)
Mr Virendra Sharma MP (Labour, Ealing Southall)
Chris Skidmore MP (Conservative, Kingswood)
David Tredinnick MP (Conservative, Bosworth)
Valerie Vaz MP (Labour, Walsall South)
Dr Sarah Wollaston MP (Conservative, Totnes)

Powers

The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No 152. These are available on the Internet via www.parliament.uk.

Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom.

The Reports of the Committee, the formal minutes relating to that report, oral evidence taken and some or all written evidence are available in printed volume(s).

Additional written evidence may be published on the internet only.

Committee staff

The staff of the Committee are David Lloyd (Clerk), Sara Howe (Second Clerk), David Turner (Committee Specialist), Steve Clarke (Committee Specialist), Frances Allingham (Senior Committee Assistant), and Ronnie Jefferson (Committee Assistant).

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).
Witnesses

Tuesday 8 February 2011


Dr Charles Alessi, Kingston Pathfinder GP Commissioning Consortium, Dr Clare Gerada MBE, Chair, Royal College of GPs, Mike Sobanja, Chief Executive, NHS Alliance, and Dr Peter Carter OBE, General Secretary and Chief Executive, Royal College of Nursing.

Tuesday 1 March 2011

Professor Calum Paton, Professor of Health Policy, Keele University, Professor Paul Corrigan CBE, Independent Consultant, Nigel Edwards, Acting Chief Executive, NHS Confederation, and Stephen Hocking, Partner, Beachcroft LLP.

Dr David Bennett, Chair, Adrian Masters, Director of Strategy, Monitor, Dr Ron Singer, Medical Practitioners’ Union, and Dr Anna Dixon, Director of Policy, The King’s Fund.

Tuesday 8 March 2011

Dr Peter Weaving, GP commissioning lead in Carlisle consortium, Christopher Long, Chief Executive Officer, Humber cluster of primary care trusts, Dr Margaret Lovett, GP commissioning lead in Hull consortium, and Dr Deborah Colvin, GP, Lawson Practice Hackney.

Sir David Nicholson KCB, CBE, Chief Executive, NHS and Chief Executive-designate, NHS Commissioning Board, Dame Barbara Hakin DBE, National Managing Director of Commissioning Development, Tim Rideout, Director of Commissioning Board Development, and Ben Dyson CBE, Director of Policy, Commissioning and Primary Care, Department of Health.

Tuesday 15 March 2011

John Black, President, Royal College of Surgeons of England, Alwen Williams CBE, Chief Executive, East London and the City Alliance PCT cluster, Dr Paul Hobday, Kent Local Medical Committee Spokesperson and ex-chair, BMA Maidstone Branch, and Sean Boyle, Senior Research Fellow, London School of Economics.

Suzanne Tracey, President, Healthcare Financial Management Association and Director of Finance and Business Development, Royal Devon and Exeter NHS Foundation Trust, Noel Plumridge, Independent consultant and writer on NHS finances, Andy McKeon, Managing Director for Health, Audit Commission, and Professor Margaret Whitehead, Professor of Public Health, University of Liverpool.
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3. Professor Calum Paton
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3. Juvenile Diabetes Research Foundation
4. Mary Hoult
5. British Medical Association
6. Urology User Group Coalition
7. Royal College of Psychiatrists
8. British Dental Association
9. million+
10. Homeless Link
11. Lundbeck
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14. British Society for Rheumatology
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28 Professor Christopher Newdick
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32 Professor Andrew Street
33 Rethink
34 British Society of Gastroenterology
35 Dr Sally Ruane
36 Parkinson’s UK, MND Association, MS Society, Epilepsy Action, PSP Association, Sue Ryder Care, UK Acquired Brain Injury Forum, Neurological Alliance, and Neurological Commissioning Support
37 Directors of the National Institute for Health Research Collaborations for Leadership in Applied Health Research and Care
38 University of Oxford Health Experiences Research Group and Georgina Craig Associates
39 Dr Pawan Randev
40 Association of Directors of Children’s Services and the Association of Directors of Adult Social Services
Good morning, ladies and gentlemen. Thank you for coming. We have a very full agenda and a lot of ground to cover this morning. Could I ask you to begin by introducing yourselves and saying, very briefly, where you come from, starting with Alyson, please?

**Alyson Morley:** Good morning. I am Alyson Morley, Senior Policy Consultant with the Local Government Association. I am here to accompany our member representative.

**David Lines:** I am Councillor David Lines, representing the LGA and also The Centre for Public Scrutiny.

**Malcolm Alexander:** I am Malcolm Alexander. I am chair of the National Association of LINks Members.

**Caroline Millar:** My name is Caroline Millar. I am a partner in the Moore Adamson Craig Partnership, which is a small independent consultancy which trains lay people. All our partners also act as lay people in various different capacities.

**Professor Tritter:** I am Jonathan Tritter. I am a professor at Warwick Business School. I set up and was the first chief executive of the NHS National Involvement Networks Members, Institute of Governance and Public Management, Warwick Business School, gave evidence.

**Q1 Chair:** Good morning. Thank you very much for that. The first session this morning is focused on the arrangements proposed in the Health and Social Care Bill for patient and public accountability. The Government has said that it is a key aim of the NHS reforms to make “NHS services more directly accountable to patients and communities”. It is timely that you are here to give evidence on this subject this morning because, as you are no doubt aware, there is a letter in various different capacities.

**Professor Tritter:** I am Jonathan Tritter. I am a professor at Warwick Business School. I set up and was the first chief executive of the NHS National Centre for Involvement during its existence.

**Q2 Chair:** Thank you very much for that. The first session this morning is focused on the arrangements proposed in the Health and Social Care Bill for patient and public accountability. The Government has said that it is a key aim of the NHS reforms to make “NHS services more directly accountable to patients and communities”. It is timely that you are here to give evidence on this subject this morning because, as you are no doubt aware, there is a letter in the *Times* this morning from a group of voluntary organisations who state that "plans to make GP consortia accountable to the public are far too weak...we urge the Government to amend the Bill and insist on a strong independent scrutiny function led by democratically elected representatives." So we have the Government’s aspiration and we have a view expressed pretty trenchantly in correspondence in the *Times* this morning. I would like to ask each group, please, to open the session by telling us, relatively briefly, where you sit in terms of your view of the extent to which the Government delivers its objectives in the Bill as it is currently drafted and proposals you might have to strengthen the meeting of this test to make NHS services more directly accountable to patients and communities.

**Alyson Morley:** If I say a little about GP commissioning consortia, Councillor Lines can then talk about Health and Well-being Boards. I heard about the letter on the radio today, and I think that is where there is a lack of symmetry in the Bill. We have a lot of specification about the membership of the NHS Commissioning Board and Health and Well-being Boards but very little on the constitutional and governance arrangements for GP commissioning consortia.

There are two ways of making GP commissioning consortia more accountable to the public. One is by having far greater accessibility from the public to those Boards, so you could have advisory members or you could have an advisory panel. In an awful lot of areas councils and PCTs have really good mechanisms for patient and public involvement and GP commissioning consortia need to build on what already exists rather than reinventing the wheel.

The second way of ensuring that GP commissioning consortia are more accountable to the public is the way they fit in with the other accountability mechanisms, most notably the Health and Well-being Board. You will know that GP commissioning consortia have to make reference and have regard to the joint strategic needs assessment, which lays out the needs, assets, resources and health concerns of the local population and the evidence of what will make effective health improvements. They have to have regard to that.

In our original submission to the Government, the LGA said that GP commissioning consortia should be required to sign off their commissioning plans with the Health and Well-being Board. While the NHS Commissioning Board will have responsibility for the financial rigour of those plans, it will be up to the Health and Well-being Board to sign off whether they were aligned to the JSNA. We still think that that
would be really helpful. I will hand over to Councillor Lines.

David Lines: Thank you, Chairman, first of all, I would mention that when this first started it was in our remit of scrutiny and it has widened. I will be the first to say that my expertise is not in the health sector. My expertise is in governance and scrutiny. If I am asked a question on health, I shall pass to my much wiser colleague on that.

The background out of which both of us are coming, in the LGA, is the three themes of subsidiarity; in other words, localism, local decision making at the lowest appropriate level, transparency and everything else that falls away from that in terms of governance—if you shine a spotlight into dark corners it is a good way of ensuring the right sort of disciplines come away in terms of governance—and best practice. We are not perfect. No one is perfect. Life is about evolution. We have to learn and we look for best examples.

If we turn to the Health and Well-being Boards, our view, fundamentally, is that they are executive boards and, as such, you shouldn’t mark your own homework. That is why the scrutiny role is very important. There is a debate there as to exactly how that should be developed. As this Committee is going through the process, the LGA is going through the process and, shall we say, there are plenty of minds made up but it has not come to a common view on how it will be best approached. The principal message is that it needs to be decided locally with less prescription from central government. If it is to go step in step with the Localism Bill, the make-up of these boards and the balance of political against specialist knowledge all has to be worked out. It will be horses for courses in that respect.

David Lines: That is the way we are going. As I say, the LGA is moving towards a considered view on that, but that is the way it is going.

Q3 Chair: If I can develop that, you are content with a position where the precise form of local engagement by local authorities in the process is for local discretion rather than prescribed by statute.

David Lines: That is the way we are going. As I say, the LGA is moving towards a considered view on that, but that is the way it is going.

Q4 Valerie Vaz: Does that mean there are going to be differences throughout the country? Each part of the country will have their own Boards.

David Lines: That is inevitable. You are caught between a rock and a hard place. If you are devolving responsibility, you have to accept that people are going to do things a little differently. From my own experience in the private sector as a manager, delegating authority is the most difficult thing in the world. So many people put it down with one hand and take it back with the other. Keep it where it is but push it all down—responsibility and authority. Therefore, you have to have differences of view.

Q5 Rosie Cooper: I have one very quick question. Do you really believe that you have the ability, the resources and the expertise to hold people who have been commissioning, i.e. the managers, not the GPs necessarily, to account?

David Lines: Straight answer?

Rosie Cooper: No.

David Lines: No. The straight answer is “In a lot of cases”, but I accept fully in such a wide-ranging organisation as local government that you are going to have the best and the worst. Is that a reason to throw localism into the bin? No, I don’t think so. I agree resources are important— in other words, support for this—and that is perhaps the Achilles’ heel or one of the Achilles’ heels in this and needs to be worked through. What will happen is that certain critical things will be looked at and studied and others will have to take a back seat. There is an inherent risk in that, and those that make this legislation and those that have to carry out this legislation must realise that.

Q6 Rosie Cooper: While you are getting the expertise, the system will be letting rip.

Alyson Morley: But this doesn’t come out of nowhere, and in an awful lot of places there is already good joint commissioning between GP commissioning clusters and councils. You will know that in many areas there are joint arrangements now with PCTs and local government setting up as one organisation. There are probably about 18 councils and areas where this is happening. So we can build on what—

Q7 Rosie Cooper: But have they commissioned anything yet?

Alyson Morley: Yes, they are commissioning services. They are commissioning joint services as we speak.

Rosie Cooper: That is Torbay.

Alyson Morley: Joint commissioning has been going on since—I can’t remember which Health and Social Care Act it was. But there is good joint commissioning. There is also an incredibly strong business case for joint commissioning. GPs will realise that it is cheaper to pay for health and social care support at a low level which prevents later high intensity care. Not only is that better for their budgets, but it is better for the outcomes of their patients.

Chair: I am going to move on to Malcolm Alexander, please.

Malcolm Alexander: Thank you very much. My involvement with commissioning and public involvement goes back a number of years and the real issue is that for the community to influence commissioning it needs to have real influence, real power, resources and capacity. What has happened over the past few years is that that has been undermined and destroyed and we are in a situation now where we need to rebuild the capacity of LINks to develop into HealthWatch organisations.

I would say that localism has been a disaster for LINks. It has meant that across the country we have absolutely fantastic LINks in one area and appalling LINks in other areas, which means that people really suffer from having organisations that cannot properly represent their interests. Culturally, GPs find it very, very difficult, in my experience, to collaborate with the community in terms of decision making. They love it when people come in and talk about the colour of the wallpaper and they love it when they come in
I would like to support what also the capacity of groups, HealthWatch certainly, we need to develop the capacity of individuals and such a way that they are given full attention. We need HealthWatch to be working actively with local authorities, but independence is the key. The proposals at the moment that make HealthWatch accountable to local authorities, we think, will be an absolute disaster. But the even bigger disaster at the moment is that the funding which has come from the centre for LINks and the development of HealthWatch, which is the same as last year with inflation, once it gets to the local authority is being cut in half. This means that many LINks are going to perhaps tumble over the next financial year and the capacity to develop HealthWatch will be infinitesimal in many parts of the country. We are facing a real disaster. Yesterday, talking to the Department of Health, that is number one on their risk register with respect to the development of HealthWatch for the next 18 months or so.

One more thing is that the relationship between the local HealthWatch and national HealthWatch will be crucial and elections from local HealthWatch up to the HealthWatch England body will be essential. Accountability and democracy must go side by side, both locally in HealthWatch and nationally in HealthWatch England. Capacity building has to be a function which HealthWatch England is able to carry on to make sure that every HealthWatch across the country reaches a certain level of capacity so that they can properly work with and represent the local community and also have real influence. That question of influence in commissioning is absolutely fundamental. It is, in my experience, one of the most difficult things a community can do and we need real power and influence to be able to do it effectively.

I welcome the Committee's inquiry. I am concerned about the lack of patient and public involvement in commissioning, and particularly the dilution of the 2007 Act, the rewriting of section 221(2)(d) suggesting that HealthWatch is now far less than two-thirds of them had any experience of that despite 20 years of encouragement, and, further, that those patient participation groups—found that less than two-thirds of them had any experience of doing public involvement. A study in 2006 looking at how GP surgeries were using PPGs—patient participation groups—found that less than two-thirds of them had any experience of that despite 20 years of encouragement, and, further, that those patient participation groups can be very successful but where successfull is the result of a huge commitment from the practice itself, usually from one individual with a major input of resources, and it has to be an ongoing thing. This is not a question of just calling them up and asking, “What colour shall we paint the walls?” This is having an ongoing relationship where they can see the impact of what they have said to you. So if they are giving information, that information is passed on and fed up into the system. We want to see that aggregated up at consortia level so that consortia also understand what patients are thinking. Then, if there are individuals who can move up through the system with training support, through the HealthWatch or through other means, those individuals may be in a position to contribute to high-level commissioning discussions. But we must not assume that just by sticking people on some committee somewhere we are going to get the lay input and public perspective. That is probably the most important aspect we need to think about.

**Professor Tritter:** I welcome the Committee's inquiry into this area. I think it is incredibly important I am concerned about the lack of patient and public involvement in commissioning, and particularly the dilution of the 2007 Act, the rewriting of section 221(2)(d) suggesting that HealthWatch is now far less about commissioning and far more about the promotion of choice. I don't think GPs are much closer to their patients. They have a patient list, but if you ask them what proportion of that patient list they see on an annual basis, it is about a third. Second, that patient list does not represent all those who need or utilise health services within that locality. Thirdly, the patient list is not representative of the community in any real way. GPs do not have any track record in terms of joint Strategic Needs Assessment and absolutely no experience of doing public involvement. A study in 2006 looking at how GP surgeries were using PPGs—patient participation groups—found that less than two-thirds of them had any experience of that despite 20 years of encouragement, and, further, that those
surgeries which did have patient participation groups were more likely to be in affluent and less deprived populations. The final thing I wanted to mention is that it is a shame HealthWatch is the name that was chosen, as this is the name of a charity established in 1991 looking at evidence-based medicine. It is essential that we find a way of having HealthWatch as a local basis for patient and public involvement engaging with the actual GP commissioning process rather than secured solely to the Health and Well-being Boards. Finally, there needs to be a way to identify how local HealthWatches are working. One mechanism which might be used is that the annual reports they have to submit be subject to some external review which would ensure they are being doing involvement, what have been the outcomes and impacts of that involvement and what weaknesses could be identified to try and intervene to support their development. That is a very different mechanism. When LINks was introduced, I engaged with the Care Quality Commission to try and encourage them to do this and align these processes with the involvement that was supposed to go on at LINks. This never happened. I hope HealthWatch provides another opportunity for this kind of mechanism to be used.

Q8 Nadine Dorries: Isn’t there a slight difference between lay people, as in your lay patient, and the people who sit on organisations such as the Patients Association, the Alzheimer’s Society or the Stroke Association? When we talk about patient involvement, are we talking about those people who have made their life’s work being involved in organisations such as the Patients Association, or are we talking about the patient who just visits the GP once every few weeks? It seems to me as though the input from the two would be vastly different in terms of knowledge and ability to influence. Therefore, when we talk about patient involvement, what are we talking about? Are we talking about the patient who is involved, part of an association and incredibly informed on particular areas of commissioning, or are we talking about the retired lady who lives in A cacia Close who would just like to do a little more for her GP practice? Which one would provide the most input and which one should we be concentrating on?

Malcolm Alexander: It is all of those really. In terms of local public involvement work, it is about strategy. The strategy is probably that you would have a steering group, or the leading group in a LINk or a HealthWatch, which would be made up of lay people with some experience of the service—perhaps people who are in local voluntary sector organisations, so they have that kind of experience. For example, if somebody has MS and they are part of the MS Society, they know about local services and they bring that experience into the local body. Other people will have a range of different experiences that bring them there. Then there will be the outreach work, which is fundamental, which is about going into the communities, meeting with groups and talking about issues that concern them, perhaps campaigning issues. Sometimes it is about the closure of a clinic or a hospital which, actually, is the one thing that really mobilises people. If you want to get people going, you have to close a hospital. That is the tragedy of public involvement work in a way. People will contribute at different levels of experience and knowledge. But how do you value those bits of information that people bring? It is like during your surgeries with people coming and bringing you a story. The weakness of the LINk and the Patients’ Forum is that it lost the capacity to listen to complaints because when CHCs closed complaints and advice went and it broke up the organisation. HealthWatch is an attempt to reunite the organisation and bring complaints back in. If you don’t hear the voice of the user, you can never build an organisation, in my view, in terms of properly representing the community.

Caroline Millar: Could I just add to that? There is a tendency to forget the well people most of the time, and this may be part of the point you were making. We hear a lot from people who have long-term conditions, and it is just what we do. But I know of examples of LINks who have not really made contact with their well populations. There are parts of London where there are lots of young, active working people and the issues for them may be completely different. They may be about sexual health or they may be about childbirth. They are quite different issues from the sort of people who are represented often through the voluntary sector groups that you are talking about. Often they are not heard. That is why the onus should be on HealthWatch, or whatever it is called, and also on local authorities to go out and find those people.

There are very good examples in local government of outreach work, of physically going out of the building, going to where the young mothers are, going to the day centres and talking to people. I see this happening in some of the provider services in Hackney, for example, where I am involved. Those kinds of approaches need to be used so that we can find out what patients, the generality of patients and the public, who may be separate from patients, think.

Q9 Nadine Dorries: I do take that, but you criticised patient involvement to an extent, or criticised GPs, rather, inasmuch as the people who get involved in GP services at the moment tend to talk about the colour or the pattern of the wallpaper. Isn’t it the case that if somebody isn’t a person who is involved with the MS Society or with the Alzheimer’s association, who has a specific single-focus interest in a particular condition, what those lay people are concerned about when they become involved in their GP practice is the pattern of the wallpaper and is the experience that they are greeted with in their GP practice because they themselves do not feel qualified or knowledgeable enough to input on issues such as young people’s sexual health services or how MS services are provided? They don’t feel qualified to comment on that. Therefore they become more involved in the GP experience that the patient receives when they arrive at their practice, such as opening hours and telephone
helplines and that kind of thing, rather than actual commissioning for care.

Caroline Millar: Those things are extremely important.

Nadine Dorries: They are, of course, yes. I’m not saying they are not.

Caroline Millar: They are part of the picture of what happens when the service is being commissioned.

Malcolm Alexander: You can do an experiment. If you meet people inside a GP’s surgery, they are very placid. If they are sitting with GPs—

Q10 Valerie Vaz: Because they are sick. Malcolm Alexander: No. Valerie Vaz: I’m sorry. I go in there.

Malcolm Alexander: No, I don’t mean that. I mean patient’s groups. If you meet patient’s groups inside a GP’s surgery, they are very placid. They sit with the GPs and they are all patting each other on the back and being terribly nice to each other. If you have a meeting in the community and you say to people, “Tell us about your GP,” it is a totally different story. They will tell you about their experiences of general practice and about the sort of services they receive. They will give you very, very rich information. It is fantastic. You just have to go to a community group and say, “Tell us about general practice,” and people are full of ideas.

I have one more thing. If you then say to people, “Tell us what would make a really good service”—and I have done this many times, you get a group of people together and say to them, “How can we improve this particular service?”—there is a wealth of ideas that come out. A technique we have used is building up quality standards based on the views of patients—the public—and it is a fantastic technique.

Q11 Valerie Vaz: That is absolutely right. It picks up the point that Professor Tritter made about the GPs—

Nadine Dorries: I hadn’t actually finished, Chair.

Valerie Vaz:—seeing people who are ill and the people who they don’t see. That is the key point.

Malcolm Alexander: Yes. Alyson Morley: One of the issues here, the challenge, is capturing all of this and everyone having access. What happens quite often with these consultations is you have an enormously rich tapestry of all sorts of information, demands and ideas on how to make the services better in a community, but what you don’t have is the putting together of that. The joint strategic needs assessment is a really good opportunity to put that together and for everyone to draw on that. So every single GP doesn’t have to reach out to every single member of their community. That is already done through tenants’ and residents’ associations, local assemblies and local mother and toddler groups, for example. They need to make the most of what already exists.

Chair: Nadine, you wanted to come back.

Q12 Nadine Dorries: Yes. I wanted to ask, just to complete my questioning, do you feel, up to now, that patients have had a bad shot at input and with defining how they input into services provided by GPs? Do you think it has been bad for them up to now? If you do, do you think that the Bill now provides patients with the platform to have their voice heard and have a greater involvement, as the Bill says in its statement, “better patient accountability”? Do you think that the Bill provides that opportunity? I know there are problems—and you have articulated those in your opening statement—but do you feel that from where they are now to where the Bill puts them, the Bill puts them in a better place to have their voice heard?

Professor Tritter: The Bill does specify a requirement of the GP consortia to do patient and public involvement, which it never has had before. In that sense, GPs now have to do it and they never used to have to do it, so that is an improvement. Since most of them have not done it, and have not done it in relation to the array of services that are provided, it is a big challenge for them.

As to this issue of lay involvement, I think Malcolm is entirely right. The mode, the mechanism that one uses for engagement, is really important. There are things they do in southern Sweden around having an open forum where you bring together health providers and members of the public and patients to talk about health priorities. It is a very different context in which to discuss those things than sitting in the waiting room in a surgery and talking about the wallpaper or how services should be provided.

Q13 David Tredinnick: On this general point, I have one question. To what extent should the voice of the user extend to patients requesting specific treatments? A lot of us are being lobbied at the moment by the Chinese medical community and the acupuncturists about regulation, and a lot of people very often want to go down that route. How are we going to manage that in the general context of choice?

Malcolm Alexander: It is an interesting issue in terms of commissioning. I have done quite a lot of work with complementary therapies where we have had rooms full of people with PCTs. The rooms full of people have said, “We want complementary medicine” and the PCTs have just said, “We’re not interested. We’re not going to do it.” This is the real challenges around commissioning. When people really want something as a community, they organise and they make the demands. What duty does that place on the commissioner to concede to those demands or to negotiate over those demands? There are two different things. One is what has been agreed and decided by those who are most actively involved as commissioners and the other is those things which are wanted by the wider community. We have to try to deal with that issue in terms of what resources are available.

Q14 Chair: I am starting to feel giddy on behalf of these consortia. They have, on the one hand, to respond to the joint strategic needs assessment and the relationship with the local authority, they have to deal with consultation groups and HealthWatch direct patient involvement and they have to deal with the National Commissioning Board. Which way are they going to turn?
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8 February 2011 Councillor David Lines, Alyson Morley, Malcolm Alexander, Caroline Millar and Professor Jonathan Tritter

David Lines: And they have to look after their patients.

Chair: Occasionally the patient gets a look-in.

Professor Tritter: NICE, in some sense, is an adjudicating authority on what services are reasonable to be provided on the NHS. They weigh up evidence in terms of the existing efficacy, the cost and quality of life, year adjustments and involve patients and the public in their consultations. That is a mechanism to adjudicate between individual patient demands and those things that are deemed appropriate in terms of biomedicine.

Malcolm Alexander: Yes, but in terms of your question, of course, it is interesting the Bill does not actually place HealthWatch together with the consortia. The Bill keeps them separate, which is quite odd and difficult to understand. The answer is that general practice locally needs to develop good strong relationships with their patients and wider communities so that those relationships enable negotiation and discussion to take place about local issues. But we need quite a developed idea of how we can democratically get people involved with commissioning boards at a level where they can have real influence. It is a very poor model and GPs will be pulled and pushed in all sorts of different ways. It will only work from the point of view of the public if we can get the HealthWatch bodies properly working, supported and able to develop and grow to have the methods available to them to conduct a proper negotiation with the GPs in the consortia. If that happens, GPs won’t be pushed and pulled in quite the same way.

Q15 David Tredinnick: I have a quick supplementary to Malcolm Alexander. You mentioned complementary and alternative medicine, and it just happens that I chair that group in Parliament and have done for many years.

Another point that is made to me by people demanding those services is they are less expensive. As we are trying to find an efficiency gap, isn’t that something we should be looking at?

Malcolm Alexander: That is a point frequently made by people who choose complementary therapies. This is slightly outside the discussion, but I suppose the answer is that if patient choice is a genuine thing and people say, “This is what I choose” and the doctor says, “You can’t have it,” we have a really serious problem. Patient choice, if it is a serious business, is not just about what other people choose for you or other people’s agendas. It is about the public’s right to be able to influence that agenda.

Q16 Chair: Though, as Professor Tritter says, presumably, if they are spending public money, there must be accountability for efficacy as well.

Malcolm Alexander: Yes, of course, there is, but are we to ignore the evidence of the patient who says, “This treatment has been very successful for me?”

Chair: No, certainly not.

Malcolm Alexander: Historically, many treatments have been used by the medical profession. We can go back to insulin therapy in mental health work, which was extremely dangerous. We should respect genuine patient choices.

Q17 Rosie Cooper: Basically following on from that, I am repeatedly saying that the Bill is high on autonomy and low on accountability and I am repeatedly told that patients will have a greater voice. I have yet to see one bit of evidence base for that and it drives me nuts.

In the Bill, the specified governance arrangements, for me, are virtually non-existent, and those which are there I will categorically say I see as pathetic. It says that they will hold one public meeting a year and, beyond this, there is no requirement as to how they would conduct their business. Anyone involved in the Health Service who ever attends a trust AGM knows how ineffectual and ineffective they are. I used to bribe people to come to mine and if I found one genuine member of the public I was always very, very lucky. This is absolutely true. We would have to drag our staff to come to make up the numbers so I wasn’t talking to myself. Maybe that is a reflection on me, but no, I understand all my colleagues have the same problem.

Looking at the governance arrangements, we really do need non-executive directors pummelled right through this, and perhaps a requirement that one of those non-executive directors should be of that particular area, representing the public. I do understand there is an argument that a group might get to be that person, but not if you have proper arrangements for interviewing and all the rest of it. I never ended up with one of those in my life and I always had a really good, strong local voice in there to fight with the rest of us who were trying to make a decision—a real voice. The truth is that is how I got involved in the Health Service. One AGM a year is not good enough and I believe that consortia meetings should be held in public, but I fear that this private and confidential or commercial confidentiality nonsense will mean that those meetings will be held in private. That, to me, is a game changer. You are not going to have real people on the board involved in making those decisions—no counterbalance.

What I am really saying is that I don’t think anyone has expressed a view that says what they have seen here is good enough. What is your view about non-executives, is your view about meeting in private and what, in this scenario, would be a good model of governance for you? Remember that I used to be a local councillor. I don’t believe there is enough expertise in there to even remotely challenge the expertise of commissioners, former PCT people, who have been doing it for thousands of years and know the intricate detail. When you have Health and Wellbeing Boards challenging what may very well be a really good clinical decision made by a consortium and there’s a row, I’ve asked the Secretary of State who decides. We have got the answer, which is The Independent Reconfiguration Panel, which is no different to now.

Chair: I think that’s an essay question, Rosie.
David Lines: My English master used to give us questions like that with the first foolish page, and then you had to write another 10 after that. But, if I can pick up some of the themes there, I think—and this is more a personal observation from a governance point of view—this Bill is trying to be all things to all men and women. In other words, in layman’s terms, if I can use that expression, in governance terms, it is trying to micro-manage and macro-manage at the same level. That is a great mistake.

I would then move on to the Government’s arrangements. Yes, you have picked up one meeting, constitution. Why bother, because it won’t be effective? If you are serious about it, do it properly or don’t bother to do it at all. I am being equally as plain-speaking as you on this.

Q 19 Rosie Cooper: No, it is good.

David Lines: That is my observation. I am a little bemused, just to go back to the original point, that scrutiny committees are not well equipped. I think possibly, maybe a hundred years ago, that was said about Select Committees, but I am scarcely going to be the one to level that criticism at a Select Committee. Scrutiny committees have only been in existence for 10 years. It is a growing process. Does that mean that they should stop? Then there is a discussion about lay people getting involved in providing choice. Actually, I am a layman.

Rosie Cooper: So am I.

David Lines: I am an elected layman, elected by laymen and women. Rather than bundle everything into an unmanageable ball of wool with bits and pieces everywhere, let us separate it out and say, “What do you want to do here?” “What do you want to do there?” and “What do you want to do there?” Why reinvent the wheel? We have a hundreds-of-years-old system, parish councils. On that are built district councils, MPs, county councils. Yes, it is mind boggling and it is bureaucratic, but it is there. Let us reshape that. There is another Bill going through Parliament about localism. Let us reshape that and reshape this at the same time. In five years’ time I think you will find the best scrutiny committees will be as good as this Committee.

Q 20 Rosie Cooper: Absolutely. Forgive me. I have obviously expressed myself really badly. It is not that they won’t get the ability do it. It is whether you have got it absolutely now to challenge the system over the next 18 months when it is going to race ahead.

David Lines: Could I pick up on the comments of my colleagues here? In effect, they said that no one has got there. We all, whether you want to do it down the public sector, the council way, or you want to do it through the voluntary sector, they all need support and that is the big—I repeat it—the big Achilles’ heel here.

Q 21 Chair: Can I bring in Caroline Millar who has been sat patiently?

Caroline Millar: Perhaps the distinction that would be useful to make here is to distinguish between the public as the moral owners of the Health Service, if we like, and those people who are users of the Health Service. We need to be much clearer about these distinctions. We talk about patient engagement and patient involvement and we talk about public engagement and public involvement. They are different things and in those two different capacities people have different needs. You are absolutely right, that in governance arrangements we need to acknowledge that the governance arrangements are there to serve the public as the moral owners of the Health Service. Therefore it is vital that in the structures those people have a voice—a substantial voice, not just the one voice in the room. It is not just about local councillors or democratic representatives. It is other people with other perspectives as well. If you take the example of non-executives on primary care trust boards or governors in foundation trusts, those are the sort of models you might look at. On paper they look like they could do the job, but I still think there is something very, very important about the status those people have within the organisation and the culture and the behaviours of the people who run the services, the GP commissioners or the local authorities, and those organisations to be able to hear and respond to the lay perspective, the public perspective. It is to do with power really.

Q 22 Rosie Cooper: Forgive me. That is why I believe there should be non-executives with a vote at the table. That is really important. I would not be misled about foundation trust governors. They are just an arm of management and never beyond that. There is a voice there, but they, again, aren’t strong enough to challenge. It is a great model and I totally believe in it. That is why my criticism is not that they can’t evolve to the point at which they will be great. I just don’t believe they are great now.

Caroline Millar: Your anxiety is about what is going to happen now. There are lots of non-executives on primary care trust boards knocking around and they are all going to be out of the picture. So where are the people and what is there to support the system now? There is some anxiety there.

Chair: Rosie, this is an evidence session, so can I—

Rosie Cooper: Forgive me. I did ask, what model of governance?

Chair: You did, and I was wanting to bring Malcolm in to answer that question, then Professor Tritter and then Alyson Morley.

Malcolm Alexander: I suppose behind this is, “Who is going to own the consortia?”, in a way, because the involvement of the private sector in buying up practices is going to have a significant effect upon this whole system. Behind the GPs, who might be in the forefront, there might be companies who are employing them. Where our taxpayers’ money goes is fundamental.

There is an experiment in Scotland at the moment about electing the chairs of Health Boards. I can’t see any reason why 50% of the members of a
commissioning board can’t be lay, and I can’t see any reason why some of those people, or all of them, couldn’t be elected locally. Certainly the chairs should be elected locally. We do need a huge amount of democracy in the system. Health has always been rather resistant to democracy and PCTs have not always been very inclusive. We need to acknowledge that. For example, in Hackney it has taken three years for us to get a lay observer seat on the PCT board. Just as they are about to close, they invited us to join them, which I thought was somewhat cynical. In terms of openness, it is fundamental that they should always meet in public. We can’t understand why foundation trusts meet in private. All bodies making high-level decisions about health care and about resources must meet in public. I don’t think it is negotiable. The one-meeting-a-year business is absolute nonsense. There should be the capacity for the public not only to elect some of the NEDs, or all of the NEDs, but HealthWatch should be there as lay observers and there should be constant interaction and parking that in the system. That is something that is deeply rooted in the commissioning arrangements in the commissioning consortia.

Professor Tritter: I agree with a lot of what has been said. The accountability isn’t sufficient. I think that we get too caught up in this notion of “lay”. The lay member of a research ethics committee is probably a professor of epidemiology. Most of us wear local hats simultaneously, so “lay” is not necessarily a useful way of conceptualising it. It might be better to think of diversity. What you want at any decision-making body is a diversity of voices reflecting a diversity of views within the community. If you are going to have non-executive directors, it might be worth specifying the different kinds of constituency you would hope that they were there to represent.

Q23 Chair: Can you have a diverse board without representatives from outside the health community on it?

Professor Tritter: I don’t think so, but it depends what you mean by “health community”.

Q24 Chair: I guess by “lay” I might mean outside the health community.

Professor Tritter: You could, for instance, look at the Scouts and Guides, who have had a very bad role in terms of supporting LINks, but they are a different way of thinking about civil society within a locality. So there would be other constituencies. I live in Leamington Spa. In Kenilworth everything is run by the Lions Club. The Lions Club would be a really good place to go and look for people who have some sense of what that community wanted in health.

Alyson Morley: I want to respond to your concern about “How do we make it good now?” You are absolutely right. It is certainly incredibly patchy, but we know that in some areas things are working very well. For example, I was talking to a councillor from Westminster very recently who was saying that their Health Overview and Scrutiny Committee, and also in terms of joint commissioning, have a really good relationship with their local LINks. They feel that they are working really well and are getting into it. The LINks are making serious differences to the way commissioning works so that services really do work for people and they are commissioned from the point of view of those individuals rather than convenience for individual organisations.

What we don’t have is any systematic evaluation of that. The Local Government Association and many others have consistently called for some sort of evaluation of what we already have, and I would agree with all of the other panelists that the proposals aren’t sufficient. What also isn’t sufficient is our idea of what “good” looks like already. To try and do something about this, the Local Government Association and the Patients Association are going to be evaluating what LINks already do to localise services, but in good practice already and seek to publicise that so we can build on the best. The problem at the moment, with the rhetoric around “building on the best”, is that we don’t really know what “good” looks like.

We accept that there should be local variation, going back to Jonathan’s point that in his area the Lions Club is an organisation that is deeply rooted within the community. That will be different in different areas, but we will be able, if we evaluate things to see what is working now, to have a better chance of this. At the moment we are working in the dark.

Q25 Chair: Do you think that if we evaluated best practice we would find some constants that we could apply generally?

Alyson Morley: Yes.

Q26 Chair: Because at the moment the Government’s policy appears to be that this will be developed locally. Out of experience of good practice, is it possible to set out some parameters of good practice that still leave local flexibility but at least deliver an assurance of standards across the system?

Alyson Morley: Yes, and that is certainly the LGA’s view, that localism should not mean that you have a wildly varying consistency in standards. The services you have—how you do it or what you do—should be based on values and those values are transparency. Another huge challenge with HealthWatch is we are doing a piece of research with the Patients Association about the awareness of LINks, and very few people, even visitors to the Patients Association site, are aware of LINks and don’t really know what they do. We have a real challenge there. So one is transparency, communication, and another transparency challenge is that local authorities and GP commissioning consortia will be working to completely different populations, possibly. That is really confusing.

The other issue is inclusiveness, and absolutely your points that people need to be included as lay members. But there needs to be a broader inclusion of their voices in other ways. You can’t put everyone on a board. You need to find other ways.

Q27 Chair: It wasn’t really an invitation to draw out what those elements of good practice are here. It would be very helpful for the Committee to have
thoughts from any of the panelists on what constitutes good practice in terms of patient and public accountability; the extent to which it is possible to preserve local variation while still applying consistent principles of good practice.

Caroline Millar: Could I say something?
Chair: Yes.
Caroline Millar: There is a lot of evidence that there are things which work and things which don’t work. There are a lot of examples of good practice and there are a lot of lists of principles of good practice out there. I have lost track of the number of times I have sat in rooms and people have said, “What is it? Is it transparency, accountability or what?” We know this stuff. My experience in the NHS—and this may change over time—is that although people know what good practice looks like, they are reluctant or they don’t find the time to go outside and find out how it works and how it looks. It becomes a process that they have to do but they will try and find the cheapest and quickest way of doing it, and that is where it falls down so often. It is not that there are not wonderful beacons of excellent practice, but my concern is how you mainstream good practice across the whole piece without focusing on what it is you have to—The only way you can do this is by saying, “This is what you have to achieve”. So it is looking at the ends rather than all the processes that go into it.

Q28 Mr Sharma: First, my apologies for arriving late. I just followed David’s last point, when Malcolm was responding to it, about patient choice of any alternative therapies, their own choice to go where they want to get help from. We get a lot of requests from those who are qualified doctors—maybe not in British standards, but certainly they have achieved their qualifications in other therapies from other countries like India, Pakistan and Bangladesh—in homoeopathy, Ayurvedic medicine and others. But when they request the doctors, the GPs, to find those alternatives they are refusing to do it. They are not supporting it. What do you think, Malcolm, is the best way for those people to get it because, within the system, they is not provided. It come from that background where it is very popular and a lot of people who came in the 1950s and 1960s are still very fond of those alternative therapies.

Malcolm Alexander: I suppose the only way for people to obtain those services is by trying to influence the commissioners and by campaigning. There are examples of that. In Gwynedd and other parts of the country where people have campaigned very hard to try to get the services they want locally, not Ayurvedic medicine but certain homeopathy, which has been in the Health Service since 1948. It is an NHS service. There has been a kind of battle going on between people who were trying to access services which they have experience of as being very positive and successful and a medical establishment that rejects those services.

In terms of commissioning, it has been a huge battle for patients to convince commissioners and I don’t know whether it is going to change in terms of GP commissioning, I rather doubt it. The situation will be much more complex and I think there is a real tension between GPs as commissioners making decisions about what is appropriate for an area and patients wanting huge amounts of choice. There is a real problem, a real dilemma, in trying to find some accommodation between those two positions.

Q29 Mr Sharma: Do you think it is a prejudice, rather than providing the services, on one—

Malcolm Alexander: I think, yes, it is partly prejudice. But, in a way, to me it is more fundamental than that. The political support for patient choice and, at the same time, dismissing the choice of the individual is a fundamental flaw in the thinking of commissioning and the medical establishment.

Professor Tritter: There is an issue about the nature of the evidence. Thus far, there are not large-scale trials that produce evidence around complementary and alternative therapies. Rather than simply lobbying for them to be provided, it would be better to lobby for the funding of those trials to generate the evidence, which is what we use in the system to justify what we spend public money on in the NHS.

Q30 Chair: There is inevitably a tension between the choice exercised by an individual patient and the requirement of somebody in charge of a public budget to determine priorities that will not always reflect the individual choice of the individual patient.

Malcolm Alexander: To expand the point, how on earth can a group of GP commissioners make decisions if there are so many choices available to the public? It is impossible. It is impossible for them ever to make sensible commissioning decisions if patients can choose whatever they want. There is an incompatibility there.

David Lines: Welcome to democracy.
Chair: Yes. There is no escape from that dilemma in a publicly funded health system. It is intrinsic in the system that we have established.

Q31 Dr Wollaston: It has been very interesting to hear the panel say that everybody knows what good practice looks like, but equally we know what bad practice looks like. The point that has been made about homeopathy also raises another issue. What happens if these participation groups are taken over by single-issue groups who are campaigning very vigorously and effectively for treatments that are not perhaps evidence based, or for treatments that then crowd out other important priorities? How do you feel we should get that balance right and not allow single-issue groups to take over?

Professor Tritter: That is a really important point. Voluntary sector organisations are wonderfully diverse, but they have a particular agenda. So Breast Cancer Care will be very in favour of breast cancer. They are not against kidney cancer or leukaemia, but they have a particular constituency of interests and those are the ones they promote. The only way around is to think about balance and diversity and ensuring there is also variation in timing, having term limits on the ways in which those representatives are able to
have a particular kind of opportunity to express their voice.

Malcolm Alexander: Interestingly, I was the chief executive of the Association of CHCs for England and Wales and so I had a lot of experience about what happened across the country with CHCs. They weren’t taken over, you know. I never came across a CHC that was taken over by a single-interest group and I don’t think I have come across a LINk that has been taken over by a single-interest group. It is about good governance and it is about having a wide membership. It is about a wide membership that helps to determine priorities and agree a programme of work. If you have good governance in your organisation you don’t get these takeovers. It is extremely rare.

Dr Wollaston: That is reassuring.

Caroline Millar: And it is about outreach. It is about going and finding the people that you are not hearing from and finding out what their views are in a systematic way, using all sorts of different methods, and bringing that information back to the board or table. You will only hear the single-interest groups if you don’t go out and find out what other people are thinking. But when you do you find a broader view.

Q32 Dr Wollaston: Yes, as Malcolm was saying earlier, going out there and canvassing people outside, so having diversity.

Malcolm Alexander: Yes. That is the experience, providing you keep bringing people in. If the steering group of an organisation allows it to be dominated by a single issue, clearly that is extremely damaging, but it does not happen, in my experience.

Alyson Morley: The best LINks have been networks of networks that bring in people who don’t necessarily want to sit on a LINk. For example, if you take young people, it is very unlikely that an average young person will want to be an active member of a HealthWatch. But groups of young people, whether they are youth councils in schools, members of youth clubs, members of faith groups or different tenants’ groups, may well have really strong views on health issues, especially around sexual health services, domestic violence and mental health services. If you can find ways of linking with existing groups, you don’t necessarily have to have everyone at the table all the time. The best LINks already do that, building on good community development strategies within councils.

Q33 Dr Wollaston: Thank you. Can I follow this up, because that has been very helpful? If there was a single amendment you could make to the Bill, have you thought about wording that you would like to have within the Bill to make all this good practice happen?

Professor Tritter: One of the things missing is the consequences of involvement. There is nothing in the Bill. You could put in a requirement to involve people, but unless you measure whether or not that involvement has led to some change of any activity it is almost meaningless. I worked with Northern Ireland to develop a framework for measuring the impact of involvement, and that is identifying both examples which did work and examples that did not work and how you might do them differently. Something which is about the impact of involvement is at least as important as providing the requirement to involve. In the response to your last inquiry, the Government said that one of the things the NHS Commissioning Board might do is produce guidance on how to do involvement for the consortia. It seems to me a key part of that guidance should be about what should be measured, what should be documented, in terms of how involvement is taking place and what impact or influence that involvement has on their decisions.

Malcolm Alexander: I agree. The National Commissioning Board has a very important duty in promoting good practice in commissioning. In terms of amendments, the issue about lay members on the boards and elected lay members is fundamental. In terms of HealthWatch, elections to the local HealthWatch and HealthWatch England are fundamental. LINks and patients’ forums have been far too inward looking, and I absolutely agree with the point about community development. We need to get them outward looking and need to make them democratic, we need them to be inclusive and we need the relationship between the public and the commissioning boards to be one where there is real accountability, real democracy and engagement. The past few years have been a very difficult time for effective public involvement and there may be an opportunity here to create something which is more profound. But unless we have elections to the different parts of the system, I don’t think it is going to happen.

Q34 Chair: Does anybody else want to come in on Sarah’s question?

Alyson Morley: I wanted to say that one of the areas we have not really focused on is the accountability of national bodies. Jonathan talked about the accountability of the NHS Commissioning Board. There are real issues about the accountability of Public Health England. At the moment there is almost nothing in the Bill about Public Health England. In fact, it is not mentioned because those powers are vested with the Secretary of State. There is also no relationship between Public Health England which will be responsible, we think, for commissioning, and provide planning for a lot of public health services, which, after all, are absolutely crucial in all of this, and no accountability framework between them and Health and Well-being Boards or between them and the NHS Commissioning Board or between them and HealthWatch. There is a vast gap in the Bill about how we hold Public Health England to account.

Professor Tritter: That is really important because 15% of the quality outcomes framework for GPs is going to be around commissioning public health interventions, but how does that come in to the ways in which GP consortia are supposed to be commissioning services? With the Health Protection Agency we have developed a people’s panel of a thousand people across England randomly, identified initially through MORI surveys. That provides you with one of the only attempts to engage with public rather than patient involvement around these kinds of
issues. I do hope that when the HPA becomes integrated in Public Health England and the Department of Health they take the opportunity to move the people's panel into that new body.

**David Lines:** In terms of an amendment—and this is not the LGA but the local politician speaking, if you like—I would like to see more emphasis on input rather than output. A lot of this is output based. The patient goes in. What do we do with them? Can we provide them with this, that, and the other? I am a great believer in “Sound body, sound mind”. I would like to see the roles that the councils take, and districts and boroughs particularly, in terms of increasing opportunities for leisure and other activities like that. I would like to give an example of good practice. Being chairman of the LSP, I invited the chief executive and the chairman of the local PCT to come along to our leisure centre, which we had upgraded, and already they were doing patient referrals. Essentially, I did a sales pitch. I went round the absolutely fabulous centre we have—full and really very impressive—and I said, “I am approaching you from three points of view: one, please continue referring your customers to us; two, you are a corporate entity and I wish to give you corporate membership,” because I would have thought of all the organisations, private or public, you would expect that particular organisation to look after the health and wellbeing of their own organisation, “and, third, I want to approach you from a capital point of view”, because they do have capital. We have one major centre and three satellites and I had wanted to develop the three satellites by putting our services closer to our clients. If I had the free will to put in an amendment, that is what I would like to see, because prevention, as they say, is better than cure.

Q35 Valerie Vaz: That quite neatly picks up the points I wanted to make. Given that we have this current system and we have the Health and Well-being Boards, which maybe are not as democratically accountable as we think they should be in terms of elected people, could each one of you give me your comments on the current make-up of the Health and Well-being Boards? And, secondly, given that we have the system, how would you, in the perfect world, want to approach you from a capital point of view, because they do have capital. We have one major centre and three satellites and I had wanted to develop the three satellites by putting our services closer to our clients. If I had the free will to put in an amendment, that is what I would like to see, because prevention, as they say, is better than cure.

Q36 Chair: It is striking that you focus your question to Valerie on the Health and Well-being Board and not on the consortium, which is where the health—

**Professor Tritter:** I thought that was the question.

Q37 Chair: In terms of increased public accountability—and the question has been glossed over in this session so far—I am unclear where our witnesses actually stand and what your views are on the make-up of the consortium and the consortium board.

**David Lines:** You have hit the nail on the head, Chairman—clarity of role. We are trying to make GP consortia democratic bodies. We are trying to do different things to other different aspects. We should be very clear about what is going on. If we just address Health and Well-being Boards, I welcome the welcoming of local elected members on that. That is important because, as I said, what is the point in reinventing the wheel? You have a structure there. It may not be functioning well but it is structured and it is supported. It may not be supported well, but at least those things can be addressed rather than throw the whole thing up in the air.

Q38 Malcolm Alexander: It is the durability of the health and well-being boards that is the issue. There is no point in reinventing the wheel every time. The health and well-being boards are not going to be going away. The LGA is saying that Health and Well-being Boards are not one, it is a system of boards, not just one, for the same reasons you were talking about to do with diversity. There also ought to be a more supported and trained expert lay people sitting there who could hold them to account.

Q39 Chair: Any comments on the roles of HealthWatch on the Health and Well-being Boards, in terms of their membership, and I am worried about their independence. They need to be more accountable. But there is something else, I think. We haven't spoken about this, but participative budgeting and citizens' juries are really important models that have been successful in bringing people in to look at complex decisions. That is a really important part of how we spend money locally, which is the participative budgeting part of it, and how we get people involved in really critical local decisions, and that is the citizens' jury part of it. With that model, getting more accountability on the Health and Well-being Board, HealthWatch being a participating observer rather than a decision maker is important in terms of its ability to hold the body to account on behalf of the public. These methods of involving the public in more critical and more detailed ways in terms of decision making are fundamental.

Q40 Valerie Vaz: Across the board, I think you just are saying it needs to be more accountable. But there is something else, I think. We haven't spoken about this, but participative budgeting and citizens' juries are really important models that have been successful in bringing people in to look at complex decisions. That is a really important part of how we spend money locally, which is the participative budgeting part of it, and how we get people involved in really critical local decisions, and that is the citizens' jury part of it. With that model, getting more accountability on the Health and Well-being Board, HealthWatch being a participating observer rather than a decision maker is important in terms of its ability to hold the body to account on behalf of the public. These methods of involving the public in more critical and more detailed ways in terms of decision making are fundamental.

Q41 Chair: Who would like to go first? Professor Tritter.

**Professor Tritter:** Thank you so much. Some of the things you have already alluded to: the ways in which HealthWatch is represented; the role of public health and the director of public health on the way in which the Joint Strategic Needs Assessment would be carried along to our leisure centre, which we had upgraded, and most importantly, that point I made last time, the need to be accountable for the impact of the Joint Strategic Needs Assessment would be carried and the director of public health on the way in which those things can be addressed rather than throw the whole thing up in the air.

**Malcolm Alexander:** I would like to see more councillors on the boards. I am a bit dubious at the role of HealthWatch on the Health and Well-being Boards, in terms of their membership, and I am worried about their independence. They need to be more accountable. But there is something else, I think. We haven't spoken about this, but participative budgeting and citizens' juries are really important models that have been successful in bringing people in to look at complex decisions. That is a really important part of how we spend money locally, which is the participative budgeting part of it, and how we get people involved in really critical local decisions, and that is the citizens' jury part of it. With that model, getting more accountability on the Health and Well-being Board, HealthWatch being a participating observer rather than a decision maker is important in terms of its ability to hold the body to account on behalf of the public. These methods of involving the public in more critical and more detailed ways in terms of decision making are fundamental.

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observation in business and in my short political career is that, once they extend into double figures, committees tend to be exponentially less effective. That is what you don’t want. Health and Well-being Boards are executive, so, yes, have democratic representation there but have people in there who know what they are talking about as well from a specialist point of view. You are mixing your democracy and your specialism. The specialists, the NEDs perhaps, advise the executive directors to do that. I would say leave the poor doctors out of it. Let them get on with what they are good at.

**Alyson Morley:** We have had meetings with the BMA, the Royal College of GPs, the family doctor—all of the GP stakeholders, basically—who are very keen on this and they are pretty positive on some aspects, especially a closer relationship with local councils. We published a joint statement, but one of the things they did say about Health and Well-being Boards is, “If it’s a talking shop, we will come along because we have to, or a rep will come along, but we won’t pay any attention to it. They have to do things.” There is a balance to be struck between not being a talking shop but being able to include all of those voices. At the moment, councils have advisory groups, reference boards and citizens’ panels. There is a whole range of hearing those voices without having to have them at every single meeting.

Q38 **Rosie Cooper:** How do you make a consortium listen to you? I think that is where the Chairman was going. What we are all doing is jumping into the bit we understand. Health and Well-being Boards are things we see, but this new consortium, this new commissioning body—this is the bit I was trying to get to earlier—is saying, “We’re not going to do this and then deal with them. Surely, if you go further down the production line is we are creating, not deliberately, any more. We’re going to do massive brain surgery,” or “We’re not going to do this any more.” They are really intricate decisions, clinically-led decisions, but decisions a patient would have a view about. It is about all of this stuff that we have talked about—and I almost go right back to where we started. How do you make consortia listen or have a duty? I know it is there, but it is quite different to actually being around and things like that, I am a life-long advocate of that, that through healthy exercise, healthy lives, one can incorporate cultural things. This is a wellbeing-type of Bill as well and its impact on employment and on productivity has wider considerations. I would hope that Parliament will look at the bigger picture of what is going on.

**Alyson Morley:** To finish off on that, absolutely. To come back to public health interventions. We know that good housing, a good start in early life, educational attainment, community safety—all of these—have massive beneficial effects on people’s health and their need for health treatments. Talking to GPs, they do get this and they do understand it. We want to go back to public health interventions. We know that good housing, a good start in early life, educational attainment, community safety—all of these—have massive beneficial effects on people’s health and their need for health treatments. Considering the NHS’s long term is not sustainable if we carry on with these health patterns. What we need to do is go back to public health interventions. We know that good housing, a good start in early life, educational attainment, community safety—all of these—have massive beneficial effects on people’s health and their need for health treatments. Talking to GPs, they do get this and they do understand it. The difficulty will be finding the evidence base for this in the short term, but certainly there is a growing evidence base that things like active walking groups can improve mental health, people’s risk factors for diabetes and heart disease in the short term as well as the long term. So GPs are willing to be convinced that there is a good public health case.
I wanted to say something about your point as to whether the change will make any difference with health overview and scrutiny. That is a tricky one which we are currently debating within the LGA. We have not come to any decisions, but when we do we will certainly give you our decision making. On the one hand, in some places health scrutiny has been somewhat marginalised because the powers reside in a committee that is subsidiary to the council and some would argue that giving that power to the council ups the profile of health scrutiny. On the other hand, you could say, as the council is a provider and a commissioner of services, it could be a conflict of interest for the council to be making decisions, but there are provisions within council constitutions already about conflicts of interest. When we have had those discussions amongst ourselves and come to an agreed decision, we will let you know.

Q40 Chair: Now the closing brief observations.
Malcolm Alexander: On the issue that David Tredinnick raised about reducing use of the Service, there is a big issue about continuity of care, especially in poor urban communities where care is not well integrated. That is when you get overuse and excessive use of A&E departments and so forth. Good continuity of care is absolutely essential. On the issue of Overview and Scrutiny Committees, there are lots of very, very good examples of successful Overview and Scrutiny Committees. I would be very sorry to see their role diminished. A lot of good reporting, a lot of good recommendations and good interaction with the community is often the case and I would like to see that role properly strengthened.

On the issue of the consortia, a lot of GPs are feeling they are not going to have very much influence in the consortia. But the issue that we raised before about the role, the lay presence in the consortia, is absolutely fundamental, and a democratic lay presence in the consortia is fundamental.

Caroline Millar: Very quickly, I absolutely agree that there is a role for scrutiny. Health and Well-being Boards need to be scrutinised somehow, and there are very good examples of where that has happened, where Overview and Scrutiny has worked well. On the point of consortia boards, somehow the consortia have to be held to account for this public involvement, and there needs to be something structural in there to make sure they do it and that the evidence is out there so that the Health and Well-being Board can see what is happening within the consortia. We might have concerns that that information may not be easily available all the time.

Professor Tritter: On that last point, the Health and Well-being Boards have responsibility to do the Joint Strategic Needs Assessment and to develop a joint strategy for meeting those needs and that is then fed to the consortia to try and implement in terms of commissioning health. That is a very loose link. There is very limited accountability, and that needs to be strengthened. It may well be the guidance from the NHS Commissioning Board on how to do involvement provides one mechanism of holding them to account in the way that they do patient and public involvement. They also have a responsibility around the QOF to do 15% on public health, and yet there is not a lot of evidence that the GPs know that much around public health. The role of the director of public health is not into the consortium but only into the Health and Well-being Boards, so where those services are going to be commissioned is unclear.

The final point is about choice and continuity of care. The evidence of Sweden, which has far more patient choice and has patient choice in terms of primary care for the last five years, shows that a lot of that has led to a loss of continuity of care and also a lot of patients receiving services outside of Sweden, going to Finland and Estonia. The implications of the EU Health Directive on patient mobility may have significant impact on how a local GP consortium actually ends up finding they have to spend more money than they thought they had to.

Chair: Thank you very much. You have given us, as ever, plenty of food for thought. Thank you very much.
catalyst—for engagement of the clinical community in the commissioning process, as we see it, it is essential. If we are to get a high-value commissioning process, that the entire clinical community feels its views, interests and specialisms are reflected in that commissioning process. I would like each witness to open the session by setting out your own views in reaction to that proposition which the Committee set out in its first report on this subject. Let us start with the Royal College of Nursing.

Dr Alessi: Thank you for inviting me too. It would be helpful to think in terms of the primary care home rather than general practitioners, because a lot of what the new Act is about is the treatment of patients in the context of a population. Anybody who accepts the fact that they have to treat a patient in the context of the population that is served and also of the resources that are available for that population clearly has a legitimate place at the table, be they a nurse, a speech therapist or anybody within primary care. That is fundamental to the way we work. I believe that the Act changes things from practising with a patient in front of one, whereby one treats a patient without a financial context, to treating a patient understanding that there is a responsibility to spend what we have in the most cost-effective way we can and also to prioritise care effectively. This is not going to be easy, but unless everybody is involved I don’t think we are going to succeed.

Q43 Chair: Dr Alessi’s contribution, in a sense, was the test case, or was interesting coming from your particular perspective. It is therefore uncontroversial among all four witnesses that we need to have the whole clinical community engaged in the commissioning process. The follow-on question is: Should that, in your view, be written in in some way to the framework of the Bill from the point of view of the commissioning consortia, and, if you agree with that proposition, how would you like to see it done?

Dr Gerada: Absolutely. It should be written into the Bill that there should be a duty of collaboration, co-operation and shared working, with respect. You also need to be mindful of the fact that this may then be proven to be anticompetitive with the issue of “any willing provider”. If you are getting groups of clinicians working together, it is inevitable that those groups of clinicians will be drawn from a local population, and it is inevitable that once you start to work together, clinical-to-clinical dialogue, you will be favouring your local clinician. So we need to be mindful of that.

Dr Gerada: Thank you very much for inviting me. I, too, agree with the fact that we must commission collaboratively with our specialist colleagues, our nursing colleagues and with patients. We, with the Royal College of Physicians, published Teams without Wails and will now go on to work on “Commissioning without Wails”. Members of my organisation have also brought up the issue as to how, in a democratically elected country, that can be devolved just to one single professional group and whether that is going to be unrepresentative and unethical as things pan out.

Before I finish, we would also like to see a distinguishing between commissioning as in the use of resources in the consulting room, the husbandry of resources. The term “commissioning” always tends to get confused, but we consider commissioning to be about being a good clinician, understanding how you use your resources and understanding how you can use resources better as opposed to planning health services and all that that entails. With respect to planning health services, that absolutely needs to be done in collaboration with others. We cannot do this alone.

Dr Alessi: Thank you for inviting me too. It would be helpful to think in terms of the primary care home rather than general practitioners, because a lot of what the new Act is about is the treatment of patients in the context of a population. Anybody who accepts the fact that they have to treat a patient in the context of the population that is served and also of the resources that are available for that population clearly has a legitimate place at the table, be they a nurse, a speech therapist or anybody within primary care. That is fundamental to the way we work. I believe that the Act changes things from practising with a patient in front of one, whereby one treats a patient without a financial context, to treating a patient understanding that there is a responsibility to spend what we have in the most cost-effective way we can and also to prioritise care effectively. This is not going to be easy, but unless everybody is involved I don’t think we are going to succeed.

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Q44 Chair: Can I ask a probing question? If it is accepted that it is right for a consortium to have expertise from across the whole clinical community engaged in the commissioning process, that is a different proposition, is it not, from saying that it must be involved always with the local clinicians? Surely part of this ought to be about calling expertise from elsewhere in the system to call the local clinicians to account against the highest standards.

Dr Gerada: Yes, that is true. But when you are designing care pathways and where you are designing...
commissioning decisions around your local population, the de facto people that you will get involved with that will be your local clinicians because, one, they are there and, two, they are working with you. Whilst I accept that, you may well pull in organisations such as NICE and the Royal Colleges, because I think we play a very important role. On the ground it will be local people that do this together. In fact, good commissioning is about good clinical dialogue, so, again, in its simplest way.

Dr Alessi: We also need to remember that the choice is made by patient, not by the clinician. That is the challenge that is in front of us, to ensure that we really put the patient at the heart of everything we do. If we continue working in a way whereby we direct patients to where they should go, this system will not succeed. If, however, the choice is made by the patient, as long as—and I pick up on comments made in the earlier meeting—the care that is delivered is deemed to be of sufficient quality by the Care Quality Commission—because there are mechanisms to ensure that we commission what is of quality, and that decision does not need to be made by the clinicians themselves, then there are bodies that have responsibilities to actually reach those decisions—I don’t see why we are going to get into such difficulty. Yes, there is—

Q45 Chair: I am sorry. Are you saying that you don’t think that a commissioning group should get involved in a quality question? They should simply assume that that is decided by the Care Quality Commission licence?

Dr Alessi: No, absolutely not. We should drive quality, otherwise we will end up with the lowest common denominator. But there is a flaw, and that flaw needs to be determined by somebody.

Mike Sobanja: On that particular point, the primary responsibility for quality rests with the commissioner and the regulator is secondary. One of the concerns that we would have about the way the current arrangements are described is that the regulator—and it may not be just CQC, it could be Monitor in this regard—might trump the commissioner and lead to a weakening of commissioning and then its links with the local community.

In answer to the Chair’s question, I am not convinced that writing that into the Bill would achieve a change in the culture and behaviour which is required. We see lots of things which are written into Bills which people then pay lip service to, although I can’t think of a ready example.

Chair: Or simply forget.

Mike Sobanja:—as if that job is then done. Personally, I am far keener to see the National Commissioning Board, in its relationships with local commissioning groups, make that a performance management and accountability issue which gets great prominence. That may be better, if not equal, to writing it into the Bill.

Dr Carter: I agree with Mike here, in that just because something is in a Bill, it doesn’t mean it is going to happen. It then requires behavioural change and commitment to make it happen. However, in relation to the nursing contribution, we would like to see this in the Bill. Whilst I don’t want to broaden this out too much at this moment in time, we do have serious reservations right from the top in terms of the role of the Chief Nursing Officer down through the various echelons where again it is wholly unclear at the moment as to where the nursing presence is going to be and where the nursing leadership is going to be. We have seen examples in different parts of the United Kingdom where, in the absence of that leadership, you do end up having serious issues to do with the quality of patient care.

Q46 David Tredinnick: I want to go back to the points Malcolm Alexander was making in the last session, this issue about the extent patients should be listened to in their request for clinical care. I raised the point about Chinese medicine and my colleague Mr Sharma touched on Ayurvedic medicine—both systems have been in operation for several thousand years—and also homeopathic medicine, which is very, very popular in India. How do we manage this in the future?

Dr Alessi: If we accept that there is a finite resource—and that is the first and most important thing that has to be accepted, because if one doesn’t accept that there doesn’t know where one starts—one can then use the mechanisms that exist, using a programme budgeting approach, for example, and using our colleagues in public health and their expertise around prevalence, to come up with indicative budgets that would be available for a condition. If that is accepted, then one can actually start to commission with local providers as long as one accepts that local providers also have a population responsibility. Perhaps if there is something which has not been as prominent as it should have been, it is that foundation trusts and acute hospitals also have population responsibilities. Their responsibility is not only to the patient that lies in front of them. If we get to that stage, then I think it is possible to prioritise care. I will give you a little example from Kingston. There is a map of variability, which was published recently by Muir Gray, which looked at levels of things like major joint replacements. In Kingston, for example, we have one of the highest incidences of joint replacements in the country. So unless the population is markedly different—and having lived there all my life I have not noticed an enormous difference between there and here—or there is something special about that population, we are clearly devoting too much resource in that single area. By definition, we are devoting too little resource somewhere else. The decisions are never going to be easy, but this is the world we are in, and it is true of the whole of the western world. We are no different to anywhere else.

Dr Gerada: I would agree with most of what Dr Alessi says. I am a scientist at heart, I am doctor, and we have to be guided by evidence-based practice. We have to plan local health services and in a cash-limited budget we have to make decisions. I am far more concerned about decisions, if you like, for mainstream healthcare than I am for things that one could consider to be on the periphery, such as homeopathy. So I am concerned about the resources for our basic, everyday patients with chronic long-term illness, patients with Alzheimer’s, hip replacements, et cetera, but this is
what public health will inform us is what a good health service needs and help us plan for.

**Mike Sobanja:** The only response I can give you is—and once in my career I was chief executive of a health authority, so I even pre-date PCTs, and it was the same then as it is now—these are judgments that have to be made. What I would observe is that what was missing in the judgments that we made at a health-authority level is absolutely critical to getting the answer to your point about transparency and accountability to local communities. Charles’s point about starting with finite resources and opportunity cost we have to recognise. Choices have to be made. We have to invest authority in somebody to make those choices. I would rather it was local than national, but they have to be held to account and to give reasons why they made those choices. This is an area which is going to create some significant tension. The notion of patient choice has started and its relation to choice? You gave a very specific example of people wanting Chinese therapies. This is an area which is going to create some significant tension. The notion of patient choice has been highlighted quite significantly and I think it has raised expectations. This will not be new to GPs who have people coming into their surgeries, having read about people wanting to specify again and again how they are going to accept members from out of area, will have a precise and a “monopoly” responsibility for a specific geographical community?

**Dr Gerada:** It is not clear because it is not clear who will mandate that. With the Secretary of State devolving responsibility now back down to GP consortia, who are in a sense going to be commercial organisations, it is not clear. Again, that is a clarification: Who is responsible for the healthcare of the entire population?

**Mike Sobanja:** If I can return to your original point—I am sorry, Peter—it seems to me that on the conversation I was hearing before, first of all we have to get arrangements in for both citizen involvement on priority setting, the opportunity cost issues, et cetera, and patient involvement in designing individual services. That seems to me to be a spectrum, and there is everything in between. I have already said that I believe there should be independent directors on GP commissioning consortia, decision-making bodies—boards, if you like, but we don’t know that they are going to be independent. It is a case—and I think that is important not only from a democratic legitimacy point of view but also from a governance point of view. External challenge is healthy on that.

What I was trying to say before about the holding to account is, again—and you will forgive me if I go back to my previous experience on a health authority—we had lots of process measures to do on public accountability and so on and, frankly, it wasn’t difficult to tick all the boxes. What would have been far more effective, in my view, in moving my own authority in engaging local communities, is if the then regional health authority had said to us “Demonstrate that you have meaningfully engaged your local community in your priority-making decisions. We are not going to tell you how to do it. Demonstrate it and we will hold to you account”. I get quite concerned about people wanting to specify again and again how everything should be done as opposed to getting to the outcome in this matter as with health and saying, “It is your job to do it” and you hold you to account.”

**Dr Carter:** Can I go back to how this particular theme started and its relation to choice? You gave a very specific example of people wanting Chinese therapies. This is an area which is going to create some significant tension. The notion of patient choice has been highlighted quite significantly and I think it has raised expectations. This will not be new to GPs who have people coming into their surgeries, having read something, suggesting that this is what they would like. Of course, what happens time and time again is the GP will discuss that with the patient and, if it is not appropriate, persuade them that it is not appropriate. We know that.

However, in relation to people having their expectations raised, can I give an example of when the drug Aricept first came on the market, which is about 10 years ago? As people will know, Aricept is a drug in relation to helping with Alzheimer’s. When that drug first came on the market, there was a huge amount of comment in the media and there was a lot...
of enthusiasm that perhaps at last a cure had been found for this most debilitating of diseases. What happened in some areas was—at that time I was a trust chief executive and I had huge contracts—for example, in the borough of Brent, in south Brent, the concept of Aricept just didn’t reach people, they weren’t tuned into it. In another part of the trust I was responsible for, South Kensington, almost immediately the good readers of the newspapers were hounding their GPs, for very understandable reasons, because they thought there was a cure for Alzheimer’s. Roll forward 10 years. What do we know? We know that Aricept is a very good drug for some people in the early stages of Alzheimer’s. What it doesn’t do is cure Alzheimer’s. But at that time some GPs were finding it very difficult to hold the line and it was very helpful that NICE took an approach to this, which was, if you like, as an arbiter. I think, in relation to these current arrangements, it will raise people’s view that they have a right to demand, and that is going to be very difficult for some GPs in some areas where you have a more informed community. GPs are going to find it very difficult to handle.

Dr Alessi: It would be helpful to reflect on whether the present system we have at the moment is as perfect as people make it out to be. I am always amused by the fact that we are incredibly worried about the potential risks of introducing change and we suddenly all assume that the present system we have is so fantastic that any change may make it a little worse than it is at the moment. I am terribly sorry to disillusion you, but the present system we have doesn’t work very well. The fact is that we are incredibly worried about the potential risks of introducing change and we suddenly assume that the present system we have is so wonderful that we are not going to be able to make it better. If you only look at the potential risks of introducing change and not the potential benefits of actually making changes, I think we are being very foolish.

In terms of how to change it and the accountability issues which were brought up, these are things we are going to have to feel our way along, certainly over the next few months, before we can come up with a final view as to how this should work. The Health and Well-being Board is particularly important because if you really believe in localism and moving away from a top-down management structure, this is where the action will take place. But it has to be meaningful and with teeth. Whether the consortium is accountable to a Health and Well-being Board or merely—to use an improper use of English—accounts to the Health and Well-being Board is another matter altogether. That relationship has to be really quite strong but there is a balance somewhere and that balance is between allowing consortia to actually develop and putting coals of assurance around them. We are very good in the NHS at those coals. We have so many of them at the moment that the thought of having even more in the new world fills me with dread because I don’t think we will actually succeed if that happens.

Chair: I now have virtually every member of the Committee and the panel of witnesses wanting to contribute.

Dr Gerada: The panel may want to ask a question.

Q49 Chair: Yes, that’s right. They want to ask questions of each other probably. Mike, do you want to come in?

Mike Sobanja: Yes. I was going to make the point that the accountability of consortia is one thing. Once we have had a look at the accountability of general practice and practitioners to the consortia as well, and there is a key issue here about the resolution of the issues around section 24(d) of the Bill, as it is currently written, which basically confers a responsibility, as I read it, Chair—

Q50 Chair: You enlighten us. Mike Sobanja:—on practices to act in a manner which is consistent with consortia policy, there is a need to rationalise that with regard to GMC requirements and also individual contracts which does not look entirely clear at the moment. What I am saying is there is an issue there, but accountability below consortia to practices is as important as above consortia to local communities and whoever else is involved.

Dr Carter: Very briefly, I wanted to make the point that we, too, see the need for change and we feel that commissioning has not worked. We want these reforms to work, but at the moment there are real gaps and real concerns about how it is hanging together. I will leave my point there.

Q51 Nadine Dorries: Dr Carter, last time you were here you were quite sceptical about the scope and the role that will be available for nurses within the new reforms. Having spoken, myself, to hundreds of GPs since you were last here, would you not agree that there is a huge amount of scope for developing the role of the nurse within the consortia? In fact, some of the doctors I have spoken to have talked about having nurses being able to provide much more reactive sexual health clinics, mental health counselling and the things that they can’t provide at the moment, but being able to do that as consortia and focus on those areas where they see there is high cost and where there are few resources channelled at the moment. Do you get the feel yet from nurses that there are these exciting opportunities which will be presenting themselves?

Dr Carter: Absolutely. With the whole of the nurse-led services, the integration, there are real opportunities here. We don’t want it left to chance and what we don’t want to see is a patchwork Health Service. That is why we think that more should be embodied in statute to ensure that nurses have adequate representation. What we don’t want to see is huge differentials in the performance of consortia and then playing catch-up. Now would be the time to ensure that that happens.

Q52 Chair: Mr Sobanja was saying earlier less emphasis on writing it into statute and more on Commissioning Board guidance as the way of achieving that.

Dr Carter: As I have said—and I agree with Mike—wherever it is embodied, it is then about behavioural change, and the last thing we want is tokenism. I do feel that the Bill really underestimates the significant contribution that nursing has to make right throughout the spectrum. Nurses are one of the few disciplines that follow the patient throughout the pathway. It is for those reasons, and it is not being parochial or nurse-centric, we feel that consortia would be well
advised to have nurses at the centre of it and, as the current arrangements are, it will be very much left to local choice.

Q53 Nadine Dorries: I totally agree with you, but I would take issue on your comment about patchwork provision. There is going to be patchwork provision because the needs of central Hackney are going to be very different from the needs of central Gloucestershire. There is going to be patchwork provision across the country because what will need to be applied and resourced is what the area needs and demands. So that will happen. To throw it back to you, can you give me a line that you would like to see, taking your words, in the Bill which would do this? I don’t see that you can actually write in the Bill a line which would give the assurances that you want because, if you do that, what you do then is exclude and restrict the amount of scope that nurses could have within consortia. I understand that it is not written in statute, but you can see, surely, that the possibilities across the country are there.

Dr Carter: May I come back through the Chair? Of course I expect to see opportunities. Currently there is a patchwork in the NHS, and whilst I am quite clear that with the previous Government there were some huge successes—and so there should have been with the amount of money that was put in—what we also know is that the health divide actually got wider. My fear is that that would increase the likelihood of that happening. In terms of the fragmentation of services and the gap in health inequalities, we don’t want to see that widening.

The Secretary of State is quite clear. He keeps saying “No more top down. Let us have bottom up.” But in relation to the role of GPs, of whom I am a great fan—and I don’t mean that in a patronising way—the Secretary of State has no problem with prescribing on the role of GPs. We don’t see why he has such a problem in prescribing on the role of nurses and allied health professionals.

Q54 Nadine Dorries: What if it was mandated that there should be a nurse on the board of every consortium? Would that satisfy?

Dr Carter: It would.

Nadine Dorries: I feel an amendment coming on.

Chair: Does anybody else want to comment on that proposal, otherwise I think we might move on?

Q55 Dr Wollaston: I am very interested to hear from the panel how you feel about the arrangements under the legislation for picking up underperforming practices.

Dr Gerada: This is again one of those areas that is a little confusing within the Bill. At the moment the performance list sits with the PCT and if the expectation that the performance list and therefore the issue around performance is going to sit with the consortium, it needs to be clear that there will not be then inherent conflicts of interest. With the size of some consortia being little over the size of a large practice—my practice is 15,000 and the smallest consortium is about 16,000—you couldn’t possibly be assessing, or you could be assessing your own performance but I think there may be inherent conflicts of interest within that. What we would feel is that, wherever you sit on the performance assessment of GPs, it ought to be transparent. The individuals doing it, or the organisations doing it, need to have the respect of the GPs that are doing it. With large consortia, clearly, the 600,000 or 500,000, you can sit it within there, but with smaller ones you may need to do it with neighbouring ones.

The other issue is that they are also about “Performance for what?” because we have already picked up the requirement for practices to adhere to the commissioning decisions. This is again moving things away from clinical performance under the GMC, where our main role is responsibility to care for patients. There is going to be a tension, and already my members are sending me comments about the tension, of adhering to commissioning decisions that may, for example, not be in the patient’s best interest. For example, the mandatory use of referral management centres. For example, the competition, where competition and price are equal—so we are having competition based on price not just on quality. Those sorts of issues need, again, to be ironed out once we start to look at performance issues and once we start to roll this forward because they will inevitably create problems as this rolls out and as the funding that we have becomes squeezed and squeezed and squeezed so issues around stopping patients going to hospital will become the priority of commissioning consortia in order to release funds.

Dr Alessi: The reforms are not only about commissioning but are also about primary care itself, about making primary care more predictable in what it does, in its outputs in particular, and allowing for the over-engineering that exists in secondary care to be reduced. Clearly if you know exactly how a patient journey is going to be managed, and one can rely on primary care to perform certain functions, perhaps that level of over-engineering that exists doesn’t need to be there. In terms of managing underperformance within primary care per se, again there is a role for the Health and Well-being Board. This is perhaps left field, but clearly a Health and Well-being Board is going to be satisfied with the results and with the commissioning decisions which are made by a consortium—and it has to be because if it is not, clearly, there is going to be significant difficulty in getting that Health and Well-being Board and the consortium to work together—it is going to have the ability to refer that consortium for remedials, if necessary, and that is at the end of a spectrum. The new world is about inclusion in practices. We have been in a world whereby it felt more like imposition, imposition of views of PCTs in many respects. The stick around performance management is something which we are going to have to use at some point, but this is a world whereby we all have to be part of the same and, as such, we have to help each other do that. Also—

Dr Gerada: I am sorry to cut across. Therefore, we need a robust measure of measuring performance. What I am concerned about is that what we hear about is performances—take away clinical performance, but, for example, on referral rates and on
prescribing—and unless they are robust, and at the moment they are not robust, you can understand variation in performance. Clearly, there are some doctors who perform incredibly badly and we need to use the current systems which we have. We may need to look at some other systems, but we need to be absolutely clear what performance we are talking about. Otherwise, what we are going to end up with is GPs, such as myself, such as anybody, “over-referring” because I know more about a subject. We know that the more you know about a specialty area, the more you refer. If we use referral management centres and we stop patients being referred to the service of their choice, we may inadvertently delay cancer diagnosis and we may inadvertently cause under-referrals. We need to be absolutely clear. From the Royal College of GPs, of course, we look at this. This is part of our raison d’être. Standards of general practice and performance of GPs we have looked at in great detail and it is much more complicated than just saying somebody has got an unacceptable variation in antibiotic prescribing.

Dr Gerada: We are in a world, again, where we are assuming that we are perfect at the moment. We have situations arising now where parts of Birmingham are stopping patients being referred for musculoskeletal conditions because the money is running out, and that is affecting the whole population. We need to get better granularity and understanding as to how we manage the referral process as well. I will stop there.

Q56 Dr Wollaston: Clare makes a very important point, that if you look at our gate-keeping role, sometimes GPs can feel performance managed on the level of referrals they make, but we also know that under-referral for early diagnosis of cancer is just as bad. How you get that balance right is going to be crucial.

Dr Gerada: And to be mindful of it. Clearly, the Royal Colleges have a responsibility in this. We must, and through the Academy of Royal Colleges we will be looking at it, but we have to be absolutely careful that we are not performance managing GPs where patients are going to be put at risk.

Q57 Chair: Can I go back a stage? In that debate, the thing that was accepted between both Dr Gerada and Dr Alessi was the principle of performance management from the consortium, which is, itself, one of the controversial areas in these proposals.

Dr Gerada: If it is a large consortium. We have concerns where you have small consortia which are little more than practices performance managing. I would not like my performance to be controlled by the practice up the road.

Q58 Chair: No, absolutely. But can I just be clear whether, on both parts, you feel it is part of the job of the Commissioning Board, through some structure, to performance manage the delivery of primary care in this new world? That seems to me to be a very fundamental question.

Dr Gerada: Yes.

Dr Alessi: Yes, but at the very end of the spectrum. There is a lot of support—

Q59 Chair: Hang on a second. Performance management—

Dr Gerada: Yes.

Chair:—is it elimination of the dangerous or is it performance management across the bell curve? Which is it?

Mike Sobanja: Chairman, what you have to do here is think about the primary responsibility, and the primary responsibility goes with the contractual holding, for me. There are lots of other people to go in because this is Matrix, there’s CQC, there’s the colleges, there’s the local consortia and so on. But what we all want to know—what I want to know as a citizen and a taxpayer—is who should have acted when something went wrong in the system, and obviously went wrong in the system? I am thinking about Staffordshire. If you think about that, from my point of view, everybody sat round and looked at each other. I believe it is the commissioner you look at first and foremost because they have the contractual responsibility. There are lots of other things that have to feed into this, and what I would wish to avoid is the confusion or diffusion of responsibility for performance management, recognising there are lots of different players to put something into the pot.

Q60 Chair: Can I ask whether Dr Gerada and Dr Alessi agree with that or disagree with it?

Dr Alessi: I am very happy with that response.

Dr Gerada: I am very happy with that response. I was just thinking, whilst Mike was talking, that, of course, in the future consortia may not be your local GPs coming together because, under the Bill, if you have two or more people coming together to provide primary care services, they may well be a consortia. So you are absolutely right to question this. On the basis of that, I don’t know the answer, because if there is a corporation that is a consortia you might then get them not as willing to look at their performance as you might do, paradoxically, a group of GPs.

Q61 Chair: Mr Sobanja, it is not just about eliminating the case of Mid Staffordshire or any of the other high-profile examples, is it? It is also about taking doctors’ delivery of primary care across the whole range of practice in order to challenge the people who are at point 40 on the scale and who could be at point 60 on the scale if they simply observed better practice guidelines.

Mike Sobanja: There will be a curve of performance, and it is about moving the entire curve.

Q62 Chair: Where in this system does that responsibility lie? It is clear where it lies for secondary care. Where does it lie for primary care?

Mike Sobanja: I believe it should rest with the person who holds the contract, which is the National Commissioning Board, supported by the commissioning local consortia and others.

Q63 Dr Wollaston: The problem, as I see it, is that their contracts are all being held by the Commissioning Board, but it is unrealistic to think of the Commissioning Board in London actually being responsible for weedling out, if you like, poor doctors.
There are two issues, are there not? There is the issue of the poor doctor individually that you want to protect patients from and the issue of performance as a whole as to how we control costs—the point that Dr Alessi was making about having the financial context to clinical decision making. I am very interested in what you feel about the role of the responsible officer that is currently with PCTs. Do you think that should be in the commissioning consortia or should that be at a more regional level or right up with the National Health Service Commissioning Board?

Mike Sobanja: Are we talking about the responsible officer or the accountable officer?

Dr Alessi: Both.

Dr Wollaston: I am sorry, when we are talking about how we actually—

Mike Sobanja: Because there is both.

Dr Wollaston: Yes. I am talking about responsible officer in terms of—

Chair: The GMC.

Dr Wollaston:—the GMC-type level.

Dr Gerada: There has been lots of debate about this, and it is passing backwards and forwards. The issue is because of the size of the consortia, because this is what we are always trying to marry up. The debate then is probably the responsible officer should sit at the National Commissioning Board devolved down to a more local level because if one assumes the National Commissioning Board is going to have regional outposts, that is probably the best place for that person.

Q64 Chair: Are we reinventing PCTs, or rather consortium clusters?

Dr Gerada: That is what we would like to ask the Secretary of State. They do feel very similar at some points.

Dr Carter: This is another area of concern, that there is a lack of detail and a lack of rigour. Whilst, of course, we want things to work and work well, you have to have contingencies as to when things go wrong. Within the current arrangements, it is simply not readily apparent to us where the accountability and responsibility should lie. I agree with Dr Wollaston. There is a heck of a distance between people sitting in London and deep out into the community, even way down in Plymouth, with the lines of communication. That is where we would advise the Secretary of State and the Government to get some more rigour and some more detail into this. Whilst I am on that theme, in relation to the financial management, we, like many others, saw Sir David Nicholson’s appearance before you and we do feel that there is a need for a plan B as to what happens if a consortium begins to get into financial trouble. You have to work in that that is a possibility. Goodness knows, I mentioned a few minutes ago, with all of the investment that was put in in the last Government, you still had trusts and PCTs getting into serious financial trouble. You marry that up with taking 4% out a year for four consecutive years—these are difficult financial times—and we would want to see, as I say, much more detail as to what the default position is.

Q65 Chair: There is another related subject, is there not, that we were talking about, performance management of primary care and how that is discharged in this new world, including some small consortia? There is a related question, which is where service is being reconfigured in a way that a particular practice or group of practices might have a good idea in which they are themselves engaged and how the commissioning process is seen to take place fairly but buying something beyond general medical services from practices that are members of a consortium. Mr Sobanja is nodding.

Mike Sobanja: I am only nodding because of the recognition that it is a very difficult area and tied up with “any willing provider”, which I would like to say something about, if I may. The issue there, of course, is it would appear that Monitor would have a role in crying foul should the consortia indulge in anticompetitive behaviour, in the broadest sense. One of the issues there is, again, if the primary purpose of redesigning the service is about improving care to patients, improving integration, and so on, that, for me, would trump the issue of anticompetitive behaviour, recognising the statute to be complied with there. In that sense, to answer your question, Monitor ought to be a servant of good commissioning, not the determinant of good commissioning. The way the Bill is currently set up, it could be that the reverse would be true.

Equally—and “any willing provider” has been mentioned—if I may, “any willing provider” was introduced as a procurement mechanism, not as a policy. Its intention was, if my memory serves me correctly, to overcome a situation where we might be tendering left, right and centre with high transactional costs, etcetera. The issue is that the way in which “any willing provider” operates in the future, and at primary care as well as secondary care level, is key to this. If “any willing provider” is triggered by a commissioning desire, then it is satisfactory as an alternative to tendering, i.e. let us get it back into being a procurement mechanism. But if “any willing provider” is to operate at any time such that any provider can enter the market, with their licence from CQC and Monitor and must be given a contract and not in response to a commissioning trigger, then it undermines commissioning. What we have to do is put more weight behind commissioning, at both primary and secondary care, not undermine it.

Dr Gerada: It is a complex question. Of course, the greatest innovations have happened when clinicians get together and see a need and then design services to meet that need. Over the last 20 years, that is how change has happened, certainly in areas where I work, and we must encourage that. But at the same time, of course, we have to be mindful of the conflict of interest. We also have to be mindful that patients must not end up receiving second-rate services delivered by primary care practitioners just because that seems to be pragmatic at the time. My view is that this is where patients come in and where patient groups come in because patients are going to be our greatest advocates and the ones that will be there as the break to anticompetitive behaviour in its rounder sense. Patients will say, “Actually, doctor, I don’t want to
come to your ENT service. I want to see a doctor who is a Royal College of Surgeons ENT.” So if we are going to make any change within the Bill, it is actually using patients and patient groups to protect us. How it is going to be done, again is for yourselves to sort out because it is a question. We have all lived through fundholding. We saw fundholding and some of the issues that that threw up. Certainly, with GPs now holding £80 billion to £100 billion worth of public money, we want to make sure there is transparency but, at the same time, not stifled innovation.

Finally, before I finish, the Royal College of GPs have supported the use of federations, which is actually groups of GPs and others as provider organisations, so pulling in providers. As federations, putting yourself forward in a position to tender under an “any willing provider” or to put yourself up as an “any willing provider” in the mechanism is exactly the same as any other “any willing provider”. We think that is probably the best way forward.

Dr Alessi: In an environment where resources are going to be even more difficult to obtain, there is no option but to think about redesigning the way we work with clinical colleagues to design new pathways. The duplication that exists within healthcare is enormous and we all know it. The handovers are the most problematic, and any system which develops into a process, which, instead of lobbing a patient over a wall, ends up with a warm handshake is something which we all would support because that is what we really should be about.

Clearly, there is going to be a degree of scrutiny that is going to be necessary to ensure we don’t enter into situations where there is a monopoly, but this is something we are going to have to feel our way through. There are significant concerns about this and significant debates about the transparency associated with this, but I don’t think they should stop people looking to reform pathways or develop new pathways with secondary care, to ensure that a patient gets the right care when in fact what the Royal College of GPs would want is enough excellent relationship with them when in fact what the Royal College of Surgeons ENT.” So if we are come to your ENT service. I want to see a doctor who

Q67 David Tredinnick: As we are running out of time, let me be as unhelpful as I can. There is an issue here about these pooled budgets, somehow for “any willing provider”, in the way I described it before, are we going to work a system where we have not got coterminosity anymore between local authorities and the commissioners?

Dr Gerada: Absolutely.

David Tredinnick: What are we going to do with the fixed and the variable together?

Dr Gerada: A gain, those are questions that we would have to iron out in the Bill, because the more I read the Bill the more I look at this, I cannot marry up how the idea that we are abolishing practice boundaries is going to improve the situation for our local population and reduce health inequalities and in fact produce better quality of care for patients. That, added with the “any willing provider”, is separating out the provider from the commissioner. There will be no relationship, let us be clear, when we have 2,000 “any willing providers”. How can you have a local relationship with them when in fact what the Royal College of GPs would want is enough excellent providers, ideally from our local community, so that we can work together and form relationships for the complex chronic patients that we see every single day?

Q68 Chair: Dr Gerada’s view is that the principle of “any willing provider” entrenches the difference between commissioner and provider and between primary and other forms of health and social care.

Dr Gerada: Not just my view, the College’s view.

Chair: Okay, the Royal College’s view. I don’t think that is necessarily the view of every other witness on the panel. Either Dr Alessi or Mr Sobanja?

Mike Sobanja: No. The NHS Alliance policy is saying that commissioning should remain accountable to the public sector absolutely, and that is the benchmark: that it is perfectly possible for “any willing provider”, in the way I described it before without going over that, to operate and for that to be in the interests of patients. My observation in some of the work I do in the commercial and the private sector is that they are actually very good at working and building relationships across supply chains in
partnerships. It seems to me that that is the issue. If I can go back to the social work question and try to wrap that in, the Health Service and local authorities have to learn to work across boundaries, not to remove boundaries. The way I read that clause about care trusts is that where care trusts are working well now let us not dismantle them. That is fine. But I don’t believe that that is going to be mainstream in the future because we have to wrap in housing and education as well as social work on those non-health determinants, healthcare determinants of health, and make people work together across those boundaries. But certainly the concept of competition with providers, I believe, can be made to work in the public interest and the benchmark is one of commissioning remaining a public-sector accountability, not necessarily a provision.

Dr Carter: Can I come in?

Chair: Yes.

Dr Carter: We are totally committed to the concept of health and social care being integrated. There has been a lot of good work and examples of this in Northern Ireland over the years. In relation to my previous specialty in mental health, there were huge developments from the late 1990s onwards which has done so much to ameliorate many of the problems that we saw with homicide, suicides and serious incidents where health and social services were working together. That is the right direction of travel. But I agree with Clare. You now have a problem where you will not be having the coterminosity. That will provide a huge set of challenges. Marry that up with the “any willing provider” and the thing I would have said, if I had got in earlier, is we don’t have a problem with it but our concerns are that, in such economic testing times, we don’t want to see cost at the expense of quality and people going for the cheapest “any willing provider”. That is something that is going to have to be watched very carefully.

We also think that yet another problem has opened up with the flexibility about choice of GPs, which, on the face of it, is a very attractive proposition, and from one perspective I couldn’t disagree with it. However, potentially, unless it is well managed, it will lead to a fragmentation of services. It seems to me that that is the issue. If I were somewhere. How many times can someone change their GP—once a year, once a month? It is simply silent on these things. Whilst the critical mass of people will continue, I believe, with their local surgery, it is actually around the edges that has the potential to destabilise things. It is not what you do with 95% of the money, it is what you do with 5% of the money that can tip you into an over or under-spend situation.

Q69 Valerie Vaz: Apologies for going slightly off-piste, but I am asking very simple questions. It is very good to have you here, Dr Alessi, because you are a pathfinder, so I am quite concerned and I just need to find out how it is all working. Presumably it is, is it? Apologies to all my other colleagues who are very well versed with the Health Service, but I suppose I am the lay person on the Clapham omnibus. I would really like to know, just to pick up the coterminosity point, are you aligned with your local authority?

Dr Alessi: We are aligned with our local authority. Prior to the publication of the legislation, we had already moved towards a one Kingston-type approach, which actually brought the local authority and all the GPs within the borough into one organisation. To a degree, we are living in sin, which is always fun anyway, so we are part of the PCT but the PCT devolved its responsibilities to us. We are going through quite a difficult phase at the moment because, clearly, we are going to have to moderate that through the journey over the next 18 months and the challenge is to ensure we don’t lose the momentum that we have already developed. Our aircraft has taken off. We don’t want to go back, start again and start assembling another aircraft. That is the debate, between allowing us to continue and levels of assurance that are perhaps deemed to be necessary in terms of delegated responsibility.

Q70 Valerie Vaz: In terms of budget, because presumably you were given a budget to do this, how much were you given and who are you accountable to for the budget?

Dr Alessi: Because we are living in sin, the budget is the PCT’s budget. The methodology we have used is that we have used groups of GPs and other professionals, including nurses, and physiotherapists in some cases as well, to determine exactly how that money would be spent. The practitioners have been very much more involved in clinical commissioning. What this has shown already is that there was a level of incoherence in terms of the contracting that existed before. The contracts which the NHS are using are exceptionally complex and they are basically standard contracts with codicils upon codicils added to them. In the end, they contradict themselves so many times that, in many respects, they are a licence for the providers rather than for the commissioners. We need to change that.

Q71 Valerie Vaz: Do you, as the pathfinder, have the budget, or is it still with the PCT?

Dr Alessi: We cannot legally hold the budget until we become a consortium—it is with the PCT—but in actual fact we are as one. It is quite an extraordinary situation. Somebody fell off a horse on the way to Damascus. I am not quite sure who it was.

Q72 Valerie Vaz: Exactly. In terms of what you do, how do you balance the individual patient need with population need? How are you going to do that and how do you do that?

Dr Alessi: Again, public health is really important. We keep on going back to public health, in terms of “Are we spending enough in respiratory medicine?” “Are we spending too little in a condition?” “Why are we spending so much more to treat macular
of its responsibility for managing GPs down to consortia. I wondered how wise you think that is. Who will hold the contract? The Commissioning Board. Will that come down to consortia in part as well? The reason I ask that question is, there is a huge question about how you manage your colleagues. How do people performance manage you? In essence, I am saying if you have a difficult doctor or practice, how do you, as a consortia, think you will performance manage them? And, for example, things like overseas locum GPs practising in this country, as an awareness of where you already are, how are you going to manage that out and who is going to be responsible?

Dr Gerada: Do you want me to go first? The question is a very complex one, but practices will have layers of clinical governance, so I do not think all of this has to be devolved to a National Commissioning Board. We need to make sure, at practice level, and this is what, through the Royal College of GPs, we are talking about—practice accreditation, and embedding clinical governance that’s live—you start to address performance as you go on day by day. Above that, clearly you need some sort of performance management, and we would say the NHS Commissioning Board, devolving that down to a reasonable geographical area. I don’t know what the answer is. I would imagine about 400 GPs, that sort of an area—a natural larger community than a commissioning consortium.

In terms of how you deal with the overseas doctors—it is the EU doctors because others will be bound by different rules—again that needs to be supported through the Royal College of GPs. We have sent guidance out to every single PCT and to Strategic Health Authorities about this, but that has to be a responsibility of the National Commissioning Board. I think, again, the devil is going to be in the detail and where that is going to be determined still needs to be sorted out.

Q77 Rosie Cooper: I appreciate we are all looking for a black cat in a dark room and I am praying someone will switch the light on.

Mike Sobanja: If I came at that from a slightly different point of view, the National Commissioning Board can delegate authority. It can’t delegate responsibility. That is one thing we have to be crystal clear about. If I go back to the question before, the notion that this National Commissioning Board is going to be sitting in London and there will not be anything else, other than all of these consortia, does make me smile because the certainties of life are life, death and an intermediate tier in the NHS. I do believe that they will be there long term and there will be lots of them, and a lot more than people actually think.

Dr Carter: Strategic Health Authorities maybe.

Mike Sobanja: But there difference here—

Q78 Rosie Cooper: Where’s the money coming from? Hang on. We are all describing how we think it will pan out. Where is the money coming from?

Dr Carter: And where is the detail?

Dr Gerada: That is again over to yourself and the scrutiny of the Bill.
Q79 Rosie Cooper: No, we are chasing it just as much as you are.
Dr Gerada: There will be no money. In a sense, the GP commissioning consortia cannot be as many because you have all the transaction costs of just keeping many, many more GP consortia going than we have currently got PCTs, but the money will no doubt have to be taken out of the management structures of those.

Q80 Rosie Cooper: So it will come out of patient care in the end.
Chair: Order.
Dr Gerada: It probably will come out of patient care in the end.
Rosie Cooper: It will come out of patient care.
Chair: You might well find you are taken up on that.
Dr Gerada: We need to learn from pathfinders. Many of the pathfinders such as Dr Alessi have been doing it for many years. They have put systems together but what we must not do is fall into the trap that what works in Surbiton is going to work in Southwark.
Dr Alessi: Indeed.
Mike Sobanja: I like the direction of travel. Perhaps slightly different to Peter, I don’t want to see everything written into the Bill. My past experience of Bills, which are hugely detailed—and heaven knows this one is detailed enough in terms of size and so on—is that that is unhelpful. I would like some answers to some of the questions about secondary legislation about directions and regulations which will colour in some of the detail that we are all looking for. I am not convinced that it should be in the Bill.

Dr Carter: Very briefly, the issue to do with evaluating Pathfinders is something that is very important to us. The RCN were at the forefront of wanting pilots, and Pathfinders is a euphemism for pilots, and we would like that evaluated because that is key to this. There is something else which at some stage I would ask, if I may, that you and your colleagues could look at, and if there had been more time today we would like to have. It is the issue to do with if a consortium has a surplus. What happens to that? We feel very strongly that any surplus should be reinvested back into healthcare and should not be part of a profit for the consortium to then be converted to salaries, even if that went to nurses and others. So, to be crystal clear, if people are doing a good job, they make better use of the money and there is a surplus, that is taxpayers’ money. It should be spent on healthcare not on salaries.
Chair: In the legal profession, it is known as the clients’ account. It is a fairly simple proposition. It is not difficult to police in reality. Thank you very much.
Tuesday 1 March 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper  Valerie Vaz
Nadine Dorries  Dr Sarah Wollaston
Andrew George

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Examination of Witnesses

Witnesses: Professor Calum Paton, Professor of Health Policy, Keele University, Professor Paul Corrigan CBE, Independent Consultant, Nigel Edwards, Acting Chief Executive, NHS Confederation, and Stephen Hocking, Partner, Beachcroft LLP, gave evidence.

Q82 Chair: Ladies and gentlemen, thank you very much for coming this morning. Gentlemen witnesses, could I ask you very briefly to introduce yourselves so we know who we are talking to?
Professor Paton: I am Calum Paton, Professor of Health Policy at Keele University.
Professor Corrigan: I am Paul Corrigan and I am an independent consultant.
Nigel Edwards: I am Nigel Edwards. I am the Acting Chief Executive of the NHS Confederation.
Stephen Hocking: I am Stephen Hocking. I am a solicitor and Head of Public Law at Beachcroft LLP.

Q83 Chair: Thank you very much. I would like to open the questions, if I may, with a very general question because I am, I have to say, increasingly confused by how we should interpret the evolution of commissioning policy in the context of the Health and Social Care Bill. At one extreme, it seems to me, we have Mr Hocking and his firm explaining that there are going to be draconian powers vested in the National Commissioning Board and that, therefore, this is presumably a centralising measure. At the other extreme, we have a number of commentators saying that this is the dissolution of the National Health Service and all its key decisions about its shape are going to be taken by local commissioning consortia without adequate accountability for the “national” element of the National Health Service. I would be interested to hear from each witness—but I will start with Mr Hocking because I quoted him as on one wing of this argument—where they feel we are in that debate.

There is a related question, which I would be grateful if you could cover at the same time, as to whether this new world happens overnight on 1 April 2013 or, as Sir David Nicholson appeared to be suggesting over the weekend, this is a process and the speed at which the process will be achieved is unclear. Sir David appeared to be suggesting there was going to be an assurance regime for the granting of earned independence for the consortia, very similar to the regime which has existed in Monitor for foundation trusts in the old world. Is that how we are to see it—earned independence—or is there an assumed liberty for the commissioning consortia? I would be interested in the views of each of the witnesses on those questions, starting with Mr Hocking. Thank you.

Stephen Hocking: Thank you, Chairman. Briefly, sir, it very much depends on the role that the Board carves out for itself and the approach that the Commissioning Board takes to its duties. The reference to “draconian powers”—and perhaps it was an unfortunate choice of adjective, I don’t know—is a reference to the Board’s powers to intervene in commissioning consortia. The trigger for access to those powers is very interestingly drafted because it refers to a consortium failing—that is fine—or appearing to be likely to fail. Then there is a key word that appears in a later subsection which explains that failing could mean failing properly to perform. That leaves the Board, it seems to me, with a very wide discretion as to how it interprets those enabling powers.

At one level, one could adopt a rather hands-off role and say, “Failure is something pretty serious—failure properly to perform—but still we are going to leave a lot of room for local autonomy.” On the other hand, you could, it seems to me equally compatible with the Bill, take quite a prescriptive approach and say, “I have a pretty good idea, as an experienced national body, what I think proper commissioning performance looks like and if I think you are likely not to live up to that then, at the very least, I feel I can have a dialogue with you about possibly exercising my powers of intervention.” You can’t get the answer to that question from the Bill. It is very much a question of how the Board decides to define its role.

Nigel Edwards: I would agree with that. Much of this is reliant on behaviour rather than prescription. One of the interesting things about how this Bill is different from health reform over the last 13 years or so, which was very much more directive about not just what to do but how to do it in a certain amount of detail, is that this takes more the view that everything not explicitly forbidden is permitted, of detail, is that this takes more the view that

Dr Sarah Wollaston: Unfortunately, I think we are going to find ourselves in this position of a lack of definition, which was the case with previous approaches to legislation. It will require the Board to be very explicit about what they mean by failure and what the markers for pre-failure are, and for those to be defined in such a way that it doesn’t give them a licence to intervene.

Prior to this session, I was talking with Paul and saying that the only way to deliver these reforms and the savings that are required is to devolve and to trust to devolution. You cannot, I think, envisage a later stage of decentralisation. I do not buy a conspiracy theory that this is covert centralisation in the sheep’s clothing of decentralisation. I can’t see why one would do that.

I have a point on the accountability. There is a paradox here because one of the markers of success in a devolved system is being loose about those things
which you should be loose about and tight on the others. The question is: are the things which should be tight tight enough? Is there enough accountability for the decisions that are made? There is some further probing to be done there about whether or not it is possible to be tight on the things that you want to be tight on for a couple of reasons. The first is that there is significant over-optimism about how easy it is to define outcomes and to measure them in provision. It is probably even harder in commissioning.

Last summer I spent quite a lot of time examining the statistical basis for standardised hospital mortality ratios, which is a binary outcome: people are either dead or not. You would have thought that was an easy thing to get agreement on. It turns out even that is hard. So there is a problem here about whether you can determine that the outcomes being produced by commissioning are going off the rails quickly enough—and that is a worry—and whether you can hold people to account.

Your second question is: overnight change or a process? A lot of the debate on this reform has been about the anatomy, the structure. The most interesting bit is the physiology, the culture change and behaviour that goes with this. Behaviour or culture change, we know, takes many years, and most healthcare reforms that seed take at least 10, if not 15, years, because that culture change takes longer. So, of course, this is a process. My preference would be to start from the basis of presumed liberty rather than earned autonomy, but, again, this is not my decision. There do need to be some agreed basics in terms of governance, systems and capability, but, again, we are in very important behavioural territory and that must not be used as an excuse for not moving forward as a proper case.

Q84 Chair: Does the Board have the power within the Bill to operate a system of earned independence, as Sir David appears to be suggesting it wants to?

Nigel Edwards: My recollection of the phrase in the Bill is, simply, that there will be an assurance process. It says no more than that. It doesn’t say anything about what the philosophical underpinning of it is, certainly.

Professor Corrigan: Everyone’s confusion may be because it is perfectly likely, when you say, “Is this either centralising or liberating?”, that it is both. I know, logically, that feels odd, but there is a different sort of logic, one might say. If you are a Government, a Secretary of State, aimed at liberating something and you do it through the form of a Bill, so much of the context of a Bill in this place is inherently centralising that it is very, very difficult to structure what goes into a Bill in a way which is genuinely liberating. You could have a Bill which says, “We just stop what we are doing”, but that creates an enormous amount of anxiety and fear and people then put in a load of centralising issues.

Quite genuinely, at the moment, both things are being centralising issues. The most interesting thing is that the NHS Commissioning Board is staffed by people from the history of the NHS with that culture, then they are likely to construct an authorisation process which is pretty top-down. If you look at what was constructed by Monitor, it was constructed from outside of the National Health Service. It was constructed by an organisation that had a very different ethos. What they have now is an authorisation process, “Are you good enough to be?”. You are in that and you now have a compliance process which is, all the time, saying, “You have a plan for next year.” “It is your plan”—the FTs have said—and you have said you are going to have a 3% growth. We are half-way through the year and it is only a 1% growth. That seems to me to be a different sort of performance management than has traditionally existed in the National Health Service.

If the NHS Commissioning Board is peopled by that old culture, we are likely to see something really top-down. Then the real problem starts. What happens if GPs walk away from that? This is a voluntary group of people. PCT chiefs or FTs, if they don’t work for the NHS, have to get a job outside the NHS. GPs have jobs. They can go on being GPs. They don’t have to do this. There is no conscription that can make them do it. You can pass a law saying they have to, but if they don’t there is a real problem. If they start to experience this, as some of them are, as something which they didn’t sign up for, then you have a much bigger problem than the one you are posing, which is people walking away from it.

Q85 Chair: You say there is some evidence of this already. Crikey, we have barely started.

Professor Corrigan: There is a piece in last week’s HSJ from Charles Alessi talking about his experience of the cluster in south-west London. If you are a Pathfinder, you have signed up to do a number of things. You want to crack on with it and, suddenly, there is someone saying, “You’ve got to do this, you’ve got to do that and you’ve got to do the other thing.” I think there is a beginning of that experience.

Professor Paton: I agree, boringly, that there probably isn’t a hidden agenda, but I almost wish there was. It is almost worrying that there isn’t a hidden agenda.
The most worrying thing of all is that Ministers actually believe in this, if I may put it that way.

There is another reason beyond pure culture as to why there are forces— not conspiratorial forces— towards taking it back. That is the abolition of what we academics pompously like to call the meso-tiers, the strategic health authorities, the PCTs, whatever they might be. They happened to be that recently but it could have been the health authorities before 2001 or it could have been other things. My concern, still answering the question about “Is it centralism or devolution?”, about the Bill is that the abolition of that whole raft of middle tiers, if you like, will lead to the inappropriate decentralisation— not devolution, but decentralisation— of some things and the inappropriate centralisation of others. That will not be because of a conspiracy. There may be those who are glad to take advantage of a chance to do that, but it is not a conspiracy, in my view, by those who wrote the Bill or had the aspiration for the policy last summer in the White Paper. It relates to the somewhat hackneyed thing now about, “Is it revolutionary or evolutionary?” It is not revolutionary in terms of building on existing structures. It is chaotic in that sense, and I am using that word perhaps non-prescriptively. It is chaotic as a description. But, also, I don’t think it is going to be revolutionary, perhaps for cultural reasons but for other reasons too: the agenda, in terms of delivering quality, cost improvement and everything else together, and the need to do that on the hoof— the hoopted boat while sailing in it— and— not a personal comment at all— the need to do that using the regime of Sir David Nicholson and his stuff. That is a very centralist phrase, isn’t it, “Sir David and his stuff”? With Sir David and other NHS managers at the centre, it is going to happen that there will be a lot of centralisation of things which could be at what you would call a regional level, and so on and so forth. It is all about performance management. Who is going to do the performance management of the interim as well as the long term?

Another very contingent but nevertheless important thing is this: it is eccentric, is it not, that those individuals who are being abolished, which might be in a cynical frame of mind, be carrying out a scorched-earth policy, are the ones that are going to have to oversee the creation of the new future? That strikes me as extremely odd. But, again, there is no alternative. It is not a conspiracy. It is just that there is a policy, an aspiration and a vision with almost no regard, I would argue, for effective implementation.

My final point, and then really will be quiet, is this. I don’t want to be rude about Alan Milburn and Paul in 2001, but the 2001 reform created a lot of turbulence and, in my view, inappropriately messed about with the middle tiers to such an extent that we saw a reaction against that later. I would predict— maybe because I am cynical as I get older, but maybe not— that you will see something similar having to emerge. That is my answer to the second question. It will be a process because it has to be. It is not such a policy as a vision. A policy needs to be implemented. A vision needs policy and implementation, and that is going to have to come on the hoof.

Q86 Andrew George: If it is not a conspiracy, then is it worth us exploring whether a cock-up is likely to happen? What is liberating about a proposed structure which has the current proposals for the commissioning of primary care— GP’s themselves, dentistry, opticians, training and of a whole set of primary care services— which, clearly, cannot be commissioned locally? That is hardly liberating, is it? Are we not, if you like, leaping from the fear of conspiracy into a cock-up?

Nigel Edwards: Can I make a response to that now? One of the things that has not been said about these reforms, which I think is one of the most important things, is that if they have any chance of succeeding they will rely on GPs getting to grips with the quality of some of their colleagues’ performance and improving the way that general practice works with secondary care. One of the reasons why PCTs have struggled is that it is very difficult, if you are not a clinician, to have that type of difficult conversation. If you really want these reforms to succeed, you need to try giving as much power as you possibly can to the leaders of general practice in these consortia locally over everything that they are responsible for, and, in particular, general practice. To me, that is worth saying in a very important missing bit of this. It therefore follows that you would be wanting, as far as you can, to delegate as much of the function that the independent Board has over the management of some of these contractors, particularly general practice— probably not dentistry, to be honest— to the consortia. Related to this, it is worth saying that there will be 200 or so different organisations with different levels of capability. One of the habits of mine that we will have to wean ourselves off is the idea that everyone will be universally successful all the time. There will be variation and that will feel very messy. The big anxiety, I suppose, that everyone has is: will there be enough success, in among that variation, quickly enough to deliver what we need, given the very difficult situations in which we find ourselves?

Professor Corrigan: It is difficult not to see the commissioning of primary care as an afterthought in this structure given that, across the country, it is, today, the most localised part of commissioning. Whether you want to put someone on the hoof, or abolish, which might follow that you would be wanting, as far as you can, to delegate as much of the function that the independent Board has over the management of some of their colleagues’ performance and improving the way that general practice works with secondary care. One of the reasons why PCTs have struggled is that it is very difficult, if you are not a clinician, to have that type of difficult conversation. If you really want these reforms to succeed, you need to try giving as much power as you possibly can to the leaders of general practice in these consortia locally over everything that they are responsible for, and, in particular, general practice. To me, that is worth saying in a very important missing bit of this. It therefore follows that you would be wanting, as far as you can, to delegate as much of the function that the independent Board has over the management of some of these contractors, particularly general practice— probably not dentistry, to be honest— to the consortia. Related to this, it is worth saying that there will be 200 or so different organisations with different levels of capability. One of the habits of mine that we will have to wean ourselves off is the idea that everyone will be universally successful all the time. There will be variation and that will feel very messy. The big anxiety, I suppose, that everyone has is: will there be enough success, in among that variation, quickly enough to deliver what we need, given the very difficult situations in which we find ourselves?

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are the most difficult to have the conversation with because they may well be coming under Niel’s, “You can’t shift me, I’m here.” A GP-commissioning organisation cannot necessarily shift that practice because they are being commissioned by someone different. The real power to make this work is going to have to have a very close relationship between the power of a GP-commissioning leader and the right of a GP to practise.

Q87 Rosie Cooper: A GP-commissioning leader is elected by his colleagues.

Professor Corrigan: Yes.

Q88 Rosie Cooper: They won’t be staying there very long.

Nigel Edwards: That is why hospitals have moved away from elected leadership models for a clinical director. It is precisely for that reason.

Professor Corrigan: As you will know, there are majorities that elect people and there may still be people that don’t like you. I know it is difficult to imagine, but they may still be there. Under those circumstances, you organise the centre—an elected leader would organise the centre—against the outliers. If you say to the majority of GPs in a consortia, “You will all lose the quality premium if Dr Fred goes on operating that way,” then there will be pressure on Dr Fred.

Q89 Chair: But that makes quality maintenance into a political process.

Professor Corrigan: It makes it into a managerial process.

Professor Paton: I agree with quite a lot of what Paul said there as to the importance of local commissioning of primary care services but also the link between what, in the jargon, are sometimes called primary care services and extended primary care services. Academics like research, or at least they like some research. I would argue that probably the biggest evaluation of most relevance to this reform—this is my subjective opinion—is something commissioned by the Department of Health Policy Research Programme from Nicholas Mays and many, many others, which was the evaluation of total purchasing pilots. Of course, it was a very different political and managerial time. I am not naive about all of that, but there is some interesting stuff in there. The most successful, enthusiastic and autonomous consortia of GP commissioners, in the broader sense at that time, were successful in which dimension? With honourable exceptions, it was not in secondary care and other areas like that, but, in terms of commissioning, what you would call, again, in perhaps HSJ jargon, the amalgam of traditional primary services and extended primary services.

My concern is, again not through a conspiracy, that the Bill—they are amending it a bit—almost does the opposite. The reason it does the opposite is that it is conscientiously trying to take account of objections to things which should not be relevant in the first place. For example, GP consortia can’t do the local commissioning because it is a conflict of interest. Yes, I understand that. But it is the old thing, “I wouldn’t start from here.” There shouldn’t be one professional group among many, in my humble opinion, taking all responsibility for all commissioning. The conflict of interest is a conflict of interest of the Government’s making. As a result, in order to respond to that, they then have to drive a coach and horses through other potentially effective arrangements. That is my response on the potential lack of local commissioning of primary services.

Q90 Dr Wollaston: Given the crucial importance of controlling outlying practitioners and the ski slope that you have referred to, do you think there is perhaps a hidden agenda in keeping contracts central to allow private provision of general practice and alternative models, as it is often referred to, of general practice to come into the market? We know that GPs themselves are very committed to having the more traditional model of general practice.

Nigel Edwards: It does allow for that. I don’t know if that is the prime purpose for doing it. Professor Paton has put his finger on the policy thinking that has led to retaining contracts centrally. The hybrid solution to the problem I posed is to delegate the power. You can retain this under contracts centrally. I am nervous about conspiracy theories, but it does certainly make it much more possible to do what you are suggesting if you hold the contract centrally.

Q91 Chair: Could I ask Mr Hocking a question, which is whether you think the powers exist in the Bill as drafted to deal with some of these outlier issues? How, in practice, is that done in the context of this Bill?

Stephen Hocking: I am not sure that the Bill is set up—in fact, this clearly runs contrary to the philosophy behind the Bill—to allow a centrally mandated response to, say, the problem of the outlier GP member of a consortium. It is presumably something that could be managed by the Board through using its powers to financially reward what it considers to be good performance. One might also look at the powers to incentivise innovation, and innovation could extend to effective ways to manage performance at consortium level. The intention, as I understand it, is that this will be addressed at the local level. No doubt, the members of the consortium know in much more detail the strengths and weaknesses of their fellow members and so, in principle, are best informed about where performance can be improved. Of course, the difficulty is that for cultural and, indeed, personal reasons they may find it uncomfortable to have those conversations.

Q92 Chair: That is the central dilemma, is it not, that the knowledge about where the issue arises is local and the power to manage it is central?

Stephen Hocking: Yes.

Q93 Chair: It is not clear to me, in the context of the way the Bill is structured, that the power rests in an effective way with the Commissioning Board to use the information that is available locally even if it can be transferred to the centre.
Stephen Hocking: That is right. After all, the Board’s relationship is with consortia. It is not a direct or indirect relationship with an individual member of the consortium.

Q94 Chair: Do you think the Bill covers Professor Corrigan’s point of a GP community— with individual GPs it wouldn’t really be so critical— concluding that it wasn’t willing to be engaged in this process? How does the Board deal with that set of circumstances?

Stephen Hocking: The Board is under an obligation to ensure that there is a comprehensive coverage of England in terms of consortia. That must mean, I suppose, functioning consortia. We said earlier that the Board’s powers in respect of what it considers to be a failing consortium are—and I will use the word without apology—draconian. It can step in and do more or less anything it likes, including taking over the functions of the consortium itself. At that organisational level, the Board is well equipped. In fact, I would say that the set of intervention powers it has been provided with are quite impressive. Of course, that only answers half of your question, sir, because one doesn’t address the problem until the end of the day, one still needs GPs in a locality delivering health care to the population of that locality. That can only be done, it seems to me, with their co-operation. One has to work with the grain and not against it. The extent to which one can drive GPs to do something that they feel professionally uncomfortable about doing must be very limited, or so it seems to me.

Q95 Rosie Cooper: Could I address my question to Nigel in the first point and then perhaps the whole panel could say whether they agree with the analysis. Nigel, you have stated that the proposed reforms move the NHS from a centrally managed system to a regulated industry similar to the gas and telecoms sector. For those of us who are old enough to remember, the last Tory privatisations of “Hissing Sid” and British Gas have left the consumer with the highest prices, huge profit and certainly far from exceptional service. This is all despite having a regulator. Is that what you meant?

Nigel Edwards: I was trying to identify the intellectual roots of these reforms. What conclusions you draw from how it may develop are up to you. But what I meant was—

Q96 Rosie Cooper: How do you get to that analysis?

Nigel Edwards: Let me try and explain what I mean. First off, because we have tended to spend so much time concentrating on GP commissioning, it is worth pointing out that this is a fundamental shift in how providers relate to the NHS. The UK has been unusual in the extent to which central Government has both owned and operated the provision of health care when compared with other countries in Europe. Even those with an NHS system, like Spain and Italy, are more regulated. This Bill will proceed outside of the control of the state, which is a very fundamental shift. That is the first analogy with a regulated industry. Of course, there aren’t customers in the way that there are for telecoms or other industries. You need a proxy for the customers and that is where the GPs come in.

A key question is: what is the role of the regulator? There are two regulators here and this does raise some very interesting questions related to your point. The quality regulator is a minimum standards regulator. There is an interesting question here about who drives quality other than just by lifting the bottom. We do know, from looking at improvement in other industries, that simply moving the tail of the distribution is not the most effective way of improving quality. The most effective way is to shift the mean. How does that happen? Possibly, by NICE setting commissioning standards. Possibly, by those being translated by the Commissioning Board into actions taken by the individual consortia. But that line of accountability looks relatively weak compared with what we have been used to.

Another key question would be: how effective is the economic regulator and what is its function? Is it just about promoting competition or is it promoting competition with a purpose? I felt, sometimes, that the conversation about this has missed the point. The purpose of this is to improve services to patients, which means an intelligent approach to it.

As with what we were saying earlier, if you make a number of relatively heroic assumptions about how people behave, I am quite confident that you can make that system work and that it will produce better results. The problem is that, as people learn how to operate it and as they try and learn those behaviours, and as there is some incentive in all systems for people in individual silos within the system to pursue their own objectives rather than the whole system’s objectives, there are some very significant risks.

Rosie Cooper: Absolutely.

Nigel Edwards: There is another point that should be made, of course. One of the reasons why telecoms has produced such great results in terms of reduced costs and wider availability of technology is that this has been a growing market in which new entrants have been able to come in and offer new approaches. The major driver of innovation in most markets, in fact, is new entrants. That has been possible in telecoms because of the growth in the scale of the market. That is not possible in the NHS in its current financial state, which means that new entrants need to displace incumbents or, even more challenging, incumbents need to start behaving as though they are new entrants, which is also a very big leap. Therefore, there are some issues about the fact that this kind of regulated industry model was designed in a period in which we had growth and now we do not. That may be an issue about its future performance.

Rosie Cooper: Thank you.

Professor Paton: Yes, that is a good question. My first point is more technical, but hopefully it is more than a technical answer. If the external regulators, and particularly the economic regulator, Monitor, displace internal performance management, then that will go against the grain of what I already said. I have sort of predicted the replacement of internal performance management. But if the regulators take over what used to be internal performance management in reality, then that will be a move away from the NHS as we have known it to external regulation, with regulators having real ability to set their own agenda. If you read
the reported comments of David Bennett from Monitor recently, which got some prominence in The Times, I think, last week, he, as quoted—and I don’t know if he is speaking for the whole of Monitor or not—has a very radical market vision, playing down the extent to which health care differs from other commodities. If that happens, it will be because the external regulators have won over, whether it is a battle or not, the internal regulators who still will be there, whether as regional officers of the Department or whatever David Nicholson and his friends cook up in the next year or two. There is that and that will be a battle. There has been a dress rehearsal for that battle in the past over things like FTs, where Sir David has form in being quite a doughty fighter on behalf of what one might call internal regulation or internal performance management.

Second is what the economic regulator does if there is price competition, despite the rhetoric. I know there has been a recent response to suggest price competition will be the exception rather than the rule, and I am sure that statement was made in good faith, but I am not sure if that will be the case when pressures come to bear. Without getting into the whole debate about the quality effect of price competition—and some worrying research over the years has been shown about that—that could be a major role, to move in that kind of direction. I totally agree with Nigel’s point that it won’t be like British Gas in the boom years, or whatever it was, but it will be in terms of the market dynamic in the NHS.

Thirdly, and this goes back to services for patients, at the end of the day, another absolutely crucial area is going to be the extent to which a radical market agenda, if Monitor succeeds in what it seems to want to do, displaces sensible arrangements for non-competitive integrated care on the altar of the ideology of “There must be competition.” That would be another thing to look out for, in my view.

Professor Corrigan: The one impressive thing, if I can use that word, that the regulators of privatised markets have done is not only ensured continued access but left the public feeling quite safe in the assurance of that continued access. If an economic regulator could do that with health it would be a very good thing. In a sense, if you are in Northumbria with Northumbrian Water, it doesn’t matter who owns the water as long as it keeps coming out of the tap. There is a faith that the light will come on and that this thing works. Rather than it being, as it were, the rough and tumble of an unregulated market, there is a feeling that these very important things will continue under any circumstances, and the job of the regulator is to ensure not that a particular company continues them but that there is 100% access. It seems to me that if Monitor can do that, then it is quite an important service, much more important than the other things which we are all concentrating on around price and competition. At the moment there is anxiety among the population that, if their hospital closes, they lose all the services rather than those services will continue. We have not been able to construct a compact around the Health Service which says, “We will make sure services are still there even if the people that are providing them change.” There is a lack of faith that we can do that.

Q97 Rosie Cooper: People talk about rationing happening today. Using what you have just said, how are you going to convince people that rationing will not affect them and that their medical needs will be met and met locally?

Professor Corrigan: The very last word is the really crucial word. I think the NHS—all of us—have constructed quite a sloppy contract, if I can put it that way, with the public, that, “You can have everything at the end of your road.” We know that can’t be the case and that we have not succeeded in constructing that picture.

Q98 Rosie Cooper: How long might that road be?

Professor Corrigan: If you want a decent piece of brain surgery, a long road. What we are learning about specialisms is that that road has to be quite long. We have not necessarily been dishonest, but we have not been open with the public about what locality can deliver. I think we need to be.

Q99 Rosie Cooper: Fundamentally, I absolutely understand what you are saying with things like stroke services and trauma centres. I don’t actually disagree. But the problem is the basis on which this Bill, commissioning and the whole regulation thing, has been sold to people—and sold to many Tory MPs of Parliament, and even a Liberal Democrat. I listened to them stand up and say that this Bill will deliver the re-establishment of the maternity service or some other service that they have just lost. Tory MP after Tory MP stood up and said it, and I couldn’t believe it. The basis of this is exactly the opposite of what they are standing up espousing. Therefore, either they are being duped or we haven’t got it.

Nigel Edwards: One of the features of this bit of the White Paper philosophy, which does resemble the regulated market model, is a sort of presumption that the invisible hand of the market will shape services. I don’t think, when you talk to GPs in consortia, they realise that quite a lot of complex services, like stroke, cancer and trauma, do require a degree of planning and that they will need to make some of those decisions. I would be very surprised if the decisions that they make will achieve the results that you are listing. That is just not going to happen.

Q100 Rosie Cooper: Those services are not going to suddenly reappear, are they?

Nigel Edwards: Not generally, no.

Rosie Cooper: No, absolutely. They are going to get more distant.

Nigel Edwards: To be honest, the forces that are propelling services in that direction are not sensitive to the type of commissioning or purchasing system that—

Q101 Chair: They are nothing to do with the Bill. They are much more to do with the budget.

Nigel Edwards: A and also changes in the way that medicine is working.
Q102 Nadine Dorries: Professor Corrigan, your point about the contract with the public is an interesting one because you cited the—I suppose we call them—centres of excellence. Is it not the case, or am I wrong in thinking this, that at centres of excellence, where there are specialisms and both academic and clinical expertise is poured into those centres, the outcomes of patients are markedly better than they are on a more general distribution of services? Therefore, would you say that if the outcome of this Bill leads to good consortia with extended roles and a greater number of centres of excellence that that would be a good thing?

Professor Corrigan: Absolutely, if we could. The mechanism the Bill has to make that happen is an empowered, informed patient. I look at going there or going there. I look at the outcome and think, “I will go to the specialist centre.” If we can construct a much more powerful relationship with the patient around that sort of information and make it much more normal and what people do—since they do it for cars and they do it for other things—then we have a vehicle to make those choices. However, the point being made is that that will mean something local closes that is not as good. I find that, sitting here and not in the sense of sitting there as a local politician, not a bad thing. The Prime Minister had a very interesting phrase in Prime Minister’s Questions the other day, which was “if you don’t use this”. He didn’t say “if you don’t use it, you’ll lose it” but that choice is a part of this, and if you systematically don’t use your local services then you have a problem about them being there.

Q103 Nadine Dorries: Do you think the Bill provides that empowerment to the patient?

Professor Corrigan: As to the empowerment for the patient, the Bill provides a looseness, if I can put it that way, which allows that to happen rather than a central organisation. We need something much more than a Bill can provide, which is a culture. The locality relationship for your public is very important at the moment and they choose locality over and locality relationship for your public is very important than a Bill can provide, which is a culture. The central organisation. We need something much more powerful relationship with the patient around that sort of information and make it much more normal and what people do—since they do it for cars and they do it for other things—then we have a vehicle to make those choices. However, the point being made is that that will mean something local closes that is not as good. I find that, sitting here and not in the sense of sitting there as a local politician, not a bad thing. The Prime Minister had a very interesting phrase in Prime Minister’s Questions the other day, which was “if you don’t use this”. He didn’t say “if you don’t use it, you’ll lose it” but that choice is a part of this, and if you systematically don’t use your local services then you have a problem about them being there.

Nigel Edwards: On outcome, I would caution that we are back to a problem. Our ability to reliably measure outcomes and distinguish between providers is not good enough to drive that. Secondly, a significant number of patients who use our services are not exercising choice because of the way the system works. They are in A&E or they are among the 20%-odd of emergencies who are taken to hospital by ambulance. You need choice, but you need other mechanisms as well if you want to drive that type of change in the system.

Chair: We need to move on.

Q104 Valerie Vaz: I want to turn to accountability because some comments have come out from the patients, the people at the end of it. We have to have a discussion with people about their having to go further and that this Bill is taking things out of the state. At the end of the day, it is people and people’s lives. We are not talking about switching on light bulbs. It is something much more fundamental, and sometimes long term. It is 80% of the budget that is going to unelected people, so I think there is a huge issue about democracy and the democratic deficit. How do we explain to people that their money is going somewhere else and is being wasted? I’m not sure I could do that on the doorstep in five years’ time. I am, therefore, interested to follow up the accountability.

Obviously, Mid Staffordshire has been mentioned a number of times and we have heard evidence from people who have complained to their GPs and the GPs are still sending patients to Mid Staffordshire. How do we prevent that? And, secondly, could you—I know this is a long question—look at the accountability which we have now and what it would be like under the Bill?

Professor Paton: Very briefly, as well as being an academic, I was chairman of the big hospital up the road from Mid Staffordshire Hospital. I was chairman of the University Hospital of North Staffordshire for five and a half years so I knew, indirectly, the Mid Staffordshire because I was in the local health economy, or in the strategic health authority. My own view on the Mid Staffordshire is that there is no cause and effect between a particular form of governance at the abstract level. By “abstract”, I don’t mean meaningless things. By “abstract”, I mean should it be patient-controlled, should it be PCT-board controlled or whatever form of governance. There were all sorts of things going on in the hospital and outside the hospital in terms of the performance management regime and the way things were handled. A lot of agencies have a lot to answer for on that one. I see the need, however, to ensure— and, perhaps, because it is not simple to be absolutely sure—that we do not lay open conditions whereby, without being melodramatic, more quality scandals and life-and-death scandals come to pass.

There is a lot of work to be done, and I bow to my colleagues on what the detail of that might be. But, again, the issue here is to try to change and challenge that and to say, “Let’s look at something real. I know it would be nice to have it at the end of our road, but let us look at something real.”

Nigel Edwards: On outcome, I would caution that we are back to a problem. Our ability to reliably measure outcomes and distinguish between providers is not good enough to drive that. Secondly, a significant number of patients who use our services are not exercising choice because of the way the system works. They are in A&E or they are among the 20%-odd of emergencies who are taken to hospital by ambulance. You need choice, but you need other mechanisms as well if you want to drive that type of change in the system.

Chair: We need to move on.
is going to be handled, but that the tier below that are effectively commissioned.

Again, it may be an anecdote from a trust chairman of a big hospital who has gone native, but from 2001 till the thing got rationalised in 2006, we, as a hospital, did not want to rule the roost but we did want commissioners to be big enough and strategic enough to know what the hell they were doing. It may be a North Staffordshire problem, but we didn’t see that because there were the small commissioners who had been sold the rhetoric. Quite rightly—or rather, understandably—they were doing what they had been told they were brought in to do, particularly the non-executive chairs and so on, and they sponsored altruistically what I will call—and not in a dismissive way—local pet projects at the expense of what I will call strategic commissioning. So that is a really difficult one.

My own preference, forgetting what inheritance we have, is that you have popular representation at a much higher level—in an ideal world at a regional level—but that is clearly not part of the demarcation we have here.

Chair: Can I bring in Mr Hocking?

Stephen Hocking: Yes. Thank you, Chairman. I will try and be brief. It is a complex picture, in part because accountability is not something you can purely legislate for. You will know, madam, that if you meet a voter on the doorstep and they think the Government or you personally are responsible for such and such a thing happening, that is a fact on the ground, as it were. Whatever the Bill has to say, I have no doubt that in those conversations with voters or with people writing letters to their local press they will continue to think that the Secretary of State for Health, or the Government of the day or Parliament generally—whatever it may be—is accountable for the way the taxpayers’ funds are spent in the Health Service. Perhaps that is no bad thing.

In terms of the Bill itself, I will highlight a few points. The first is I am a huge chauvinist—and probably a rather unfashionable chauvinist—for local government, and it is quite heartening to see local authorities and local government referred to in the Bill, not centre stage or anything like it—that would not be appropriate—and perhaps more on the public health side than the health care side. But opportunities are there for switched-on and creative local authorities themselves to carve out a role in ensuring accountability, and, of course, your point about democratic legitimacy. There are the Health and Well-being Boards as well.

The other point I would make is that, on the face of it, there is an awful lot of report writing. Plans are produced and then they are reported on and then consortia have to have a public meeting at which they defend their report and what they have done in the last year. We don’t know whether that is going to be seized upon by local people in a really effective way to drive accountability or whether it will become something that is honoured in the breach. I suspect the answer is that in different areas there will be different pictures. And there is a challenge because, of course, without wishing to stereotype, it is easier to get people who have maybe got some time on their hands and who are comfortable and articulate to come along and hold their local consortium to account. It can be more difficult in the very areas where that accountability is most important. But there is a lot on the face of the Bill that could be used. How it will translate in practice is a more difficult question.

Q105 Chair: Would you like to have a go at how it will be translated in practice?

Nigel Edwards: It is useful to look at some practical examples, isn’t it? If a hospital like Mid Staffordshire is performing poorly, who do you talk to? If a GP consortium has decided it does not want to prescribe a high-cost monoclonal antibody, what is the nature of that conversation? I am very clear—I would agree with Mr Hocking’s analysis—that there is an awful lot of accountability machinery, in theory, in the Bill. It is how it plays out with those examples. I am not fully able to articulate. I am probably not the right person, but I am not sure who you have those conversations with, other than the organisation itself. If that doesn’t work, I am not sure there is anywhere else to go, in the case of the GP consortia, but through the judicial review process, and, in the case of the foundation trust that is not performing, back through the commissioners and back through the regulator. I can see, in theory, how this all works. What I am not able to tell you is how that will play out in practice. What I can say to you, though, is that it is quite a complex system. You will have trouble explaining it on the doorstep, I think.

Professor Corrigan: Which probably means we do know what is going to happen: they will come to you. They are absolutely bound to. I would like to say that they will come to you because they are not daft. This is paid for out of national taxation that you vote for and the public really have that in their head.

Q106 Rosie Cooper: Can I give you a very quick example? I have a GP-led service, a commissioner-led service. It is a really brilliant service and has been operating a year. Suddenly, a few weeks ago, there was a problem—a four-and-a-half-hour waiting list. You are absolutely right. Where did those people come to? They came to my office. I was here. The office then phoned up the PCT, “Not us, because it is a clinician led.” The office phoned the clinicians and was told, “Why is an MP phoning us? Why are they going to you?” They said, “There is a four-and-a-half-hour waiting list.” The next question came, “If they have a problem with the process, there is a complaints procedure. Log it in there.” “No. These are waiting four and a half hours now.” “What do you want us to do, take that patient out of order?” “No. We would like no patients to be waiting four and a half hours. What are you going to do about it?” It went into meltdown. In that situation, yes, they will be coming to us. We will be looking to the Secretary of State—
Nigel Edwards:— who has no powers.

Professor Corrigan: The interesting thing is that is why he has the powers he has. All these draconian powers are precisely because you are going to be coming to him.

Q107 Rosie Cooper: Does this mean, then, that adjournment debates, debates on the floor of the House, are simply all going to be swamped with Health Service things because we and our constituents have no measure of getting any resolution of those difficult and local problems?

Nigel Edwards: May I clarify? The Secretary of State has no powers until things have reached a point where the commissioner, and not the provider here, so your problem is a commissioner problem, is evidently failing.

Rosie Cooper: But that is them as well.

Nigel Edwards: Is that right? Yes.

Q108 Chair: The other way of putting what Rosie was questioning you about is that I thought that is what the civil war was all about.

Professor Corrigan: And we won, I would just like to point out. It would be quite interesting for the Committee to look at the accountability around foundation trusts. I do not think, when the current Secretary of State was raising this issue about Mid Staffordshire in Opposition, that Parliament had to say, “Yes, you are allowed to raise that.” I don’t think the accountability was with you, as someone who was involved in that Bill. But it didn’t stop it from being raised. It didn’t stop the Secretary of State from going and answering and then going back—

Q109 Rosie Cooper: But how many people had to die to get there? That is what is so wrong with all of this. Forgive me for being angry. We have listened to people’s stories and they are dreadful—absolutely hurt and dragged through a system. I have looked at the Care Quality Commission’s way of operating. You feed it in and they will send somebody out. When they look at it, they will just refer it to another body to look at it again. Those people didn’t get the service they needed, paid for by their—taxpayers—money. To say that so many of them have got to die and it has to be critical before anybody gets off their backsides and sorts it, is an outrage.

Chair: I think what Professor Corrigan was saying was whether or not we had the power didn’t make any difference. There was an issue—

Q110 Rosie Cooper: I appreciate that, but the point has to be made. There has to be some mechanism in here where people’s voices can be heard. It is all right saying, “You’ve got all the power to choose whoever is going to do x, y and z,” but if they don’t do it, tough luck.

Professor Corrigan: Irrespective of the Bill, the Secretary of State will be held to account for the Health Service at the next election—whatever the Bill says—because the public will expect that to be the case.

Chair: Of course.

Professor Paton: Very briefly, it was interesting to see David Nicholson’s exchange with the Public Accounts Committee last week or 10 days ago. I don’t know if you have seen that, but, basically, David said, in terms of accountability to Parliament in one form or another, “If there is a problem with any of the GP commissioning consortia, it is me, Nicholson, that you talk to.” That was teased out of him. With the foundation trusts, he said, “It is each of these.” That is not tenable. It is this tension, isn’t it, between parliamentary accountability, which is absolutely right—and efficient, quick parliamentary accountability where it is necessary, especially in bad cases—and, on the other hand, adequately devolved management of the NHS?

Nigel Edwards: The train-operating companies will probably give you the analogy that you are looking for. Foundation trusts’ accountability will be similar to that of train-operating companies. You may or may not find that reassuring, but that is my reading of how that works.

Q111 Rosie Cooper: There are some very complex things that are going to go on and happen, let me tell you. But I think foundation trust chairmen and non-executives are getting paid shed-loads for absolutely nothing. I tried to find out how much each of them gets paid, and, do you know, nobody will tell me? They get paid between £40,000 and £60,000 a year per foundation hospital. That is okay, but no one is accountable. They will say they are accountable locally, but can you get a list of what that is and what that amounts to? No chance. That is a drain on the Health Service.

Nigel Edwards: The role of governors and members in the new dispensation becomes extremely important and is the major route by which foundation trusts, in future, will be held to account. The measures that are in the Bill to strengthen the role of members, and governors particularly, although they don’t look very important, are extremely important because that is the bit, they are the people—

Q112 Rosie Cooper: You are looking at a former chair—albeit for a month—of a foundation hospital. Let me tell you, I watched those members. They had become an arm of management. They really do need to get far more powers and a bigger voice. The direction is great. The reality doesn’t bite anywhere near hard enough.

Q113 Chair: Shouldn’t the important accountability of a foundation trust be through the commissioner for the shape of care and the value that is delivered to patients? Do you think that accountability line, through the commissioner to, ultimately, the Secretary
of State, who is responsible to the House of Commons for the budget, is strong enough in this Bill?

**Nigel Edwards:** It doesn’t answer the question about whether there are internal processes or whether what is paid to the chairman is appropriate—that is through the governors. But, in terms of the quality of care and care provided to the patient, then it is through the commissioners. I believe that if the commissioners are doing their job properly, then that is a powerful enough mechanism to hold them to account, yes.

**Professor Paton:** But not to here.

**Q114 Chair:** To the Commissioning Board and then there is the question of the—

**Professor Corrigan:** That is what I am unclear about in the Board. The Secretary of State talks about a mandate to the Commissioning Board. Whether that mandate means I then will answer a question about a particular locality within the year, again, force majeure, I don’t think he will have a choice. But that may not be the powers the Bill gives.

**Nigel Edwards:** He has no powers to intervene in individual consortium areas.

**Chair:** Are there any other issues here?

**Q115 Rosie Cooper:** Yes, if I may. Under the Bill, the Secretary of State will no longer have a statutory duty to provide health services and will only have to act with a view to securing the provision of health services in relation to the Board. How accurate is it to see this as spelling the end of a state-provided National Health Service?

**Nigel Edwards:** That is precisely what it is, is it not? That is what it says. It is there in black and white. That is my reading of it as well. In fact, when every NHS hospital is a foundation trust, apart from the fact that the state would be a residual owner of roughly £36 billion of assets which belong to the taxpayer, there is no direct state control over the provision of health care except indirectly through the commissioning process. That is my reading of it.

**Q116 Chair:** Can I push on that because Rosie’s question was: “Is this the end of state-provided health care?” The trusts are still owned by the state and they are delivering care in response to a tax-funded budget that is accountable, through the process we have been discussing, to the commissioning boards.

**Nigel Edwards:** I was taking a narrower view of the definition. But you are absolutely right, yes.

**Professor Paton:** I am not trying to be smart but that expresses part of the theology of the purchaser-provider split—expressed in 1989/1991 up to 1997; which was then suspended in culture but not in structure between 1997 and 2001; and then was gradually rolled out again in a new and indeed more radical form. It is just putting the top hat on that. That is what it is saying, but the practical reality will be exactly as the Chairman says. In other words, the reality is that public money is in the providers by one way or another and the theology may not be worth more than that proverbial bucket of spit when it comes to the reality.

**Q117 Rosie Cooper:** Meanwhile, at the next election, each and every one of those Members of Parliament who have voted for this will be held accountable for the mess they have created and the Health Service they are or are not getting at that time.

**Professor Paton:** Yes.

**Q118 Chair:** All MPs will be held accountable for what has happened during the term of the Parliament.

**Stephen Hocking:** Briefly, sir, I am wary of analogies but there may be a helpful analogy to draw with other public services, and in particular perhaps with state-funded education, which, of course, has never been directly provided by the Secretary of State for Education. It has always been indirectly through local education authorities. In 1992, what is currently the further education college sector, as no doubt you will remember, madam, was carved out of local authority ownership and set loose in a way not wholly dissimilar to what is being proposed here.

**Rosie Cooper:** I might have a bad education, but I won’t die. Carry on.

**Stephen Hocking:** No doubt, both health and education are important in different ways. I accept that analogies are dangerous things. My point was simply that if one looks at the ecology of state-funded education, with voluntary-aided and voluntary-controlled schools, with further education colleges and with universities, it would be unfair to characterise that as not being state-provided education, albeit it is certainly not provided by the Secretary of State for Education. Maybe the analogy helps, maybe it does not. I offer it.

**Professor Corrigan:** Because this was something I was involved in, it seemed to me there was a very important distinction—at least it was important to me—between “These will be publicly provided but not state owned”, and the creation of the public form of organisation of the foundation trust. It was very carefully constructed so that it could not be privately owned. Pushing, a little bit, what Stephen said, I don’t think it is necessary for the state to own these things for them to be public. We have a state-paid-for—a publicly-paid-for—system with public provision but not necessarily owned by the state. I think you are right, that is the end of that.

**Nigel Edwards:** When I reviewed the evidence and published this in the Journal of the Royal Society of Medicine, I think we can say that the evidence seemed to suggest that ownership is not a crucial factor in the quality of health care provision, that governments probably do it worst of all and there may be some gradient between for-profit and not-for-profit, but it is highly contested. What is important is the environment in which the providers operate, the regulation that they are put to, the quality of the purchasing and the commissioning that is done to secure their services. Ownership is, at the very most, a second order issue in terms of quality of care.

**Chair:** Nadine has one question to do with health inequalities, and then we really need to move on, if you will allow me.

**Q119 Nadine Dorries:** The NHS Commissioning Board has a responsibility to reduce health
inequalities. I know, Mr Hocking, that you spoke before about the Board having the right to define its role. How do you see the Board will define its role in terms of health inequalities? Will that be seen, as and when it does, as part of these—and I know you said it was a poor use of words—draconian powers, and will this just be part of the draconian, interfering kind of role it will take with regard to consortia at the point at which it interferes?

Stephen Hocking: I hope not. This is something I am sure we all feel very strongly about, and I do, personally. I welcome seeing written on to the face of the Bill provisions relating to health inequality and I think the way that that is addressed and the way health inequality is described is well done. It certainly performs, and I would argue, mandates—the Board to place reduction of health inequality as being one of its very highest priorities. If I have a comment, it is that one could perhaps have gone a little further. I think of this particularly as someone who may, in due course, be advising Health Service bodies on how one goes about delivering on this objective, and of course we all know that the causes of health inequalities are complex and not easy to address.

I would have welcomed a little more air cover in the Bill for bodies that want to take a very positive and proactive approach to reducing health inequalities, to make it clear. For example, in the Equality Act there are provisions relating to, in certain circumstances, taking positive steps. In this country we have never really gone in for positive discrimination. The Equality Act still does not really, but there is an acknowledgment that, in certain circumstances, in order to address disadvantage, you may need to take positive steps. This Bill is silent on that point, and purely in terms of people feeling comfortable about taking forward the health inequality agenda, perhaps that is somewhere the Bill could have been a little more ambitious.

Q120 Nadine Dorries: Could this possibly be because health inequalities are very geographical? It depends on which part of the country you are in. There are much greater inequalities in some than in other parts of the country and therefore it is difficult to legislate within the Bill for that to the degree that you have just stated.

Stephen Hocking: That must be right, madam, in the sense that one could not write on to the face of the Bill that one must be concerned about the health inequality between men and women or people of different ethnic backgrounds or whatever. Clearly, one takes it at a global level and then allows each locality to identify both the inequalities it thinks are most serious and then the measures it can take to address them. My point was simply that a general statement in the Bill making clear that it is possible to take positive steps—to put it bluntly, to treat some people differently from others—if the objective is the overall reduction in health inequalities is something that, personally, Health Service bodies would have found helpful.

Q121 Nadine Dorries: How do you see the NHS Commissioning Board addressing this? What, practically, do you see them being able to do?

Stephen Hocking: They can do a lot. As you know, they will be issuing guidance on commissioning functions. They will be proposing draft commissioning in contracts. They can make it very clear, as you say, very positively backed up by the statements that are in the Bill, that this is to be a priority on the commissioning side. Then one waits to see what the consortia do in response and monitors them against that. Of course, there may be a role for other bodies here as well. No doubt, the Commission will keep a close eye on this, too. But I think it does have to be—and maybe, madam, it is your point—that the priorities have to be identified locally.

Q122 Nadine Dorries: To finish off on this, then, if they prescribe the way in which the consortia should deal with health inequalities and if the consortia are not seen to be abiding by this guidance—and you have described it as “likely to fail” or “failing consortia” at the point at which the NHS Commissioning Board can step in—would you see it as a fair “likely to fail” scenario if they are not meeting health inequalities?

Stephen Hocking: Yes, absolutely. If they had, in good faith, attempted to address health inequalities and, for whatever reason, had not succeeded in doing so, and they were going back and thinking again, that is one matter. But if they were not addressing the issue seriously in line with the guidance to be issued by the Board and the duties imposed on the consortia themselves by the Bill, then absolutely I would see that as a “likely to fail”.

Nigel Edwards: Can I make a point? It is worth remembering that the Board will only really have powers over access to health care inequalities and that one of the major health care inequalities is, of course, access to general practice, for which the Board itself is responsible, so the Board is a co-creator of this policy locally. I am not sure that the failure will be only on behalf of the consortium because, if you are failing to deliver health inequalities, it is probably likely that your primary care system is failing too and that is the responsibility of the Board. The other thing the Board could do that would make an impact is that it will, at some point, to make any of this policy work, need to renegotiate the GP contract. There is a proposal to put some points in the Quality and Outcomes Framework to relate to prevention and public health priorities. There are a number of responsibilities that the Board has directly, and this is another area where there may be some confusion of accountability between the Board and the consortium, perhaps.

Q123 Nadine Dorries: Can I finish up on one last sentence? It is interesting, Mr Hocking, to hear you say that the statement that was perhaps misquoted, or you felt was a bit strong, was that the powers of the NHS Commissioning Board to step in would be draconian. But then you also say that you feel it would be an appropriate point at which to step in if they felt they were not meeting health inequalities. You can’t
have it both ways. The NHS Commissioning Board has to have the power to step in if they are likely to fail on a number of criteria. That does not necessarily mean it is draconian. It means it is about accountability and about not wanting consortia to fail. We want to get in before they fail. Therefore, it is appropriate that they have the right to do that.

Stephen Hocking: I couldn’t agree more, madam, and if “draconian” was taken to be a pejorative term in that sense, I withdraw it.

Chair: If we may, it is best now that we move on to our second session. Thank you very much. That has been helpful. We are confused at a higher level, I think.

Ev 36 Health Committee: Evidence

Examination of Witnesses

Witnesses: Dr David Bennett, Chair, Monitor, Adrian Masters, Director of Strategy, Monitor, Dr Ron Singer, Medical Practitioners’ Union, and Dr Anna Dixon, Director of Policy, The King’s Fund, gave evidence.

Q124 Chair: Good morning and thank you for coming to the second session. What I would like to do, if I may, is begin by asking you to introduce yourselves and then we will open the questioning.

Adrian Masters: Adrian Masters. I am the Director of Strategy at Monitor.

Dr Bennett: David Bennett. I have been Interim Chief Executive at Monitor for the last year and, as of today, I am the Chair of Monitor.

Chair: Congratulations.

Dr Bennett: Thank you.

Dr Singer: I am Ron Singer, a recently retired GP and President of the Medical Practitioners’ Union.

Dr Dixon: Anna Dixon, Director of Policy at the King’s Fund.

Q125 Chair: Thank you very much for coming. I would like to open the questioning on the subject that is at the heart of a lot of the comment about the effect of the Government's proposals on commissioning, and that is the effect of their proposals on the establishment of stable pathways of care around the system and the effect that competition—Any Willing Provider market will be, which is where you would get competition for patients in the market, and where there will be scope for commissioners to much more actively shape services in the way you describe.

Stephen Hocking: I could not agree more, madam, and if “draconian” was taken to be a pejorative term in that sense, I withdraw it.

Chair: If we may, it is best now that we move on to our second session. Thank you very much. That has been helpful. We are confused at a higher level, I think.

Ev 36 Health Committee: Evidence

1 March 2011 Professor Calum Paton, Professor Paul Corrigan CBE, Nigel Edwards and Stephen Hocking

I am very cautious about using examples from other sectors, lest I be immediately quoted as saying “Health care is just like X”, which, of course, it is not. Health care is different. But one example which I was discussing with a colleague just the other day is the way the car industry works. You have very effective competition between the manufacturers of different cars but, in practice, when you are making a car you have all sorts of suppliers working together collaborating in order to produce the finished product. Indeed, you will sometimes finish up with providers who are working with more than one manufacturer. You may think it is a big step to go from there to health care but, in practice, if what you are talking about in a similar sort of way is multiple providers working together, collaborating—maybe a couple of different groups working in competition with each other but nevertheless providing the sort of integrated or long-term care that is needed—then that should be entirely consistent with a degree of competition.

Q126 Chair: Can we take each witness in turn on those core questions and then respond? Perhaps we can go to Dr Dixon next.

Dr Dixon: Thank you. I would agree that competition and integration are not incompatible, but it really depends on how the market is going to work in practice. Commissioners need to specify products, in a way, and the Commissioning Board and Monitor specify tariffs in a way that can promote that sort of collaboration to deliver an integrated package of care for complex patients, or to deliver a pathway of care. Of course, it will probably take more than one provider to do that. We need different clinicians working together and we need different organisations working together, both public and private and the voluntary sector, to deliver integrated care. It is integrated care that we want, not necessarily organisational integration.

It is possible that the arrangements set out in the Bill about how a tariff can comprise of more than one service does allow the possibility that commissioners could use this to commission integrated pathways of care. What is fundamental as to whether this will happen in practice is to do with the extent of the Any Willing Provider market. At the moment, there is a lack of clarity about the scope for where an Any Willing Provider market will be, which is where you would get competition for patients in the market, and where there will be scope for commissioners to much more actively shape services in the way you describe.
through the commissioning process—clearly through an open and competitive tendering and procurement process—will be allowed to actively shape services. That is the fundamental issue, about how extensive the Any Willing Provider market will be and whether we will be talking about an Any Willing Provider for quite small and defined bits of care, and the scope that there will be left for commissioners to really shape innovative products—pathways of care, packages of care—and seek to commission, hopefully with consortia, innovative providers across public, private and not-for-profit sectors to really deliver what is the true outcome—I would agree with David—which is good value care and good outcomes for patients.

Q127 Chair: Does it come down to who has the power to define the terms of the competition? Dr Dixon: There are two issues. One is who determines whether there is an Any Willing Provider environment for certain types of services and, therefore, the scope for tendering. It seems—and obviously this has been clarified most recently in David Nicholson’s letter—that there will be areas where Any Willing Provision will be allowed, so that will be by the Commissioning Board. In his letter he talks about “many NHS-funded services”, suggesting a pretty broad scope. But in the same letter it also says that commissioners will be able to go to competitive tender and offer their services to one provider or a prime contractor. Those two things seem perhaps slightly contradictory, that many services will be under an AWP model and, at the same time, there will be scope for commissioners. It is going to be the Commissioning Board, perhaps, that will be determining this and then the question will be that Monitor will check whatever of those models is happening, that if it is competition for patients, there is competition and they are under competitive behaviour by providers, and if there is a tendering process, that the commissioners are tendering in line with procurement guidance set down by the Department which says that these are the rules by which you have to compete. The Commissioning Board is key.

Chair: Will come back to Monitor in a moment. Could I bring Dr Singer in?

Dr Singer: There are various levels at which we have to look at this. If we take something simple like a hip replacement, then, in a sense, we can split it up. We can have the physiotherapy, the pre-assessment, the operation and the after-care and that can be integrated pretty easily, whoever is doing the providing. If we come to something like diabetes, it is much more difficult to get the integration that you require if there are multiple providers vying for part of that market. You can have people going there for their eyes and there for their feet. If the systems don’t talk to each other for these various providers, you then fail to get integration of care.

The third element, for me, is the integration in primary and social care because that is what we do. We try and integrate. That is the job of the GP, in a sense, to integrate all these various services. What we have found, over the last few years, is that the demise of the primary health care team, for various reasons but nevertheless the virtual demise, has been a fantastically negative factor in trying to integrate care. If we now put those sorts of scenarios into the Bill, I find it quite difficult to see how this is going to work. I find it quite easy to see for the simple stuff, and I think Any Willing Provider for cataracts, hips and hernias and all that business is going to be the patient’s choice, not the consortium’s, as I understand it. The consortium is not going to commission the elective care, as we call it. When we come to the more integrated stuff, the diabetes care, the pathways and all that sort of thing, there will be room, perhaps, for consortia to be able to shape some of that, but my fear is that there will be provider dominance and you will get big providers who will do the commissioning. They will do the specification and they will come to the commissioners and say, “This is what we can provide for your people with diabetes.” There could be a tendering process with the specifications and the commissioning done by a series of providers presented to a commissioner to make a decision. That is commissioning the wrong way round, in a sense. Nevertheless, it is a very potent part of what opening up the NHS market can do.

Dr Bennett: To pick up on Anna’s point about the scope of Any Willing Provider—and you are right that the intention is that the Commissioning Board will broaden the scope—my presumption is that one of the determinants in deciding what is and is not within Any Willing Provider will be precisely this point. If you are looking at services where it is most important that you get integrated care, then those are the services where you are more likely to see them outside than inside the scope. On the issue of the role of providers in determining what it is that is provided, inevitably it is going to be a dialogue. It should be a dialogue between the commissioners and the providers to work out what can be provided and what will meet the needs of patients best.

Q128 Chair: If an individual commissioner takes the view in a particular locality that the service for a particular group of patients is going to be better provided by pursuing an integrated model, is that something that Monitor would take a view is open to challenge?

Dr Bennett: Not that decision per se at all. By the way, a lot of this will be complaints-driven, so it is a question, in many ways, as to whether somebody else feels it is not being done properly. Where a challenge could come and where a complaint could arise would be if commissioners decided, in their locality, that they wanted the provision on an integrated basis and they were, say, in dialogue with a provider who could, working with others, provide that care and then another provider said, “We could do this too, working with another group of providers” and the commissioner said, “No, we’re not interested. We only want to talk to you”. That would be a situation where someone might complain and we would get involved.

Q129 Chair: I totally accept that point, but it is an important point, is it not, that if a commissioner has the power in the new world to determine that a
particular service or group of services is better provided on an integrated basis, that is a commissioner decision and is not, itself, open to challenge by Monitor on competition grounds?

Dr Bennett: No.

Dr Dixon: I would agree.

Q130 Chair: That seems to me to respond to some of the points that you were making.

Dr Singer: Is it not open to the provider that does not get the contract to make a challenge?

Q131 Chair: Yes, but only, as Dr Bennett was saying, to challenge it on the grounds that they could have offered the same integrated service that the chosen provider did. That is a different proposition from saying, “We want to be able to offer a bit of that but not the rest of it.”

Dr Dixon: I don’t think that contradicted what I was saying. The concern I have about this is what scope will remain for GP commissioning consortia at the local level to be able to have the flexibility to decide where they want to go for commissioning. A more integrated service provision will depend largely on the scope set by the National Commissioning Board about the extent of Any Willing Provider. What will be important is what rules there will be to govern if local commissioning consortia said, “We want to commission an integrated diabetes service but the National Commissioning Board has said that there is an Any Willing Provider service for podiatry.”

Let us take that as an example. It is a simple thing that you could imagine could easily lend itself to a price and an open competition of podiatry service. What flexibility would that local commissioner have as part of that commissioning process to say, “No, we have an integrated service provision. They have their own podiatry as part of that integrated package of care and, therefore, we are not going to have Any Willing Provider for a podiatry service because, for our population, we have this integrated diabetes service”? If you had a new kind of service, like a very integrated service, for example, for patients with serious long-term conditions or co-morbidities, et cetera, that is a new service. There is no standardised offer available. There may also be questions of scale. You would look to the commissioner to say, “Go through some kind of open process” and come up with a specification of that service that they think is appropriate and to make it go through a similar open process with other providers being able to come in and offer to provide that service. That is led by the commissioner because they are specifying the service and that wouldn’t be on the choice offer. There is no standardised offer to be putting on a choice offer.

Q133 Chair: That definition of service by the commissioner could include some elements of a service that elsewhere and for other patients is provided as standardised.

Adrian Masters: That is the critical question in the middle, isn’t it? Let us imagine podiatry is on that list as a simple service of what is on the national list and somebody comes along and says, “We can bundle this together as part of the offer for this particular group of patients and we will give an integrated offer for these groups of patients with these long-term co-morbidities and conditions.” The rule is going to need to be set out by the Department in the regulations that the Bill says they are going to set. My belief is that they will say, in those circumstances, that it is appropriate for the commissioners to say, “For these groups of patients we will bundle the podiatry service into this contract.” It has to be written by the Department because it is the issue where that two parts of the policy—

Q134 Chair: Hang on a second. Is it the Department or is it the Commissioning Board or is it—

Adrian Masters: The legislation says the regulations are written by the Department. That is what it says. I imagine, probably, what they are going to do is say that the Commissioning Body is going to set the list of what is on the national choice menu. The legislation says the regulations are set by the Department.

Chair: I now have a number of colleagues wanting to come in.

Q135 Andrew George: As to the integration of the service, in this car-assembly plant—or whatever analogy is operating—as far as diabetes is concerned, I can see that. But as to an integrated service which commissioners may want to ensure is provided so that acute services, particularly acute emergency services, have sufficient capacity around them to deal with the range of emergencies that arise—which tend not to arise in car assembly plants, I have to say—to what extent does this model allow a commissioner to design that, which one might call a general hospital—in other words, with all the services that are necessary in order to receive a range of emergencies coming in? To what extent is that model of, one might call it, a general hospital put at risk by this commissioning process?

Dr Bennett: Adrian, you may want to have a go too, but this is again getting to the heart of the decisions...
the Commissioning Board will need to make. I am sure what we will see is the services currently provided by a DGH being, to some extent, broken up into separate services commissioned or provided on an Any Willing Provider basis separately, but you are right to say, of course, that there is the need to work out what that implies for the connections between the services. If you have a DGH that is providing a range of services, some of which are provided under an Any Willing Provider, and they are successfully providing all of them, then they will be able to go on providing the whole set of services even though patients are making choices about individual services. To some degree, that is the way it is working now.

Q136 Andrew George: Are you saying that if a commissioning consortia defined a package of service that was equivalent to a DGH, you, as Monitor, would defend those other providers of services and say, “No, we could provide elements of this, so we are going to disallow the consortia from designing that particular service because it is too big, too integrated and it is skewing the market in favour of a particular provider”?

Dr Bennett: Those are separate points. If you got into a situation where a commissioner wanted to commission such a large integrated package of effectively everything a DGH currently provides, almost certainly that will run counter to what the Commissioning Board will be trying to do through Any Willing Provider. Many of those services are going to be provided under AWP anyway, so there will be the fundamental difficulty in trying to do that. It is not an issue for Monitor at all. It is a Commissioning Board issue.

Chair: Can I bring Dr Dixon in?

Dr Dixon: Your question raises a number of very important points and we are uncertain exactly how this will work. The intention is that, in future, commissioners will be less focused on commissioning organisations. So there will be less about having a contract for an organisation for all it does and it will be much more focused around service lines and so on. It is unlikely that that type of commissioning specification would take place.

But you raise some very important points about how we commission for services such as emergency and ICU, where you need to assure a certain amount of capacity regardless of activity. They are not suited to the type of volume-based contracting or AWP models or activity-based models. We do need commissioners to have other types of contracts which ensure that they are commissioning for capacity regardless of activity.

We know in things like urgent care there is also a need for not just focusing on the DGH and what currently is provided there, but systems and networks of urgent care provision which link up your out-of-office, walk-in centres and so on. Even in an area like urgent care, it is likely in future, that there should be people looking to commission. The difficulty here is that GP commissioning consortia are probably too small and too local to look at the sorts of regional network structures for different levels of urgent-care provision that are needed.

The final point that you raise by your question is the interdependencies between services currently provided by single institutions. These reforms do have, by creating greater transparency about separation of price, separation of service line and, indeed, through designation of services—which I think we may come on to a bit later, and I don’t want to pre-empt your questions but that is the issue here—a lot of hidden cross-subsidies. There are a lot of hidden interdependencies that I don’t think we particularly understand that well. These reforms will start to tease out some of those and make them more transparent. For example, if your orthopaedic surgery is under an Any Willing Provider and patients and GPs refer elsewhere and that diminishes—it is not designated—you, as an FT, say, “We are not getting any patients. We are not making money on this. We are going to close down our orthopaedics.” But you have an A&E and there are interdependencies. You need those trauma surgeons around to continue to run your emergency service. Do we then have to designate part of your orthopaedic services and subsidise them, even though they are not making money under the choice environment? There are some really, really important questions that will be very challenging to work out and I don’t think we will know the answers to these things on day one of implementation.

Q137 Dr Wollaston: This is obviously going to be incredibly expensive and risky, particularly over the transition.

Dr Dixon: I think that that is the case. This is an enormous technical challenge, even—looking down the table at colleagues from Monitor—in making the market work, in setting the right prices and having the right feedback loops to tell you whether your prices are handling large windfall gains to certain providers, whether you really have an efficient price, what is the evidence for designation, how can we be clear about the impacts and benefits of competition? To make the market work, this is going to be a big job. It is going to have costs.

Q138 Dr Wollaston: Do you think it is compatible with delivering the Nicholson challenge?

Dr Dixon: I think there is a high risk that it will be too slow to deliver, given that we need to make the productivity savings now.

Q139 Valerie Vaz: Who does that job of pulling it all together?

Dr Dixon: What job?

Valerie Vaz: The one that you just described, pulling it all together.

Dr Dixon: It is not clear who in the system will, at least at the strategic level, drive the sorts of reconfigurations of service across whole systems of care that are absolutely necessary and are necessary now. There is a real tension between the strategic commissioning and the hand of the market. As I say, it is going to take quite a long time before we can see the beneficial effects of the hand of the market on shaping services, and there is really a job to be done now. Obviously, PCT clusters are not in a great position, I don’t think at the moment, having gone
through a lot of reorganisation, to be continuing to lead some of the work around strategic reconfigurations of services which are necessary. You had the previous discussion about “We can’t have everything at the end of our road.” That is the point. In order to deliver the productivity challenge, we need to change where and how the services are delivered. Those things, if they are to be done, need to happen sooner rather than waiting for this new decentralisation. Then there is the question of whether that new mechanism will do it and do it effectively. I am not going to judge on that, but your point about the transition is that we haven’t got the time to wait for that. We need another mechanism now, and that has been the need for strategic-level commissioning. But with the way things are going, with PCT clusters looking towards and GP consortia and pathfinders not yet in a position ready to do that, there is a question mark about where and how that happens in the system.

Q140 Andrew George: This will require armies of accountants, will it not?
Valerie Vaz: It will require accountants, GPs can’t do this, can they?
Andrew George: In order to be able to identify those costs, there is going to be an enormous amount of work and it is going to be contested as well.

Dr Dixon: David and Adrian may want to say more about the skills, but certainly Monitor and the National Commissioning Board will need a very different set of skills, I think, than the traditional NHS manager skills, whether that be in actuarial risk pooling. There are all sorts of new terms that we are going to get to a lot more familiar with. Yes, to set efficient prices we are going to need more than the current number of civil servants sitting in Skipton House working out the national tariff.

Chair: I am going to bring in Dr Singer, and then perhaps Dr Bennett would like to comment on the armies of accountants point.

Dr Singer: We are beginning to discover that what was offered to the GP body was they would have 80% of the budget and control of the NHS. This is simply not viable. Consortia can be more than two practices—6,000 patients—and we are talking about reconfiguring, in the case of A&E, for a population base of 500,000 to 1 million. A&Es have to have 24 hour access, 365 days a year, to everything. There is no point in having an A&E if you have no orthopaedic surgeon on call 24 hours a day. That is obvious.

It is not clear at all how consortia, even if they have a 500,000 population, are going to manage this because we have lost the next tier up. I don’t know who is going to do that job and I don’t know how you have a hospital with the local A&E is going to be able to survive if there are falling departments within that hospital and that is not attended to or there is a better tender. This is a big issue. A&E is obviously crucial to everybody’s feeling about the NHS, and we know about trolley waits. It is absolutely crucial that that bit works, and I don’t see how it can do unless you designate the whole lot, which, of course, is exactly what this is designed not to do.

Dr Bennett: On the armies of accountants point, Anna raised that there is continuity of the provision of the service if the provider of the service is the only provider of that particular service that is available to its local community but the provider gets into difficulty. Designation is all about making sure that there is continuity of the provision of the service even if the provider themselves gets into difficulty where there is no alternative provider. On the integrated care for A&E, yes, there are similarities. I think the critical issue is where you draw the boundaries. If you finish up in a situation where you define the boundaries around A&E as being the whole of the DGH, then you have somewhat frustrated the policy, but I don’t think that should be necessary.
There are a couple of things. There have been concerns aired about whether any financial interests that the GPs might have as a consequence of being part of commissioning consortia might affect the level of trust that patients have in their clinical decisions.

Q144 Chair: I understand that, but simply to say, "We are defining this integrated package to be whatever happens to be provided at a particular moment in time on a particular site" is presumably a view that could be contested.

Dr Bennett: Yes.

Q145 Chair: But with a proposition that, "This is what is required to deliver an integrated A&E service", it seems to me, if you can defend it for the diabetes patient why can't you defend it for the A&E service?

Dr Dixon: If I may come in, you are right that, in principle, there is no reason why you couldn't commission an integrated service. The difference is that for A&E, for stroke and for some of these other services, the level, that is, the population size, at which you would need to commission that integrated service has to be on a much larger scale. At the moment, it seems in the guidance and provisions in the Bill, the expectation is that GP consortia would come together in order to do this and, if they failed to, the Commissioning Board could do this on behalf of the consortia. In our view, it will be necessary for there to be some types of service that are commissioned at a more strategic, higher level, whereas, obviously, the prevalence of diabetes means that any commissioning consortia, one would hope, would be very well placed to commission an integrated diabetes service, with some innovations around that.

The other thing is we were making the distinction between these easy-to-measure defined episodes of care, that we might have an elective and saying that they lend themselves to Any Willing Provider, but nothing in the area of chronic disease, or whatever, would. In time, there is no reason why you couldn't have a national specification, based on NICE standards, for an integrated diabetes service. If we had good information about what a really high quality, integrated offer with self-management support actually looked like, it would be possible to come up with a tariff—--a year of care, risk-adjusted capitated price—and have quite a lot of nationally specified standards, contracts, prices, for an integrated diabetes offer. So even in areas like that, over time, I think the Commissioning Board could choose. Again, that would seriously constrain GP commissioning consortia's ability, perhaps locally, to do that, but do we want repeated innovation and different contracts written? We could waste a lot of energy and, given the small management costs that consortia are going to have, they are not going to have the capacity to take every service and do a redesign on it locally. We have to strike a balance between national standards, what we know to be best practice, and the ability for local clinicians to work together to adapt that and how they want to offer the service locally.

Adrian Masters: If you can specify and set a price, you can give choice to patients, and get competition for improvements in quality. That would be the direction we would like to move the service in over time.

Q146 Nadine Dorries: Dr Dixon, where do you think the GP's patient fits in all of this? We hear so many conflicting stories—we know that 4,000 GPs are signing up for this so they are probably not peddling these stories—that GPs may feel patients will look at them with suspicion because they will feel that they are commissioning in a way that is not appropriate or in a patient's best interests. Some people feel that patients will now be almost lobbyists in their own right and become more empowered. I have to say I buy into that, about the patient going to tell the GP what they would like to do and have far more power. But where do you think the patient will be in all of this? Will they be better off as a result of GP commissioning? Will they be more empowered or will they look at their GP suspiciously? What do you think?

Dr Dixon: There are a couple of things. There have been concerns aired about whether any financial interests that the GPs might have as a consequence of being part of commissioning consortia might affect the level of trust that patients have in their clinical decisions.

Q147 Nadine Dorries: Is there evidence of this from the fund-holding days?

Dr Dixon: I am not sure about any evidence, but obviously at that point my understanding was that the issues were about reinvestment and practices rather than direct personal financial gain. Obviously, in the current proposals, GPs personally won't be able to pocket any savings they make on the commissioning budget, so that would need to be made clear to members of the public. Obviously, practice income would be contingent on the outcomes they achieve as commissioners. That is what the quality premium is around. But I suppose you could argue how different is that from achievements on QOF, where the higher-performing practices get a higher practice income, or indeed on some of the local-enhanced service payments. I am not sure that the principle is particularly different.

What is perhaps more fundamental is GPs' role in future in making rationing and priority decisions. The extent to which they are seen to be doing that could have a fundamental impact on the relationship between patients and GPs. There is some discussion about the role of NICE in that respect. The further away some of those difficult priority decisions are, or at least the evidence for those decisions is generated nationally, the better because they are necessarily going to be fraught for local GPs if they have to do that.

Q148 Nadine Dorries: However, if NICE assumes that role, it means patients are left with very little power again.

Dr Dixon: Of course, one does want some variation in what purchasers prioritise because we want it to be in relation to the needs of the people they are serving. That is the case already with primary care trusts, so it is getting the balance right between justified variation, because of differences in population need and population priority, and unjustified variations, which might arise in the different services that are funded.
The other element on the patient-GP relationship is in relation to choice. With other organisations, we, at the King's Fund, did the Department of Health-funded evaluation of patient choice at point of referral, which is, to date, the main example of where we have patient choice and Any Willing Provider. GPs that we spoke to—and these were enthusiastic GPs on the whole—were quite reluctant to be routinely offering patient choice. They made their own decisions about who valued choice and the differences regarding how routine or specialised the onward referral was. I think there is a tension there between raising patients' expectations about their abilities to choose and how involved they are going to be in decision making and the realities of a busy clinical surgery and how willing the professionals are, both GPs and, to some extent, around choice of treatment, secondary care, to take the time to involve and inform patients in decisions both about where they go and about their choices of treatment. We have an awfully long way to go. We know from survey data that patients want to be more involved than they are in decisions and, certainly from the evidence that we had, only about half of patients are offered a choice. Many of them are happy to rely on a GP recommendation as to where they go, but people do think choice is important and it is not always the people that you imagine who value choice. There are a lot of stereotypes about it being the articulate middle class, and our evidence does not support that. I am happy to share more on our choice work with the Committee if that is helpful.

Q 149 Dr Wollaston: Following up on that point, in substance is it meaningless for GP commissioners to be commissioning integrated care pathways if patients can have a choice to go anywhere they like? Could they still choose to go outside that commissioned pathway if they wanted to?

Dr Dixon: That was our earlier conversation. We are not sure at this moment what degree of flexibility there would be, or indeed rights, for the patients, at least for parts of that care, to opt out of the commissioned package. That is yet to be determined.

Q 150 Dr Wollaston: Or wholly outside the commissioned package.

Dr Dixon: Or wholly outside it, yes.

Q 151 Nadine Dorries: Would that be a conversation between the patient and the GP based on the decision by the GP? Or is that where you see NICE stepping in if the patient has an appeal, if you like, to the already-commissioned pathway? Would that be the point at which you see NICE coming in?

Dr Dixon: This points to the need to be very clear about how GP commissioning groups will engage patients and the public in their commissioning. Clearly, they are not necessarily going to be required to have a public representative in the governance, but they do have a duty to involve them in the "what" is being commissioned. But, obviously, once that is commissioned, there is a question about whether GPs, who are providers but are associated with that consortia, have to then refer patients into that preferred provider arrangement—the integrated package—or whether GPs, with their patients, have the right to choose to not be part of that. Those issues will have to get worked out locally. I don't think there is anything that has been specified about that.

Dr Singer: Because I am in danger of coming across as very negative, I want to bring some good news. The experience of talking to patients about swapping their drugs on the advice of prescribing advisers—because they are coming off patent, there is a cheaper deal or whatever—is that you can engage patients in a sensible, rational discussion and patients will come in and say, "That's fine. How is your budget going?" There is an understanding out there that there is this thing called "a budget" and GPs hold it. It is a misconception, often, where they think there is a practice budget and you can't overspend. But never mind. There is at least an awareness of that.

There are conflicts of interest, because you can have GPs on the Commissioning Board who are not only GPs locally but are directors of a private company that has a tender locally, and there could be difficulties in explaining to patients their choice, pushing people in one direction or the other. This is the other thing that happens—and this happened in the days of the 18-month waiting list—is what we call the blunting of perception. That is, you are aware there is an 18-month waiting list and you tended to refer people later for their hip or their knee replacement because you knew that if you just bunged them on the waiting list they would be there 18 months anyway. That is established.

There could be a similar blunting of perception here. If you are aware that your consortia is overspending, there is a conflict between the ethical responsibility to do the best for the patient in front of you and the wider public health responsibility to stay within budget for the consortia. Already, GPs get letters from PCTs regularly saying, "You can no longer do this because we are over budget on this elective. Can you hold on and wait till April when the new budget comes in?" All those things will come into play but in a much, much bigger form. My younger colleagues are going to have difficulty in disentangling some of these issues.

Q 152 Andrew George: In view of that, if competition is being encouraged on the one hand and patient choice is being freed up and made more available on the other, and I know this has been partly teased out, perhaps this is an attempt to try and bring Monitor into this difficult conundrum as to how you can widen patient choice in the kind of scenario that Dr Singer was describing, in other words one where, inevitably, there is going to be—I don't think anyone is disagreeing with this—greater rationing, or at least the prospect of greater rationing. A supplementary is that it is not just the treatment when all of the diagnosis is agreed and the prognosis understood and you know that it has to be a hip replacement or whatever—it is something very straightforward and everyone understands, an easy to define, mechanical solution treatment—but how much patient choice is there, for example, in the process of defining what treatment should be? In other words, what if that...
patient is saying to the GP, “Sorry, I want to be referred to another specialist because I disagree with that specialist’s proposed treatment, which is more physiotherapy rather than a hip replacement”? Then you have clinicians not necessarily agreeing with each other on the best way forward. I can’t see how patient choice is going to be provided in this system.

**Dr Bennett:** I will attempt to answer some of those points. On the rationing, of course it exists today. You are quite right to say it will be done in a different setting in the future, but I don’t think these changes fundamentally change the nature of the problem. They do move where the problem lies.

In terms of choice, clearly there is an issue if the budget is exhausted in a particular consortium, say, or for a particular activity within a consortium. Indeed, the consortia are going to have to work out, with guidance from the Commissioning Board, how they deal with that. I don’t know the answer yet. In terms of choice, once it is agreed that there are no issues about the rationing or budgetary constraints, then, in principle, the initial point of choice is where the patient is referred. If we get into a situation where a patient is referred somewhere and then is, in some way, unhappy with the care they have received, which I think is what you were postulating, clearly that has to come back to the GP. Exactly how they deal with that, to be honest, I am not sure, but, in principle, the fact that there is a set of providers ought to mean that another provider can be chosen.

**Q153 Andrew George:** A GP, as part of a consortia, will have commissioned particular providers and now he or she is offering choice to their patients who may opt for a provider that they have not commissioned.

**Dr Bennett:** A lot of what you would be talking about would be under Any Willing Provider, so they are not being commissioned by the GP consortia. They are providing a service under Any Willing Provider, accredited in some way.

**Adrian Masters:** They might just go on the national Choose and Book menu, for example.

**Q154 Andrew George:** So they may go from Cornwall to the north of Scotland or—

**Adrian Masters:** If there’s family. It has happened.

**Dr Bennett:** If, for some reason, they wanted to, in principle, yes.

**Adrian Masters:** Yes. They may have family locally in Newcastle and maybe they want to do it up there. It is plausible.

**Q155 Andrew George:** Yes, under that arrangement, of course. And you don’t think that that will conflict in any way with the attempt to encourage competition among providers.

**Dr Bennett:** In a sense, it is at the heart of it. In so far as you have a significant number of willing providers, all accredited, providing a similar service, with users making their choices based on the quality of the service and whatever else they are concerned about in deciding where to go, then, effectively, you have competition among those willing providers. If you have a provider who is not getting as many referrals as they would like, then, hopefully, they will look to why it is that patients are choosing to go somewhere else and understand how they are making their decision and adjust.

**Q156 Andrew George:** Can they then compete on price?

**Dr Bennett:** No.

**Q157 Chair:** Can I probe you on that? In the circumstance where a provider agrees with a commissioner that it makes sense to both sides to do it at lower cost, below tariff, but there are other AWP providers at tariff, does the patient have the freedom to choose to go to a more expensive provider outside the reduced cost?

**Dr Bennett:** It is not clear to me—and I think Adrian would agree—how a commissioner could agree a lower price. Within Any Willing Provider the prices will be set by us as national tariffs for a given service.

**Q158 Chair:** But commissioners are agreeing to it every day and have been for years.

**Dr Bennett:** Under the current system, yes.

**Q159 Chair:** So those concessions will have to be withdrawn, will they?

**Dr Bennett:** That is our understanding of how it is meant to work.

**Q160 Chair:** So costs go up.

**Adrian Masters:** The key question is: are you committed to the choice offered to the patient? If you are committed to giving them a choice, you can’t say, “Here is the one provider I have made a deal on the unit cost with and you have to go there.” I would say you would start off by saying, “What is the choice offer that we are making to patients?”

**Q161 Valerie Vaz:** What he is trying to say is that you can’t have it both ways. You can’t have it both ways. Can I follow up on that? Does that mean that you license Any Willing Provider and do you license them with conditions or not?

**Dr Bennett:** There are three issues. A provider will have to be registered with the CQC to make sure they are providing a safe service. They will have to be licensed by us, and that is how we will set prices and so on, but they also have to be accredited by the commissioners in some way to say they have met any other condition.

**Q162 Rosie Cooper:** Mid Staffordshire was licensed, credited and all the rest of it. It has an NHS badge on the front door. It still killed some of its patients.

**Dr Bennett:** There were problems in Mid Staffordshire, absolutely.

**Rosie Cooper:** That does not really give me any great comfort.

**Q163 Valerie Vaz:** The answer to that is, yes, is it?

**Dr Bennett:** What is the specific question?

**Q164 Valerie Vaz:** Do you license Any Willing Provider or do you have conditions?
Dr Bennett: There are three different things. The CQC register any provider that is meeting the required standards. Mid Staffordshire had issues, but, hopefully, they will be picked up under the new system. We would license any provider that meets our conditions, but our licence is mostly the mechanism through which we are able to do things like set prices. Then there needs to be an accreditation by the commissioners.

Adrian Masters: There are two other steps. Of course, we would want to give the patient information about the quality of the various providers and we would want them to get advice from their GP, who will say, “I would advise you go for this provider rather than that one because I think they are better quality for your purpose.”

Chair: Dr Dixon has been trying to get in and Dr Singer.

Dr Dixon: There are a number of issues. The whole issue of price competition, and so on, is still very vexed. There has been a bit of exaggeration, I think both ways, about what is or is not implied by a maximum tariff. Clearly, if you have an Any Willing Provider market, as we have just discussed, that is, where you have market entry based on meeting minimum quality standards and it is about being licensed by the regulator and about saying, “We meet the contractual standards as set down by the commissioners”—probably set down once by the Commissioning Board would make sense—certainly the CCP’s recent report is suggesting that the move away from a single national contract, which currently operates for choice at point of referral, the extended choice network, and the move to having PCT-based contracts is a complete nonsense because of high transaction costs. If you are going to have this, you may as well have one contractual basis and then you need a fixed price.

The issue, we know, is that even when you offer patients a choice, many of them value local providers—convenience—and are quite loyal to local providers, particularly if they have had a positive experience. If they have not had a good experience, there is a very high predictive that they will go somewhere else. That is what our research on choice tells us.

If you are a commissioner and you know you can predict that, even if you offer a fully informed choice to every patient, about 70% of your patients for a particular procedure are likely to choose that, then you are a bulk purchaser for that provider and you don’t necessarily want to be paying the full price. You are not guaranteeing that provider volume, but you are predicting that it is more or less likely you will be one of their significant buyers over the course of the year. Given you have to make some productivity savings, you might want to negotiate a bulk-purchase deal, and that means going below the tariff price. The question is whether that would all be allowable. I am saying it is not guaranteeing the volume but it is making a pretty good prediction and therefore you want to negotiate with that provider. You are still giving patients a choice. Would that be allowable?

Q165 Andrew George: Dr Bennett has already told you that it is not.

Dr Bennett: Our assumption—

Q166 Chair: Dr Bennett said he was not sure.

Adrian Masters: Probably not—

Q167 Andrew George: Are you saying absolutely not, because this is quite critical?

Dr Bennett: It is, and the reason that we are maybe expressing slightly different views at its fundament is because these are issues to be resolved in their final detail. Our assumption is, because it is difficult to have choice of Any Willing Provider if you start negotiating on price—you could do it in the way you are suggesting, but you can see difficulties in that—it is unlikely that that is the way it should go, and we are particularly concerned that we don’t have competition on price in a way that starts to drive down quality. That is what we are worried about.

Q168 Andrew George: I know, but there is the pressure. If there is genuine competition, all the market signals that any provider would want to give would include price. It is inevitable, is it not, that there will be pressure, particularly in a crowded market, for that to happen? Signals will be given. How are you going to resist that? I can’t see how you can resist it.

Adrian Masters: The payment that is expected is a nationally set tariff. The prices are fixed. Then you compete on quality.

Andrew George: But you are saying, in response to Dr Dixon’s comment—

Q169 Chair: It might be easier if I can interrupt. That has been the theoretical public policy for some years and we now discover, when we go and talk to PCTs, that nobody has taken any notice.

Dr Dixon: There are also always going to be services, as we have described previously, that are not appropriate to have an activity base, or are not subject to Any Willing Provider. The issue there is we already have within PCTs, within block contracts and other mechanisms, in effect, local price negotiations. So even where we have had this system of transparent fixed prices, there have always been elements of care that have been subject to negotiation. The issue is not “Are we having no price competition or are we having full-blown price competition?” The issue is about how we strike a balance between the two, where it is appropriate and where it is not appropriate. I agree that one of the fundamentals of having an Any Willing Provider is that you have to have a fixed choice. You have to have certainty, both from the point of view of the payer and of the provider, that if a patient turns up, they take their referral and shows up, they know what they are going to get paid. You do need that.

Q170 Chair: It is worth also rehearsing, is it not, the argument that is used on the ground for the flexibility that has grown up, which is that existing on tariff prices in each case creates a whole series of perverse incentives in particular health economies where costs
are different in one provider as compared with another? If you apply a tariff in a health economy where the costs associated with that procedure are lower than the national average, what you do is create a perverse incentive for high activity in an area where what you want to see is resources released in order to meet a real demand rather than an artificial demand.

Dr Dixon: A greed.

Dr Singer: I just want to say this is a crucial issue for my organisation because, for us, it is the issue of what is on the face of the Bill. We can all agree here to be benign about what is on the face of the Bill and later people may agree not to be quite so benign. But if the Bill states that there will be a national tariff and there will be a maximum price, there is no point in stating that unless people can get under that price. Why else do you have a maximum price? This features very heavily in the chapter on pricing and in the chapter on competition. If we are going to have a system where competition is a very big element—and part of that has to be price, it just has to be, and I can’t see any reason why it would not be—we are going to go into this scenario that I think is extremely dangerous because we will not have quality data on new entrants. Let us be very clear about that. I, as a GP, am sat there trying to advise my patient, there is a new person just arrived on the list—and this is happening at the moment, where people are getting on the list that comes up under the Choose and Book programme—and I haven’t a clue about them. There is no data on them in terms of their NHS provision and you cannot get data out of the Freedom of Information Act on them because it doesn’t apply to them. So we are in a situation where we are saying that the GP will help the patient to decide and the GP will not have data. This is not really fair.

Q171 Rosie Cooper: If I may, I would just broaden this a little. In many of the conversations we have had this morning, we have talked about the commissioners and we have talked about the NHS Commissioning Board. To me, the relationship between Monitor and the Commissioning Board is one of the big unknowns at the moment. The Commissioning Board, subject to the approval of the Bill, will have a very wide remit. I would like to ask Dr Bennett, as Monitor, how Monitor would distinguish between, as I see them, the three roles of the NHS Commissioning Board. First, national leader for quality improvement, promotion of choice and working with you in the design of tariffs. Secondly, it is also the body accountable to the Secretary of State for managing the overall commissioning revenue limit, delivering specified outcomes and, in turn, holding consortia to account. And, thirdly, it has a role as a commissioner for services. It is almost Chinese walls. What is your relationship going to be with the National Commissioning Board in relation to their activities in those three spheres? For me, there is potential for conflict and interrelationships there.

Dr Bennett: If you take the first of your three categories, which is around designing tariffs, promoting choice and promoting quality improvement—I think that was your first bucket—we will have to work very closely with them on that. There is no question about it. But I don’t see any fundamental conflict. On things like quality improvement, if, for example, the Commissioning Board, or together, we felt that there was some way of structuring tariffs to incentivise improvements in quality—

Q172 Rosie Cooper: How, in practice, will you get there?

Dr Bennett: How will we work together? We have to work that out. I can only say what you said, really. It is going to be incredibly important that we have a very effective working relationship in all sorts of ways to do that because it has to be hand in glove for that to work.

Q173 Rosie Cooper: Forgive me—and I don’t mean this in a wrong way, I am saying it genuinely constructively and I think this is just the use of words—but, before, when we were talking about complaints and organisations not working properly and you said you hoped it would be picked up, the great body of NHS users will be thinking, “Hope is not a strategy.” They need more than that. They need to know that it is not going to happen again. We talk about Any Willing Provider. How do we know that certain hospitals are not going to be left with the complex stuff and Any Willing Provider does the easy stuff? I know that was the old line, but there is still some truth in it. How will Any Willing Provider drive innovation? And clinical training? Where does it all fit? How do we make this better? People tell me all the time it is going to be okay. I don’t see the evidence base.

Dr Bennett: You raise a lot of different issues in that. Earlier on, you were going back to the issue around Mid Staffordshire because I had said I would hope it would be picked up. I would like to address that specifically because, obviously, that is a very important issue. All the evidence indicates that that was a trust providing care which was not of a sufficient standard for too long. Fundamentally, the way I believe the system should now prevent that from happening again is the way CQC works, the quality regulator. CQC, of course, wasn’t around when the major problems were happening in Mid Staffordshire and—

Q174 Rosie Cooper: Is that true?

Chair: It was the Healthcare—

Dr Bennett: It was the Healthcare Commission. But I think that is an important change. When CQC was formed from the merger of the HCC and some of the other regulators, they decided to take a different approach. I am not here to defend the CQC, but if you look at the sorts of things they are doing, their objective is much more to spot problems at an earlier stage and intervene as soon as they do. That is the main line of defence for the quality issue, and it should apply just as much once these reforms are in place as it should today.

Q175 Rosie Cooper: Will you have any input in seeing whether it has enough resources to be able to deliver the service?
**Chair:** We, Monitor? No. That will be an issue for the Department, absolutely, of course—

**Q176 Rosie Cooper:** But if you are relying on it? **Dr Bennett:** The whole system does today and should in the future rely on CQC as the main line of defence, beyond the trust boards themselves, to make sure providers are providing safe care to an appropriate standard.

**Q177 Andrew George:** But how do you address the point that Dr Singer just mentioned, that newcomers to the marketplace have no pedigree?

**Dr Bennett:** This is really a question for the CQC. But I believe what they would say is that, first of all, any newcomer into the market has to be registered by CQC. They would be inspected and would have to meet their standards. The moment they are in the system, they will be subject to CQC’s regular processes of inspection. They have this quality risk profile where they maintain a constant monitor using all sorts of data that they collect, including soft intelligence. One of the things that I think went wrong at Mid Staffordshire was that soft intelligence, things like trends in patient complaints and so on, wasn’t being used. They are now trying to use that to spot where there may be problems. That is the way that should go.

**Q178 Chair:** We are at one o’clock and there is one question we would like, if we may, to put in particular to Dr Bennett. The impact assessment for the Health and Social Care Bill says that existing NHS providers have a 14% cost advantage over independent providers. In your evidence to the Public Bill Committee you appeared to suggest that not only might that not be right but there might be a cost advantage the other way. This is, shall we put it, salient if we are going to start setting national tariffs, is it not?

**Dr Bennett:** Yes. The point is that the impact assessment lists out a number of different ways in which there are advantages and disadvantages for the public sector versus voluntary or private sector providers. It then goes on to put a number on just a few of those. For whatever reason, it just puts numbers on those which are advantages for the public sector providers. The first thing I said is that that is an incomplete analysis. You cannot draw any conclusion from that 14%. In fact, we are not in a position to say whether the 14% is right, but whether it is or not, there are definitely big chunks in the analysis that would need to be done, including quantifying the cases where the public sector is disadvantaged. Only when you have done that analysis as carefully as you possibly can, can you say, in net, who is advantaged or disadvantaged.

**Q179 Chair:** But it needs to cover such things as training costs and the other free-rider costs that, as is often argued, exist in the private sector.

**Dr Bennett:** Exactly. Those are the sorts of things which are not quantified at the moment.

**Dr Singer:** So there will be different prices for different providers?

**Dr Bennett:** No, that doesn’t follow. There are different costs for different providers and if those different costs in some way represent an unfair advantage, then at some point we will need to think what to do about them.

**Dr Singer:** Who will pay that? If you have a skewed thing because of expenses in the system and you have got the consortia having to choose or advise, then how does that happen? They are going to go for the cheapest, presumably.

**Dr Bennett:** That is a good reason why price competition needs to be dealt with very carefully. Any Willing Provider or fixed national tariff, from the commissioner’s point of view and from the user’s point of view, they all cost the same.

**Dr Singer:** Who pays the difference?

**Dr Bennett:** Under those circumstances, the providers will have different costs, but they are all facing the same price. The users of the system, the people paying for the care, pay the same amount wherever the user goes.

**Q180 Chair:** But there remains a public policy question. If you are then seeking to equalise the costs in a national tariff for providers who do meet costs that other providers do not, in particular training costs—which is the one that is always quoted—you can’t simply provide the money and pay it to the private provider and not collect a training cost out of the private provider, presumably?

**Dr Bennett:** That is an example of the way you might want to tackle it. You make sure that everyone is making their own fair contribution to training costs, exactly.

**Q181 Rosie Cooper:** When will you be in a position to know that and, therefore, feed that into this new system? You are obviously not able to say that today.

**Dr Bennett:** At a technical level, we take over our role in April next year, but, frankly, a lot of these issues are going to have to evolve over a period of many years, and they are issues that exist today. They are not new issues.

**Dr Bennett:** We will have to set priorities. We will have to decide which things we are going to focus on first—which are most important.

**Q182 Rosie Cooper:** So some could get by?

**Dr Bennett:** Some?

**Q184 Rosie Cooper:** But if any Willing Provider will be knocking on your door the day after, how are you going to deal with it?

**Dr Bennett:** We will have to set priorities. We will have to decide which things we are going to focus on first—which are most important.

**Q183 Rosie Cooper:** But how do you address the point that Dr Singer just mentioned, that newcomers to the marketplace have no pedigree?

**Dr Bennett:** That is an example of the way you might want to tackle it. You make sure that everyone is making their own fair contribution to training costs, exactly.

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things like training—the kind of things I was talking about, complexity?

Dr Bennett: If you take the level playing field issues, what it may mean is that, in so far as there are some advantages and disadvantages today in the system, they will remain for a while until we can get round to dealing with them.

Q185 Rosie Cooper: Absolutely, but an Any Willing Provider coming along and knocking on your door—but knocking on the wrong door because you are not working on that bit at the minute—may look as if they are competing on cost or quality and get through. But when you then come later to analysing it to the same degree, you will find that they are not providing the same things.

Dr Bennett: On the quality front, that is absolutely for the mixture of CQC and the commissioners. I can’t see circumstances in which they will be providing fundamentally different quality. They have to provide what the commissioners want. What might happen is that a private sector provider may say, “We think we have got a cost disadvantage because our pensions aren’t being subsidised”, or whatever they think is the source—that is a common one that the private sector will mention. We will say in due course—

Q186 Rosie Cooper: But they may not be contributing to training.

Dr Bennett: And that’s what the public sector would say and we would say, “That’s the way it has been for quite some time and that’s the way it is going to stay until we are able to take a considered view about what the real situation is and what we can do about it.” If, in the meantime, they are, nevertheless, willing to provide the service, then that is good. Even if they feel they have a cost disadvantage but they are still willing to provide the service—

Q187 Rosie Cooper: But then they have a major advantage.

Dr Dixon: If it is the other way, they could make a windfall.
Dr Bennett: They could make a windfall today.
Rosie Cooper: Exactly.
Dr Bennett: So our objective over time ought to be to address these issues.
Rosie Cooper: But how long—
Chair: We are already on borrowed time and we are unlikely to resolve this issue before people—
Q188 Rosie Cooper: How long do you think that “over time” would be?
Dr Bennett: My key point is that it is us fixing issues that already exist today. It is not that we are creating new issues.
Chair: Thank you very much. That was an interesting and useful session. The story will run.
Tuesday 8 March 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Yvonne Fovargue
Andrew George
Chris Skidmore
David Tredinnick
Valerie Vaz
Dr Sarah Wollaston

Witnesses: Dr Peter Weaving, GP commissioning lead in Carlisle consortium, Christopher Long, Chief Executive Officer, Humber cluster of primary care trusts, Dr Deborah Colvin, GP, Lawson Practice Hackney, gave evidence.

Q189 Chair: Ladies and gentlemen, thank you very much for coming. Welcome to the Committee and welcome in particular, if I may say so, to Dr Colvin. We visited Hackney, enjoyed the visit and look forward to hearing what you have to say further, as well as your colleagues on the panel. Could I ask you briefly to introduce yourselves and then we will get the evidence session underway?

Dr Colvin: I am Deborah Colvin. I am a GP in City and Hackney PCT.

Christopher Long: My name is Chris Long. I am the Chief Executive of NHS Hull. I am now—since last Thursday—the Chief Executive of the Humber cluster of primary care trusts.

Dr Lovett: I am Margaret Lovett. I am a GP and acting chair of the NHS Hull consortium.

Dr Weaving: I am Peter Weaving, co-chair of the Cumbria Senate consortium.

Q190 Chair: Thank you. I should have said to you, Dr Weaving, welcome back to your second session with the Committee.

I would like to open the discussion, if I may, with a fairly general question which relates to the three health economies represented here. I would ask you to identify what you think are the key differences, and equally the key similarities, in the world before this Bill process started and the world that will result from the implementation of the various proposals that are now being worked through. In other words, what difference is all of this going to make in the context of your own local health economy? If I may, I would like to start with Hull and then move to the other two. What are the key differences and similarities?

Christopher Long: Thank you. We have got a bit of phasing, haven’t we? The first phase is how we move between now and 2013. The real challenges there, as we manage that transition, are, first of all, the loss of quite significant numbers of staff in the primary care trusts. I am losing about one quarter of my staff over the next four weeks to redundancies, to achieve the management cost reduction targets, and we are going through an exercise that feels like we are getting rid of the bureaucrats but we are not minimising the bureaucracy as a consequence of that. So I have some concerns about how we manage upwards as we move through the transition.

Then there is how we work with general practitioners locally to develop them to get ready to take this over, and I have confidence in that because we have a good group of engaged GPs working on that particular agenda. And then there is the macroclimate we are working in. Pressures are starting to emerge in providers due to reductions in the tariff and some of the inflationary pressures and the fact that our local authority has had to reduce its budget by £76 million this year, nearly 25% of its total revenues. There is a real challenge there as we move through. The next bit, having got to 2013 and the point where the GPs are leading, is: what is the net difference going to be on top of if we hadn’t done anything? That is the great unanswered question. I will be looking forward to watching that as we move through into the next election.

Q191 Chair: That is, in a sense, the core question I am asking, trying to separate out the changes that are coming because of resource pressures—which we refer to as the “Nicholson challenge”, which is something quite outside the legislative process—and how much is changing as a result of the legislative process. One thing you said that I latched on to was that we are reducing bureaucrats without reducing bureaucracy.

Christopher Long: Yes.

Q192 Chair: That is not necessarily good news. The other was your comment about your work with the GP community, and I wondered as to the extent that was work going on anyway and whether it is going to end up in a different place from where it would have done if this legislation had not been proposed.

Christopher Long: Yes. Inevitably, as we move through change in a period like this, we are going to see an increasing and tightening central grip on things. That is completely understandable. There is a huge amount at stake as we move through the transition. We had very good engagement with GPs anyway; we had very good GP leadership; we had a devolved locality model in Hull, where we had three localities chaired by general practitioners—and Margaret was one of those—and we had a lot of clinical involvement, in both primary and secondary care, in terms of designing the goals and our actions for our strategies. I don’t think we are going to see a significant increase in the amount of clinical engagement in the short to medium term as a consequence of these changes over and above where
we were already. I accept that Hull might have been a bit further ahead of some others in that particular regard but by so much! When we see a range of performance across 152 primary care trusts now, I think we will see a range of performance across 200 to 300 commissioning consortia in four or five years' time.

Q193 Chair: Would Dr Lovett like to comment?

Dr Lovett: Yes. The change that there might be is more interaction between primary and secondary care, which there hasn't really been, for the simple reason that, if we are going to make any changes, it is that communication between primary care and hospital doctors which will make the difference.

Dr Weaving: I would like to start by going even further back. Ten years ago I was the executive chair of a PCT, a PEC chair, and there we basically ran community services. We did no realistic commissioning. In Cumbria we have had a journey of three or four years of realistic clinical engagement in commissioning, gradually increasing over that time. We are now at the situation where, in a way, I don't want to see big changes occurring in the next year or two. I want to see a continuation of the journey we have made whereby I can sit down with colleagues in secondary care and say, "This is the patient pathway. This will get us the best deal. What do we need to do to put in place this commissioned service?", and then do it.

For me, that has been the real improvement over the last three for four years and that is what I want to see continuing—clinical engagement on both sides, primary and secondary care, with appropriate input from patients in terms of their experiences and also their preferences. That is how I would like to see this evolving in the future. The systems and structures, as described, provide a framework within which that can happen, but, at the end of the day, it is the engagement and the active participation of those clinicians which will be key to making it happen.

Dr Colvin: We have also been engaging very closely with secondary care and we have been able to make some changes. I don't know whether you noticed, in the Health Service Journal we were one of five PCTs in London that has reduced the number of referrals this year, whereas most PCTs the GPs have increased outpatient referrals. We have done that through working extremely closely with secondary care and it has been a lot of hard work. My worry is that this process is going to start to slow that down. As foundation trusts feel more threatened—as, no doubt, they will with decreasing resources—it is going to be harder for them to work with us. We are already beginning to see signs of that. Clinicians are saying, "I quite agree we could do this better this way, but what impact will it have on our income as a foundation trust?" I am worried that all the close clinical working may start to slow down, and that would be a huge loss to everybody.

My other worry, in relation to three or four years' time, is that I am very concerned about equity. In City and Hackney we will have two separate consortia. What are we going to do when the patients of those consortia have different quality services? I can't see how the general public are going to understand this and I can't quite see how it is going to benefit anyone. It is a National Health Service and all patients should have the same service.

Q194 Chair: Why would the emergence of two consortia lead necessarily to different levels of quality of care for their patients?

Dr Colvin: I have no doubt that different consortia will have different ideas about the best way to do things for their patients—and they may have very good reasons behind that—but if you have two people living in the same street and one consortia has a different offering on the plate it is going to cause a lot of difficulty.

Q195 Rosie Cooper: If I may, I will ask a general question of you all and then a particular question of Dr Weaving. How satisfied is each of you that your local health economy will be in financial balance by 2013 and that the consortia will not inherit debt?

Christopher Long: Hull will be in financial balance by 2013. There will be no inherited debt for the consortia.

Q196 Rosie Cooper: You are absolutely sure. What do you think generally? Do you think there will be a PCT, or clusters and consortia that are in difficulty?

Christopher Long: I think there will be difficulties. The fine line between being in recurrent balance and in recurrent balance because you have had to take additional non-recurrent means to get you to recurrent balance on a year-by-year basis is going to be where the debate is. The focus is very much on ensuring people are in financial balance and—not in Hull, I am pleased to say, but in one or two other places—they might have to do some fairly unpalatable short-term things to achieve that.

Dr Colvin: We have a £30 million gap to reconcile in City and Hackney, and that is going to mean some dramatic changes in what we can offer. We are in a better position than some neighbouring PCTs, but, again, I worry about the effect of PCTs with big hospitals that have been built with PFI and have those huge costs to deal with. I don't quite see how that is going to pan out and how the citizens living in those boroughs, if we are going to get rid of the overspend, will get the same level of health care as those where there isn't a PFI going on.

Q197 Rosie Cooper: I am putting you on the spot, but I don't wish to be difficult. How do you see that £30 million in terms of the difference in patient care? How do you think you are going to really address that?

Dr Colvin: We are going to have to address it by looking very closely at the things perhaps people can't have. That is what worries me every time you hear politicians talk about "patient choice". If you are somebody with problems of infertility and you want to have as many goes as you can for treatment, that is your choice. But how are we going to fund that? We

1 Note by witness: I want it to be made clear that this is £30 million over the next three years, not just for this year. I'm sorry I didn't make that clear at the time.
are not going to be able to. We are going to have to say, “No. You can have two goes.” We are going to have to make those decisions.

Q198 Rosie Cooper: Are there any other others you can think of that would probably be at the forefront of that rationing? Dr Colvin: Personally, I think we should look very closely at prescribing. Probably we could save quite a lot of money on prescribing.

Q199 Rosie Cooper: Saving money on prescribing is not necessarily a bad thing, is it? Dr Colvin: No, it isn’t, but, again, it is having that public debate with the nation and saying, “What is important to us all?” We can’t all have everything all the time. We have to make choices. Patient choice doesn’t mean getting what you want. It means getting what is important.

Q200 Rosie Cooper: From a narrower field. Dr Colvin: I think generally.

Dr Weaving: We will have a gap at the end of this year, not a big one but a definite gap. We have a plan that we will have no gap by 2013. For me, the more important question is why the gap has arisen rather than starting 2013 with a level playing field of financial balance. That is no use to me if the issues within the organisations that are going to take me back into financial deficit are still there. I would be more concerned about finding out what the underlying issues are rather than what the balance sheet says at the end of the year.

Q201 Rosie Cooper: Have you any idea what that imbalance will be at the end of the year? Dr Weaving: At the end of this year it will probably be about £6 million.

Q202 Rosie Cooper: Dr Weaving, if you look back, Cumbria has done really well. Can I ask you where you think the Cumbrian economy would have been if you had not had what I would see as considerable external support in the past? Could you have got to where you are today without that influx of cash? Dr Weaving: Almost certainly not. That influx of cash, right at the beginning, enabled us to put in place some fairly radical plans for a whole close-at-home plan for improving the health economy. The challenges of Cumbria, as I am sure you are well aware, are about rurality and deprivation and the diseconomies of scale in trying to provide district general hospital services from three sites for a population which would support one. If you want to make ends meet and provide good quality services for patients, you have to make it run extremely efficiently. That means quite small, very effective, efficient DGH’s and very good community services to provide as much out-of-hospital care as possible. You also have to make sure that your primary care services are very focused on admission avoidance, good prescribing and sensible referring. What we have seen over the years, with that support, is reductions—¿

Q203 Rosie Cooper: You are making my point really. Cumbria is considered to be superb. It is well-quoted and all the rest of it. For that to happen, you had external support. But in the health economy generally, other areas are being asked to do that under the weight of the Nicholson challenge and everything else which will not have that external financial support. How are they going to do it? Dr Weaving: I would say our Nicholson challenge arrived four years earlier and that is because of the diseconomies we have.

Q204 Rosie Cooper: But you had that financial support to help you do it. Dr Weaving: Yes. How the—

Q205 Rosie Cooper: Everywhere else is not going to get that pump priming, if you like, to get them going. Dr Weaving: Agreed. To go back to Deborah’s point about “Where is the money in the system?” the money is in the system. It is not in management costs. It is in what we already do in terms of our health spend—the prescribing, the admitting emergencies and the referring of patients. There are huge sums of money within that.

Q206 Rosie Cooper: I don’t disagree. The problem is how other parts of the health economy are going to get to the point where you are without that input of money. At the moment everybody is struggling, money is coming out and they will not get that pump priming. But I would also like to go on to ask you this: you are in a reasonably good position now, with a possible £6 million gap at the end of the year, what do you think will happen in Cumbria if GPs take more and more work out of the acute sector without having an agreed plan with the hospitals so that you can sustain what is acute care, essentially? Dr Weaving: If you did it in an unplanned way, without complete sign-up with your secondary care colleagues, it would fall over.

Q207 Rosie Cooper: We are already hearing that foundation trusts and people are very worried about income. You may have a willingness to achieve an aim in the future with the trust not able to engage in the way they would like because, if they do, there will be continuing costs being taken away from them and they will fall over. Dr Weaving: Yes. It is a very adult conversation between primary and secondary care and the public about “This is the amount of money that’s available. For you to survive as an organisation”—a hospital or whatever—“you need this amount of money coming in. We want these services to be provided from you.” The discussion, which is the core of this whole process, is about how you make that work. I have that discussion with my colleagues in secondary care with appropriate expertise, in terms of financial, intelligent support and so on, and with the full understanding of the public.

Q208 Rosie Cooper: With an acute trust, the system is designed so that it will be there and be financially viable, ergo Monitor, or it will not be. If it isn’t, it
will either be taken over or it will not be there for the
people. Are you really saying to people, “Choose. You
can have me, your GP, or an acute hospital which is
not 20 miles away but 40 or 50 miles away”? Is that
what you are really saying?

Dr Weaving: No. What I have said to the people of
Cumbria is that I guarantee that, as a GP
commissioner in Cumbria, they will have their district
general hospital where they want it, which is in
Carlisle and is in Whitehaven. I have said that.

Q209 Rosie Cooper: But what if the money doesn’t
add up?

Dr Weaving: The money does add up and the
close-to-home plan takes us there.

Q210 Rosie Cooper: You are sure that you have an
agreed plan for the future of acute services in
Cumbria.

Dr Weaving: Indeed, and I sit down on a regular basis
with my secondary care colleagues.

Rosie Cooper: That’s cool. We will revisit that one.

Q211 Valerie Vaz: The picture that is emerging so
far is that there is lots of good work going on, and
you don’t really need this disruption as GPs and
commissioners, et cetera. My specific question—and
I have heard from Dr Weaving and I met Dr Colvin—
is really designed for Hull. You must be doing
something right because you came top of the league
in World Class Commissioning in 2009–10. Why have
you not joined the pathfinder process?

Dr Lovett: As a consortium, we didn’t see that there
were any advantages to being a pathfinder. There
certainly weren’t any advantages to patient care
to make us be a pathfinder. Ours is a fairly disparate
group of GPs with not everybody jumping, waving
their flag about and wanting to sign up and do things.
The GPs leading the consortium want to do it in a very
considered fashion and let somebody else’s patients be
the guinea pigs first.

Q212 Valerie Vaz: The other specific question to all
of you is: in this brave new world that we are heading
for—do we know what is going to happen at the
end of it—i.e. who is making the decisions about
population medicine versus the individual patients?

Dr Colvin: That is a very good question. It is a
question I am sure we all think about a lot because,
of course, we are constantly faced with the dilemma
of what benefits the population as a whole. The
benefits to the person sitting in front of you may be
so tiny that you could argue whether it is beneficial or
not. We have to make those decisions all the time with
patients and I’m not sure we always do it very well.
I’m not sure how you marry the two up because if
you ask the public—if you ask the person in front of
you, “Do you want this for yourself or not?”—their
answer will be very different from what public health
tells us would be good for the nation. It is a very
difficult dilemma. As GPs who have always worked
with the patient in front of us, and are their advocate,
shifting to saying, “That might be good for you, but
for all of you in this area it’s not good” is going to be
hard. The way we are going to have to do it is to make
sure we have the public working with us on this so
that these decisions are shared.

Christopher Long: I will give a slightly different
answer. World Class Commissioning, at one level,
didn’t have a lot of fans. But what it did do was bring
an awful lot of structure and rigour to the way we
work that I thought was quite helpful. We worked very
closely with our colleagues in primary care, and
indeed in secondary care, as we identified what the
big killers are in Hull and how we address those. We
also established a membership model, which is like
but better than the foundation trust membership
model, for people in Hull. We have about 8,000
people signed up as members out of the city at the
moment. We went out and did a very big consultation
with them. We went to one in six households across the
city to find out what their priorities and aims were.
That helped us to build a strategy in Hull, which, for
those of you who don’t know, is an area of very
uniform, high levels of deprivation. We are the
eleventh most deprived local authority in the country,
which is not a badge I wear with any pride.

If you look at the pathway we are commissioning,
which is about prevention, detection, diagnosis,
treatment and ongoing care, we were able to target our
investments in those areas in a way that will bring
about a good impact. It is an impact that people told
us they wanted, that was coherent to professionals
and practitioners, both in primary and in secondary care,
and which had some science behind it in terms of the
lives it would save and the morbidity it would reduce.

As I say, in that respect, by bringing rigour to the way
that we worked, World Class Commissioning has been
helpful. You don’t need to revisit that every year
because you have a five-year strategy lined out which
has an accompanying investment plan to make it
work. That is one thing I would hate to see lost in this
change. In particular, I would hate to see that lost in
the kind of fragmentation of commissioning that we
are going to see, with some of it going to local
authorities, some to the Commissioning Board, some
to Public Health England and some staying with the
GP consortia. It is about how you can continue with
that incoherence in the future.

Dr Lovett: I agree with Chris. We have fairly common
problems that extend across the patch with regard to
depivation—people dying early from things like
cancer and ischaemic heart disease—and most of our
planning is done on those public health terms.

To get back to what happens when the patient is in
front of you, you make a decision each time. Usually
there are indicators you can call upon that would make
you think, “Is this person exceptional and therefore
exceptional treatment is required?”, and not just for
things like cosmetic surgery. GPs do tend to make that
decision bearing in mind the individual patient that
they are dealing with and tailor the treatment to that
individual patient. Unless somebody’s demands are
totally unreasonable, GPs can fit patient demand in
with the greater public health initiative.

Q213 David Tredinnick: I want to ask this to Mr
Long. When you did your patient survey, which is
very interesting, and you came up with this
preventative care programme, did you ask them what
types of treatment they would like or did you just ask them what their problems were, please?

Christopher Long: It was more focused on what their problems were and what they saw as the priorities.

The thing that emerged, and the thing we always have to balance when we ask that, is that we all know there is a great fear of cancer in the community but the number one killer in Hull is coronary heart disease. There is something about how we tease out those answers and how we then balance that across.

In terms of the treatments, we didn’t go down the line of “Would you rather we fluoride the water or have seven cycles of IVF?” We didn’t think that was appropriate for the work we were trying to do, which was fundamentally about reducing mortality in the city.

Q214 David Tredinnick: The Government has put some emphasis on choice, and I wondered how you were addressing that. That is my last question.

Christopher Long: It is about choice of who treats you rather than choice of where you go. Hull is a very isolated community. We have about 32 square miles of city surrounded by thousands and thousands of square miles of green. People don’t want to go anywhere else. They want to have high quality services on their doorstep that are accessible to them and suit them. That is the main choice they would exercise.

Q215 Dr Wollaston: Could I return to the wider issue of clinical engagement, which the panel have touched on at some point? I am wondering if all of you could clarify whether, in your local area, practice-based commissioning has engaged with nurses and secondary care and, if so, what benefits that has brought. Furthermore, are the provisions under the Health and Social Care Bill going to help or hinder that engagement in each of your areas?

Dr Lovett: Practice-based commissioning made us engage enormously. The work we have done within our PBC organisation has been very exciting. We have involved members of the public, nurses and practice managers and we have a liaison committee with the hospital. We have done an enormous amount of work with them. As you know, we have rewritten a lot of pathways and we have consultant advice lines. It has been very constructive.

We are just setting out on a piece of work to look at urgent care and GPs working in A&E alongside the consultants and learning from each other. It has been wonderful. But, as I said to you before, my real anxiety now, as the foundation trusts feel the pinch and become threatened, is how easy it is going to be for them to continue. We had a very interesting discussion with the gynaecologists about the value of some of their follow-up appointments and whether or not they needed to see the patients after certain procedures. We discussed whether it was necessary or not, but they did then say, “If we stop, what is going to happen to the department? How much can we take?” I know we can think creatively about it and we can think around, “If we freed up resources from this area you could move that money into something more effective”, and that is absolutely true. I think that is what you were saying, that there is money in the system and we just need to use it better.

To a certain extent, what politicians have not said out loud to people is, “If you do this—if we are really careful about how we use the money and we use it appropriately—there has to be a loser somewhere.” If our local hospital stops doing lots of unnecessary outpatients and things like that, and they can offer their services more widely to other boroughs, somewhere out there is going to be another hospital which is losing. Somewhere out there, eventually, one hospital is going to become financially unable to continue. That may be appropriate. It may not. But that is the consequence. We have to be honest about where it is going. There is money in the system but we need to spend it in a better way and there will be winners and losers.

Dr Lovett: With regard to engagement of other partners, in the localities we had practice nurses, optometrists, dentists and pharmacists. They all had a say on things that went on in the locality. As a small consortium, we did work with long-term conditions to reduce the COPD re-admissions. That worked quite successfully. It was mainly, obviously, working with secondary care clinicians, but the COPD thing was run by the long-term conditions nurses. We also set up a community DVT service to reduce emergency admissions—just for DVT. That was run by a nursing team. Obviously, we work very closely with the nurses for palliative care so that people can choose to die at home, with support.

Q216 Dr Wollaston: To summarise, there is a wide range of clinicians involved at the moment. In the future, do you see that getting worse or better?

Dr Lovett: I would hope it would get better. Certainly, on the consortium board we are going to have a practice manager and a practice nurse and invite in other clinicians as required for specialist topics. A lot of it is working more with the consultant. We have tended to all be in our silos busily getting on with what we have to get on with. It is that—communication—which has created the problem and that is why pathway development is important. It is hospital doctors and GPs getting their heads together that is the key.

Q217 Dr Wollaston: You see it happening on an informal basis, that, as a consortium, you would invite secondary care colleagues and consult with them but not have them—under the arrangements you can’t have them—on the board with you.

Dr Lovett: We haven’t firmly decided if there will be a hospital representative on there, but we would invite them to do pieces of work in a specific area.

Dr Weaving: Before answering the question about clinical engagement, could I return to the very important point about the potential loss of public health in GP commissioning? What I have learnt over the last few years—and we are blessed with Professor John Ashton who has turned us, the GP commissioners, into a group of very public health-minded commissioners—is the old adage about “The swamp is full of crocodiles. Keep shooting the crocodiles.” The crocodiles in Carlisle are that
person every other day dying of lung cancer. You can continue to fail to treat those or you can go upstream, in a public health sense, and do something about smoking cessation and other issues. If anything, GP commissioning has driven me closer to public health and not further away. I appreciate that there might be a separation of organisational structures around public health but, very definitely, we see the future as being very closely aligned with the public health agenda. Basically, the lifestyle choices we make are the most significant factors that we need to influence to improve our health in the future. We will still need some hi-tech medicine, but, realistically, if we want to improve health it will be at the preventative end of the agenda. As to clinical engagement, none of this works, as I said before, without clinical engagement. We have had two years of largely GP-focused clinical engagement, with developing links with secondary care which have become strong. In spite of quite significant organisational changes, between us we have maintained very good clinical links with our secondary care colleagues. On a locality basis, we have opened the fold wider and we now have the other health professionals involved. We have learnt, to our cost, that if you don’t involve a practice manager it doesn’t matter what the GPs say about what their practices will do. You need the practice manager, the practice nurses and the community staff and you need to have a dialogue and realistic involvement with all of those in the way you are planning services and taking the agenda forward. Clinical engagement is key and it does need to be in a broad church.

Q218 Dr Wollaston: The Royal College of Physicians is calling for mandatory involvement of secondary care clinicians in commissioning. I am wondering whether you see there are advantages and disadvantages in that.

Dr Weaving: I would say, almost by definition, you will not get mandatory engagement. If you legislate for it, people might tick the box. But it will not happen.

Q219 Dr Wollaston: Do you think it is best to do as you are all suggesting already happens, that, de facto, no one is going to be able to commission without involving them?

Dr Weaving: Yes. Everybody needs do it but it needs to be realistic, people sitting together saying, “These are the best clinical pathways”, “This is the most cost effective”, “This gives the best patient outcomes.” How you put that into legislation to make people do it, I don’t know.

Dr Colvin: I would also say to the Royal College of Physicians, “In that case, let’s have mandatory GPs on foundation trusts.”

Dr Wollaston: Yes.

Q220 Chair: Would it be fair to regard this as part of the standard operation of a good consortium for which the consortium should be held to account by the National Commissioning Board?

Dr Colvin: Yes.

Q221 Chair: I say that with the representatives of the emerging Commissioning Board sat behind you, but is that a fair description of how you think the consortium relationship should evolve or not?

Dr Weaving: They need to demonstrate realistic engagement.

Q222 Dr Wollaston: Do you think that is something that should be looked at by the Commissioning Board when they are reviewing performance?

Dr Weaving: Yes.

Dr Colvin: I absolutely agree and we have done that, but I would also say that for many years there has been a balance of power which has been very much on the secondary care side. GPs do need to be able to make their voices heard and secondary care needs to work with us, not feel that they are running the show.

Q223 Chair: Do you think there is a risk in these arrangements, which clearly put primary care in the driving seat of the clinical engagement process, in some parts of the primary care community that this would lead them to place inadequate importance on their relationship with the rest of the clinical community?

Dr Colvin: Yes, I do.

Q224 Chair: If so, how do you think that should be addressed?

Dr Colvin: I do, absolutely. It is difficult, isn’t it? How are we going to make sure that we are safe and appropriate? At the end of the day, always, you have to think about patient safety and them getting the care they need. That has to be at the centre of everything, and I know it is for everybody. But, you are talking about GPs. GPs are like anybody else. They are like MPs. There are good ones and bad ones.

Chair: It’s nice to know there are some good MPs.

Andrew George: Yes. Perhaps we could name them.

Dr Colvin: We have to have some system to make sure that consortia can’t go wild and harm patients. We do need secondary care looking in and helping us do that.

Dr Weaving: There is no harm in having the GP at the centre of that conversation because they are quite useful in the sense that they know what happens to their patients. People talk to them all the time about their experiences of services. If I am going to change a service, let us say, a cardiology service, I would want the advice of a cardiologist. I would also want the advice of a financial expert and a public health expert. But in terms of sitting in the middle, it’s not a bad place to be.

Q225 Dr Wollaston: But how are you going to prevent the rogue consortia, if they do emerge, from not consulting? How would you write that into the Bill?

Dr Weaving: I would say that a consortium which did not consult would not work. It would not be able to operate.

Q226 Chair: It comes back to the relationship with the Commissioning Board—quaere?
Dr Weaving: It depends what the Commissioning Board puts in place to monitor things which, in some ways, are as soft as professional relationships.

Christopher Long: It comes back to how the whole regulatory framework is going to operate in this regard. To talk about clinical engagement is important but, in terms of secondary care, those clinicians are employees of a business entity called “The Foundation Trust” or something else. There has to be a mutual relationship, not just on a clinician-to-clinician basis but organisation-to-organisation as well, so that commissioners are aware of the impacts of their actions on their supply chain. There has been quite a lot of debate about the impact of the market—is it good or bad— in terms of this, but I think it is much more about supply chain management than market management when you are a commissioner. If you are an effective supply chain manager and you are working with your supply chain to develop it to ensure that you are getting a good quality product and to ensure you are getting productivity gains out of your system, you are not working just to screw them down to the last penny. Unless you have the willing sign-up of the organisations and of those working in them who are responsible for those pathways, it will not work. There is something not only about how the Commissioning Board regulates the commissioners but about the relationship between the Commissioning Board and Monitor, where the early warning signs are in that too so that we can have this mutual alert system going on across the entire system, as opposed to in segments of it.

Q227 Chair: Thank you. We need to move on, but Andrew has one question to ask about referral.

Q228 Andrew George: I am interested about a practical nuts-and-bolts aspect. When you are referring patients on, to what extent is that informed by the budget that is available?

Dr Lovett: Basically, if a patient comes to see you and they need referring, you will refer them. If you don’t, you risk being sued. You don’t refer people for fun.

Q229 Andrew George: No. Okay, I wanted an indication as to what kind of signals there are to GP practices with regard to the available budget and your general referring patterns. I wanted to find out to what extent those referrals, those decisions, are informed by the financial consequences of those decisions taken, because they are decisions to refer and not, if you like, automatic actions, are they?

Dr Colvin: It is slightly more complicated than that. You could refer the patient on or you could say, depending on what the problem was, “I will work this patient up. I will do the work.” That is what is difficult. There is a whole grey area of conditions where, traditionally, GPs referred patients to hospital that they were perfectly capable of looking after themselves. There are things which, as you said, absolutely you have to refer to hospital because they need to be looked after in hospital. I don’t think cost would come into it and it would never enter my mind to think about it. But there are a number of cases where I think, “I could do this myself” and it takes a lot of time and resources. What we have been trying to do with our work in our PBC consortium is to develop ways of doing more in the community so that we are referring less. But somebody has to do the work. We are not saying to the patient, “We will just do nothing.” The decision for me, sometimes, is almost, “Have I got the energy to do what I need to do?” “Does it make sense for my practice for me to be spending all this time doing this when I could refer them?” It is quite complicated.

Q230 Andrew George: Do the existing referral management arrangements that most PCTs have in place, as well as the choose and book systems that exist, help? Do you think that that helps GPs to inform them in terms of the decisions that they are taking, because often you are overruled by that management system?

Dr Colvin: We don’t have referral management systems.

Q231 Andrew George: You don’t have them?

Dr Colvin: No, we don’t. We have reduced our referrals without that.

Q232 Andrew George: None of you?

Dr Weaving: We don’t run a referral centre where a GP cannot refer a patient to a consultant specialist without going through a separate system. What we have put in place is a very robust system of education, best practice and evidence-based referrals. We have support in each practice so that each practice is aware of how it behaves as a practice using the finite resource that is available. It is basically trying to make clinicians aware of the financial consequences of their actions and also to get the best practice in place. We benchmark practices against each other. They know how they perform in this arena, as with everything else they do, whether it is emergency admissions or prescribing behaviour. There are reasons, some of which are driven by the needs of their patients and some of which are driven by clinician behaviour. My role as a GP commissioner is to tease out which are the ones which represent good practice and which are the ones which indicate an area that needs more support.

Q233 Andrew George: In terms of the referral process itself—both now and presumably as you see it in the future—it is one in which the only way the budget comes into play is purely in retrospect. You have retrospective information which informs you and which guides you as to what would be an appropriate pattern of referral if you are to meet your budget target. Is that right?

Dr Weaving: Yes. Almost by definition, you have to measure it retrospectively. Demand and behaviour are remarkably static, so you can see relatively early on where the hot spots are going to be and take appropriate steps to try and improve that situation. The intelligence is already there. The key is to take it
back to the individual clinician because, as Dame Barbara said 10 years ago, it is the doctors that are spending the money. They are making the referrals, prescribing the drugs and admitting the emergencies and they need to have a good understanding, and the GMC now specifies that it is a requirement of a good clinician that they make appropriate use of resources. All we are doing is giving them the information and the intelligence and benchmarking them against their peers in a non-anonymised way so they can see how they are doing.

Q234 Andrew George: Does the existence and availability of patient choice to any extent at all interfere or destabilise that process?  
Dr Weaving: We are looking at the number of referrals going wherever. We are not interested in where the patients have chosen in that aspect of the commissioning.

Q235 Andrew George: What proportion overall, from your experience, take advantage and become assertive in respect of their own entitlement to patient choice? Is it a persistently small proportion or is it used to a large extent, in your experience?  
Dr Weaving: I have no problem with people asserting their authority on behalf of their patient. Being a patient advocate is absolutely their role.

Q236 Andrew George: No. I mean the patient themselves asserting their entitlement to patient choice.  
Dr Weaving: It’s a spectrum of human nature.

Q237 Andrew George: Does it happen a great deal?  
Dr Lovett: It does happen, but certainly in Hull it is only a small percentage of people who come in and say, “I want referring for x, y and z.”

Q238 Andrew George: Is it less than 5%?  
Dr Weaving: Yes. I would say less than 5%.

Dr Colvin: Yes.  
Dr Weaving: Indeed, one of our referral criteria is either extreme anxiety or concern from the patient that they wish to see a particular specialist even if it is not clinically indicated. That is a reasonable reason for referral.

Q239 Chair: Could I ask, as a question of fact, whether Hull uses centralised referral management, or do you rely on similarly decentralised—  
Christopher Long: It is similar to the Cumbrian model.

Chair: Thank you very much. I would like to thank all four witnesses for your attendance. We have a lot to think about. You have contributed some more. Thank you very much.

E xamination of Witnesses

Witnesses: Sir David Nicholson, KCB, CBE, Chief Executive, NHS and Chief Executive-designate, NHS Commissioning Board, Dame Barbara Hakin, DBE, National Managing Director of Commissioning Development, Department of Health, Tim Rideout, Director of Commissioning Board Development, Department of Health, and Ben Dyson, CBE, Director of Policy, Commissioning and Primary Care, Department of Health, gave evidence.

Q240 Chair: Good morning. Thank you for coming and for sitting through the previous evidence session. I suspect you don’t need introductions but, for form’s sake, briefly introduce yourselves and explain the position you hold in the Department.

Tim Rideout: Good morning. I am Tim Rideout. Subsequently, I am Chief Executive of NHS Leicester City, but my current position is supporting the development of the NHS Commissioning Board.

Dame Barbara Hakin: I am Barbara Hakin. I am the Managing Director of Commissioning Development in the Department of Health.

Sir David Nicholson: I am David Nicholson, NHS Chief Executive and Chief Executive-designate of the Commissioning Board.

Ben Dyson: Good morning. I am Ben Dyson. I am Director of Policy for Commissioning and Primary Care in the Department of Health.

Chair: Thank you very much. Before we get into questioning about the detailed proposals and evolution of policy, Dr Wollaston has a general question that she would like to put.

Q241 Dr Wollaston: Could I ask Sir David a general question, because I was looking at the written evidence that we all received—the CFI 01 document—from the Department of Health? It refers to the consistency of the message since the general election and reports that the Bill has been the outcome of a “process of consultation, engagement and discussion”. I am interested to know, therefore, how you feel it is that we have seen support from the professions ebbing away over the course of the Bill?

Sir David Nicholson: I think I understand the question. Inevitably, in something of this scale, the devil is often in the detail. It is only when people understand the detail that they can start to contribute properly to that debate. Whistl the discussion, initially, was on broad principles, now we are getting into the detail of it. It is an incredibly complex and difficult set of changes and issues to take forward. My guess is that, while we are going through all of that, people, inevitably and quite rightly, will start to raise the whole series of concerns they have about the detailed implementation of these arrangements. I am pretty satisfied that, overall, we are making good progress on that. If you look across the NHS as a whole, the NHS is now moving much more to a place where they are thinking about, “How can we make these things work?” as opposed to “Let’s have a debate about whether they work or not.” It is a natural consequence of the kind of changes we are trying to make.
Q242 Dr Wollaston: For example, would you describe the fact that Monitor takes such a central stage in the Bill as a detail?

Sir David Nicholson: No. What I do say—and I may have said it at the original hearing—is that people were focusing all of their attention on the commissioning side when, in my view, it is the provider side which is much more radical and much more far reaching. This is a reflection of people getting to understand that the provider side of the changes, in my view, are very radical indeed.

Q243 Dr Wollaston: You think it is the provider side that has caused the loss of confidence from the professionals.

Sir David Nicholson: I couldn’t explain the view that you describe about the profession. Certainly, in all of my dealings with the leaders of the profession and people in the system, people are raising issues but they are determined to make it work as well. The provider side is quite a big set of changes and, as people understand it, they will understand the nature of the impact of the Bill.

Q244 Valerie Vaz: I am sorry, but we had a discussion about this right at the beginning. The Select Committee told you, when the White Paper was coming up, that there are going to be problems. We asked if pilot studies had been done and you said no. I am confused, in terms of public money being spent on all this, as to why you feel it is okay to bring through a Bill where we highlighted issues and concerns.

Sir David Nicholson: I am sorry. What I said initially—and I think it is the case—is that if you look at the major planks of the change, so if you look at GP commissioning, we have a lot of experience now from fund-holding to practice-based commissioning. We have quite a lot of experience, as you have heard this morning, about where people have gone on that journey and we can build on that. We know, in relation to the provider side, the development of foundation trusts, that we have a lot of experience now of developing foundation trusts and having them work and operate and we can learn and build on all of that. If you take the other issue, which is contentious, the Any Willing Provider element of the changes—

Q245 Valerie Vaz: The privatisation part?

Sir David Nicholson: No, the Any Willing Provider bit of it. We have quite a lot of experience of that as well, because, certainly in the last two or three years, patients have had free choice of any NHS organisation and 127 private sector organisations to choose for elective care. We have built experience over the last few years in all of these areas. It seems to me that building on that is a safer way of taking it forward and that is what we are trying to do.

Q246 Valerie Vaz: Not quite. There are £80 billion going to GPs, which wasn’t the case before. You can’t say that you are building on that. In fact, we did tell you that there are some good areas, like Cumbria and Hull. They are good areas of practice. Why didn’t you just build on that?

Sir David Nicholson: We are doing.

Q247 Valerie Vaz: No, you are not.

Sir David Nicholson: That is precisely what we are doing. If you look at the timetable, it isn’t until 2013 that the individual consortia—not GPs, but the consortia—will get the resource. They certainly will not get £80 billion, because obviously—

Q248 Valerie Vaz: We will come on to what you do know about what is going on and what is going to happen in 2013.

Sir David Nicholson: I’m sorry, I don’t understand the point.

Q249 Chair: I am not sure that that is gathering evidence, Valerie. Can I suggest we break off that line of questioning there?

I would like to bring you to this question of what happens, on 1 April 2013, to the £80 billion. Sir David was quoted in an interview a couple of weeks ago saying it is not accurate to say that the consortia will be left to their own devices to work out how to use this £80 billion with effect from 2013. You have made it clear, Sir David, that you expect, or you intend, as the Commissioning Board, to put in place an assurance regime around approval of these consortia to ensure both that the financial controls are in place and that the quality controls are in place around health care delivery and around the commissioning process itself. I would be interested to hear how you envisage that process being developed. Will it look similar to the process that Monitor has, up till now, enforced in the approval regime for foundation trusts? Is that the kind of process you have in mind, and an important process point, given that PCTs are going to be abolished, as the Bill is currently drafted, on the date of 1 April 2013? What happens in areas where this assurance regime concludes that the emerging consortia are not yet ready to exercise the powers anticipated for them?

Sir David Nicholson: I am sure Barbara will talk about the details of the authorisation process, which is what you have described, but can I say a couple of things in response to that? First, from now on we expect GPs and the developing consortia to be engaged and involved in all of the financial, organisational and service planning going on in the system. Indeed, the planning process we are going through now across the NHS, as a whole for 2011–12, in some parts of the country has significant involvement, to the extent that the pathfinder consortia and members of the consortia are signing off individual plans. We will build expertise and knowledge over the next couple of years to enable people. It is not a kind of “Suddenly there’s no responsibility and then suddenly there is.” It is not a cliff edge in that sense. That is the first thing I would say.

It is quite a different process from foundation trusts, for one obvious reason. What we don’t have is several years of trading of an individual organisation before you can make the judgment. We don’t have that. Quite a lot of it is going to have to be based on perspective. Obviously, it is going to be based on the experience
people are having over the next year or so, but thinking more about the way they organise themselves and the way they plan when they have got themselves ready. So it will be slightly different.

The other thing we want to make different is that we want it to be much more clinically relevant to the responsibilities of the consortia as they go forward. For example, I would like to see, as a principle, a 360° part of the process so that patients—patients' voices—local authorities, secondary care clinicians and other clinicians would be able to have their say in relation to the authorisation of that organisation. That is a very different and much more open process, it seems to me, than perhaps we have had in foundation trusts in the past. Barbara can give you the details.

Dame Barbara Hakin: Yes, I am happy to give you the details of that. If you wouldn't mind, I will add a comment after Sarah Wollaston's initial question about the profession because, with my background and the role I have at the moment, I spend a lot of time with the leaders of the profession trying to tease out some of these things. It does seem to me that the issues fall into one of three categories. There are some issues where there is a genuine disagreement of policy intent, but we think those are very few. Talking to the leaders of the profession, they agree on that. There are a lot of areas where it is simply that there is not agreement that the wording of the Bill makes things clear enough, which we are working together on, or simply that there is a misunderstanding, and I think Any Willing Provider is one of the areas where there is a genuine misunderstanding of what it is about. We shouldn't assume that about the profession. We have a lot of problems, but much of it is to do with misunderstanding. I felt I wanted to add that point.

On to authorisation—if I can echo what Sir David has said about the authorisation—first and foremost we want to look to these organisations to be absolutely sure that they can improve the quality of services for patients. The number one category is that they have a credible plan and the infrastructure to deliver continuous quality improvement through clinical change and, obviously, to deliver that within the financial envelope—by eliminating waste, not by denying patients evidence-based treatment. That is the first area we would look at.

Secondly, we would need to be sure that the organisation has the appropriate infrastructure and governance arrangements to discharge its statutory duties, because it has a considerable number of statutory duties. These will be big organisations with, as you rightly point out, huge responsibility for both the health services for their patients and the public’s money, so we need to make sure that the infrastructure the organisation has is appropriate.

Thirdly, as Sir David has pointed out, it is absolutely critical the Board is satisfied that the organisations have the full range of engagements with all the relevant stakeholders: that they have the systems and processes to make sure they are listening to patients and the public, that they are engaging secondary care colleagues and that they are engaging clinicians other than doctors. That will be a key part. It will also be critically important to ensure we look to see that they have the arrangements to commission services across a wider geography than their own consortium. It is key that we look at whatever systems they have in place for working with other consortia or buying in—commissioning—services.

Q250 Rosie Cooper: Should we call it a PCT?
Dame Barbara Hakin: I am sorry?
Rosie Cooper: Should we call it a PCT?
Dame Barbara Hakin: Should we call what a PCT?
Rosie Cooper: This greater strategic vision?
Dame Barbara Hakin: No. It is a commissioning consortia because it has a different ethos and basis. It is based on the practices.
Rosie Cooper: Rubbish.
Dame Barbara Hakin: We have built it up from a different area, but it doesn't mean it is any less important for us to make absolutely sure that these organisations are delivering better quality services for patients and better value for the taxpayer.

Q251 Chair: Can I put Rosie's point to you perhaps slightly more delicately?
Rosie Cooper: It's still rubbish.
Chair: You used the phrase, and I quote, "They are huge organisations." That is, I thought, quite an interesting phrase to have used to describe the consortia.
Dame Barbara Hakin: I am sorry, the phrase should have been "They have huge responsibilities." They don't necessarily need to be huge organisations. Some of them may be quite small.

Q252 Chair: Your phrase "a huge organisation" wasn't out of place in describing an organisation with that scale of responsibility.
Dame Barbara Hakin: It is "huge responsibilities", a huge scale. I agree completely. One of the things we need to look at with these organisations is what a consortium absolutely has to do for itself and what it might reasonably buy in or secure from elsewhere. That is where we get the difference in the size of scale. The scale of responsibility they have is enormous. However, in a lot of cases we will see consortia not trying to do everything for themselves. Again, in terms of the authorisation process, what we would be looking to define with pathfinder consortia are the things that only the consortium could do—that they wouldn't be a commissioning organisation if they asked somebody else to do that. Those are the things about the final decision making, the clinical input and the changing services. There is an enormous raft of things that are part of commissioning which, by and large, all PCTs have tried to do for themselves. They are things for which, if we are going to make this system really different, we are going to get the economies of scale out of the back-office commissioning functions. Hopefully, we will see consortia doing those things that they, and they alone, can do and do well, which are the clinical things, and using economies of scale so that they can discharge these huge responsibilities without necessarily being enormous organisations themselves.

Of course, the other thing we need to look at is that they have the appropriate leadership capacity and capability. Again, in terms of the authorisation, what
we want is not to increase the workload and not to create a bureaucracy out of this. We know the organisations have to have constitutions and we know that they have to have commissioning plans. Much of the authorisation, therefore, will be based on that already-present documentation. We also feel—although this is evolving and we are still working with pathfinders to work through it—as Sir David said, that the 360° view of stakeholders, local authorities, public, patients and other clinicians will be important with, potentially, a site visit in the end to thoroughly understand what makes the organisation tick.

Q253 Chair: Can I also ask you to address this question? You have described a complex authorisation process, and it doesn’t come as a surprise that it is relatively complex. What happens on 2 April 2013 if the Commissioning Board isn’t satisfied that the consortium in a particular locality qualifies under this authorisation process?

Dame Barbara Hakin: I hope what we have described is a comprehensive authorisation process. The process over the next year will be discharging this, finding a way of working with consortia to discharge this in a way that doesn’t create extra complex work.

Q254 Chair: I understand, but there must be a provision that covers that circumstance.

Dame Barbara Hakin: Yes. The Board will have a number of options where it feels a consortium doesn’t meet all the criteria set out in the eventual authorisation process. First, it could confer partial authorisation on the consortium. It could choose to say, “For these services, which are slightly more straightforward to commission, we are happy for the consortium to commission them.” But the Board itself, or another more effective consortium, might, in the short to medium term, take over the commissioning of the more complex services.

Q255 Chair: Does that mean the Commissioning Board has power to allocate, for a particular locality, the commissioning function between different consortia, because if a consortium is going to do part of the commissioning, and you said another consortium might adopt another part of the commissioning for that locality, effectively, the Board is in a position where it can almost compel merger.

Dame Barbara Hakin: The Board has to be satisfied, in its overarching role, that the commissioning arrangements for the whole of England are appropriate. In discharging that role, it would seek to make arrangements to ensure that was in place. In the early stages, if that meant a partial authorisation or an authorisation with some conditions—perhaps some advice and support—that is what the Board will do. My understanding is that that is the Board’s authority and it has the mandate to do that. David, I don’t know if you have anything to add to that.

Sir David Nicholson: Yes. A good example would be if there were a series of consortia all working around an individual acute hospital and you believed that a particular consortium did not have the capacity to do the acute commissioning. You could reasonably expect to arrange for another consortium essentially to be the lead consortium for the commissioning of acute services for that particular area.

Q256 Rosie Cooper: Should we call that one a PCT, then?

Sir David Nicholson: I don’t know how you want me to respond to this.

Chair: Can we allow our witnesses to respond to one question at a time? This is supposed to be evidence gathering, not tennis.

Sir David Nicholson: But, to take the point, there is an issue here. One of the things about PCTs is that there was never a right size for a PCT. From when they were first designed, everyone said they were the wrong size—they were too small or they were too big. So there isn’t a right size for an organisation. In a sense, that is why we are giving consortia a good deal of flexibility about what their sizes are. What there are, though, are population bases which support particular services. They are graded. The population base that you need to commission a service for wound care for an individual group of patients is small but for proton beam therapy it is huge. There is a gradation all the way along, and they don’t fit, sadly, into easy geographies. What you need is a system which is capable of flexing, so consortia will be working as individuals, as groups and as even larger groups for different services. That is the inevitability.

Q257 Chair: I will have one more shot and then I am going to call Rosie. There are two competing concepts around here, aren’t there? One is earned independence of the default option, which is the National Commissioning Board, and the other is presumed independence. I am not clear. What you are describing doesn’t come as a surprise to me in a National Health Service, but it sounds much more like the Commissioning Board holding the responsibility until it finds somebody to whom it can delegate it than presumed local independence.

Sir David Nicholson: I don’t know whether you can have “the best of both worlds” really, because that is what we are trying to get to. As clever as this authorisation process is, you will not be able to cover absolutely everything in every circumstance. You are going to have to make a set of judgments. The judgment we try to make, and the way I would describe it, is that we want these individual consortia to be the best consortia they could possibly be. Our job is to help them become that. If there is a presumption, it is that we want them to be the best they can possibly be. In a sense, the things that we are describing here are just a part of the journey on to that.

Q258 Andrew George: Could I ask something very briefly on the issue of the strategic nature of the decisions which have been taken and how they are being taken? I can quite understand that the Commissioning Board have a role with regard to the high level stuff—the complex neurosurgery. Clearly, that can’t be easily commissioned by a consortium like that in Newquay representing 28,000 people. That can’t be done. Someone needs to make strategic decisions about the pattern of those services. At the
same time, it seems the Commissioning Board is also commissioning individual dental practices at Land's End. I don't quite understand how you can square the Commissioning Board's role in relation to very localised services, which it seems to be responsible for, and taking a strategic view on issues too.

**Ben Dyson:** You are absolutely right. There are some services which the Commissioning Board will commission itself, but it is important to emphasise that that doesn't mean that all the commissioning will be done from a single central location. It is not as though there will be a team of people sitting in a building responsible for the relationships with, say, every dental practice in the land. One of the things the Board will need to do is to make sure that it has sufficient presence in different areas to be able to manage relationships—

**Q259 Andrew George:** Like strategic health authorities, really?

**Ben Dyson:**—with providers.

**Rosie Cooper:** Good grief.

**Ben Dyson:** There could be a number of models for doing that. Having said that, and I think this builds on what—

**Rosie Cooper:** Back to the future.

**Chair:** Can we please be fair to Mr Dyson.

**Ben Dyson:** This builds on what Sir David and Dame Barbara have already said about the different levels of commissioning. One of the things that has happened in the PCTs is there has been a tendency to assume that that size of organisation is the right level—the right size—to do everything. When you start to unpick commissioning, whether it is the commissioning of dental services or the commissioning of community services, one quickly finds all kinds of different levels at which it is likely that things could be more optimally done. For instance—and I don't want to go too far into dental services—it may very well be that some of the work involved in monitoring dental contracts, looking at the services provided, doesn't have to be done 150 or 200 times over, or however many times it is. That could be done on a more central scale. Where you need more of a local presence is to manage issues that arise from that monitoring and be able to have conversations with individual providers. It is the same issue about finding the right level to do the commissioning.

**Q260 Andrew George:** The really big strategic tertiary issues, the complex neurosurgery and the major burns and very complex cardiology and so on, can't be commissioned by GP consortia either, can they?

**Ben Dyson:** No. It is by the Commissioning Board.

**Q261 Chair:** That is clear. Specialist commissioning, it has always been clear, would be done by the Commissioning Board?

**Ben Dyson:** Yes.

**Q262 Rosie Cooper:** I am going to ask you some general questions about accountability. But, before I do, following on from some of the things we have heard today, I would like to ask Sir David about this.

You are the accountable officer for the NHS and I am really interested in how the National Commissioning Board will operate. I have heard what you said, but will it just operate in one place in London? Will it have local knowledge? Will it just be London and Leeds then? When things go wrong, when my constituents have a problem, who do I phone? Who will be on your Board? How big will it be? It sounds like you will need a cast of thousands. Will they have local knowledge? How will you know what is going on in West Lancashire? How will I know who I am going to—

**Chair:** That's enough questions for now. It gives the flavour.

**Sir David Nicholson:** I think you have brilliantly described the complexity. We are trying to do a very complicated set of things here. If I was to sit here and say, "We have sorted them all out" I would be fibbing to you. At the moment, we are involved in a process of building and organising ourselves in order to make ourselves do it. I am the accounting officer for the NHS, for the vote for the NHS at the moment, and my understanding is that the Chief Executive of the Commissioning Board will be the accounting officer for the NHS Commissioning Board vote. That is relatively straightforward in the arrangements.

In terms of the way the Commissioning Board will function, you are absolutely right that it has to function at a national level and a relatively local level, which is a challenge for any organisation. It is inconceivable to me that you will have a very centralised organisation, all based in London and Leeds. They are the two bits of the system that we have identified, that the headquarters will be in Leeds but there will be a sub-office, in a sense, in London. There will be people out working in the service, inevitably, but we haven't been through all of the process to identify how that is. If, for example, you take the relationship with the consortia, which is a very important relationship for the Commissioning Board, that is multifactorial. On the one hand, you are commissioning services from primary care directly into the people working in the consortia. Then you have a responsibility for authorisation, for monitoring the performance, for identifying and taking forward the Commissioning Outcomes Framework and you have a responsibility in relation to the accounting officer. That is quite a complex set of relationships. What we are trying do at the moment is tease out each of those relationships and work out how best the Board could organise itself to do that. That is exactly what we are doing.

**Q263 Rosie Cooper:** How big do you think the Board will be? It is not the direction I shall be asking you about, but how big will the Board be? How many employees will you have? How many satellite organisations, if not sites? How do you see it being delivered? Who do I phone?

**Sir David Nicholson:** We have published the financial number, haven't we? £400 million is the amount of money that has been allocated for the Commissioning Board to operate on. If you add up all the things the Commissioning Board does that are currently done by other organisations, it comes to a much bigger figure...
than £400 million. It will be a significant reduction in the amount of people involved in this kind of process, but it is about £400 million. As to the question about how many people it employs and how many people it buys services from, we have not concluded where we are going to be on all of that. It very much depends on the kinds of things I just described. The other thing is that the Commissioning Board has a right of representation on every Health and Well-being Board. There will be some local individual who would be identified, in a sense, as the Commissioning Board’s representative, or whatever you would describe it as, on each of the Health and Well-being Boards. There will be a local presence in that sense. They may not be based in that particular one, and they may be based in more than one Health and Well-being Board, but there will be somebody identifiable on the Health and Well-being Board who will be the person you could talk to.

Q264 Rosie Cooper: So when an MP has a problem, they phone “Mr or Mrs A.N.” Other who may be on a Well-being Board. Why when my constituent has a four-and-a-half hour waiting list, or some problem, I am to phone Mr A anonymous?

Sir David Nicholson: It depends on the issue. For most of them it will be the consortia, will it not, because the consortia will be commissioning the services for your individual?

Q265 Rosie Cooper: In other words, if MPs have problems, they phone GPs. As to GPs, I can tell you what one said to me not weeks ago—not to me but to my office: “If somebody has a complaint, just get them to put the complaint in in the normal way.” That is not responsive or dealing with it. I park that as a problem that is going to be really big there. Otherwise, the Secretary of State and the Prime Minister are going to be faced with more adjournment debates than enough because we will have almost every complaint debated on the Floor of the House.

Sir David Nicholson: The issue is the resolution of the complaint, and if the consortia are the best place to resolve the complaint, that is who you should talk to, isn’t it? If you can’t get any satisfaction there, there is the Commissioning Board itself.

Q266 Rosie Cooper: Absolutely. I suppose I got knocked off course earlier on because you were talking about the number of people being employed. What I can’t understand is—and you have the National Commissioning Board—how the accountability falls out, because we keep on getting different ideas. The Department says local authorities get extensive scrutiny powers, and you know I am far from convinced, but the power to refer service reconfigurations only refers to designated services. Some people view that as limiting. Some people are suggesting that consortia boards will have quite a large contingent of lay or elected members. I am not talking about Well-being Boards, but consortia boards. I am really confused—and I think many people are—as to where are we up to on the roundabout that talks about accountability in consortia? I ask you a direct question: Will there be non-executives on consortia?

Sir David Nicholson: What we have said on consortia is that they will come up with their proposals. Each individual consortium will decide on the kind of constitution that fits their local circumstances and their Commissioning Board will sign it off.

Q267 Rosie Cooper: So there is not necessarily any outside accountability there. As to Health and Well-being Boards, where is the real accountability there?

Sir David Nicholson: For what, exactly? The commissioning consortia are accountable to the Commissioning Board. That is really straightforward and not complicated at all. But, of course, they account to a whole series of different people. The consortia account to the Health and Well-being Board and that accounting means that they have to agree their plans and they have to work—

Q268 Rosie Cooper: The Health and Well-being Board, in your view, can sign off the consortia’s plans. Do they have to sign off the consortia’s plans? Do they have to agree them?

Tim Rideout: You will be aware that we have to have a Health and Well-Being Board for every upper tier local authority. The Health and Well-being Board, the parties and the commissioners across health and social care, working with elected representatives, will be responsible for developing a strategic needs assessment for their population. They will then be responsible for developing a strategic plan that responds to that. The legislation places a requirement on commissioners, both in social care and health, to pay regard to that plan. Effectively, for the first time, we have a formal environment, set up by the local authority, which brings those parties together and requires them to act in that way. That really builds upon the good practice that we have previously seen across the country in different places when those parties come together to identify the real things that are important for local communities and then come up with a shared response to those problems.

Rosie Cooper: There is regard, but no power—

Q269 Chair: If I can be clear, a plan has to be signed off.

Tim Rideout: The legislation talks, I think, about due regard. But the reality is, if I talk from my operational experience, that there is a kind of assumption behind the question that people were trying to avoid doing these things. In effect, if you want to discharge these duties well you have to do this. For a consortium to do its job and for a Health and Well-being Board to function properly, it will have to do the needs assessment well and it will have to come up with a good strategic response to it. That will play out as part of the authorisation process and as part of the assurance process, so there are good safeguards in the system that speak to the—

Q270 Rosie Cooper: There were good safeguards in the system that allowed Mid Staffordshire to happen. I am genuinely tired of being fed what I consider—not particularly from this board, so don’t be insulted—evidence after evidence where people are telling us
It may be reasonable to say a couple of things. First, at how is the Secretary of State Rosie, can I bring in your colleagues? That is coming out of the It is quite difficult to certainly, in terms of the How much is this whole different parts of the country, but I wondered if you confused and I don’t know what is going on in terms of consortia and PCT clusters? I am completely SHAs and the PCTs. Sir David Nicholson: Where is that coming from? Q272 Valerie Vaz: A and the pathfinders. The Minister had said, in response to questioning, that no one is monitoring the spend on pathfinders. Is someone accountable for all the money that is being spent now? Do you know? Dame Barbara Hakin: Could you just repeat that? Q275 Valerie Vaz: The Minister has said in a written answer to me that no one is monitoring the spend on pathfinders. Is someone monitoring the spend on all this reorganisation and do you know how much it is all costing? Dame Barbara Hakin: Certainly, in terms of the whole reorganisation there has been an impact assessment and there are figures around that. In terms of the spend on pathfinders, we are supporting pathfinders through the current system. In other words, all the funding to support pathfinders and all the development support is coming out of current budgets which PCTs and SHA’s hold. We have said that in this early year, when they are pathfinders—they are not necessarily shadow consortia, they are just groups of GP practices who want to work out how they can become shadow and, eventually, full-time consortia—they will have £2 per head of population to help them with their internal support, but that has to be identified out of the PCT budget, their running costs. We have also said that pathfinders have to have resource in terms of some individuals to help and support them. All nascent consortia have to have individuals from PCTs and SHAs who can help them understand what their needs will be in terms of financial functions, organisational development, governance, etcetera. All the resource is just coming out of the current envelope. Q276 Valerie Vaz: How much is this whole reorganisation process costing now? Do you know? Dame Barbara Hakin: Do we have a figure? Sir David Nicholson: It is quite difficult to disentangle the support to the consortia from the general running of the PCT because, in a sense, the same people are doing the work. We have not reallocated resources in that way from the new system and from the old system. We have not worked it like that. We have said that we expect them to have £2 per head available for them to work to develop the consortia from 1 April 2011, and that is £2 a head of population. Q277 Valerie Vaz: How is the Secretary of State accountable to Parliament for the money that is being spent? Sir David Nicholson: Obviously, he is accountable for the money, as I am, but what we are doing is setting a running-cost envelope and that running cost includes the running of the current service and the development of the consortia. Q278 Valerie Vaz: How much is that?
Sir David Nicholson: That is £5.1 billion for the system as a whole, and it goes down, at the end of the period, to £3.4 billion.

Q279 Yvonne Fovargue: Can I return to the assurance regime? How are you going to call consortia to account? Rosie has already referred to the Mid Staffordshire issue, which had all the signs of failure. Everybody was saying it was failing and yet it wasn’t called to account by anyone. The commissioners and the regulators— everybody—I left it. Is this new system going to make it easier to detect early signs of failure in providers?

Dame Barbara Hakin: There are two things that need to be really different. I am sure there are many, but there are two things that we are focusing on that need to be really different in terms of avoiding Mid Staffordshire for the future. The whole of the NHS, irrespective of this Bill and the reorganisation and the commissioning side, is now paying much more attention to information for quality and ensuring that we are collecting and identifying a much broader set of information, that we have a more systematic approach to some of the softer elements of quality information, such as patients’ views, patients’ reported outcomes and complaints, and that, as a system as a whole, not only do we have more information which might have led us to understand Mid Staffordshire earlier, but it brings together all the relevant players. Often it is all the pieces of information that individual groups or organisations have, once brought together, that make the difference.

That is the kind of general change in attitude to the systematic collection of quality information which allows us to see problems and have an early warning. The other side to that coin, of course, is that we are changing commissioners so that, instead of having a managerial focus, the commissioners, in the form of GP consortia, will be much more clinically led. You suggested that a lot of people knew what was happening in Mid Staffordshire. What this new system should have for us is, first, a group of clinicians who would use the hospital all the time. They would have their referrals, see the results and see patients coming in and out of the hospital. Also, we have people who are in constant contact with huge rafts of patients who are using secondary care services. The idea is that in the form of these clinically-led GP consortia we create the kernel of something which is the most able to identify and focus on clinical quality. But that, on its own, doesn’t work. We also have to have a better systematic collection of quality information.

Q280 Yvonne Fovargue: My concern is that was all there before—or a lot of it was there—and Mid Staffordshire still happened. How are you also going to identify the consortia that are failing and who is going to call them to account at an early stage?

Dame Barbara Hakin: There are huge rafts of things that have been put in place in the NHS to improve our understanding of quality, our focus on quality, the way we identify quality and the way we deal and act with the concerns that we have. But we are changing to a system whereby the commissioning organisations are much more clinically focused. Therefore, they should have much more of a focus on quality outcomes and have, at their heart, people who have very frequent constant day-to-day interaction with patients and can pick up their causes and concerns. The next stage, beyond that, is to create the systems and processes that make it clear, when those concerns are being raised and identified, that the whole system works to bring those together and identify where there is a problem. As Sir David has rightly pointed out, those are many of the things that will be key and central to this and are in addition to the consortia and the changing clinical focus of the consortia rather than being entirely dependent on that.

Q281 Yvonne Fovargue: What about the governance arrangements as well? What plans are there to check the governance of the consortia and their decision making?

Dame Barbara Hakin: In terms of support for consortia’s development and the authorisation processes, both of which are part of the same framework, we have been clear that consortia must have a constitution which demonstrates their governance arrangements. The Bill, as Ben pointed out, made it very clear that they will have a duty to involve patients and the public and other relevant stakeholders. When the Board is assessing the consortia for authorisation, it will take into account whether their governance arrangements and their constitution meet all those duties of partnership and stakeholder engagement.

Q282 Chair: In effect, the standards of accountability and quality management are all seen as part of the authorisation process.

Dame Barbara Hakin: Yes.

Ben Dyson: And ongoing accounting.

Dame Barbara Hakin: And ongoing assurance.

Chair: That is clear. It may not be satisfactory from everybody’s point of view, but it is very clear where the monkey sits.

Q283 Chris Skidmore: Sir David, I want to talk about the ongoing process of reconfiguration that is going on at the moment, in particular your letter to NHS Chief Executives on 17th February, in which you stated that the end-point for the PCT clusters that are currently being set up would be “a single organisation covering the whole country and supporting a vibrant system of local consortia: the NHS Commissioning Board.” Forgive me if I am mistaken, but this seems to lead to the integration of the PCT clusters into the NHS Board by 2013. Would it be correct to say that?

Sir David Nicholson: The PCT clusters will be part of the NHS Commissioning Board from 1 April 2012, so the PCTs will be part of the Commissioning Board right up to the end of 2013 when the PCTs are abolished. We haven’t yet made a judgment about whether that cluster of people—obviously not a statutory organisation, but a cluster of people—would continue to be part of the Commissioning Board operating in the way that they will over the next 18 months or so. We will have to make a judgment about that to see how successful it works in practice.
Q284 Chris Skidmore: Could you give any estimate of when that judgment may be made?
Sir David Nicholson: The Commissioning Board is set up from 1 April 2012. You would think that within five or six months the Commissioning Board would be able to make a judgment about whether they would continue past 2013. That would be reasonable and fair for the staff as well.

Q285 Chris Skidmore: We heard from Christopher Long in the first session that he felt there was an “increasing and tightening central grip on things”—that is the quote I have got from what he said at the beginning of the session—and yet you have talked about the 360° open process. I was also interested in the comments you made in the GP online interview of changing since the beginning of 2002 through 2003, of foundation trusts and independent autonomous organisations, which are different from what we have ever had in the past in terms of their accountability. That changes the nature of the way in which the system operates.

Sir David Nicholson: Clearly, the NHS is not what it used to be. In lots of ways it has improved and its performance has increased enormously over the last few years. But in organisational terms, it has been changing since the beginning of 2002 through 2003. In a structural sense, in the sense of the development of foundation trusts and independent autonomous organisations, which are different from what we have ever had in the past in terms of their accountability. That changes the nature of the way in which the system operates.

The commissioning system, though, is not quite the same as that. What I mean by it being different is that the NHS Commissioning Board is a corporate entity. It is one organisation for the whole country. It is not a set of statutory organisations all working together with an organisation. It is one. As such, it is a really important and powerful mechanism to get consistency of service across the NHS in a way we have not been able to do before. As you see there, what you have is two things happening simultaneously. On the one hand, you want to increase the amount of autonomy and freedom that people have locally to get on and make the changes in services that they want. On the other hand, there are things you have to do once centrally in order to get consistency. Very often people have had difficulty holding those two things together. They want to lurch either to one, i.e. we give the money out to GPs, “Do your best,” or they want me to take every decision in the centre. Of course, in reality, in organisations, it is quite different.

Q286 Chris Skidmore: “When asked whether the Board would have a regional presence in the same way that there are strategic health authorities now, Sir David says: ‘This is not the NHS as used to be.’” I was wondering what you meant by those comments and, in particular, whether you would agree with Nigel Edwards, the Acting Chief Executive of the NHS Confederation, when he said that the process we are going through now is moving from a centrally managed system to a regulated industry similar to the gas and telecoms sector. Would you agree with that in terms of the NHS in a no longer what it used to be and that this is the process, this is where we are going to head to?

Sir David Nicholson: No, I haven’t seen it. I have been on holiday.

Q287 Chris Skidmore: Since the introduction of the White Paper, do you feel that your views have changed over the level and nature of central control needed to be levered by the Commissioning Board itself? I know there are still a lot of things under debate. For instance, some GPs have criticised plans to allow the Board to decide whether consortia’s accountable officers are appropriate, so the appointment of officers is still under debate. Obviously, all these things will shake down, but do you feel at the moment we are moving possibly towards a more Stalinist control mechanism where everything is decided in your office?

Sir David Nicholson: No. There are a whole series of things happening simultaneously here. It is very complex and difficult to do, even for myself because I am holding two different things in my head at the same time. On the one hand, we have the transition. In any transition, and particularly a transition of this scale, you need to have a firm grip on finance and other things as you go through. If we lose financial control as we go through this next period, it will all be irrelevant because the consortia will not have the ability to create budgets with the money to do anything. If we lose control in the first instance in order to give the freedom further down the line. That is what is playing out, that is what Chris Long was describing and that is what you can see. For example, in the planning round for this year, every PCT has to identify 2% of their budget that they can allocate non-recurrently but can’t allocate continuously. They can only allocate it non-recurrently if they have the approval of the strategic health authority. That is a big shift in terms of central control and is absolutely essential, in my view, in order to deliver the transition. On the other hand, we are trying to create a system where there is more autonomy in the consortia. We are trying to give consortia the maximum amount of freedom in order to deliver the shape and nature of the organisations that they want. We are trying to do both of those things together and sometimes they trip over. I perfectly understand how they do it, but it is a complicated thing to have to do.

Q288 Chair: May I refer you back to the first half of that answer. It was, I think, when we both look at the record, very clear. You described the NHS Commissioning Board as a more powerful instrument for national commissioning—and I am not quoting, but I don’t think I am misrepresenting—that we have had in the Health Service previously. I want to link that with what you were saying earlier about the authorisation regime, which very much sounded like a series of conditions that needed to be passed by consortia in order to be authorised. It seems to me that what you are describing is, as you say, something that is a more powerful and more centralised, as Beachcroft have said, commissioning process than we have had up until now with proper respect for local freedoms and so forth, because that is how to do it effectively, but the power starts off in the centre.

Sir David Nicholson: If I could just describe, in a sense, the thing that is driving quite a lot of that, which is the development of national quality standards that NICE are now producing. They are going to...
produce what really good services look like. The Commissioning Board, in a sense, will take those, turn them into commissioning guidance and then the commissioning consortia will work out how to do it and get on and do it. We have never had that before. We have never said, from the centre, “This is what the evidence shows is a really good stroke service, dementia service,” or whatever, and then hold people to account to deliver it. I would argue that that is about getting consistency. In a sense, the Commissioning Board’s bit is putting the “N” in the NHS. That is our unique selling point, and we have never quite done it in the potential way that we can now. In that sense, I think it is a powerful mechanism for taking services forward.

Q289 Chair: You also said, and you drew a distinction—I forget the precise words but you emphasised this—the consortia would be accountable to the Commissioning Board. They will have to account to local communities through Health and Well-being Boards, but where is the accountability? In a statutory sense, it is to you as the accounting officer for NHS Commissioning for the whole £80 billion. NHS commissioning rests in the Commissioning Board.

Sir David Nicholson: Yes.

Q290 Chair: Nowhere else.

Sir David Nicholson: Yes.

Q291 Chair: It is pretty clear.

Sir David Nicholson: I think so.

Q292 Chair: Now a related question. One of the questions we are quite often asked is where the responsibility rests for doing major service reconfiguration, where that is necessary, in order to deliver good value, high quality health care. Does it follow from the model of, frankly, delegated central responsibility for commissioning that it is for the Commissioning Board to determine who in the system has responsibility for planning major service reconfiguration?

Sir David Nicholson: No. Barbara explained the authorisation process in which consortia will need to explain to everybody how they are going to deal with services which cover a bigger geography than their individual consortia. We would expect consortia to have arrangements in place with other consortia in the geography in order to bring these things together. We would expect the drive and the push for any configuration that needs to be done would be exercised by consortia, either working individually, if they are large enough and cover the area, or collectively through the arrangements that we want them to put into place when we are going through the authorisation process. We don’t see the Commissioning Board, in that sense, being a big player in terms of driving reconfiguration of services. It is much more about putting the systems and processes in place to enable local people to do it. The only exception to that, of course, would be with the nationally commissioned elements of the service.

Dame Barbara Hakin: Could I add something on that, if I might? What we see as the biggest driver is the quality standards that are set. Rather than that there is a non-evidence-based, “We will move this service here or there,” the order would be, on the basis of the Commissioning Outcomes Frameworks and the quality and standards of the commissioning guidance that the NHS Commissioning Board has set. So that consortia will, in the methods by which they contract, be very clear that the services which they commission for their patients must meet these clear quality standards and criteria. That is what is then likely to prompt providers into examining, “Can we deliver those quality standards with the current shape that we have?” Again, the absolute primary thing here is to ensure that all patients get the best quality services they can and that there are no safety risks arising from things being done in units which really don’t have the quality infrastructure in place.

Q293 Chair: I think I understand the pure milk of the theory. I wonder whether, in practice, it is enough in every circumstance to rely on the sure knowledge that individual parts coming together to make the case for necessary service reconfiguration or whether there might also need to be a counterbalance looking at the totality and saying, “There is a better way of doing this if you look over the horizon.”

Dame Barbara Hakin: The answer is that the Commissioning Board will always have a responsibility to oversee that things are being done properly and appropriately. Clearly, in part of the mix, there is obviously the local Health and Well-being Board and the fact that hopefully, constantly, during the joint strategic needs assessment and the working through of their plans, if the evidence is that there is an issue with a service because it can’t meet the quality of standards then the local population through the Health and Well-being Board and the local authority ought—and local clinicians ought—to be able to understand the reasons and be party to identifying that. The Commissioning Board still has a role to ensure that, in all parts, the appropriate actions are being taken.

Sir David Nicholson: We have to start with the consortia and work through that. If the Commissioning Board has the idea that it is going to have some mega strategy, a service configuration for the whole of the country, and then expect everyone to do it, that is not going to happen. It doesn’t work anyway. It has to start bottom up. Clearly, the Commissioning Board, if asked, could support and help them do that.

Chair: Fine. Thank you.

Q294 David Tredinnick: Let us move on to price competition—or lack of. Sir David, you are on record as saying “There is no question of introducing price competition”, and the Secretary of State has said that there will not be price competition in the NHS but that providers can negotiate lower prices at the end of a financial year if they have spare capacity and the commissioner cannot afford full price. How will that fit with the rules on competition in the NHS, please?

Sir David Nicholson: I am sorry, in what sense?
Q295 David Tredinnick: I want you to explain the rules on competition because there have been challenges about whether or not there is going to be competition on price. And are you on record as saying there was not going to be and so is the Secretary of State. How do you reconcile that if, at the end of a period, there is apparently a change in the rules so that there is a degree of competition, or something that has been picked up? I really wanted to ask you about that.

Sir David Nicholson: Competition on the basis of quality, not price, we have made that absolutely clear right the way through. There is a fixed price through the tariff system. The example that you use is that, at the end of the year, a particular provider has some capacity, the commissioner has some money but he can’t pay for the full amount of capacity that is available and the provider suggests a lower price. If they agree that, if they can show the tests around, the measurement of quality, the empowered patient, all of that sort of thing applies, and they can have—up to 1 April 2012—the agreement of the strategic health authority, then they can do it.

Q296 David Tredinnick: There is no reduction in quality, merely a reduction in price.

Sir David Nicholson: Yes. They have to demonstrate how they do it as well, not just that they can say it.

Q297 David Tredinnick: Moving on, if most care is open to Any Willing Provider and patients have a wide variety of choices, in what sense will commissioners be commissioning?

Sir David Nicholson: The first thing I would say is that the whole thing about Any Willing Provider is that we are on a kind of journey with it. There is not going to be a switch flicked on 1 April 2012, 2013 or 2014, which will suddenly open up the whole of the NHS to Any Willing Provider. That is not how it is going to work at all. We are slowly but surely experimenting, working and understanding before we move on to the next issue. The most obvious one, as I described earlier, was elective activity where we have essentially an Any Willing Provider process in place now so that you can choose any NHS and a selection of private and independent-sector providers for your elective care. We want to look at those areas next in terms of Any Willing Provider that are particularly susceptible to patient choice, and slowly but surely, by the end of this year, we are proposing to set out the next phase of that and, over the next few years, we will start to move that forward. There will not be a day when suddenly everything is Any Willing Provider. Simultaneously, we will also be working on tendering arrangements, so there are some services that will be more suitable for tendering rather than Any Willing Provider—some services that will be much more conducive to long-term arrangements between organisations to enable investment and—

Q298 Valerie Vaz: Who decides that?

Sir David Nicholson: The commissioners.

Q299 Chair: That is an important point because when David Bennett was with us last week we asked him whether a commissioner’s decision to tender a particular service as an integrated package of care would be subject to being challenged by Monitor on competition policy grounds. He made clear it that the answer to that question was no, that the commissioners were accountable to the Commissioning Board and a decision to tender a particular range of services, for example, for diabetes care, would not be subject to challenge on competition grounds. Is that your understanding as well?

Sir David Nicholson: Yes.

Q300 Chair: Mr George then immediately followed that up and said, “If that is true for diabetes patients, presumably it is also true for A&E patients.” In other words, that if a commissioner can tender an integrated service for a diabetes patient, then a commissioner can also define an integrated range of services for A&E for a local community—is that not the same principle—without challenge from Monitor on competition grounds? The importance of that question is clearly that if you tender an integrated set of A&E services then in order to deliver that you need a very wide range of emergency care within the hospital.

Sir David Nicholson: Yes. One of the things that will govern all of this is the guidance that the Commissioning Board sets out around it all. We simply have not done it, yet. We haven’t got to that kind of place. It would seem to me unlikely. The diabetes is quite an interesting one—and I think you talked about it at the last sitting, didn’t you—because you could see there that even within tendering you could have an Any Willing Provider element to it. The example I would give is you could tender for a diabetes service but, within that, you could stipulate that for podiatry, or one or two other services, individual patients would still have choice. It is perfectly possible to do all of that. As I say, we just haven’t quite got there. I would think it is extremely unlikely that the guidance would say you can just do a whole hospital and call it an integrated organisation and tender for it. That would just seem to me—

Q301 Chair: The purpose of the question, I think, was to preserve the integration.

Andrew George: Yes.

Sir David Nicholson: But you don’t have to manage everything to have an integrated service.

Chair: No. That’s the point.

Q302 Andrew George: To tease out that point—I would like to come back on the issue of price as well in a moment—you only know that a patient has a specific requirement, if they come in as an emergency case, in retrospect. Therefore you do need to have the provision of a range of referral services, not just the A&E consultants and staff and other forms of emergency intervention. Rather than simply having an A&E service in a tent in the middle of a field, you end up with something which looks like a district general hospital, don’t you, surely—

Sir David Nicholson: Yes.

Q303 Andrew George:—in order to be able to provide the range of services which would ensure that
Sir David Nicholson: But you would deal with a lot of that through, presumably, the designated service arrangements, wouldn’t you?

Q 304 Andrew George: You would use that mechanism, so a district general hospital could be a designated service.

Sir David Nicholson: No, it will be each individual service. People said that if you took stroke services, hyper-acute stroke, out of a DGH, it wouldn’t really exist. They do exist. There are DGHs that exist without major trauma. There are different ways of organising your clinical services which are much more flexible. I know it is very easy to talk about—and people do and I can perfectly understand why they do—every bit of the DGH being completely dependent on every other bit of it. But when you dissect it, it is not absolutely true.

Q 305 Andrew George: That is an interesting comment. Do you mind if I come back to the issue of price which David was asking about earlier? Just so I am clear—and you have said, and the Secretary of State is now saying, and there is going to be an amendment to the Bill taking the word “maximum” out, as I understand it, from the clause in relation to tariff—how is Monitor going to decide what the tariff is going to be unless it is receiving some kind of market signals? Are they going to have quiet words with providers and say “I think we can provide it cheaper?” How are they going to know how to set the tariff if they are not getting market signals?

Sir David Nicholson: They will get market signals, won’t they?

Q 306 Andrew George: In what way are they going to get these?

Sir David Nicholson: The first thing is there is a huge—I say industry, but it is not quite the word—amount of activity that goes into reference costs at the moment, so every NHS organisation sends all of its reference costs into the Department, and out of all of that analysis and work comes the setting of the tariff. All of that real reference cost information will be sent to Monitor and Monitor will have the full array of that—what it is costing in practice for every hospital in the country—in front of it, so that when it makes its assessment about what the actual tariff will be, it has that information. It will also have information from the Commissioning Board setting out, in terms of the structure of the tariff, the things that we regard as increasingly important. There might be a particular service or a particular arrangement for a service that we might want to set out in the tariff. They will have all that market intelligence, in a sense, from the commissioners as well.

Q 307 Andrew George: But the tariff, when it is set, can only be based, surely, upon the information which is available to Monitor at that moment in time.

Sir David Nicholson: Yes.

Q 308 Andrew George: In other words, if there is not competitive tendering on price, then I can’t see how, unless you can provide us with some kind of written documentation which explains what kind of detail of reference material is available to it, it can take signals to vary the tariff without market signals. You are saying it is entirely based on reference material rather than on market signals, are you not?

Q 309 Chair: Material drawn from individual providers within the NHS presumably.

Sir David Nicholson: Yes.

Q 310 Andrew George: Yes, within the NHS, and also private providers. Private providers will be providing this reference material as well.


Q 311 David Tredinnick: Coming in on Andrew’s question, you referred to patient choice, but what about patient preferences? If a group of patients comes forward with a preference, or there is a clear indication that they want a particular service which is not available, is there any mechanism to establish that? We heard Mr Long talking earlier on about the survey that he had conducted in Hull, which has been very helpful, but I am thinking of patients that, say, want to use herbal medicine, which is about to be regulated through the Health Practitioners Council, or wanted to use homoeopathic medicine. What mechanism is there to listen to those patients, please?

Dame Barbara Hakin: There are two areas on this. In terms of the individual patients and their choices, it is important to remember that Any Willing Provider comes into play when there are two criteria met. First, we have a currency—we have a fixed price to which all providers can meet such quality standards—and, second, that the patient is in a position to make a choice. Those are the areas where Any Willing Provider is a way of giving individual patients the best possible choice that they can have.

There are times when patients can’t make a choice, either because their personal circumstances at the moment make it inappropriate, in other words, perhaps it is an emergency situation, or, as you rightly point out, when a range of services is not at the time available. That is when the commissioners would have a responsibility, would have due regard to working with patients and patients’ groups and the public, to identify what range of services their patients would wish to see. But they would need to be evidence based, because, again, we are moving to a system where it is absolutely clear that the two central tenets are that patients and the public have much more influence on the service and many more choices in the service and that there is a clarity that we are delivering evidence-based outcomes. For any new service where there was evidence that this would have benefits to patients and the patient required it, then those are the sorts of services where we would be more likely to move into the tendering—the consortium would be more likely to move into the tendering—situation and tender for those services, or, alternatively, once we had a tariff for those evidence-based services, that
they could be done on the Any Willing Provider. But it does all, I think, depend on the heavy evidence base.

Q312 David Tredinnick: Given the cross-constraints, it is very important that you look closely at the therapies that I have mentioned, which are much more cost effective than some of the mainstream ones.

Dame Barbara Hakin: That is the role for NICE, and again we are looking to put in place a system whereby all treatments are assessed more rigorously nationally. Over time, increasing numbers of treatments will be assessed by NICE on the quality outcomes, and we will be clear about the evidence and the cost effectiveness of those treatments.

Q313 Dr Wollaston: Could I come back to Dame Barbara, please? You came back to me referring to the question about the loss of support from the professions and the public, having previously been very positive, and I hope I am not misquoting Sir David in saying that he thought it was because they had not really understood the detail of the Bill and you yourself saying you thought it was because they had misunderstood the Bill. What we have been hearing today is that there is a surprising lack of detail in the way that the new system will operate. Do you find it surprising that we are halfway through the Committee stage of this Bill and that these issues still have not been resolved?

Dame Barbara Hakin: There are two things. We have said from the very outset that this was a very significant change and that there was a lot to work through. Also, there has been a commitment in all of this that we would create a bottom-up process and try and work with patients, the public and clinicians to make this as good as it could be. Therefore, it might have been easier to create some of the answers in just a top-down process, but if we are trying to consult with people, work with pathfinders and the profession, then it will take us longer to get the answers, but hopefully we will get better answers.

The point I was making in the first instance is that from my discussions, and I perhaps have time for more detailed discussions with some senior members of the profession, it is very important that you look closely at the therapies that I have mentioned, which has also got to think not just about today but 10 or 15 years in the future. All the indications are in most professions is that there is really very considerable support for the policy intent. There are areas where there is a suggestion that the wording of the Bill could be better and could give more explanation. There are areas where people are simply worried about the detail that lies behind it, some of which will come in regulations and some of which will come out in the operating model for the Board and the commissioning consortia. There are areas where, with something like Any Willing Provider, which is really complex to understand, once that is explained, and the fact that the tenet behind that is ensuring that where patients are taking that choice and that we have a currency, a tariff, for a particular procedure, then, rightly and properly, the patients should be able to have the choice from as broad a range as possible. All I was trying to say was that there is lot to work through on this in terms of people understanding how it is going to evolve, but I think there is more support from the policy intent than sometimes comes out, particularly in the media.

Q314 Dr Wollaston: I would certainly agree that there is support for the policy intent when it comes to having clinical commissioning and designing logical care pathways, but the reality is that clinicians, and all the professions and patient groups, are concerned about the role of Monitor and what Monitor will become. Will it become an enforcer rather than an enabler? They do genuinely see there is a risk of fragmentation of services and they do worry about the cost and scale of the reorganisation and, as I say, about the lack of detail. To say that there is broad support for the policy objective is correct, but would you say that it is reasonable for them to be concerned about the role of Monitor and a risk of fragmentation?

Dame Barbara Hakin: It is reasonable for any stakeholder to be concerned about the future of the NHS because, after all, it is something that everybody in this country holds very dear. What we need to ensure is that, as this policy is implemented—and by working with stakeholders, the public and clinicians—we implement it in a way that gets the best results. If everybody is agreed that the policy intent of giving patients much more choice and influence, and basing what we do on evidence of what are good clinical outcomes and that we do that by involving clinicians much more as patient advocates—if that is the right parcel—then, inevitably, as we work through the scale of changes that David has suggested, with the operating model, it will take us some time to work out exactly what the detail is of how we are going to get the best of that policy intent.

Q315 Andrew George: I want to ask about patient choice. You heard those giving evidence earlier when I asked them about what proportion were asserting their right to choose, and it is less than 5%. Is that your impression as well, or do you have robust data at present, or have you undertaken surveys as to the extent to which patients are demanding their right to assert choice, because it seems you are creating an entire system which is based on patient choice. I am not sure whether patients are able to have these discussions with all members of the profession—is that there is really very considerable support for the policy intent. There are areas where there is a suggestion that the wording of the Bill could be better and could give more explanation. There are areas where people are simply worried about the detail that lies behind it, some of which will come in regulations and some of which will come out in the operating model for the Board and the commissioning consortia. There are areas where, with something like Any Willing Provider, which is really complex to understand, once that is explained, and the fact that the tenet behind that is ensuring that where patients are taking that choice and that we have a currency, a tariff, for a particular procedure, then, rightly and properly, the patients should be able to have the choice from as broad a range as possible. All I was trying to say was that there is lot to work through on this in terms of people understanding how it is going to evolve, but I think there is more support from the policy intent than sometimes comes out, particularly in the media.

Sir David Nicholson: The first thing is we are trying to create a system which will sustain itself, i.e. we have also got to think not just about today but 10 or 15 years in the future. All the indications are in most of the way we live our lives, and if you look at it internationally, that people want more choice. That is the first thing. It is not just about now. It is about the future. In terms of what patients say about it, we do survey patients about choice. I think about half of patients, after they have been through the consultation, say that they were given choice and recognise that they were given choice. The issue is that more and more of them are taking that choice, but it is a relatively small number, so if you take elective care, about £400 million is currently coming from the NHS into the independent sector for people who have made a choice. That is a tiny proportion of the population, but all the indications are that that will grow.
Q316 Chair: Is it not also that choice is not just about where you are treated but about the type of treatment and engaging the patient in the type of treatment that is provided? Many of the decisions are micro-decisions, which probably don’t show through in patient pathway charts.

Sir David Nicholson: No, and indeed it is one of the things in the QIPP work we are doing at the moment around all of this, because there is some really good evidence that shows that patients who are informed in this way tend to take the least expensive and the least invasive procedures when given that kind of choice.

Q317 Dr Wollasten: Do you worry that we are promising patients this brave new world of endless choice when, in fact, we have also heard evidence just today that because of financial constraints people aren’t, realistically, going to be able make those choices? For example, in the field of fertility treatment, they may not have those choices. We are leading them to have expectations that we will not be able to deliver.

Sir David Nicholson: We are trying to create an environment where they can exercise choice in those areas that we have identified they can at the moment. As we have more resources available for the NHS, or less, or whatever it is that Parliament decides, we can adjust that accordingly.

Q318 Valerie Vaz: Obviously, patient satisfaction levels have been extremely high before this process started, so we would like you to take that into account, but I want to clarify something, Sir David. It was something that was in the paper, that you had had discussions with someone from McKinsey who is running a company and wants to float GP surgeries on the stock market. Is that where you are—

Sir David Nicholson: I have had discussions with them?

Q319 Valerie Vaz: Yes. Apparently he ran the plans before you. Is that not right? Are you not having discussions with anyone?

Sir David Nicholson: I am having no discussions with anyone in relation to that. I can genuinely say “It wasn’t me, guv.”

Chair: A nother David Nicholson.

Sir David Nicholson: Yes.

Q320 David Tredinnick: In answer to Sarah’s question, you said that more and more patients, according to your surveys, are looking for non-invasive treatments. Surely there is a duty there to try and translate the choice of treatments into as close as possible what patients are requesting. I am thinking about the widespread concerns about the multiple use of antibiotics and things like that and, if there are other alternatives out there, then are you proposing to encourage NICE to look at them?

Sir David Nicholson: Yes.

Q321 David Tredinnick: Is this part of the whole patient choice agenda?
where organisations—Wrightington Hospital in my constituency is but one—are doing really specialist work and they are going to be seriously threatened by the tariff? There is an ongoing dispute, which has gone on for a number of years now. How will that be handled in the new world?

Sir David Nicholson: It will be a matter for Monitor, in a sense, to identify if any subsidies or extras are going to be paid to individual specialist organisations or whatever.

Q 325 Rosie Cooper: But if it has not been able to be resolved inside the Department of Health, how is this magic person who is just going to number crunch going to sort it out?

Sir David Nicholson: They have been resolved. The paediatric top-up, which is the obvious one, has been resolved.

Q 326 Rosie Cooper: Specialist orthopaedics has not been resolved, has it?

Sir David Nicholson: In a sense, it has been resolved because we have said what we are going to do. We have not satisfied everyone’s requirements in relation to that, but then again we seldom do.

Q 327 Chair: Can I raise two questions to close? The first concerns PCT debt. As I understand it, the undertaking is that the consortia will not inherit PCT debt that has accrued before March 2012. If it is the intention of the Department to write off the PCT debt that sits on the balance sheets at 2012, what is happening to the compensating asset that sits in PCTs or trusts that have provided that cash through brokerage to cover the debt that is outstanding at the end of the financial year 2011–12?

Sir David Nicholson: What we have said is that they will not take any debt before 1 April 2011—not 2012, but 2011—on the basis that if they get into any debt over the next two years the consortia may have a responsibility for that, i.e. this is an incentive on everyone to work together over the next two years to make it happen. That is the kind of incentive that we have tried to put in the system to engage people in the here and now as opposed to having the consortia sat over here watching it happen. That may or may not be successful, but that is what we are trying to do in relation to all of that.

As you know, there are resources currently held by strategic health authorities in the arrangements. Our ambition is to get every PCT into place, and all of the debt paid off, by 31st March 2013, so we want them to do it. If, in one or two cases, that is not possible, then we have enough flexibility in the system to sort it out.

Q 328 Chair: The reason I asked the question—and I am sure you understand—is that this is money that PCTs have borrowed from somebody else in the NHS, and those other people, the counterparties here, look at those assets as reserves which are available to them. Are those reserves still available? That is the key question.

Sir David Nicholson: Yes, they are. We think there is enough money, as well as that, held by SHAs that will enable us to do that. If, however, the number becomes very large, then the items you have just described would not be safe. Our ambition is to get them to a minimum amount and to use the extra free money the SHAs have got, which is not linked to an individual PCT, of which there is a substantial proportion, to pay off any of those debts when we get there.

Q 329 Chair: At this stage it is your ambition, but not your guarantee, that those saved reserves are safe.

Sir David Nicholson: We are currently going through the planning process for 2011–12. We will have completed all of those plans relatively soon. The indications are that we can deliver that ambition up to 1 April 2012. We then have another planning process to go through at that stage. Then I think I am in a much better position to be able to give a cast-iron guarantee. At the moment, it would be inappropriate for me to do so.

Q 330 Chair: That is the first question. The second question concerns one of the things you said at the beginning of this session, Sir David, which surprised me, to be honest, where you said that you thought that the most radical changes currently planned by the Government were on the supply side of the NHS rather than on the commissioning side. I was fumbling back during the evidence session to the Government’s response to our previous report on commissioning, of which I would like to read couple of sentences to you: “It is important to emphasise that the proposals do not involve fundamental structural changes to the organisations that provide the great majority of NHS care. The changes are to the organisations which commission these services.”

Sir David Nicholson: The point I am trying to make is that although the organisational change—and often we focus on organisational change because that is the thing that you see—is on the commissioning side, the actual change to service, which is what this is supposed to do, is all on the provider side. If you talk about the shift from secondary to community services, that is on the provider side. If you talk about the drive for productivity, that is on the provider side. If you talk about Any Willing Provider or competition on quality, it is on the provider side. All of those things will affect the provision of service in significant ways.

Q 331 Chair: What are you looking for is change of health care, not change of management structure.

Sir David Nicholson: Yes, that is exactly it.

Chair: I think that is an ambition that the Committee shares. Are there any other questions?

Q 332 Andrew George: Yes, on price competition. When we were talking about the various options which were available through Any Willing Provider or the tendering process, you can explain in the circumstances where a service is provided on the basis of an open tender, for how long can those contracts exist? In other words, can the commissioners establish those contracts for a number of years, and to what extent might they be vulnerable, if you like, to requests to refer them by other providers who might
then challenge those contracts and put an alternative offer during the period of the contract itself?

**Ben Dyson:** This is something that the NHS Commissioning Board would certainly be able to give advice to commissioners on, but it is reasonably well established—and it depends on the nature of the service—that for a number, particularly, of more complex services, maybe some of the more integrated services that were being described earlier, it would be, for instance, entirely satisfactory to have a contract that lasted for, say, five to seven years.

**Q333 Andrew George:** If any other provider of a service wished to come along and say, “We think we can do a better job or a more effective job than those that currently hold this five-year contract”, to what extent can that contract be challenged, be referred?

**Dame Barbara Hakin:** It couldn’t if the terms of the contract were that it was in place for five years.

**Chair:** A simple question to end what has been an interesting and complex session. Thank you very much for coming.
Ev 71
The reconfiguration of services is a priority. It is a priority for a number of reasons, but principally to ensure the delivery of effective clinical outcomes, good quality patient experience and, in some cases, that NHS resources are used optimally. In north-east London we have a number of examples where we have transacted a reconfiguration of some specialised services, for example, a heart attack centre, hyper acute stroke services and trauma services. There is a clear evidence base in relation to the impact of that reconfiguration in terms of patient outcomes.

In terms of the impact of the reforms, there will be an issue as to how the functions of GP commissioning consortia and reconfiguration issues. Often they are issues that require very close collaboration and partnership across a range of commissioners. That depends on the nature of the services being addressed, but one of the issues will be the way in which GP commissioning consortia work together across broader population bases and are held to account for the delivery of high quality, effective and cost-efficient services on behalf of their populations.

Q334 Chair: Do your current responsibilities include Chase Farm?
Alwen Williams: No.
Chair: In that case, I won’t ask you to comment on it.
John Black: The reconfiguration of services is constantly with us as patient treatments change. My college would take an attitude that if there is a clear evidence base in relation to the impact of that reconfiguration in terms of patient outcomes.

Q335 Chair: Thank you very much. Could I ask you to begin the session by setting out for the Committee, in general terms, your view, first, about the importance, or lack of importance, possibly, if that is the case you wish to argue—the relative importance—of reconfiguration of services in delivering good value and high quality health care? Is that something that ought to be a priority? Secondly, whether or not it is a priority, what do you think is the impact of the changes currently going through Parliament on the ability and the methods the Health Service will use to manage the reconfiguration of health care delivery? Shall we move from left to right and start with Alwen Williams? Thank you.
Alwen Williams: Thank you. My personal view, and very much from personal experience, is that the reconfiguration of services is a priority. It is a priority for a number of reasons, but principally to ensure the delivery of effective clinical outcomes, good quality patient experience and, in some cases, that NHS resources are used optimally. In north-east London we have a number of examples where we have transacted a reconfiguration of some specialised services, for example, a heart attack centre, hyper acute stroke services and trauma services. There is a clear evidence base in relation to the impact of that reconfiguration in terms of patient outcomes.

Q336 Chair: Good morning. Thank you for coming to the Committee. In the first half of this morning’s session, we want to focus on the effect of the changes proposed by the Government in the Health and Social Care Bill on the management of reconfiguration of services within the NHS. That is the main focus of this session. Could I ask the witnesses to introduce themselves, briefly?
Alwen Williams: Shall I start?
Chair: Yes. Thank you very much.
Alwen Williams: I am Alwen Williams. I am the Chief Executive for the inner north-east London cluster of PCTs.
John Black: John Black, President, Royal College of Surgeons.
Dr Hobday: Paul Hobday. I have been a full-time GP in Kent for 30 years and—a slight correction to the order paper—I am an ex-chair of the local BMA.
Seán Boyle: I am Seán Boyle. I am a Senior Research Fellow in LSE Health at London School of Economics.

Q335 Chair: Thank you very much. Could I ask you to begin the session by setting out for the Committee, in general terms, your view, first, about the importance, or lack of importance, possibly, if that is the case you wish to argue—the relative importance—of reconfiguration of services in delivering good value and high quality health care? Is that something that ought to be a priority? Secondly, whether or not it is a priority, what do you think is the impact of the changes currently going through Parliament on the ability and the methods the Health Service will use to manage the reconfiguration of health care delivery? Shall we move from left to right and start with Alwen Williams? Thank you.
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to give good evidence for the value of the reconfiguration, considering we see 90% of patients in the NHS and have over 300 million consultations every year.

Locally, as to the four rules that Mr Lansley has imposed, I have a very good example where all four rules have been broken and GPs’ opinions have been totally ignored. I would hope that that would not continue to be the case.

Q337 Chair: Could I ask you to comment on what Alwen Williams said, that there are questions in the new world about the ability of GP consortia to be large enough to look across the range of services required to plan a large scale reconfiguration?

Dr Hobday: The size of the consortia is one of the major questions I don’t think anybody has an answer to. Clearly, everybody knows that if they are too small they have no influence and if they are too big they lose the local value. In my years as a GP, having seen a dozen or so reorganisations, from Family Practitioner Committees to FHSA’s, et cetera, they have continually followed this cycle of starting off small, merging and then breaking up again. When PCGs were first introduced, as a policy, that seemed favourable because, initially, GPs were on board. But when they became PCTs, they became far too large and lost their local influence. I really have no answer to how big consortia ought to be.

My local example is that we have worked fairly well in a local PBC group of about 112,000 patients and 70 something GPs. We have had a little bit of influence in tinkering but, of course, we had no great power against a giant local acute trust. We have now merged with two other consortia to produce a group of 361,000 patients and 252 GPs. We have already lost our local “feel” and the people that are running these are self-selected because no GPs have come forward yet to want to run them, apart from the enthusiasts.

Q338 Nadine Dorries: You just said that if consortia are too small they are not effective and if they are too large they lose their local influence. That conjures up a mental image of all the GPs practising in one place and we know that they are going to be, still, in their individual practices. Could you define what you mean by large consortia losing local influence?

Dr Hobday: Locally, I can give the best answer by quoting what has happened in Kent. Our local trusts and the local area merged because it needed the size to build a new PFI hospital. But it produced real divisions in the whole area between the two main towns in our PCT group, Maidstone and Tunbridge Wells, where there was almost warfare between the two ends. Without decent co-operation, you cannot produce decent services because people were coming from completely different directions. That was when it was too big.

Q339 Nadine Dorries: That is not exactly losing local influence, though, is it? That implies something else. The GPs in those two groups were still practising as GPs and I am sure the patients didn’t receive any better or lesser treatment because of what happened.

Dr Hobday: No, but in the long run it influenced the services provided. For instance, Maidstone has lost its consultant-led maternity unit against the wishes of local GPs because they were put together with the Tunbridge Wells GPs who had no interest in Maidstone.

Q340 Nadine Dorries: And that is as a direct result of that?

Dr Hobday: That is the direct result of the group getting too big and not local.

Chair: Could I bring in Seán Boyle in answer to the original question?

Seán Boyle: Yes. I don’t think we should say that reconfiguration is necessarily a good thing in itself. What we always need to do is look at the case for reconfiguration and the case for change. That should work in the best interests of the populations concerned. What we should be doing is ensuring that businesses cases are presented on a case-by-case basis with the clear evidence underlying each part of the case. You need to look at a financial case but also at access for populations as well as clinical quality and deliverability, if there are going to be major changes. This is a process which we have had in the NHS for some time now and that is key to delivering good change.

In terms of the country as a whole, we have different practices in different parts of the country. That is often a good thing, but you also have to recognise that, over time, there are technological changes which mean you have to change the way you do things. Colleagues on my right have said that, and that is important. Always—and I suppose I would say this—the evidence has to be clearly presented and it has to be presented to the public so that people will feel they are properly consulted on what is being proposed and will understand. Often the public are treated like fools, but they do understand a lot of the technical side of this. They can see what a trade-off between access, cost and quality might mean. They also know when they are not being given the real story.

Q341 Chair: There are two different models here, aren’t there? One is that the commissioner is responsible for planning a reconfiguration of services and the other is that the commissioner directs the patient to where the patient is best treated and it is for the provider to plan services in response to the referrals by GPs. Do you have an instinctive preference for one of those routes or the other and do you think that the Bill currently going through Parliament changes the balance of that argument?

Seán Boyle: To take the first point, I don’t have a preference one way or the other. I believe you need to present the case in a way which makes clear the choices being made by professionals on behalf of patients and then bring it back to patients for their view to be taken account of. I have been involved in a number of issues around reconfigurations over the last 20 years in different parts of England. The sort of choice I mean is that it may be, in order to keep a maternity unit open or an A&E department open, you need to spend another £1 million or £2 million. If you present that as a choice
to the public, that if you are going to spend that on keeping local access then you are going to lose something else, and make people aware of that, then the public are making those choices. They are deciding whether or not their local unit should close. They may well say, “No. We can see the need to do that.”

As to the changes, it remains unclear to me what is going to happen in the future. Often, what is being proposed is very similar to what we are doing already in terms of business cases, consultation and changes round the edges about who is actually doing things. You may come on in later questions to discuss the structure of commissioning and these sorts of decisions and the way in which local authorities will influence this.

Chair: That is exactly where Mr George wishes to take us.

Q342 Andrew George: That is good, yes. Could I begin by refining the term “reconfiguration”? I am not aware of any community being up in arms or petitioning against having a dialysis service closer to their home or having an ophthalmic service in a smaller hospital closer to them. When you are reconfiguring and bringing services closer to people, those are pretty uncontroversial. If we can refine the term “reconfiguration” to the contentious side, which is the concentration, the centralisation and the reduction in numbers of centres providing those services, could you say how you think the dynamics of centralising the services are best managed under the new GP consortia arrangements? In other words, how will decisions, as you see them, be made by GP consortia when we are talking about the centralisation of services? To what extent will they have a say in terms of that type of reconfiguration?

John Black: We are slightly concerned about the gap between the National Commissioning Board and the GP consortia about services that are not nearly big enough for national commissioning, which is rare diseases with two centres in the country, and areas which the members of the GP consortia will not even see a patient. I can only speak with any understanding of surgical services, but there are many surgical specialties, such as cardiac surgery, paediatric surgery and neurosurgery, which seem to work best when they are commissioned considering the needs of a population of about 5 million people. I am not saying they should be retention of any of the regional specialties or any of the regional bureaucracies, which most people would be quite pleased to see the back of, but I do think there has to be some commissioning element looking at it between the national basis and the GP consortia basis.

The model for this, of course, is cancer services which have been centralised and we have seen improved outcomes from that. Again, that was more or less done on that population set-up. Cornwall have had that number of population. It is a point that was made by Paul Hobday earlier.

Q343 Andrew George: Yes. Can you see how that dynamic of the kind of grey area between where the scale at which the GP consortia will be operating and the management of national services by the NHS Commissioning Board is going to be covered? Is that something in which you—any of you—have had any kind of engagement in this process so you can be clear about how those services are serving populations of 1 million or more where you need to have that operating because, clearly, there are not going to be any GP consortia at that scale. A lot of them—and even in Cornwall, one pathfinder is 16,000.

John Black: There is no reason why there should not be that sort of arrangement in place. It doesn’t have to be, physically, in any one place and the clinician involvement is particularly important at that sort of level. I see this as a gap we have been asked to be filled, and not necessarily with a formal structure, but either at the bottom end or the top end there should be some arrangements put in place.

Q344 Andrew George: How do you manage the dynamics between the clinical governance issues that you are covering and local loyalty to one’s hospital and much loved local clinicians who, no doubt, people believe can do almost anything? This is going to be made worse, is it not, by a GP consortia structure which is at a very local scale? There will be many more GP consortia than there are PCTs.

John Black: Yes.

Q345 Andrew George: Therefore, they will be much more bound in to the aspirations of their local community, perhaps.

John Black: This is true. We saw this with fund holding, that the more distal based commissioning is, i.e. the nearer it gets to the patient, the more the local hospital is defended.

Q346 Andrew George: Do any of the rest of you wish to comment?

Dr Hobday: Yes, briefly, to add that, when the choice agenda appeared, my patients said to me, “I don’t really want choice. I want a good, local district general hospital that is safe, clean and will produce the basic services”, which obviously includes maternity, some general surgery, et cetera. We know that every district general hospital won’t be able to produce vascular surgery, cardiac surgery, et cetera. On the GP commissioning basis, considering when we refer one in 20 of our patients to secondary care and most of those referrals are basic bread-and-butter stuff—they are not for neurosurgery, et cetera—the majority of our work relates to a local district general hospital. Clearly, we have got to have contracts, or whatever it may be, to deal with the supra specialist field. That is a small proportion but it is one that may distort all these arguments if we are not careful.

Q347 Andrew George: Do you feel that you and your colleagues are qualified to make those kinds of judgments about the scale and the clinical governance issues with regard to some services where the level of intervention is perhaps a level above where the DGH will be?

Dr Hobday: We won’t be making those decisions on our own, of course. Our role as GPs is to know when
to consult and when to refer on when we have passed our limit of expertise.

Q348 Andrew George: But as a consortia what is the formal structure? Where will you get that advice and when do you know when you need to seek that advice?

Dr Hobday: From experience, there will be a constant dialogue with our secondary care colleagues.

Q349 Andrew George: But would it not be better to have your secondary and tertiary care colleagues on your commissioning board to help you make those decisions?

Dr Hobday: Yes, and I can’t see any reason why not.

John Black: We would strongly support that. In fact, if you called it clinician-led commissioning rather than GP-led commissioning and merged the secondary care sector and the primary care sector—and it is already beginning to happen, which is slightly encouraging—

Q350 Andrew George: I am sorry, can you explain more?

John Black: I was told of a case recently in a town where the local GPs have arranged to meet the local physicians prior to the new arrangements to discuss how they are going to cut the number of emergency admissions to hospital. That is just the sort of dialogue we would all wish to see, with the sectors working together and the clinicians providing the same advice.

Q351 Chair: Mr Tredinnick wants to come in but, before you do, David, Alwen, do you want to comment on these points?

Alwen Williams: The points I would like to make are these. It feels to me that where we have achieved success in terms of consensus around reconfiguration goes back to John’s earlier point about a very strong evidence base. Where we can encourage and find ways of GPs and secondary and tertiary care clinicians working well together in looking at the whole system of care with a strong evidence base, certainly my experience is clinicians will come out of their institutions to look at the whole system and what is the best design of services to produce the best clinical outcomes—the best use of NHS resources. We have examples in north-east London where we have just been through a significant consultation on reconfiguration of services. It has been very strongly clinically led and clinically driven with strong patient involvement. When I talk about “clinically led” it has not just been the GPs. It has been acute clinicians as well. The outcomes that we have secured as a result of that, building a consensus of what “good” would look like for the health community but, again, clinicians engaging with patients and patient groups in that process, feels to me to be a sound model. We then need to think about how, potentially, we could get that to work with the new commissioning and indeed provide a landscape that is being developed.

Q352 David Tredinnick: I wanted to take you up, Mr Black, on the point you made about specialist services needing a catchment of 5 million people and, also, that the links with commissioning structures are already starting to happen. If you are going to have one neurosurgery hospital serving 5 million people how do you get down to all these different commissioning groups? Do you have a formal structure? Have you got a representative or does each commissioning group nominate a doctor who is responsible for talking to the neurosurgery hospital? How does it actually work? I see a very hazy tree there or inadequate coverage.

John Black: I see a very hazy tree, too. There are two ways. The consortia themselves could work as a group with those involved in providing the 5 million size service or it could, of course, be done centrally on a virtual level. The services that are required to be commissioned at that level could be all organised centrally in a virtual way. For example, if you look at the reconfiguration of children’s cardiac surgery that is going on at the moment, with support from us because there is an evidence base, the location of the centres should have been decided on a level playing field nationally, I would say.

Q353 David Tredinnick: If you have different commissioning structures bidding for scarce resources, who is the gatekeeper going to be? Do you decide that this tumour is worse than another tumour? How do you evaluate the actual pitch that different commissioners are making? You might get a multiple application, like the Olympics, and you have to say, “I will pick and choose one of those.” I don’t want to be facetious. Maybe it is difficult to answer.

John Black: The answer is you want clinician involvement from the appropriate clinicians. I fully support the point. By “clinicians” I don’t mean doctors. I mean clinicians of all specialties. Nurse clinicians are particularly important in various safety measures such as setting nursing levels. One mechanism might well be for that to happen nationally with clinician advice rather than coming from two directions. But I share with you in that I am not at all clear how that is going to work.

David Tredinnick: Thank you.

John Black: But it is not rocket science to produce some mechanism whereby it could work.

Q354 Dr Wollaston: With reconfigurations it is always difficult to persuade the public of their case. Take an example in the south-west of reconfiguring upper GI cancer services, which was initially unpopular but has now been accepted. Subsequently, the evidence is clear and people now accept that that was the right thing to do. I am interested to hear from the panel how many reconfigurations in future will be financially driven rather than clearly clinically led and how difficult you think it will be to persuade the public of the need for that to happen, say, in London which is over-provided with hospitals.

Chair: Who would like to go first? Dr Hobday.

Dr Hobday: Following on, I would like to make a point that we refer to people not buildings. The medical world is quite a small world, so I know the neurosurgeons even though it is a big district, for instance.
On the arguments about whether it is financially driven or not, we have a good example in the last 10 years again in Maidstone. There was always total denial that the reconfiguration of the surgical and orthopaedic services, and, later, the maternity and the paediatrics, was a financial decision. But it has turned out that it clearly was a financial decision and there was no transparency for people to scrutinise it. The consequence is that, in our area, there is now immense suspicion that the policy is made and then the evidence is looked for, rather than the other way round. That is widespread in my area. Transparency has got to be there.

Q355 Dr Wollaston: You think transparency is the key to this, being open with people that this is a tough financial decision but “This is why we are doing it”. Dr Hobday: Yes. Locally, this reconfiguration may go to judicial review because it is so contentious and there are so many faults in it, as far as we can see. But when the trust has gone it is the same as when the trust goes with the doctor-patient relationship. We have to be incredibly careful there because the suspicions of the patients will always be, “Are you doing this for financial reasons rather than for my clinical good?” That is the small example extended to the reconfiguration process.

Q356 Chair: Surely the reality, in most of these decisions, is that it is a balance of clinical and financial questions. It is a question of how you get the best value for the money that is available, which will always be limited.

Dr Hobday: Absolutely, but admit that. In our local area that was not admitted. It was always, “This is not a financial decision.” It became obvious, eventually, that it was.

Q357 Dr Wollaston: Do you think it is going to be something that GPs, as commissioners, will find easy to do—easier to do than perhaps has been the case for PCTs?

Dr Hobday: That is a very good question, of course, because PCTs were fairly impotent, as they were in our area, to tackle the acute trusts. I don’t see how GP consortia will be much stronger, unless we go back to the size issue and we have so much clout that, again, it covers vast areas and vast population numbers.

Seán Boyle: The issue about whether it is financially driven is often key in terms of looking at changes and reconfiguration to services. My view is that clinical arguments have often been used to mask what have really been financial considerations in the past. I know we are looking to the future now but you can learn from how things were done in the past. If things were not done well in the past, in terms of being transparent and in terms of your arguments, which is what my colleague has been referring to, we should learn from that and the Government should go forward committed to laying out the arguments in a clear way. The problem for me, always, has been that I have never seen really good financial arguments put forward in business cases in the NHS. I am not aware of major changes in services—reconfigurations of services—that have resulted in large savings or any savings within health economies. I have not seen the evaluations of change that show you this. In fact, if you look at what the National Audit Office does, it often looks at changes which are supposed to realise benefits and they don’t realise benefits. Why is that? I don’t believe business cases are put forward in a way which is honest in the sense of saying, “We are going to make these savings, we are going to improve quality and we will be tested against this in the future.”

Q358 Chair: It is a very important point you are making. If it is true that service reconfigurations are routinely carried out in order to achieve better use of resources and you are saying, in the event, they fail against that test, then that must undermine the case for these reconfigurations as we consider them going forward, doesn’t it?

Seán Boyle: I think they did fail that test. I have not seen evaluations which show otherwise, is perhaps the way I should put it. I have seen individual changes taking place where the NAO has shown some evidence to this effect. Going back to this notion of consortia, if we think back to strategic health authorities, they drove a lot of the reconfigurations. That is true. That is the way it worked. PCTs were working locally but the framework within which they were working was determined by the strategic health authorities. The Commissioning Board is in a similar position, in a sense. From my reading of the Bill, it will be determining whether or not the plans of consortia will work for local populations, to put it very crudely, and whether the way in which they interact will work. I personally believe that a Commissioning Board at a national level cannot do that. I know, from the evidence of David Nicholson last week, that he has hedged his bets a bit. He said that the Commissioning Board will not be involved in reconfiguration but, at the same time, that the Commissioning Board will have people at local levels. I would predict that, within a couple of years, what we will have are regional bodies as part of the commissioning boards which might not be called anything but “Commissioning-Regional”. But they will be there to ensure that things are working appropriately on the ground. Whether or not we go back to the command and control system that we had under the previous Government depends on whether the current Government wants to use the Commissioning Board in that way. That is their choice. I will be interested to watch what develops.

Q359 Chair: Would any other member of the panel like to comment on that prediction?

John Black: I would like to say that, where there is an evidence base, clearly bodies such as the Royal College should be prepared to defend it. Sarah has mentioned upper GI reconfigurations, of which we have made certain recommendations. In that event, we should be prepared to stand up and say so to the local population. Indeed, I remember getting out of Rugby only just with my head on my shoulders a few years ago. But that is a very good point because the history
of trust mergers in the National Health Service is that they don’t save money.

Q360 Chair: But do they achieve better clinical standards? There are two justifications, one is clinical and the other is financial. Do they achieve either of their objectives? If they don’t, then taking local patient groups with us is going to be impossible because they are right.

John Black: You could argue that in the City about all these mergers that go on there. Do they actually improve anything for anybody? Pass.

Q361 Chair: Can I ask Alwen Williams’ views on this?

Alwen Williams: Going back to the issue of whether this is financially led, I would want to emphasise the point that this is about the best use of NHS resource. Looking at the focus, that trusts and commissioners and GPs are looking at efficient systems, we risk having too much capacity in certain hospitals that would then not, in my view, warrant a good use of NHS resource. Again, it is about how the system plans that to ensure that, indeed, NHS resources are best deployed.

There is also a link to increasing quality. To a certain extent, a key driver for us has been increasingly consultant-delivered services rather than consultant-led services—that is key to improving the quality of patient outcomes—and if we can achieve that within a best value approach, as opposed to an incremental cost approach, when we know the reality is that there are real constraints in terms of the financial allocations. Again, I would say it is looking both at how you best choose NHS resources in terms of the application to front-line services and how you can also, at the same time, drive up the quality and cost-contain for the future.

Q362 Dr Wollaston: Can I come back to you on that point about consultant delivered as opposed to consultant led and bring in John Black, who is sitting next to you, because you also, earlier, touched on the issue of the Working Time Directive. How effective do you think the new arrangements will be in enabling primary care to work together to deliver those outcomes?

Alwen Williams: It is how we design the system. My concern is that one could design a system that is pretty fragmented. You have touched on small scale, potentially, GP commissioning consortia, in a set of relationships that may be more about transactional contracting with NHS trusts and foundation trusts. My view is that isn’t going to deliver the best NHS. It is very much about how commissioners play their role and how providers play their role but we need to ensure that, as we design the system, the system needs to be an integrated offer. Only by doing that, I believe, are we going to continue to improve quality of patient care, make the best use of financial resources and not create, inadvertently, a system that is, in a sense, at loggerheads with itself or, in a sense, so fragmented it is unable to achieve large scale service change.

John Black: We strongly support a consultant-delivered service where the service is delivered by trained specialists assisted by people trained to be consultants. It is inevitable because we now have enough doctors coming out of UK medical schools to supply our own needs. Like every other first world country, medical graduates will want to have been properly trained to specialist level and to work at that level. GP consortia commissioning with that stipulation would be very valuable and, indeed—sorry I am going on a bit—the old fund-holding practices sometimes used to stipulate that they wanted their patients seen by consultants. The patient group really do. The trouble is the patients do not know if they are seeing a consultant or not, which is yet another issue we might take up one day.

Q363 Valerie Vaz: I want to fast forward. You have mentioned this elephant in the room or the person looking over your shoulder in the shape of Sir David Nicholson. I wondered, in terms of GP commissioning in the future, whether you think it is going to be easier or more difficult to drive through reconfigurations?

John Black: It has always been difficult and will remain difficult. One of the stresses in the Bill, which we were very pleased to see, was a stress on measuring outcomes. If you measure outcomes, there should be more evidence on which to base reconfigurations. Hard fact is very difficult to argue against. For example, if all commissioners had to insist that outcomes are measured as best they could, that, in surgery, would be the biggest single measure you could do to improve patient care.

The classic example of that is the cardiac database where every cardiac operation, 10 years ago, with a bit of kicking and screaming at first, was entered into a national database. What happened? The outliers looked at themselves and there were various reconfigurations driven by the profession, not by commissioners or managers. The profession said, “We’ve got to reconfigure.” The outliers were eliminated and we now have the best cardiac surgery results in Europe—probably the world. That could be replicated, with proper outcome measures that could be put into the Bill, if commissioning is absolutely based on outcomes. The difficulty is that it is relatively easy in surgery but, of course, very difficult in other areas. It is easy for me.

Dr Hobday: I would add that, yes, we all fully agree with what John said about outcomes. It is very easy, or easier, to measure in surgery but in mental health and dermatology and all the other specialties how do you measure outcomes? There is this over-emphasis, I believe, on outcomes although we have to measure it somehow.

Q364 Valerie Vaz: Do you think it is going to be easier or more difficult? You are in the driving seat as GP commissioners. There may not be an answer. It may be something else.

John Black: If they were persuaded to make a condition of commissioning that you measure the outcome, that would drive standards up inevitably and I would hope to see that. In fact, the Bill does say “outcomes, outcomes, outcomes” all the way through, which is good.
Dr Hobday: I believe the devil is in the detail. When the White Paper on the Bill was first published, a lot of GPs were in favour of it because there was a simple statement that GPs were going to be put in the driving seat of commissioning. As soon as the detail was looked at, now there are polls that say the vast majority of GPs are against it because of the conflicts of interest, etcetera. It purely depends on the mechanics and nuts and bolts of how it is going to be put into operation. If it is put into operation properly, I believe reconfigurations and commissioning will be easier.

To add a further point, yes, referrals to consultants are the sort of things that must be written into contracts. We now have a situation, and have done for some years, where, as I said earlier, we seem to be referring to buildings rather than people. If we try to refer to named consultants we find our patients in front of a nurse specialist. That sort of thing, in my opinion, is one of the first things that will be stamped on if we ever get the reins of commissioning.

Q367 Chair: You hold the chequebook.

Dr Hobday: But not without our saying so.

Q366 Valerie Vaz: Do you see yourself doing it over a wide geographical area or would it just be your local patch?

Dr Hobday: Mainly within the patch but I do not see why, as long as we know the specialist and know the reputation, people should not go further afield. Again, when I first started practising there was no restriction to where I referred patients. I could have sent somebody to Newcastle, if I wished. In 1990 that was taken away so we had difficulty referring to people of our choice. Then it became more generic. We were referring to hospitals and to a named consultant but it was all watered down and that patient was seen by whoever was thought appropriate by the managers.

Q368 Rosie Cooper: What powers do you have? You talk about bringing people together and getting them going but what powers, in your current role as chief executive of a cluster, do you really have to knock nurse practitioners and nurse specialists because they do a good job when they have the appropriate patient in front of them. I have nurse practitioners in my practice and the skill is making sure that the right person is seen by the right type of professional. But when, for instance, I, myself, might refer somebody, after 30 years of experience, and find that they are seen by a nurse practitioner who is aged 25 and has not got any experience, I would think, “I won’t bother referring in future.” But the patient is then denied a choice. Their choice is obviously that we are wanting to consult somebody. That is where the phrase came from, “a consultant”.

Q365 Chair: Dr Hobday’s point, as I heard it, was that if you are referred to see a consultant then it should be the original decision by the GP rather than by the institution they are referred to.

Dr Hobday: Yes. If I can clarify, I have no intention of knocking nurse practitioners and nurse specialists because they do a good job when they have the appropriate patient in front of them. I have nurse practitioners in my practice and the skill is making sure that the right person is seen by the right type of professional. But when, for instance, I, myself, might refer somebody, after 30 years of experience, and find that they are seen by a nurse practitioner who is aged 25 and has not got any experience, I would think, “I won’t bother referring in future.” But the patient is then denied a choice. Their choice is obviously that we are wanting to consult somebody. That is where the phrase came from, “a consultant”.

Alwen Williams: My instinct is that it is going to operate strongly at a local level. At the higher level we are talking, maybe, about £3.5 billion worth of activity— at a really specialised level. Where the action is in terms of money is at a lower level in terms of specialisation. My instinct is that the Commissioning Board will be operating at that more local level. If it doesn’t do that, then it will not be able to work effectively, I would suggest.

I am not putting that forward as a model that I would say, “This is the best model.” I am saying I think that that is the way it will work because that is what comes out of the culture of the NHS eventually. There is a way that things often fall back into an almost natural position in terms of the management of the GP.

Alwen Williams: It is early days, but as a cluster chief executive I can certainly see the benefits of having a degree of a sub-regional structure for the National Commissioning Board. That may need to be for a transitional period when we look at the functions of the National Commissioning Board in relation to direct commissioning in terms of ensuring that GP consortia are developed and are transacting their responsibilities fully. I can see in my role now, for example, as a cluster chief executive with five GP commissioning consortia in situ, that the cluster does play a role in brokering relationships in the GP commissioning consortia coming together with acute clinicians looking at how the system can be best managed. I am not, for one minute, saying that necessarily has to be replicated in terms of that geography but that approach, certainly in the medium term, I can see working well, and particularly with the direct commissioning responsibilities of the NCB.
Alwen Williams:— the deployment of NHS resources, the contract held with NHS trusts, and clearly a responsibility for the development of GP commissioning consortia and an ambition to ensure that the legacy handed over in 2013 is a good one from the cluster, means that we have a range of current accountabilities and responsibilities that enable us to do things in the way that we think is right for patient care and in a way that enables strong clinical leadership of that agenda.

Q369 Rosie Cooper: Can I ask a quick question? The Secretary of State is saying that some commissioning boards are coming together now and the inference is that they are "commissioning". If, between now and 2013, you have boards which are moving towards, perhaps in 2012, beginning to pull together a commissioning plan and you hold the purse-strings, as we have just been told, could you veto any of those plans? If so, what would that do to the emerging consortia? How would they feel? What confidence would they have in themselves?

Alwen Williams: I would say it is a sign of failure of my system if I got to a position of having to veto a plan. There is a huge reliance on good working relationships, trust and confidence and the GP commissioning consortia having confidence in the management team of the cluster to give strong advice to provide high quality commissioning support services. Certainly in my experience of over 10 years as a PCT and, latterly, a cluster chief executive, I have never been in that position because you have to broker. You have to problem-solve together and broker solutions together and a system that ends up, in my view, either voting at a PCT board or vetoing someone’s plans feels, to me, a system that is clearly not working as well as it should be.

Q370 Chris Skidmore: A key part of a discussion we have had this morning has been to look at laying out the argument for reconfiguration, whether that is on the basis of cost or on the basis of clinical output. I would be interested in what Mr Black had to say about that. But I was also interested in to what extent Government can drive principles of reconfiguration. The previous Government set out, in 2006, that there should be a clinical case for change. I can’t remember what the mantra was but it was something like “localised where possible, centralised where necessary”. Since the coalition Government has come in we have obviously seen Andrew Lansley’s four tests for the reconfiguration of services that were placed under a moratorium and to what extent those tests will carry on through will influence future programmes of reconfiguration. I would be interested in your views on that. When it comes to outcomes, which are not always empirically measurable, to what extent can we have principles set by Government that are to involve the public and often people have not done it very well. I am thinking of that chap from the west country who did reviews.

Chair: Carruthers

Seán Boyle: Yes. Carruthers was called in to make recommendations. His recommendations were, basically, “Do what you are supposed to do.” Again, the final one, consistency with current and prospective patients. In my view, I would translate that as, “Analyse what the historic patterns are and analyse what you think future patterns of activity should or will be and try and match your services to those.” That is not rocket science but I was glad to see, at that point, that quite a few were being reiterated but it was a reiteration.

Q372 Chris Skidmore: There is also an important difference, from now on, with any future reconfiguration. That is, with the progress of the Bill, we will have new providers entering the market, and to what extent reconfiguration will have to reflect that. I was wondering if you had any views on whether future reconfigurations will necessarily have to reflect the fact we have these new providers and that possible reconfigurations in the future will be, in essence,
Will the reforms make it easier for you to improve outcomes or more difficult?

**J ohn Black:** If the reforms could be done in such a way that what was done in cardiac surgery was done for every form of not just surgery but procedure with a clear outcome it would undoubtedly improve outcomes. That could be put into the commissioning process. It could be put into the present day commissioning process as well.

**Q378 Andrew George:** But you have done this before the reforms?

**J ohn Black:** Yes. It was done before the reforms.

**Q379 Andrew George:** What lessons have you learned which you could now apply to a reformed NHS with GP commissioning and in an environment where any other willing provider is also providing the services and competition law will be applied?

**J ohn Black:** I think I said that. Everybody should have a level playing field and a condition of providing the service should be that they measure the outcome. What has been done in cardiac surgery, and is happening in other specialties where the results are not quite so mature, is a model to which any commissioning system should aspire. They should look at what was done and insist that this goes in to their commissioning from now on. So-called world class commissioning—I cringe when I hear that word—would measure outcomes and insist that those outcomes are fed back in to changing the services.

**Q380 Andrew George:** So the Royal College supports the reforms.

**J ohn Black:** We support the stress on outcomes. As a college, we would not have an attitude per se. We think how health care is delivered is for Government and Parliament and the people of this country. But we thoroughly support the stress on outcome measures and we would push for more clinician involvement.

**Q381 Andrew George:** In the commissioning process?

**J ohn Black:** In the commissioning process.

**A lwen Williams:** To answer your question—and again, today, we have discussed structures and size of consortia—what we need to inject into the debate, whether this comes as part of the authorisation process, is that commissioning competencies are key requirements. My view, having worked in the NHS for over 30 years, is that we work with different structures as long as those structures work in an integrated way. It feels to me that the competence of commissioning as well as the competence of providers
is absolutely key. As somebody who went through world class commissioning on a few occasions, relatively successfully, I have to say—and I know maybe it is the terminology “world class”—I think the fundamental framework which was about how you measure commissioning competence, how you make sure you have a clear strategy and how you ensure you have very good transparent governance, which goes to your point on reconfiguration, was a very good framework. My answer to your question is that it would largely depend on how competent the future commissioners and commissioning support services are to ensure that the right commissioning processes and decision-making processes are put in place for the benefit of patients.

Q382 Andrew George: Do you share the same confidence?

Dr Hobday: I am worried that the upheaval will slow down the improvements that we have seen in trends and I recommend John Apleby’s paper in the BMJ a month ago from the King’s Fund who, I am afraid, discounted a lot of these claims of how poorly our Health Service is doing. If trends continue, for instance, as they are, next year we will have equally if not better myocardial infarction survival rates than France. It was not pointed out that France spends 29% more on health than we do, so there was a bit of selection and cherry-picking among the statistics there. I am afraid. The paper produces a lot more examples about how the cancer care in this country is much better than Mr Lansley is making out. I could give you the reference for that in the BMJ, if you wish.

Q383 Chair: Could you write to us with that?

Dr Hobday: Yes, certainly. If things are left as they are now, we will have equally if not better myocardial infarction survival rates than France.

Chair: Just to emphasise that point. It would be helpful.

Dr Hobday: Yes, certainly. If things are left as they are, the trends would continue in the right direction and we would be doing very well and on a par with most European countries, if not better. I worry that the upheaval of the changes will sabotage a lot of those trends.

Q384 Rosie Cooper: Could I first ask Alwen how Government policy on reconfiguration has changed since the coalition came to power and how you think GPs will play a role in that reconfiguration process? Then, if I may, I will put that to other members of the panel.

Alwen Williams: We were in the throes of a reconfiguration process as the new Government came into power and introduced the four tests. So we have been a bit of a guinea pig in north-east London in terms of reviewing the processes. The measure of success has to be strong clinical engagement—I would say GP commissioners as well as acute clinicians—in ensuring that the reconfiguration proposals are based on good evidence and clinically led. That feels to me, certainly from our experience in north-east London, looking at a dialogue that then ensues between clinicians, patients and, indeed, local government is a much more powerful dialogue and set of conversations than, I would suggest, between an NHS manager like myself, and local government with GPs and clinicians being towed along.

I think the way in which we design reconfiguration processes to be very strongly clinically-led is absolutely key. We have certainly worked through the four tests and, as a result, from external validation we were enabled to go through to a joint decision making of the joint committee of the PCTs on those reconfiguration proposals. They have since been referred to an IRP process as a result of a referral from one of the overview and scrutiny committees. One of the tensions in the systems, to me, is that if there is a strong clinical evidence base and a strong financial base, and I don’t think we should kid ourselves to say that absolutely everybody will agree because that is not going to be the case, but if there is a substantial degree of consensus in relation to “This is the right thing to do”, there is something about the current process taking so long that it mitigates against securing the optimum result as a result of a reconfiguration process. One of my pleas going forward is not only to continue to sustain very strong clinical leadership but to see whether there is a degree of streamlining some of the processes in terms of construction of the case and the decision-making processes. What we absolutely do not want is, having made a very strong business case around clinical quality and patient outcomes, to find that there is significant delay in enabling delivery of that as a result of the processes that are currently in situ.

Q385 Rosie Cooper: I will come back to accountability of that in a minute, if I may. I would like to ask Dr Hobday: how is that working in practice?

Dr Hobday: I am sorry, accountability?

Rosie Cooper: How is the policy working in practice? You had an example before.

Dr Hobday: Going back to the Maidstone example, yes. In practice, for conditions locally, they were totally ignored. They really were. This is one of the reasons why the trust has completely gone. Seán was mentioning about how you can measure these. We had a survey in our area that was audited correctly and showed that 97% of GPs were against the closure of a consultant-led maternity unit but it was ignored. We had a clinical evidence base ignored and genuine public opinion ignored. The interesting thing was that GPs, in this reconfiguration process that started in 2003, were not asked their opinion once until July last year when Mr Lansley produced his four conditions.

Q386 Rosie Cooper: Now you have been asked and ignored.

Dr Hobday: Absolutely.

Q387 Rosie Cooper: So that makes it better.

Dr Hobday: I was going to say that the commissioning side, as far as the GPs are concerned, is only going to work if the GPs are listened to a little bit at least. But there should be a reversal of this policy of diluting the GP role. How can we become gatekeepers and look after the commissioning side if
people can squeeze round the side of the gatekeeper, whether it is because they are going to walk-in clinics or Dari centres and all the sorts of things over the last 10 years which have diluted the GP's role? I am not saying that they are necessarily bad things but it will sabotage or not make the commissioning easier. My main concern with whether the commissioning can work well is that worry I have of the interference with the doctor-patient relationship—bringing rationing into the consulting room—and, therefore, all the people that have self-selected themselves on to the boards of these groups really ought to be producing declarations of interests before they put themselves forward. In our area, the board has been elected because there were so many places and not many people came forward. So they were a self-selected group.

Q388 Rosie Cooper: Accountability, as something that I have followed right through this process, worries me greatly. On reconfiguration, for example, in the very early days when we had the Secretary of State before us, I asked the question, "What happens if clinicians make a decision pursuing a reconfiguration, the consortium then believe that is the best course of action, yet the Overview and Scrutiny Panel or the Health and Well-Being Board, as it will be, the local population, were against that clinical decision which led to a reconfiguration?" I asked the Secretary of State what would happen in that instance. There is no real level, for me in my understanding of this, of accountability anywhere. We can't see anybody on the consortia—no patient or external people—there at the table with a voice involved in the decisions. Health and Well-Being Boards will not sign off the plans of the consortia. There is a lot of consultation, there is a lot of influencing but no actual being there at the centre of decision making. What would happen, I put to the Secretary of State, if we had the populous, if you like, against a clinical decision? He said exactly that, it would go to the Reconfiguration Panel. That is exactly the same as we have now without the pretend of consulting and ignoring clinicians.

I suppose I would like to ask the panel generally where you really think you are today. I understand that it is at Chase Farm, in north London, where a reconfiguration of A&E services has been going on, as I think we heard before, for 17 years. That is now on hold yet again. If that is going to happen, where are you going? Does anyone want to pick up that point?

Chair: This needs to be a wrap-up question, if I may. Where are you going?

John Black: If clinicians in professional bodies give clear advice that something should be done to provide higher standards they should stand by that decision and they should become involved in the processes to persuade the patients that it is in their interest to do so. If you don’t do that, you are shirking your duty. But it has always been difficult, it is always going to be difficult and it will never be easy. But if someone like my college says, "We think this service would be safer if it moved from A to B", we should stand up and say so and try to help the local population understand why this should be done.

Q389 Andrew George: But, finally, who is making the decision, is the point I am trying to get to? Is it the clinicians, is it the population or is it the Secretary of State?

John Black: I don’t know—I am not an expert in parliamentary governance—but it is going to land on the desk of the Secretary of State, isn’t it? It is like a planning thing. What is the Secretary of State for but to make the ultimate decision?

Seán Boyle: I will try to answer some of your questions. I agree completely that what we are looking at in terms of the way the process is working, at the moment, is one where the Reconfiguration Panel will look at cases on an individual basis and make recommendations. I would recommend a report from them which I pulled out, Learning from Reviews, which I can let your clerk know the reference for. If you look at that, all that we have been talking about today is contained in the way of the problems of presenting a case for change that will work effectively for patients. That is one thing.

I said, just now, that this is the situation at the moment where we are in a position of transition. What will be interesting—and it is difficult to forecast—is what will happen if we are in a situation where we have independent foundation trusts who should be making decisions themselves about how they are going to reconfigure services and presenting an array of services to commissioners who will then be thinking about how to negotiate with these trusts on the basis of price, quality, etcetera—things which have always been there anyway? At this point can the Secretary of State intervene and say, “Barnet, Edgware, Chase Farm and North Mid, you might be one trust but I am not going to let you close this one down” or is the legislation going to be such that the Secretary of State will have to stand back and say, “You are an independent body, you might not get the business and you might get the business. It is up to you to see what happens”? That is a crucial question. I can’t tell you what will happen in the future. I have given you a bit of a forecast. That one is much more difficult to judge but that is crucial.

Alwen Williams: Your point highlights that the NHS is a complex system and making change to that complex situation requires a degree of resilience, focus and real passion to ensure that we get the very best for patients whatever structures and processes we have in place. We have probably rehearsed with you today what we believe to be some of the key ingredients of success. Often the success is in the execution rather than in a set of principles or a kind of diagnostic. It is how you execute well a plan that involves clinicians, the public and local politicians. In a sense, some of the elements of that, which we have articulated today, are very much related to a strong clinical base.

I think strong relationships are important and I think strong clinical leadership and more sophisticated ways of engaging our local communities with clinicians being much more visible in that process feels, to me, not a recipe for guarantee but perhaps a recipe for success in terms of ensuring that we are able, as we reconfigure, to reconfigure effectively as opposed to reconfiguring in ways that either do not happen
because they get stuck in bureaucratic systems or reconfiguring for the wrong reasons.

Chair: Dr Hobday, and then we really need to move on.

Q390 Rosie Cooper: Forgive me. Before Dr Hobday comes in, there is a real flaw in here which is that we can do all that consultation and everything else but the financial base of a foundation hospital or a local general hospital will depend on what is being commissioned and if those conversations do not involve the hospital and consultants and their financial base is challenged then, when the hospital is threatened, you will see that debate will change pretty rapidly.

Alwen Williams: Our experience, in north-east London, is that you absolutely need your clinicians across the system to engage in that. We have had very strong clinical leadership from the medical directors of the acute trusts who see that some of their services are not sustainable and that it is not a good use of NHS resources and that health inequalities persist. I would not underestimate the potential of acute clinicians as well as mental health clinicians as well as GP commissioners to want to do the very best for their health economies and their health systems because many of them have worked in those areas for many years and really have a commitment to high quality patient care.

Dr Hobday: You will only take the public with you on a certain policy produced locally—we have had bad experience in Maidstone of this—if there is total honesty, transparency and no vested interests with the policies, as has happened in Maidstone, and if declarations of interests are there.

Chair: On that note, we need to move on. Thank you very much for your contribution. We shall reflect on what you have said. Thank you.

Examination of Witnesses

Witnesses: Suzanne Tracey, President, Healthcare Financial Management Association and Director of Finance and Business Development, Royal Devon and Exeter NHS Foundation Trust; Noel Plumridge, Independent consultant and writer on NHS finances, Andy McKeon, Managing Director for Health, Audit Commission, and Professor Margaret Whitehead, Professor of Public Health, University of Liverpool, gave evidence.

Q391 Chair: Good morning. Thank you for coming this morning. I am sorry we are running a little late. Thank you for listening to the earlier session. Could I ask you, briefly, to introduce yourselves and your particular interests? The subject we are going to wish to move on to now. I should say, is the management of deficits by commissioners, both inherited deficits and how they move forward. It is more financial rather than the reconfiguration issues we have been discussing. I would ask you to introduce yourselves.

Professor Whitehead: Good morning. My name is Margaret Whitehead. I am the Professor of Public Health at the University of Liverpool. I am also a member of the Technical Advisory Group of ACRA, the Advisory Committee on Resource Allocation, but I must make clear that I am not speaking on behalf of TAg or ACRA. I am in my capacity as Professor of Public Health.

Andy McKeon: I am Andy McKeon, Managing Director for Health at the Audit Commission. The Commission appoints auditors to all SHAs, PCTs and NHS trusts. We have assessed the financial management in PCTs and trusts for each year from 2005–06 to 2009–10 and we have published annual reports on financial performance in the NHS and also some specialist reports. In 2006 we published something called Learning the Lessons of Financial Failure in the NHS.

Suzanne Tracey: Good morning. I am Suzanne Tracey. I am President of the Healthcare Financial Management Association. My day job is as Director of Finance and Business Development at the Royal Devon and Exeter NHS Foundation Trust.

Noel Plumridge: Good morning. My name is Noel Plumridge. I am a career NHS Finance Director although, for the last 10 years, I have been working independently as an author and, increasingly, as a trainer.

Q392 Chair: Thank you very much. I would like to ask you, please, to set the scene in terms of the current level of recurrent deficit within PCTs and, therefore, the inherited level of recurrent deficit that threatens as we move into the new commissioning structures. The Secretary of State has made it clear that he wants those recurrent deficits removed by 2013 and I would be interested to know whether you think that is a realistic and achievable target for the outgoing regime, given the scale of the financial challenge that the NHS currently faces. We will start with Professor Whitehead.

Professor Whitehead: I am going to pass directly, Andy McKeon: It is very hard to identify what the recurrent position of PCTs is, or even of trusts. It is quite clear when a PCT posts a deficit. It is less clear what their underlying position is from year to year. Last year there were only four PCTs with a deficit and there were six trusts which incurred a deficit. This year there is a forecast of four PCTs and three trusts which have a deficit. These are not significant sums. On the other hand, it is also clear that PCTs receive support from SHAs in one way or another. For example, last year North Yorkshire and York received some money as a non-payable transitional grant to enable them to get rid of their current problems in that year financially and to concentrate on a recovery package in the next year. I am afraid the message is that I can’t give you a figure for the underlying position across the country on PCTs and trusts. Having said that, it is clear that there is probably enough money in the system to deal with outstanding legacy debts but not whether a PCT is over-trading,
There are many factors in terms of deficit. It is the threat of deficit you are talking about, as in life. Once you have gone over by a certain amount, you have to keep paying back on your credit card bill you have to keep paying back. One of the sure things about people is that once you have got into a deficit it is quite difficult to get out of it. One is that once you have got into a deficit it is quite difficult to get out of it.

Q394 Chair: Could I ask Mr Plumridge this? We have heard the response from the people who are in the line management roles, effectively. Can you have an estimate as to what you think the position at a recurrent level is?

Noel Plumridge: The recurrent position is difficult to put a figure on. The most recent national figure we have from the Department of Health was a surplus, echoing Suzanne’s words, of some £1.3 billion. However, that most recent figure was as at the end of September. A surplus in this financial year is encouraging news. We will need the surplus because of the pressures that are building up through matters which the Committee has already touched on, reconfiguration and the cost of change associated with current changes. But we are in surplus this year.

Q395 Chair: That is looking at the PCTs.

Noel Plumridge: That is on the PCT side and a further £200 million surplus on the NHS trust side but, of course, the Department of Health does not cover the foundation trust world. Could I add a couple of footnotes to that? It is a rosy position but, since September, we have seen a pattern at individual PCTs of deficits emerging. Some that have been publicised recently have been south-west Essex, a forecast deficit of £18 million, and Cumbria, a further £7 million. Those are some specifics in the last month or so. More generally, we have seen a pattern of restrictions, especially on access to surgery, being imposed by PCTs which suggests a need to make savings in a hurry, either through rationing or through delays. I would add one further footnote, if I may, Chair. A recent paper by the Nuffield Trust has commented on how the efforts of making savings have been concentrated in the acute hospital sector. The acute hospital sector is less than half the average PCT commissions and the suggestion is that if we try and focus savings of at least 4% entirely on the acute hospital sector, we will face difficulties. That is a way of saying it may not be quite as rosy as that September projection.

Q396 David Tredinnick: I want to talk to you about the PCT deficits in respect of how they are caused. Is it by mismanagement? Is it by a failure to reconfigure? What do you say to that? Why do we get these deficits in the first place? Is it poor accounting? Do you see them miles out?

Chair: It is the threat of deficit you are talking about because, at the moment, they may be in surplus. But where is the risk of a deficit?

Suzanne Tracey: There are many factors in terms of what could be the underlying cause for those deficits. It could be, very simply, the ability for providers and indeed PCTs to generate the level of efficiency. If you are working in a hospital that has a high reliance on agency staff, for whatever reason, that might lead to a different approach in terms of efficiency. It could be as a result of different referals and different infrastructure in terms of social care. It could be down to different cost bases, particularly in relation to capital. There are all sorts of reasons why those underlying deficits could arise.

Q397 David Tredinnick: I would suggest to you that, with modern computer programming models and tracking systems, it is almost impossible to get into deficit without knowing you are going to get into deficit. There must be, inevitably, a degree of negligence if you get into deficit.

Andy McKeon: From our experience and research, up to a point management and mismanagement is a factor in creating a deficit. In our study in 2006 about financial failure it was clear that, in a number of cases, there was poor leadership by the board, there was often a turnover on the board or the information systems were not very good—Noel did quite a bit of work on that and research— and all of that created a position where these organisations get into deficit. Again, poor financial information and poor information about activity, despite modern computer systems, is still a problem, and so, perhaps, is setting the budget in a way which doesn’t allow for the potential real level of activity and putting in something that is more optimistic. Failure to meet cost improvement programmes is another reason why people get into deficit. Management, undoubtedly, has a part to play in this but there are two or three other things I would say about deficit. One is that once you have got into a deficit it is quite difficult to get out of it.

David Tredinnick: As in life.

Andy McKeon: As in life. Once you have gone over on your credit card bill you have to keep paying back the credit card company and so on. The same difficulty getting access. One of the sure things about people who have a deficit is they have had one before. Of the four organisations that are PCTs posting deficits at the moment, three of them have appeared before in the past three or four years, perhaps on a regular basis.
That is true of trusts. Some people, though, are dealt a more difficult hand so there is a link with allocations. I don't want to stress this too much but the deficits tend to cluster around outer London and in some of the shires. There is a statistically significant—meaning it is there—but weak link between allocations and deficits.

Q398 David Tredinnick: Do you have a view on whether the Private Finance Initiative has contributed to deficits through projects?

Andy McKeon: The Private Finance Initiative is clearly on the hospital rather than the PCT side. It is a bit unclear. There is some evidence that private finance might add something like two or three percentage points to overall costs. That is the difference between non-PFI and PFI hospitals. It is relatively small in the scheme of things but it may be there.

Q399 David Tredinnick: Should pathfinder projects have a role in eliminating deficits, do you think?

Andy McKeon: Yes, pathfinders will have a role in eliminating deficits or, rather, put us in the way of trying to make sure that the commissioning and clinical activity and finance are properly aligned because that is, ultimately, it seems to me, at the heart of putting GPs in charge of commissioning.

Q400 Chair: Before we leave deficits, and I want to move on to the funding formula, could I ask about inherited debt as well? You have said that four PCTs reported deficits last year. How many reported inherited debt to carry forward into the new world? What is the quantum of that? We asked Sir David Nicholson about this last week and he suggested that there were sufficient reserves within the system to discharge that debt. The reason for asking him the question was that the Secretary of State has said that the debt will be paid off before the consortia established. That raises the question, if there is a debt within the NHS that tends to be a lend and asset somewhere else in the NHS, are trusts going to be asked to lose their reserves, effectively, that have been lent to PCTs with inherited debts as opposed to deficits? Shall we go to Mr Plumridge?

Andy McKeon: Yes. I was thinking of nominating Noel.

Noel Plumridge: To the extent that there is an accumulated debt, it would seem that there is a reasonable match between the money that is available in the system this year with a potential of being committed next year to meet some of those costs. There may well be a reasonable balance between the surplus that has been accumulated to date, the surplus that is being generated this year and those costs that are being classified as debt. What is less clear is the continuing legacy of existing commitments. The PFI has been mentioned. But Suzanne mentioned the wider issue of the cost base of individual hospitals and the sustainability of those costs year by year in a system that is trying to save money with very limited growth. The continuing effect is harder to give assurance upon.

Q401 Chair: You are saying, crudely, that existing reserves and this year’s surplus can pay off the debt as now but we must expect deficit somewhere in the system—I am not quite clear where—to accrue between now and 2013 which we don’t have resource to pay?

Noel Plumridge: I am saying that, though with some caution about the level of debt that is in the system as a result of the current reconfiguration.

Q402 Andrew George: Moving on to funding formulas, the issue here is that a lot of that discussion presupposes the allocation of resources is fair in the first place. I carry the scars of 10 years of dealing with ACRA and challenging the formula which, I would say, is not something to be taken on by the faint-hearted. Certainly, I would not recommend it to anyone. This is, in particular, in relation to the basis on which the market forces factor had been allocated and the weighting given to it. I simply want to ask Mr Plumridge, to begin with, how many people in the system, do you think, understand how the formula is arrived at, how the weighted capitation is achieved? A second question, if you like, and this may be taken up by others, is what you think are the key differences between where we are now and where we will be once the weighted capitation arrangements are put in place for the new commissioning consortia.

Noel Plumridge: How many people understand the formula?

Andrew George: Yes. Are you satisfied the people who are dealing with this system actually understand how the formula is arrived at?

Chair: The Schleswig-Holstein question.

Andrew George: Yes, it is the Schleswig-Holstein question. Do you think that the people dealing with this understand how the weighted capitation is arrived at?

Noel Plumridge: I would hope that 152 primary care trust finance directors have at least a smattering of knowledge around the theme because it is so important to the financial position and outlook of any one PCT. I imagine there are plenty more people who have taken a keen interest in the formula. There may not be quite so much awareness of the significance of the formula and how it works in practice. For instance, I hear a number of arcane discussions about whether the weighting in the formula should be biased towards age or towards deprivation and towards rurality without looking at the scale of the adjustment. To give a feel for those numbers, City and Hackney PCT, £2,235 per head of population this year, Liverpool, £1,237—those are the organisations that would gain most out of the current formula—whereas Cambridgeshire, £1,350 and Oxfordshire, £1,362. There is quite a material spread between where the money is now and where it would be going under the formula. How quickly that will change is harder to say because, in a time of limited growth, providing extra funds to one PCT requires taking it from another. That is a much more painful exercise than the redistribution of growth money. We may stay in that position for some time. Exactly how that will work under a funding system that is based on consortia rather than simple geographic areas is quite hard to
Q403 Andrew George: Professor Whitehead, are you content that this system is fair?  
Professor Whitehead: I am a great believer in an equitable resource allocation formula. We need it because all health care needs are not equally spread across the population. We do, and we have since 1977 endeavoured to develop such a formula. I agree with you that it is very, very difficult to understand but it is absolutely imperative to have within it an age adjustment, an adjustment for need and deprivation and the market forces factor. It is absolutely imperative but the shift that we will have from resident population to the registered patient system under a consortium is enormous and very difficult to predict how it would work.

The current PCTs have responsibility for all people resident in a defined geographic area. They cannot pick and choose which people they serve. They have the lot. That is an incredible protection against cherry-picking. You don’t have that constraint with consortia. It is based on registered patients only in a very, very, ill-defined area. You have GP practices coming together and choosing which of their colleagues to work with in consortia. You can have great scope for cherry-picking. You can get some practices shunned because of their patients. You can have some, perhaps, from more affluent areas encouraged to join a consortium. There is great scope for cherry-picking at that level as well as other levels. Then, when it comes to trying to devise a formula to allocate resources to consortia, you have a big problem. You haven’t got the geographic footprint that you have with the PCTs, none of the data are configured in the ways that the consortia are configured and trying to pick out measures of deprivation and other health care needs of the population will be incredibly difficult.

Q404 Andrew George: On the basis of your understanding of both registrations and unregistered patients and the problems of defining geographic boundaries, do you have any indication as to what types of areas are going to gain and what types of areas are going to lose out under this new allocation system?

Professor Whitehead: Obviously, the new allocation system has not been devised yet.

Andrew George: But it is clear that the consortia will be very different from each other. Trying to work out which are at a similar level of deprivation, for example, to give them a deprivation weighting, will be very difficult because you do not have the geographic footprint that previous commissioning authorities have had. You could get a situation where very aggressive, competitive consortia could configure themselves very favourably in terms of receiving money and using the commissioning budget in such a way that they are in a very good position to make profit, et cetera. In that respect, you could get a situation where some consortia are much better placed than others to thrive and to make profit and to improve services for their patients, whereas others are not in that situation.

Q405 Andrew George: Is it fair, then, to say that there is an incentive for consortia to configure their own boundaries in such a manner that they will pick up areas of high registration, possibly, to the middle-class communities and try to avoid drawing their boundaries where they will be picking up large populations of, for example, Travellers and Gypsies and others that may have low levels of registration? Would you say there may be incentives there for those consortia to configure themselves in that manner?

Professor Whitehead: It is not just a matter of registration. It is more the characteristics of the people in different areas and those living in deprivation. Where the prevalence of ill health increases with increasing deprivation, you then have more costs involved with treating that population. They are also likely to have multiple interacting health problems so their treatments are complex and costly. They are likely to have poor living conditions, making recovery harder and making it necessary to have more intensive services to reach them, et cetera. Those populations are more costly and less profitable if you are thinking in market terms. They are perhaps populations that, if you are trying to work in a market, you would avoid.

Chair: Both Mr McKeon and Mr Plumridge would like to contribute.

Andy McKeon: I am sorry, I do not quite agree with what Professor Whitehead said. A possible way of doing this is to take the method that PCTs are currently using in allocating resources to practice-based commissioners which is known as person-based resource allocation that is being developed by the Nuffield Trust. I had better declare I am a trustee of the Nuffield Trust and you need to take that into account. But the intention would be to take into account the characteristics and the use made of the hospital and other services by the GP practices’ registered population to match the resources to the practice and the way in which the practices have brought themselves together. Therefore, if it is the consortia that have brought together practices which, essentially, make little use of hospital resources, for example, then that would be reflected in their resource allocation. It is a slightly different thing about the area and the practices. That is an important bulwark, to make sure that the allocations are fair between practices.

The second thing, as I understand it, is that there are more people registered with GPs than ONS counts for the population of this country. The registrations are greater, as I understand it, in areas of deprivation. One of the bits of work that has been going on is to try to identify the differences between that because that would mean more money would be sucked in to those local areas.

The third point I would make is that, clearly, allocations to consortia are going to be different from those for PCTs because their responsibilities would be different. Consortia will not have responsibility for primary care, for example, and they will not have responsibility for tertiary specialist services. Those will be the responsibility of the Commissioning...
Board. Also, there will be an allocation of public health budget to local authorities which would currently mostly rest with PCTs. Their responsibilities—and there will be a formula for allocating that—will, presumably, be geared to health inequalities. One of my messages is that the Department are aware of the issues between person-based resource allocation and consortia and understands those very well. Also—and this is the other point—the picture is going to change because of the different responsibilities of consortia and the Commissioning Board and local authorities from what they are now.

Q406 Chair: The Government has also made it clear, hasn’t it, that the consortia, in addition to having a responsibility for their registered population, will have a population-based responsibility which, presumably, will be reflected in the resource allocation process somehow?  
Andy McKeon: There will have to be allocated non-registered patients, essentially, yes, and the resources to go with that.

Chair: Yes, Mr Plumridge.

Noel Plumridge: It might be worth highlighting a further pressure in the system which we may see emerging. Professor Whitehead mentioned that the formula we have had since the 1970s has effectively been based on an estimate of health need and is, therefore, a means of redistributing funding within England. Crudely, lorries load up with money in the south-east of England. Some falls off the back as it goes round the M25 but a lot more makes its way up the M1 and the M6 and is redistributed to the northern cities. How you then measure age or deprivation is another matter, but the people in control of funding in the south-east have been saying, for some time, that this is not their version of fair and perhaps those who pay the greater share of taxes ought to get a better health system than those who do not. That is a pressure that we have seen recently from the leaders of the south-easternshire counties. We would, you might say. But the pressure has not gone away. It is also one that is visible in some other European countries as the economy has come under pressure, for instance in Belgium and in Italy. That may rear its head as time goes by.

Q407 Andrew George: Last year’s allocation showed that most of those PCTs who were above target were, indeed, within the M25 and those who were at the maximum 6.4% below target were largely in Cornwall and the north, and I say this on pain. In terms of, in future, being able to both assess what is going on and then also challenge, which seems to be something that has never happened, the amount of money that you are being allocated, will there be anything in the system that you can see that would allow the consortia to, if you like, engage in any discussion or will they simply accept what they receive and there is no conversation whatsoever?

Chair: It is unlikely, in the world that I would recognise, that there would be no discussion, I suspect.

Andy McKeon: Yes, I think there will be a discussion. Eventually, money will be allocated and there will be a decision about that but I assume—and it is only an assumption—that functions like ACRA will continue within the Commissioning Board and consortia as PCTs and health authorities before them were able to make their pitches about why it was fair or unfair in their particular circumstances or in general.

Q408 Chris Skidmore: I am aware from the Command Paper that the NHS Commission Boards are going to have the power to adjust the allocation given to consortia, perhaps even annually, reflecting overspend or underspend. Is that not just going to compound an historic problem we have in the NHS that you reward those people who often overspend and penalise those who underspend?

Andy McKeon: It obviously depends how it is operated but the principles would be, yes, you might have to tide somebody over in the short term because they are overspending in order to meet the needs of their population but they would then have to pay that money back in future years. That is one of the reasons, as I said earlier, that, once into a deficit, it can be very difficult to get out of it.

Q409 Chris Skidmore: Yes, but then we get into a situation where one consortia may take over the consortia that is performing badly and it would drive, in itself, expansion.

Andy McKeon: It may do and the GPs may decide to join a different consortia because the one they have currently joined, maybe, is not very good.

Q410 Yvonne Fovargue: I would like to go back to the cherry-picking and almost move a stage further from that. The fund-holding GPs were suspected of bouncing patients from their list and keeping the patients who needed the least on the list for financial reasons. Do you think that this could happen under this system as well? Will it create practices that have a high level of expensive patients and those that have ones that need minimum care?

Professor Whitehead: Yes. It is theoretically possible that practices could pick and choose patients. Whether it would happen in practice is another matter. Certainly, as I said, at the formation of the consortia level it is a real possibility. It is feasible that you could cherry-pick the practices that you have in your consortia and consortia are unstable. As has just been mentioned, they might reconfigure after one or two years and keep on reconfiguring.

Q411 Yvonne Fovargue: I would go further. It is practices choosing the areas trying to remove patients from their list who are the most expensive and refusing people who they consider may be more expensive when they apply to join. As to those particular practices, do you think that is a danger?

Professor Whitehead: It is certainly a possibility. I wouldn’t like to say whether it happens or the extent to which it would happen. I would not like to hazard a guess.

Andy McKeon: I think it is much less of a danger because the allocation is to the consortia and not to
the individual practice. Therefore, I am not clear what the advantage would be to a practice in the future arrangements to cherry-pick patients. The allocation, as I say, goes to the consortia and not to the practice. The other issue is, looking at the resource use by practices, which will take place, I have absolutely no doubt that GPs in the practices will be looking carefully at the resource use by their colleagues and the sort of patients they have and so on. I think the danger is exaggerated that you are suggesting.

Q412 Chair: Am I right in thinking the consortium will have the power to allocate patients who can’t find practices to individual practices? If it is not consortia, presumably somebody in the system has that power.
Andy McKeon: I understand, as the commissioner of primary care, it ought to be the Commissioning Board that has the power to allocate patients to individual practices if that individual cannot find one.

Q413 Chair: So it will rest with the National Commissioning Board?
Andy McKeon: One of the things about this is that the National Commissioning Board will be commissioning very local services and if you cannot find a practice you will have to apply to the Commissioning Board or one of its local arms to get one.

Noel Plumridge: There is an assumption, I think, that acceptance on to a GP practice’s list is absolute and one either is on the list or not. I am starting to hear messages from GPs that acceptance is conditional, for instance, on compliance with management regimes for long term illness. Many GPs are motivated, I believe, less by filthy lucre than by the smooth running of the practice and improvement in patient conditions. Yes, there might be some reluctance to take on the person who has, for instance emphysema, but is unwilling to take some of the measures that might mitigate the symptoms. That is partly because of the nuisance value back to the practice, but it is also back to how the GP spends the time and what rewards, in terms of clinical improvement, are visible from it.

Q414 Dr Wollaston: I am wondering how confident the panel is that the person-based resource allocation formula will be ready to be used in shadow form in 2012–13 and then for going live in 2013–14 and what kind of shifts we are likely to see, what sort of scale of shifts in funding when it comes in?
Professor Whitehead: There is still a lot of work to do on the person-based resource allocation before it is ready to go live and to be used in that way. Maybe it won’t be ready in time, is the short answer.

Q415 Dr Wollaston: There is a huge amount of uncertainty, do you feel?
Professor Whitehead: Yes.

Q416 Chris Skidmore: It has got to be ready by June 2011. Is that right?
Chris Skidmore: Simon Burns told us at Westminster Hall that ACRA are going to report back in June 2011. Yes, but not on the person-based one. I thought you mentioned the person-based one.

Dr Wollaston: We have here, in our brief, that it should be ready to use in shadow form in 2012–13.

Professor Whitehead: Yes.

Q417 Dr Wollaston: But you are not sure that will be ready?

Professor Whitehead: Certainly ACRA will report.

Q418 Chris Skidmore: Your recommendations in June will encompass a wide range of suggestions.

Professor Whitehead: Yes. The June one will report on wider briefs.

Q419 Chair: There is uncertainty about whether it is ready in 2012–13. Has there been any discussion between ACRA and the Department yet over the scale of testing this formula in practice, looking at what the impact is going to be before it goes live? There is potentially a very significant resource shift between different practices and different consortia implied by this formula and seeing how it would work in practice is going to be key to success, isn’t it?

Professor Whitehead: Yes, it is going to be key to success. I can’t answer that because it is part of the work of ACRA at the moment. I can’t speak on behalf of ACRA.

Chair: I understand you can’t speak on behalf of ACRA. I wondered if you were aware of any discussion about the principle of testing or if any member of the panel was aware.

Professor Whitehead: Obviously, it is very important to test but I am also aware of all the difficulties. That is why I am saying it would be optimistic to think that things could be ready in time.

Suzanne Tracey: The point I was going to make is not only is it going to be important to be able to assess and test the impact of the changes to the resource allocation, but also to be very clear about the pace of change that will apply to that because we need to make sure we are doing that in a way that is not going to destabilise current health economies more than is absolutely necessary. That needs to be assessed alongside the allocation formula itself.

Q420 Nadine Dorries: Do you think that all the consortia will be ready and able, by 2013, to take full control of commissioning budgets?

Andy McKeon: That is uncertain, isn’t it? It would seem as if the Department is preparing an authorisation process, rather cynically, that perhaps implies that not everybody will get through it. It would be surprising if there was 100% coverage of all consortia by April 2013. But it is uncertain how many will be authorised.

Q421 Nadine Dorries: Is that uncertainty shared by anybody else on the panel?

Suzanne Tracey: I would share that in terms of there is going to be different understanding and involvement to date under practice-based commissioning and the shift into the shadow arrangements for consortia. Some will be very
actively involved and engaged and, therefore, would be far more ahead in terms of their ability to take responsibility on. Others may need some further support in terms of getting there.

Q422 Nadine Dorries: What kind of support do you think will be available, because it will be a brave new world for the consortia, in terms of balancing their books and ensuring that they don’t go into deficit, particularly in their first few years when this is all new? What kind of support is going to be there for those consortia?

Suzanne Tracey: First and foremost, one of the only two statutory requirements is for a chief financial officer. One would hope that the role of that individual was to help support. I could give you a plug for HFMA here in terms of the work that we have been doing to prepare our GP colleagues as to what to expect and training and education facilities that we are making available to ensure that GP consortia are ready to take on that role. The whole point about the assessment process as well, one would hope, is that that identifies what is required. Part of the arrangements put in place is a development fund for GP consortia to take time out and invest in the training and education required to get them to the point of competency.

Andy McKeon: If I can pick that up, it is the question of what tests are going to be applied for authorisation and, therefore, what support would be available or is necessary. If I am thinking about this and looking at past failures I would say, first of all, the degree of clinical engagement that there is within the consortia is the critical point. The quality of their financial planning, which is going to be rather difficult because some will not have a track record but there will be a way of looking at whether their plan is a sensible one, what it takes into account and so on. The degree of financial awareness across the consortia, which perhaps goes with clinical engagement, would be another critical test, and the supply of information and their ability to monitor that and to act on it. I am sure there are other clinical things but those seem to me some of the critical financial tests that should be applied, perhaps drawing on the work of the consortia to manage to the money that they are going to get.

Noel Plumridge: Could I highlight two potential risk areas? Assuming that GP consortia achieve a level of capability and competence that we have become used to with PCTs, I suspect that there is a risk about the governance regime and the effective freedom to act that the new organisations will have. We have already seen the enthusiasm with which GPs are approaching commissioning, particularly within the first year or the first two years, which is additional to what is there at the moment to help those GPs who may struggle with the new funding formula and the new commissioning, particularly those who are not in a pathfinder and particularly the ones who will come forward in 2013.

Professor Whitehead: Could I say that I think more support is needed not just in financial terms? Speaking out for public health, I think that the consortia will require considerable public health support in needs assessment, in service planning, in performance management, et cetera, and it is not clear where they will get that support. Certainly the NHS Commissioning Board should make adequate provision for that support because they will be floundering if they do not have it.

Chair: Bearing in mind that the average budget of one of these commissioning boards is going to be something between £0.25 billion and £0.5 billion a year.

Professor Whitehead: Yes.

Andy McKeon: I am probably more confident in that funding and GP capacity to understand that because it seems to me that one of the essential points is to start off with what use is being made of services by a GP practice. There is quite a lot of information on that available and that is what is being used in allocations to practice-based commissioners and so on. The question is about how you insure against risk, in a way, and what would be the best way of doing that. The proven method of doing that in the NHS would be to have some sort of top-slicing in order to create a risk pool across consortia. One of the issues is if all bits of the commissioning side of the NHS decide to keep back an amount to insure against their own risks that would place the hospital side in difficulty. Making a judgment on what would be a prudent risk pool would be an important point for the commissioning board to think about, and the capacity of consortia to manage to the money that they are going to get.

Suzanne Tracey: To come back on a point I should have said, on the fact that GP consortia are not starting totally from scratch, this is about how we get clinical leadership married with good financial management and good financial planning. Of course, those skills exist already in the PCTs and one of the key points is how we make sure that that experience and skill does not get lost in the transition. The cluster arrangements being put in place are a good way of looking to not lose that from the Service. We need to build on that as well.

Noel Plumridge: Could I highlight two potential risk areas? Assuming that GP consortia achieve a level of capability and competence that we have become used to with PCTs, I suspect that there is a risk about the governance regime and the effective freedom to act that the new organisations will have. We have already seen the enthusiasm with which GPs are approaching their task. However, they will be working within a governance framework that will be unfamiliar and will need to be tested. There may be some ripples in 2012–13 as that emerges.

A second risk point, I suspect, is the context. By April 2013 we will have been through a further two years of an NHS with cost pressures but negligible growth funding. That suggests that the financial challenge and the need for action may be rather greater than they would have faced were they sailing on a smooth sea.
Valerie Vaz: I am conscious of the time, so it is just a quick question, but it may not be a quick answer. We have this patient choice and An Any Willing Provider, I wondered if I could have your view on what sort of effect that will have on the health economy.

**Suzanne Tracey:** The answer is it could have quite a profound effect depending on how far that whole agenda is taken. From my personal perspective, the important thing for my own hospital—and this is what is happening locally—is to engage very early with the GP commissioners in terms of the sorts of decisions that they are looking to make, and to encourage this not to be a short-term agenda but to plan for the long term. By understanding what the long-term aims are, we can plan to work in tandem in how they are implemented and delivered. Whether that will be the same across the country remains to be seen.

**Noel Plumridge:** If our main choice is being regarded as patient choice, with the support of a GP, of a hospital for a procedure, I think there is a wider dimension of choice. One that intrigues me is how I, as a consumer, would choose the GP practice and its consortia membership that might meet my personal needs which is, I fear, classed as cherry-picking or health tourism that would seem to be an equal dimension of handing choice over to the end user.

**Andy McKeon:** First of all, I think this is a long term agenda. I would not expect to see much change in the first two or three years, at least, through patient choice. It does not seem to have had that much effect on patient referral or patient flows so far so I would be surprised if there was some significant change in 2013. As to An Any Willing Provider, there are two sorts of willing providers: one who will enter the market and take their chance on patients choosing them and operating under the tariff, and there seems to be quite significant barriers to entry that the previous panel talked about in terms of gearing up to be a competing hospital or section of a hospital, and then there is where tenders are let for a provider to do some form of community services. Clearly, the consortia will be in the driving seat for doing that because they will be letting the tenders. It is very easy to exaggerate the degree of change that is going to happen. That, itself, is a very powerful mechanism for change and what they are spending on individual treatments. That starts to influence behaviour. That is certainly what we are seeing in the acute sector when we start to give them an alternative and so on in order to improve the practice. Although you could speak very negatively about demand management and rationing, it could be rather positive in terms of improving clinical practice and getting your GPs—all GPs—up to the standard of the best.

**Chair:** Is that significantly different, though, from the current structure? That is the reality in the tax-funded health care system, isn't it?

**Professor Whitehead:** Yes, it is. It will not be any more relaxed. It may, in fact, be a tighter control by each consortium of its members.

**Rosie Cooper:** The GP won't be able to displace the blame to the PCT, maybe.

**Chair:** That is a difference.

**Andy McKeon:** There is a slightly more positive side to this, that if this system is to work then the consortia will have to influence the clinical practice of their GP constituents and, hopefully, improve it. You talk about demand management and rationing, it could be rather positive in terms of improving clinical practice and getting your GPs—all GPs—up to the standard of the best.

**Q425 Rosie Cooper:** Can I ask how far it would be down to individual GPs to undertake rationing of demand management in clinical prescribing and referring decisions? Coming right down to it, is this going to affect the patient-GP relationship?

**Professor Whitehead:** The individual consortiums will have to devise methods of monitoring their individual practices and, in some way, managing them. In that respect, it will come down to individual decisions by GPs and there will be a delicate relationship between the individual GP and the management of the consortium. I am sure there will be quite a lot of conflict in some places in that.

**Q426 Chair:** Is that significantly different, though, from the current structure? That is the reality in the tax-funded health care system, isn’t it?

**Professor Whitehead:** Yes, it is. It will not be any more relaxed. It may, in fact, be a tighter control by each consortium of its members.

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**Andy McKeon:** There is a slightly more positive side to this, that if this system is to work then the consortia will have to influence the clinical practice of their GP constituents and, hopefully, improve it. You talk about demand management and rationing, it could be rather positive in terms of improving clinical practice and getting your GPs—all GPs—up to the standard of the best.

**Q427 Rosie Cooper:** Anybody else?

**Suzanne Tracey:** I think it will be limited in terms of the amount of impact that will have on an individual consultation with a patient. I can’t believe that at the point at which there is a patient in front of the GP, if they are in any doubt about the care of that patient they will not refer the patient appropriately. Where you will start to see the impact is where you start to use the data to look at differences and variation across peers and how other people are performing and then that starts to influence behaviour. That is certainly what we are seeing in the acute sector when we start to get into information about individual consultants and what they are spending on individual treatments. That, itself, is a very powerful mechanism for change and probably more so than that you allude to.

**Noel Plumridge:** We may see more differentiation within a GP practice between partners who are ultimately setting and looking at the enforcement of protocols under which non-partner GPs will be working. That may form a source of tension. It has done in other countries where insurance companies set the protocols. I think we are moving towards that sort of system, not in terms of funding but in terms of the style of performance management within primary care.

**Q428 Rosie Cooper:** In terms of funding, will consortia hold on to the surpluses? Does anybody know?
Andy McKeon: It is not clear exactly how the funding will be arranged but in any system if people are making surpluses from good practice, part of the incentive is to let them carry it forward. If not, then there is no incentive.

Q429 Rosie Cooper: And GPs holding on to any profit element in their practices, any build-up—some of those decisions back to the choices that the patients are seeing—will there be an increased tension?

Andy McKeon: We were talking then about what the consortia were doing and how the consortia will spend its commissioning money and what it will do with any surpluses it makes, not about individual profits of GPs in individual practices.

Q430 Rosie Cooper: But the perception will be, if consortia hold on to their profits, what happens to them if they invest in buildings or whatever else it is—there is a general increase in asset there—and where does that feed back into practices? Then patients will see that they may or may not be allowed a treatment. Whether it is absolutely right in technical detail, there will be this fear that will be out there, “The treatment I am getting is being influenced by all these external financial things going on.” Would you agree with that?

Chair: It is not entirely clear why patients should react differently with a consortium in that position from the way they do when a PCT is in that position.

Rosie Cooper: That is the point I was saying before about the doctor laying the blame off to the PCT, “We can’t do this because”. Now, in the new world, if the patient believes the GP has the power to make all those decisions, then all those other things do come in to play and they can’t offload the blame.

Chair: It has now become a debate within the Committee. Are there any other quick questions to the witnesses?

Q431 Valerie Vaz: I wanted to ask about the Department of Health impact analysis, that if you take the directors of public health out of the PCTs then commissioning is not cost-effective. Do you agree with that statement or not?

Professor Whitehead: As I said before, there is an essential element of public health expertise required in the commissioning of services, whether it is from directors of public health or whatever. You must have some of that input else it will be inefficient and ineffective. But I don’t see that the directors of public health in their role in local authorities will have the resources to support all the different consortia in their patch. Something extra is needed.

Chair: Does anybody else want to contribute?

Andy McKeon: Only that public health advice will be important to consortia. It clearly doesn’t have to be an officer within the consortia. It could be obtained from elsewhere. It is not only epidemiological advice on traditional public health. Public health doctors traditionally included in their decisions effectiveness of treatment, for example. There is no doubt that that sort of advice will be required.

Chair: It has been very helpful. Thank you very much indeed.
Tuesday 22 March 2011

Members present:
Mr Stephen Dorrell (Chair)
Nadine Dorries
Andrew George
Grahame M Morris
Chris Skidmore

Q433 Chair: Thank you for joining us, Secretary of State, Dame Barbara and Sir Bruce.

Before we start, could I give advance notice that two of my colleagues have commitments before this session is likely to end? Both Grahame M Morris and Sarah Wollaston will be leaving because they have prior commitments, and for no other reason. They wanted to make that clear at the beginning of the session.

You will be aware that this is a follow-on inquiry on work we did before Christmas, published at the beginning of the year, as to how commissioning in the Health Service is made more effective as an instrument for driving change, delivering good value, high quality health care. We published a series of recommendations in our report after Christmas and said we had some follow-up work we wanted to do. We are grateful to the Department for the support that you have given in that work.

One of the areas we didn’t cover in that report, which we want to start with this afternoon, is the relationship between strengthening commissioning through the consortia and the arrangements for clinical engagement—the relationship between those institutions—and Monitor as the strengthened economic regulator.

One of the questions we asked Monitor, when they were here, was the extent to which it was going to be possible for commissioners to determine for themselves that they want to commission integrated pathways of care without Monitor then, on the grounds of competition, opening the door to competition for individual elements of that pathway of care. Within the current operating framework, we are working with the Cystic Fibrosis Trust to do that. I hope there will be rapid progress in that.

I would like to begin, if I may, by asking you how you believe it is possible to reconcile the objectives of commissioners to commission integrated pathways with the commitment of Monitor to open the door, wherever possible, for competitors who may feel they have a better option for parts of a unified pathway.

Mr Lansley: Thank you very much. I am grateful to the Select Committee for inviting us along. We are very happy to work with the Select Committee as we develop commissioning in the National Health Service. You will know, in relation to your predecessor Committees, of the lack of focus and priority given to commissioning inside the National Health Service in the past. Therefore, all the focus and priority it is currently being given, not least by your Committee, is absolutely right.

We need to be clear that Monitor’s role is to act as an economic regulator, remembering that we have the Care Quality Commission whose task it is to ensure we meet essential levels of quality and safety. Those two must be harnessed together on the provider side.

Where Commissioners are concerned, there is a read across into Monitor’s role because if we were not to have the ability of an economic regulator to ensure that there were no anticompetitive practices operating against the public interest on the commissioning side, on the purchasing side, we would have a competition authority that did not have the full scope of responsibilities. In a sense, as you will know, in the Health and Social Care Bill, to that extent we do not give Monitor competition powers that do not already exist. We give Monitor concurrent competition powers to those that already exist but are exercised by the Office of Fair Trading. Indeed, in the National Health Service this is not a new concept, since the Co-operation & Competition Panel, to that extent, seek to replicate the same application of public procurement rules and competition responsibilities already.

From my point of view, as compared to the present, commissioners will have additional opportunities and options as to how they can secure the right structure of commissioning. For example, as we develop the tariff structure, we are already moving progressively towards payment by results which is focused on outcomes, not on procedures, and which enables commissioners of services to commission for a pathway of care. Within the current operating framework, we are working with the Cystic Fibrosis Trust to do that. I hope there will be rapid progress in enabling commissioners to do that.

To that extent, the role of Monitor is not to interfere with the way in which commissioners go about securing the services that they want for patients. If the commissioners wish to commission a service with a particular structure that might be set out in payment by results, or, indeed, notwithstanding how payment by results is structured, if they issue a specification they want their services to conform to, then, on the basis of any qualified provider being able to meet those services, Monitor would have no locus to interfere.
Q434 Chair: Can I push you on that point specifically because it is quite important? When Dr Bennett was here from Monitor, he was quite explicit in that he said Monitor had no role to review a decision by a commissioner on the shape of the integrated services that a commissioner wished to commission.

Mr Lansley: Exactly. Yes.

Q435 Chair: That couldn’t be challenged on competition grounds. Is that it?

Mr Lansley: That is right. To put it in a nutshell, Monitor’s role is only to intervene in circumstances where commissioners are behaving in a way which is both anticompetitive and acts against the public interest.

Q436 Chair: For example, if a private sector provider, or indeed a public sector provider, sought to challenge a specification that a commissioner was seeking to commission on competition grounds, they would simply be knocked back and told it was an issue for the Commissioning Board.

Mr Lansley: I think this is a matter for the commissioners.

Chair: Thank you.

Q437 Dr Wollaston: It is reassuring to hear you say that it is not extending either EU or domestic competition law. But am I right in thinking that, up to now, clinical services have been relatively exempt and this is just applied to procurement of non-clinical services, and that there is a crucial difference, that Monitor could have the power to impose fines of up to 10% of turnover commensurate with the Office of Fair Trading? Do you think, as we have heard from your colleague, that they would be responding to complaints? Therefore, if they are constantly responding to complaints, are we going to be opening up a Pandora’s box of a different type of bureaucracy—shifting one type of bureaucracy for a legal bureaucracy of challenge?

Mr Lansley: I see no reason why the latter should be the case since exactly the same powers currently apply. It is just that they apply in the shape of the Office of Fair Trading and the way in which the Co-operation & Competition Panel apply their rules. Public procurement rules apply to health care services. The European Commission, when they do so, categorise them Part A and Part B and different extent of rules apply. If my recollection is right, health care, generally, is Part B services. Essentially, the providers of health care services have public procurement rules applied to them. Commissioners of health care services already have EU public procurement rules applied to them.

Q438 Dr Wollaston: Can I clarify, because I am not clear from your answer? Currently, are the competition panels able to impose fines of up to 10%?

Mr Lansley: On providers?

Dr Wollaston: Yes.

Mr Lansley: No, because that is a power enjoyed by the Office of Fair Trading, not by them.

Q439 Dr Wollaston: Will that now apply to Monitor? Will we see commissioners potentially facing fines?

Mr Lansley: No. The point is as I have described previously. The Bill does not extend the scope of either public procurement rules or competition law.

Dr Wollaston: Right. They won’t face fines.

Mr Lansley: It simply creates a sector regulatory function. Monitor exercises, concurrently, the functions of the Office of Fair Trading.

Q440 Dr Wollaston: Can I clarify, so I am clear about this? It means that consortia will not face fines of up to 10% of turnover.

Mr Lansley: No.

Dr Wollaston: Thank you.

Q441 Chair: It follows, doesn’t it, from what was said previously, that the commissioning decisions of consortia are not subject to challenge on competition policy grounds? They couldn’t be subject to a fine because they are not open to challenge. Is that correct?

Dr Wollaston: But isn’t that decision open to legal challenge? I know the Department has taken legal advice on this and I am wondering whether you would be able to publish that legal advice as to whether or not, if somebody did challenge that—

Dame Barbara Hakin: One important thing to remember, of course—whether it is the Office of Fair Trading or the economic regulator—is it. It is not that you cannot do something which is anticompetitive. It is not that you are forced to tender everything. It is not that you must. It is that, in situations where you have been seen not to offer competition to relevant organisations, you must have reasonable justification for it. Even if it was the Office of Fair Trading, just because a commissioner chooses not to tender a service, if they can demonstrate their reasons why that tendering process was not appropriate, that is perfectly acceptable. I am sure we could go away and come back with the kind of legal—

Dr Wollaston: It would be useful to have that legal opinion.

Dame Barbara Hakin: To understand better, yes.

Mr Lansley: It is quite important to reiterate that we are not changing the scope, the extent of the application of competition law, or indeed EU public procurement rules through the legislation.

Q442 Grahame Morris: Could I follow on that one? It really runs to the heart of many of the public concerns about the Bill, that it will pave the way for privatisation of the service. Your contention, Secretary of State, is that there is no extension of the competition rules. But, on this side of the Committee, we are concerned that the architecture of the—

Chair: This Committee does not have sides.

Grahame Morris: From this seat on the Committee, I am concerned that the structure—the architecture—of the Health Service is changed in such a way, particularly in relation to commissioning with the loss of the primary care trusts and the establishment of GP consortia, that it will then allow the application of EU competition laws and, indeed, the issues that were raised by my colleague about potentially private sector
providers using legal redress with GP commissioners with the threat of a 10% fine of their turnover. My understanding, from clause 60 of the Bill, is that it is implicit in the Bill.

**Dame Barbara Hakin:** While the powers of the regulator mirror the powers of the Office of Fair Trading, we have to accept we have competition law and have to abide by that. Currently, if a company or an organisation appeals that an action has been anticompetitive, that can be investigated. If it is deemed to be anticompetitive without good reasoning behind it, there are ramifications. The same will apply with the regulator. But it is very much on the basis of an appeal and of an organisation proving that they could have provided as good as or a better service for patients and the commissioning organisation not being able to defend that they had not considered that when they set the contracts. If they have good reasons for not going out to competition, that is perfectly acceptable.

**Mr Lansley:** Can I make two points, quickly? First, as I understand it, essentially the sanction would not be a fine on the commissioners in this particular instance but, if they were to pursue a contract in a manner that was anticompetitive and against the public interest, to declare the contract void. But, as Barbara says, we will send you a note about all that. The other thing I would say is it further illustrates the benefits that will be associated in future with going down the route of an any qualified provider approach. To that extent, of course, one is clear about the specification that one is looking for, one is clear about the quality one is looking for—if necessary, the structure of the service and its integration—and one will have established, by that route, a national or local tariff that is the basis upon which one is inviting providers to put themselves forward. Almost by definition, if you go down that route, as opposed to trying to do it on a competitive tender basis, it would not be open to a competitive challenge or a challenge using public procurement rules. Strictly, they are the public procurement rules we are talking about and not the competition law as such.

Q443 **Grahame Morris:** Secretary of State, can I follow this point to its natural conclusion, because I think it is a very important one for people to understand, and for me to understand in particular, in relation to the changed structure? Isn’t it the case that, in the current structure, the primary care trusts are state enterprises, whereas the GP commissioning consortia are independent contractors? You mentioned exemption under Part B. Lawyers are arguing about it now and, if there is a point of debate, isn’t there a risk that we could be involved in litigation as a consequence of these structural changes?

**Mr Lansley:** No. I come back to the point. You say “changed structure” but we are not extending the scope of public procurement rules and we are not extending the scope of competition law. GP commissioning consortia will be statutory bodies exercising a public function, publicly funded and for a social purpose. To that extent, there is no reason, as compared to the current interpretation in relation to primary care trusts, why they should be regarded any differently in terms of public procurement or competition law.

**Dame Barbara Hakin:** All this is simply designed to protect the public interest. If the public interest is not protected, then Monitor, the economic regulator, can intervene on the individual contract, as the Secretary of State says.

This Committee has raised some concerns about the conflict of interests in GP consortia on a couple of occasions. This is one of those safeguards. Consortia are statutory NHS bodies. GP practices are independent contractors, but the consortia will be an NHS body very similar in constitution to a PCT—not in the way it operates but in its overall constitution. If the consortia was acting in an anticompetitive way and favouring the people on the consortia, then this is designed exactly to protect those things which this Committee has asked us about on a couple of occasions.

**Mr Lansley:** The intervention powers are specifically in relation to what is effectively an abuse.

Q444 **Grahame Morris:** But the issue about EU competition laws could be quite simply resolved if you published the legal advice that the Department has.

**Mr Lansley:** We have been very clear, both here and in the Public Bill Committee, about the simple fact that the Bill does not change the extent or application of competition law. It is not required.

**Grahame Morris:** It changes the architecture of the Service.

Q445 **Valerie Vaz:** Secretary of State, that might be correct but, to clarify, have you taken legal advice on the compatibility of the Bill and EU competition law?

**Mr Lansley:** You will forgive me for saying that those who have been responsible for the production of legislation will realise that all legislation is drafted and progressed on the basis of legal advice. Of course it is.

Q446 **Valerie Vaz:** What does that advice say?

**Mr Lansley:** That’s not the point. The point is—

**Valerie Vaz:** No. What does the advice say?

**Mr Lansley:** Ministers, here and in Committee, have set out very clearly to the Public Bill Committee—

and I am telling you now—what the legal position is.

Q447 **Valerie Vaz:** Which is?

**Mr Lansley:** That the Bill does not—

**Valerie Vaz:** Is it compatible or not?

**Mr Lansley:** The Bill does not change the extent or application of either public procurement rules or EU and domestic competition legislation. It is simply—

**Valerie Vaz:** Is it compatible with EU competition law?

**Mr Lansley:** That is not a meaningful question. Since EU competition law has direct effect, it cannot not be because EU competition law simply applies.

**Valerie Vaz:** I just asked the question. I don’t expect you to put me down. I am asking a simple question. Is it compatible with EU competition law, and could you publish the legal advice?
Mr Lansley: It's a meaningless question.

Valerie Vaz: It is not a difficult question.

Mr Lansley: EU competition law applies now and the issue of the extent to which it applies is a question you would have to ask the EU competition authorities. The point is that, literally, our legislation cannot affect the extent of EU competition law. It can't do it.

Valerie Vaz: Could you publish the legal advice?

Mr Lansley: It can't do it because the EU itself determines the extent of EU competition law.

Valerie Vaz: Then could you publish the legal advice?

Mr Lansley: There is no need to do so because I have just explained it.

Q448 Valerie Vaz: Why? Do I have to make an FOI request?

Mr Lansley: No. There is no need to because, actually, that is. That is it.

Q449 Valerie Vaz: Is it not in the public interest to publish the advice?

Mr Lansley: You are making a—

Chair: It is not a dialogue.

Q450 Andrew George: Can I come back to this very point but not from the same angle? You keep saying that the Bill doesn't extend the scope of the public procurement or competition law in any way. Of course, under the present arrangement that applies to non-clinical services—the purchase of toilet rolls or other services which come in to the NHS. Those public procurement rules clearly apply—the purchase of buildings and other services—but they do not currently apply to the purchase of clinical services. Is that not right? What you are doing with this Bill, this so-called reform, is extending it to clinical services, whereas, at present, those procurement rules apply—

Mr Lansley: I am very happy, and I say it—we will send you a note, by all means—that my understanding is we do not change the extent or application of public procurement rules or private procurement rules—

Q451 Andrew George: No, but that's not your role, is it?

Mr Lansley: No, and we are not intending to and we are not doing it. My understanding, at the moment, is that it is possible for public procurement rules to be applied to the procurement of clinical services. For example, if a primary care trust, at the moment, were to set out a competitive tender document which included clinical services as part of the tendering process but then, in the process of that, were to engage in an anticompetitive and abusive process, public procurement rules would apply to that.

Q452 Andrew George: Yes, but if the commissioners of those clinical services were a commissioning process and not a product of tendering those services, then those rules would not apply. In other words, if the present arrangement were to continue, the scope for legal challenge under competition law would not apply.

Mr Lansley: Andrew, you will forgive me, but when you say "a commissioning process as distinct from", competitive tendering is part of the commissioning process. Commissioning is about understanding the needs of an area and seeking to translate the needs of that area into the process of contracting for services in order to meet those needs. The contracted process may be conducted through an open competition or a tender, or it might be on an any qualified provider basis. The point I have made to the Committee is that our expectation—not least by the extension of tariff into a wider range of services—is that we will help to support, thereby, less use of the competition process and more use of an Any Willing Provider process.

That reduces the risk of breach of public procurement rules because a competitive tender engages in some anticompetitive process, but I don't think it changes any of these rules at all.

Q453 Andrew George: But it may in relation to the bundling together of services. Any responsible commissioner of services in any area would recognising that you need to integrate those services, which would be an entirely responsible thing for them to do in their own area. Under competition law, as I understand it, any provider of any service could challenge the decision for a commissioner to bundle together services in a manner which would ensure their integration where that alternative provider of services would say, "This means that we are unable to deliver our provision of"—for example—"hip operations or for fit people in this area. You have designed that service—bundled it together—in order to constructively avoid us providing services in your area."

Mr Lansley: It is helpful to ask the question in that way because it illustrates precisely the point I hope we have made already but will happily make again. If the commissioner sees it as being in the interests of the patients they look after to invite providers to provide a service in a particular way or to design a service in a particular way, bundling services together or securing services on a care pathway basis, that is their decision. I don't think there is any basis upon which a provider can go to anybody, be it the Commissioning Board, the consortia or anybody else, and say, "You're not allowed to do that." They are allowed to do that.

Dame Barbara Hakin: The issue is that the economic regulator has the public's interest at heart. It is not there simply to create competition for competition's sake. If, under the circumstances, the commissioner had not offered that service, or part of that service for competition when it would reasonably have been in the public's interests to do so because there were alternative providers who could have provided services that might have been better for patients or better value for taxpayers' money and would not have had another significant impact, at that point the commissioner has acted in an anticompetitive way. Again, it is about being clear. It isn't just about not tendering or not going out to competition. What the economic regulator is doing is seeking, in the public interest, to ensure that commissioners don't avoid going out to competition when it would have been in the public interest to do so.
Q454 Andrew George: If a commissioner decided to ensure that we have an integrated service in order to, for example, bolster an accident and emergency service—and therefore one ends up with a structure looking rather similar to a district general hospital—that decision in itself could not be in any way challenged. That decision to bundle would not be interpreted as anticompetitive and, therefore, open to any legal challenge.

Dame Barbara Hakin: I would not want to put myself in the position of deciding, in a specific instance, what either the regulator or the Office of Fair Trading would see as reasonable or not. What I am saying is that they would take the range of circumstances into account as to why the commissioner had not competed that service before making any decision about whether the behaviour had been anticompetitive or not.

Q455 Andrew George: It is fundamental though, isn’t it? Integration of services—and we all know and understand why a district general hospital looks like it does, in order to have the capacity to be able to deal with the range of circumstances and unknown events which might come through its front door—is going to happen across the country as a whole. We need to be very clear that the bundling together—the integration—of those services and the commissioning of those services is something which can be planned for, commissioned for, tendered for and provided without any risk that it is going to be undermined by the salami-slicing of the services which are provided through that hospital.

Mr Lansley: What we and commissioners will want to see is that they are commissioning the services they need to meet their population. The process we have discussed, of commissioning, is about ensuring you have the services that are available. The Bill, compared to the present, substantially takes us forward in that respect. First, it is much better for us not to have a process of hidden cross-subsidisation. There will be a transparency about the services that are being commissioned, the quality that is being looked for and the price that is being paid—generally, often, through a tariff process. But it is very clear that there will be circumstances where, in order for the essential services and designated services to be maintained, there needs also to be a transparent process of paying more than might be paid to another provider under the same circumstances in a different place. That needs to be transparent as well. But it doesn’t mean, from the commissioner’s point of view, that somebody can simply say, “We are going to provide this service and that service” and the district general hospital will no longer be viable. In order to sustain designated services, there is a transparent process of designation which can lead directly to a process of payment that meets the additional costs of providing those designated services.

Dame Barbara Hakin: This is not my policy area but, obviously, I am very interested in it from the commissioning point of view. I am enormously reassured from what I understand of the policy, which I hope is quite extensive—and I am sure the Secretary of State understands it even better—that, with a note, we could allay a lot of the Committee’s fears because some of the fears are unfounded.

Chair: If I may, it would be helpful to the Committee to have a note from the Department which sets out, as clearly as you are able, the extent to which the pattern of services which is going to be commissioned in any locality is within the discretion of the commissioner and a clear description of the circumstances in which that might be challenged, in particular by Monitor but by anyone outside the commissioning chain, on competition policy grounds.

Andrew George: It would also be very helpful to have some clarity, perhaps with some examples, of precisely the kind of services which you, the Secretary of State, see as potentially being designated. That seems to be crucial in all of this. The reference to “a range of services will be designated and therefore effectively protected” is an important issue which also needs to be clarified.

Q456 Chair: It is important, clearly. We are having a discussion about moving on to the framework of commissioning, but what is important is the authority of the commissioners to make their run to deliver the service that they seek to commission on behalf of their population.

Mr Lansley: Yes. I will gladly do as you ask and, as Andrew asks, will gladly illustrate that. I would, however, emphasise that the process of designation is something which we are not intending to dictate. It is something which should be derived from decisions being made on the part of commissioners about where they regard it as important to assure themselves about the continuity of services. It could be that in different places—we say in Cornwall—there may be a much wider scope of designation than in other places, precisely because of the sort of physical geographical circumstances you know well. I will gladly do that.

To reiterate the purposes, we are very clear and the commissioners are very clear that the intention is to secure, for the commissioners, the opportunity to design the services that they need in the best interests of their patients, to do so to secure the public interest and that, in so far as they do so in a way that is not abusive and not contrary to the public interest, there is not a process by which they can be interfered with by Monitor on grounds of competition law. It might, in that sense, be quite a short note.

Q457 Chair: I understand that. It seemed to me that a considered statement, albeit short, might be quite helpful.

Q458 Nadine Dorries: To follow on from Andrew’s point about district hospitals and patients walking through the door—the unknowns—one of the problems is that we all know non-elective care in hospital—the emergencies, the A&Es—has always been paid for by the siphoning off from the elective. There is an area of concern as to how that will be funded in future, what areas will be covered and whether the NHS Commissioning Board will be involved in that. It is important to communicate clearly, both to the public and to hospitals—particularly district general hospitals—how they are...
going to cope. We can all see this brave new world of GP practices and the amount of capital expenditure projects that are going to happen. There are going to be practices merging together, probably even a revival of cottage hospitals, and GPs extending their skills and the services that they offer, which will take away services from district general hospitals. That leaves them worried on two points. They are up for becoming Any Willing Providers and taking on the challenge, but they are also concerned about the A&Es, the non-electives and the unknowns and how they are going to be paid for if some of their elective stuff is going to end up being taken out of the district general hospital.

What reassuring words would you give to the chief executives and chairmen of district general hospitals who are facing that problem and that concern at the moment?

Mr Lansley: Yes. We have had these sorts of conversations. Bruce and I will have had these sorts of conversations with many of the hospital chief executives and, indeed, some of the senior clinicians. Essentially, from their point of view, what always gives them greater reassurance is that, in designing these services in the future, they are going to have a much stronger clinical relationship with their commissioners. It is not just a managerial discussion about cost and volume. It is quality based. Many of the specialists take immense reassurance from the fact that the competition is on quality and not on price. To that extent, therefore, the opportunities they have to use the specialisations they have in the secondary sector to design better pathways of care extending into the primary sector is terribly important. That does mean, in terms of the response, particularly on the part of district general hospitals in their areas, is one of shifting from seeing themselves as being hospital trusts to seeing themselves as being health care trusts.

In order to respond to these kinds of changes, they need to do that. Clearly, the whole process of quality, innovation, productivity and prevention, the QIPP programme, and the need to secure efficiency savings in order to make the resources of the NHS meet rising demand, itself, is helping to drive a process of delivering services more appropriately in the right place at the right time, often with more accessible, community-based options. We know that the best way to design those services is with primary care and secondary care working together, and not shift the resources into primary care and let primary care do it and simply cut the budget at the hospital. All of that begins to change the business model in district general hospitals.

Q459 Nadine Dorries: You are saying it might be a desire on behalf of the primary care and the new GP consortium to do that, to take on those services and to bring them into primary care.

Mr Lansley: I will tell you a really interesting example of that, and it might be sensible to bring it in here, rather than be theoretical. All over the country we have new commissioning consortia coming together. One of the principal exciting opportunities is for them to think about how they redesign urgent care in their area. When they do that, they start to talk to the providers of emergency care in hospitals and realise that that relationship is a terrifically important one. The hospitals do not want to be in a position, as things currently stand, where the structure of the tariff often means that the primary care trust sets up a whole string of walk-in centres and urgent-care centres and front of hospital services. In fact I can remember being in one—and it must have been in Redhill—where the PCT set up a process by which they triage the patients at the front end and they take those patients. The way the tariff has been structured has meant that disproportionate amounts of income have been taken away from an emergency department that is left with all the complex and difficult operations and procedures to do.

Nadine Dorries: Exactly.

Mr Lansley: On the contrary, what we should be looking for is something that is a more integrated process and a tariff that is more responsive in that sense as well—a tariff that is more reflective of the complexity and cost of what is being done. Most hospital chief executives, when you have that conversation with them, realise that, with testing as it is, to be in a situation which is not simply block contracts that are progressively being whittled away by primary care trusts and where they are expected to cross-subsidise and cope, is not the right way to go. What they would much rather have is a transparent process by which there is an independent voice—and this is Monitor—whose job it is to ensure that the tariff accurately reflects the cost of the services they provide without that kind of hidden cross-subsidisation.

Q460 Nadine Dorries: To finish, you can guarantee there will be no district general hospital in the future who will be struggling financially because of the number of unknowns and emergencies—the non-electives—that have walked in through the door, because of the way the tariffs have been set. They will be able to manage and cope with those in the future.

Valerie Vaz: Secretary of State for the future, in perpetuity.

Mr Lansley: Thank you very much. That is very kind of you, Valerie. You helpfully illustrate that I cannot make that kind of guarantee.

We have many hospitals that are in exactly that position and have been in that position, sometimes, for years. We have hospitals at the moment in that position and I have inherited many of those problems in many of those places. The best way to avoid those things happening is for there to be what is essentially a clinically-led design of services that extends, in this particular instance, into urgent care in the community, does so effectively and does not just throw the problem back into the lap of the district general hospital—who are effectively the provider of last resort—on the back of a block contract that then does not give them proper compensation for what they do.

Chair: That is a good key in to Sarah who wants to move the conversation on to reconfiguration.

Q461 Dr Wollaston: Can I clarify one point before we move on? I was very interested, Dame Barbara, that you said Monitor was not going to be about
competing for competition’s sake. That goes to the root of many people’s concerns about the role of Monitor and the issue that, although the intention is benign, maybe years down the line Monitor could interpret its powers differently. Looking at the possibility of the NHS becoming more like a regulated industry along the lines of Monitor following a position like Ofwat and Ofgem, certainly if you asked anyone in the south-west whether they feel Ofwat protects consumers’ interests, you would get a very interesting reply. I am interested to know where you think in the Bill there are protections to prevent Monitor becoming more powerful with time and interpreting its powers in a way that does introduce competition for competition’s sake.

Dame Barbara Hakin: Throughout the Bill it is clear that the policy intent is the public interest. The policy intent is to ensure that patients get the best choice and the best range of services possible. Monitor, the economic regulator’s role is to ensure, if anticompetitive behaviour is brought to its attention, that it reacts to that in trying to determine whether that anticompetitive behaviour was founded on the public interest or, alternatively, whether it was an abuse of the system, at which point it would act. Throughout the Bill, the clarity is there, that the role of the economic regulator in health is to protect the public’s interest in health and ensure that our patients get the broadest range of options and the best services, depending on which organisation can provide those services.

Q462 Dr Wollaston: You are satisfied that the fact it is there to broaden choice does not mean it is going to see its remit differently, and how you interpret the public interest is open to interpretation.

Mr Lansley: Monitor is there to promote the interests of people who use the NHS and use health care services. It should be promoting competition where appropriate because competition has that potential benefit, but, equally, through regulation, where that is appropriate, too, because we are talking of a social market, not a free market. We are talking about regulated prices, not price competition. Monitor has a specific duty to co-operate. It does not simply act on its own. It co-operates with CQC in the licensing process and has a duty to co-operate with the NHS Commissioning Board and Monitor. Monitor also has statutory duties to maintain the safety of people who use health care services, to secure continuous improvement in quality of health care services as well as continuing improvement in efficiency. We shouldn’t discount the fact that it has to secure improvement in efficiency. Just as there are people who are worried about the impact of price competition, there are people who have said to me, “Hang on a minute. If you don’t have price competition, how do you get that continuing process of delivering greater efficiency from providers so that we use money more effectively?” A answer: we depend upon Monitor, through its process of regulation of prices and knowledge of the providers of health care services, to help to drive that too. So we have safety, quality and efficiency.

Q463 Dr Wollaston: It is going to have quite draconian powers, isn’t it? It is going to be able to change the operation of the pension scheme and possibly move away from national terms and conditions of service. It has all sorts of powers, including preventing commissioners from favouring incumbent providers, possibly leading to hospitals having to share their premises to provide a level playing field. These are the potential areas that they could have powers in, presumably. Is that correct?

Mr Lansley: I am not sure that the legislation says they should do those things, as I recall, and I am not sure where you are quoting from. It is not the legislation.

Q464 Dr Wollaston: No. It is about how we are going to have fair playing-field distortions ironed out. Where do you see Monitor fitting in?

Mr Lansley: I think it is rather important to have a level playing field in this respect because, in the past, we have had a situation where the NHS has, under the last Government, advantaged private providers relative to NHS providers. NHS foundation trusts were closed out of an independent sector treatment centre competition. ISTCs were given, on average, 11% more than would have been the equivalent payment through the tariff. The independent sector treatment centres were given, in total, £250 million for operations that they never provided.

Dr Wollaston: I accept that.

Mr Lansley: We are making it clear, through the legislation, that Monitor would not have the power to advantage private providers in the way that has happened under the previous administration.

Q465 Dr Wollaston: But do you see us maybe moving in the other direction, for example, obliging hospitals who hold assets—incumbent providers—to share their premises to level the playing field, or do you not see that happening in the future potentially?

Mr Lansley: I am not sure that I know under what circumstances that would be appropriate, but I will gladly think about that.

Chair: We are going to get a note from the Department on the legal constraints on commissioning which, from the point of view of an inquiry on commissioning, is the context. Grahame, did you want to come in on this? Otherwise I want to move on.

Grahame Morris: On Monitor, yes, I would.

Chair: Can we have one more round on Monitor and then move on?

Q466 Grahame Morris: My question is in relation, Secretary of State, to the role and the costs of Monitor. On 8th February, I received a written answer about the costs of the new economic regulator which were estimated to be between £50 million and £70 million per year. As recently as last week, that estimate was revised and figures that were given to the Health and Social Care Bill Committee now indicate that that figure has been doubled to £140 million. Does this square with the Government’s commitment to
abolishing bureaucracy? Would it be fair to say that what you are doing is removing clinical bureaucracy, with the SHA's and PCTs, but you are replacing it with a competition-based and economic bureaucracy?

**Mr Lansley:** It is fair to say that, as compared to the past, we are intending to reduce the overall costs of administration in those parts of the NHS which are responsible for commissioning and regulation. Strictly speaking, I don’t have the power, and I am not intending to impact on the administration costs in hospitals directly because, like foundation trusts, they are their own management organisations. As to the NHS management costs, we start with a total of £51.1 billion, of which £39.9 billion are in primary care trusts and strategic health authorities, £600 million in arm’s length bodies and a further £500 million overall in the Department of Health. We are intending to reduce those management costs in total by a third in real terms.

**Grahame Morris:** In relation to the sections we are dealing with here in Monitor—

**Mr Lansley:** What you describe in Monitor is consistent with that because, of course, the estimate in Monitor is comprised within that total.

**Q467 Grahame Morris:** With respect, the costs of Monitor at the moment are £21 million per year. That is £100 million over the lifetime of a Parliament. Contrast that with the new role Monitor is given on both the provider and commissioner side—an expanded role as economic regulator—and the costs over the lifetime of a Parliament are going to be £500 million. A Member of this Committee said, “Are we liberating the NHS from top-down political control only to shackle it to an unelected economic regulator?” Is that a fair assessment?

**Mr Lansley:** I will gladly send a note. We have been assiduously seeking, through the impact assessment on the Bill, to set out the best estimates of what these running costs look like. As far as Monitor is concerned, I understand they fall within the range £50 million to £70 million. They are, of necessity, more than the current costs of Monitor, and entirely because Monitor has a completely extended role in relation to—

**Mr Lansley:** ... the pay-by-results system is conducted inside the Department of Health. Of course, in so far as that is being done inside Monitor, there is a transfer of administrative cost into Monitor to make that happen. It is perfectly reasonable to ask the question, but it is unreasonable to expect that the cost of Monitor can be at the level it is now when there is such a significant extension of its relative role.

**Chair:** It would be helpful to the Committee to have a brief note of the anticipated cost of Monitor currently and the Departmental cost of the regulatory role that is going to be assumed by Monitor currently and then looking at what they might be in the future. That might answer that point.

I am conscious that Sarah needs to go. She wants to talk about reconfiguration.

**Q469 Dr Wollaston:** Thank you, Chair. We know that about 20% of the Nicholson challenge is due to come from service changing—shifting services nearer to the community—and reconfiguration is immensely challenging. I was looking at the King’s Fund report on Lessons from South East London. They make it clear that these service reconfigurations can’t come about with market forces, are unlikely to do so with commissioning consortia and that, currently, it is strategic health authorities that have been able to drive those reconfigurations. I wondered where you feel, under the legislation, we are going to be able to drive those reconfigurations from because we will not have strategic health authorities.

**Dame Barbara Hakin:** It is important that the reconfigurations are largely driven on the basis of quality. We are moving into a situation where commissioners are much more focused on quality and describe very clear quality standards that they expect for their patients. That is likely to lead to some providers needing to reassess how they deliver services because it is evident, as you will well know, that the volume of service you provide, quite frequently, has an impact on the quality outcomes. Therefore, it is really important that we get the specialist expertise and the infrastructure to make sure patients with less common conditions are kept absolutely safe.

However, in order to look across a broader geography and a lot of areas where services will change, it will be essential that consortia work together to make sure they can take the overview of the services they want to commission and then work with a range of providers across that geography to help providers...
understand the best reconfiguration and the best configuration to give the quality services. The NHS Commissioning Board will have a responsibility to ensure that happens. Again, there is an assumption that these organisations will all act in isolation and will not be capable of coming together to work together. Over the history of the NHS, most of the time, we have seen organisations come together to identify the shape of services for patients across a larger geography than one organisation. Looking back over time, I remember the original health authorities doing exactly that. Chief executives of PCTs and SHAs in a lot of areas—the PCTs in my patch—would work together to commission ambulance services, et cetera.

Dr Wollaston: Sure.

Dame Barbara Hakin: The Board will have a responsibility to ensure that consortia do the same. Again, the early indications from consortia, as I go round and speak to quite a lot of them, is that they are very aware of this. They are very keen to make sure that they have an infrastructure that allows several of them to work together.

Q470 Dr Wollaston: Perhaps, Secretary of State, you can clarify whether you have decided what the intermediate layer of the NHS is going to be. Is it going to be the NHS Commissioning Board that carries out service reconfiguration or will there be a regional presence, and have you clarified what that will be?

Mr Lansley: No. It is not the job of the NHS Commissioning Board to carry out reconfiguration because, clearly—

Dr Wollaston: No, but somebody needs to.

Mr Lansley: The first responsibility lies in the hands of the providers themselves to respond to the shape of services that are being commissioned. The prime impetus comes from commissioners being clear, through their Joint Strategic Needs Assessment, of what services they do need. That is a combination of commissioners and local authorities coming together. If you remember, what we have been clear about, since the election, is the process of applying four tests to try and bring into the current system an appreciation of how the system should work in the future. There needs to be a public voice, through HealthWatch, and that public voice should be taken into account now; there needs to be a democratic voice, through Health and Well-being Boards, and we are trying to make sure that that voice is being heard now; there needs to be a patient voice, again through choice—and, clearly, some of these changes will be the result of the disclosed choices of patients—of where they want to be treated and by whom, and there is the voice of general practice-led commissioning consortia. All these things come together.

Clearly, that doesn’t mean there are not circumstances where the consequences of a service designed to meet commissioning consortia’s choices doesn’t give rise to a need for review. We set out in the legislation that there are processes by which, where there are major service changes, there is scope for those to be referred to the NHS Commissioning Board or, ultimately, to the Secretary of State—with major reconfigurations where the local authority, as a whole, cannot accept what is being proposed. I would say, as Barbara says, we can see this happening now. South London Healthcare is a very interesting case in point because these things were not happening. They weren’t being brought together. Now, for example, through the Bexley, Greenwich and Bromley Clinical Cabinet, we have general practice commissioning consortia coming together directly in order to look at some of the consequential issues, particularly for Queen Mary’s. Sidcup, and saying “We can offer our view.” Technically speaking, they are due to let me know, next Thursday, what their view is about how accessible, safe services can be provided and should be provided on the Queen Mary’s campus.

Q471 Dr Wollaston: You see that all coming from commissioning consortia and not needing—

Mr Lansley: In the first instance it has to be led by clinical leaders, and not least because at the heart of this is safety and quality. There does need to be a clinical impetus behind getting safety and quality right.

Q472 Dr Wollaston: You think they will have the levers to be able to carry out those functions.

Mr Lansley: A Barbara says, if they don’t have what they regard as the levers themselves—and you do ask a very fair point—we are intending that the NHS Commissioning Board, instead of having, as it were, rigid tiers of management in 152 primary care trusts and 10 strategic health authorities with all the costs and 10 strategic health authorities with all the costs associated with that, should have a significant role and it will need to discharge that role in ways that enable it to aggregate together some of its responsibilities for supporting commissioning consortia and indeed, if necessary, for performance monitoring and oversight.

Q473 Chair: Can I push Dame Barbara about that because she said the Commissioning Board “will have a responsibility to make certain these things happen”? I am not sure I quote you precisely, but that is what I heard you to say. What is the quality of information that is going to come to the Commissioning Board? Who, in the Commissioning Board, is going to provide the assurance that these things are going to happen? Who, in the Commissioning Board, is going to be taking action if the information coming to it gives rise to concern that opportunities which should be taken for service reconfiguration are not being taken?

Dame Barbara Hakin: First, I would reiterate the Secretary of State’s point that a lot of the reconfiguration, or the change in service, needs to be driven by providers on the basis of commissioner plans and quality specifications. The legislation is quite clear that the NHS Commissioning Board, first and foremost, authorises consortia. It has a role to support and develop consortia to make sure that they are fit for purpose, capable and competent and it has a responsibility to assure that consortia are delivering on all their duties. As yet, the precise shape and way the NHS Commissioning Board functions has not been decided. But Sir David Nicholson has been very clear that he sees an enormous strength which we will have through one organisation having a consistent
operating model in the way that it supports and develops all the consortia who are the frontline organisations.

In order to be assured that consortia were discharging all their duties, the Board would have to be sure that they were able to come together, because there are certain duties as a consortia, as a PCT and, frankly, as an SHA Chief Executive that you couldn’t discharge without colleagues. All NHS organisations have a duty to work in partnership. The Board will be there to ensure that, where appropriate, the consortia do work in partnership where consistent commissioning plans across a wider, broader geography of one consortia are important. At the moment, I couldn’t give any details on exactly what shape that will be because there is a discussion, and I think it is overstated—to believe that the productivity requirements in the NHS, in contrast to the last decade, are going to be delivered, principally, through structural reconfiguration of hospital services. This is simply not true. Indeed, when one looks at the overall structure of the QIPP programme, there are considerable expectations in terms of productivity gained in hospitals, but principally by the application of productive care principles and of doing things more efficiently inside hospitals that do not fundamentally change the structure of those hospitals—merely the productivity with which they are delivered.

Yes, there is a need to improve the quality of care and the accessibility of care for people with long term conditions, and that represents about 10% of the overall QIPP programme. That will reduce the demand for emergency admissions to hospital and so on. Again, I do not think that, in itself, is going to lead to major requirements in terms of reconfiguration of sites of hospitals. It will be more of an incremental process of responding to changes in demand.

Chair: Interesting. We could have a long dialogue on that.

Mr Lansley: I have one more point, if I may. Of course, if you ever did get to the point where there was major structural reconfiguration—we have been in situations in the past, which you will be familiar with, where there have been questions about hospital reconfiguration—the NHS Commissioning Board may, in any case, be a participant in those discussions because they, themselves, will be commissioning services. They will be commissioning specialist services that are currently embraced within the national and regional specialised commissioning processes. So they are very likely to be a participant in the process.

Chair: We could spend a long of time on that, I suspect.

Q474 Andrew George: On the issue of the reconfiguration and configuration of services, I get the sense that there is a fog somewhere between the NHS Commissioning Board and the consortia in terms of making decisions about the shape of local or regional services, particularly acute services. I will give the example of coronary care, stroke or obstetrics. In Cornwall, we have a pathfinder with a population of 28,000. If you think that that is an appropriate, integrated way in which it is possible to make a decision about the shape of services, it would be interesting to know how that might happen and how simply GPs, which is one sectoral interest, might be making that decision. Local authorities have a role, of course, but where does clinical governance come into the shaping of those services? What will lie between those commissioning consortia and the NHS Commissioning Board? You still haven’t really addressed that. There is a lot of uncertainty.

Dame Barbara Hakin: I want to reiterate that the Board is not just a board. The Board is an organisation with a very significant range of responsibilities, both in supporting, developing and overseeing consortia and in its own commissioning. What we are trying to create is a commissioning architecture which works across all geographies national and it is very important that there are processes. This is simply not true. Stroke care, for example, in some cases can be commissioned entirely on a quality basis. You don't need to redesign the structure of stroke care across a whole area. You might do at course, that isn't true. Stroke care, for example, in some cases can be commissioned entirely on a quality basis. You don't need to redesign the structure of stroke care across a whole area. You might do at
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Form follows function and we are in discussion, through the NHS Commissioning Board. It is the Board's responsibility to identify that prospect of failure and to intervene early, not to wait for a failure to occur. We have had too many instances of waiting around for failures to occur. In fact, in the NHS, we have had too many instances of failures occurring and people not—

Sir Bruce Keogh: It depends what you mean, in many senses, by "reconfiguration" because it means different things to different people. To some people it means the way real estate is configured and to others it means simply the way a service is delivered. With the National Commissioning Board, the major reconfigurations generally relate to specialist complicated services. Those are the big, more tricky, reconfigurations. The National Commissioning Board will be responsible for commissioning about 20% of activity and it will be around those major complex areas where they are either expensive or the risk to patients is the highest.

In terms of other types of reconfiguration, which is the way that services are delivered, they are more appropriately devolved down to local consortia, or to a local level. The key issue in all of this is that the decisions are not going to be made in isolation by people working in primary care. We are absolutely clear that what we are talking about here is not GP commissioning. It is clinical commissioning. We will expect there to be intimate involvement of the people who deliver the specialist services in discussions about the nature of their delivery. There is a spectrum of reconfiguration and the key to that spectrum is the discourse between those who provide the service and those who are commissioning it.

David Tredinnick: I want to talk about the Armageddon factor. What happens if a consortium has a catastrophic failure and something goes seriously wrong—a Mid Staffordshire Trust situation? Where does the responsibility lie there? Do you grab it, as Secretary of State, and pick it off the wall? What happens?

Mr Lansley: No. The responsibility, under those circumstances, lies with the NHS Commissioning Board. It is the Board's responsibility to identify that prospect of failure and to intervene early, not to wait around for a failure to occur. We have had too many instances of waiting around for failures to occur. In fact, in the NHS, we have had too many instances of failures occurring and people not—

Valerie Vaz: What would trigger any—

Mr Lansley: We are in discussion, through the NHS Commissioning Board, with the pathfinder consortia about structuring what those sorts of triggers and intervention points look like. The answer to the question is that it is the Commissioning Board's responsibility and, of course, if there were a failure, to step in. It has powers, if necessary, literally, to take over responsibility, or indeed to ask another consortium to do so.

Q478 David Tredinnick: Are you going to have spotters out there—scouts? Are you going to have a department that is looking down, checking each individual organisation to make sure, ticking off points, provided they get 70% success? Where does it click in? Is it a percentage success rate?

Mr Lansley: Form follows function and we are starting with the perfectly reasonable proposition that we are talking about a National Health Service and the National Health Service Commissioning Board has a substantial set of responsibilities at a national level. Indeed, some of the responsibilities that are currently distributed to primary care trusts could, should and will be discharged by the National Commissioning Board in a way that I hope will deliver greater consistency and economies in the future. At the same time, there has to be a series of processes by which the Commissioning Board doesn't just sit at the centre. It has to have a process by which it monitors performance, is capable of intervening and, frankly, is also capable of supporting. We are now designing what those support mechanisms look like because, where commissioning is concerned, there are a range of different population characteristics which, in themselves, are optimum in relation to commissioning for different purposes.

Q479 David Tredinnick: This is my last question. You have an audit function, then, at the Board. You are auditing what is going on through the whole range of consortia.

Mr Lansley: Yes. Clearly, the Commissioning Outcomes Framework, in itself, creates a whole structure of accountability on the part of the commissioning organisations for the results they are achieving. Also, the Board Commissioning Board has a direct responsibility, through monitoring its own contract with the commissioning consortia and, by extension, its contracts with GP practices, to ensure that the money is being spent in a proper and effective way.

Chair: Before I bring in Grahame, there was one important phrase you used there "Its contracts with commissioning consortia". That is how you envisage the Commissioning Board operating, is it, on an agreed contractual basis which defines what the Commissioning Board is looking for?

Dame Barbara Hakin: The Commissioning Outcomes Framework is not a contract as we understand the contracts between commissioners and providers. The NHS Commissioning Board will have a Commissioning Outcomes Framework, and it is that which makes clear, alongside staying within the financial allocations, its expectations of consortia. But running alongside "These are the expectations", the Board will put in place a range of tools, supports and guidance to mean that consortia do not have to reinvent things however many times there are of them.
Mr Lansley: These are, of course, statutory bodies in a statutory relationship.

Q481 Grahame Morris: In relation to the point that has just been made about reconfiguration of GP commissioners, and indeed the failure rate, I have been making quite extensive inquiries. I have written and I have tabled Parliamentary questions to try to discover what the Department’s or Ministers’ estimates are of the anticipated failure rate among GP consortia, and indeed local health services. I am not sure if you are aware of a piece of research that was carried out by the Nuffield Foundation. They did a very large study in North America of 3,000 commissioning groups. They went back, some 15 or 20 years later, and there were only 300 left. 90% had failed over that period. It wasn’t because of any lack of goodwill or clinical expertise. The failure was because of a lack of management input and financial oversight. I would be very interested to know what your figures are—what the Department’s estimates are.

Finally, the impact assessment that is published with the Bill seems to assume that there is some potential for failure built into the Bill, otherwise it wouldn’t create much of a market.

Mr Lansley: Let me say three things. I am familiar with the Nuffield Trust’s paper in relation to America. It is instructive in the sense that we knew the impetus for general practice in clinical commissioning is because we want clinical leadership in the design of services for patients. If we thought that the purpose of GP commissioning was in order to have better financial managers, that would be rather absurd, would it not?

Q482 Grahame Morris: Wasn’t the lesson—Mr Lansley: In America—let me answer the question—yes, there were failures and those failures of physician-led commissioning were largely to do with their inability to operate in an insurance marketplace. We are not looking at comparable situations, since our organisations have to manage finances but they don’t have to engage in risk management in the way that the physician-led commissioners did in America.

The second point is we are intending—but our recognition has always been that we are intending—for the consortia to establish themselves in a way that has strong financial support alongside them. That is why we are establishing the PCT clusters. The clusters, over the course of a two-year transition process, will ensure they do have precisely that kind of strong financial framework, including the establishment of that strong financial and other management expertise accessible to the consortia when they take over their legal responsibilities. Is there a risk of failure? Of course there is a risk of failure.

Grahame Morris: Failure is a risk.

Mr Lansley: Strictly speaking, we are in a learning process with the pathfinder consortia now. They are engaging directly with commissioning. There will be substantial delegation of responsibility for commissioning to them in the course of this next year and then, of course, shadow running in the year after, which will allow us to make more valid estimates. The Bill contemplates that, in order to respond to that, there is not only the power of intervention on the part of the Commissioning Board but, if necessary, a contingency fund in order to manage any consequences that flow from that because patients will always be looked after.

Q483 Grahame Morris: In relation to that point and the reason for failure of the cases that were looked at in the Nuffield Trust study, a particular case, in fact, the West Cumbrian practice-based commissioning, has been held up as a model, as an example. My understanding is that it is currently £11 million in deficit and the strategic health authority has effectively bailed it out. That organisation will no longer exist under the new structure, the new architecture. What will happen in these circumstances? Is this going to be a pattern of failure?

Mr Lansley: I am perfectly happy to send you a note. I have been to Cumbria and discussed it. It is perfectly clear to me that the general practice commissioning groups that came together, but out of practice-based commissioning—

Grahame Morris: There is no argument about their clinical expertise. It is their management expertise.

Mr Lansley:—demonstrated, in Cumbria, their willingness to get to grips with what were longstanding financial problems in the health economy in Cumbria. They are substantially improving the financial and service prospects in Cumbria as a result of that, not least by literally facing up to their problems which, in the past, were simply being ignored and were accelerating.

Grahame Morris: It is a huge deficit.

Q484 Chair: If we are going to go round every health economy with issues, we are going to be here all night.

Can I refer to some evidence Sir David Nicholson gave us when he came here to talk about the authorisation regime, how these risks that we have been discussing are going to be managed and the way in which the Commissioning Board is going to satisfy itself that these risks can be properly managed before a commissioning consortium is authorised in the arrangements in the new Bill? When Sir David was here, he made it clear he left open the possibility that in some parts of the country there wouldn’t be a consortium ready to be authorised by 1 April 2013.

He also introduced the thought that, in some parts of the country, there may be partial authorisation. Could you tell us how that might work and, importantly, who would be the commissioning authority in an area where there was either non-authorisation or partial authorisation on 2 April 2013?

Dame Barbara Hakin: I am happy to answer that. I would say—as I am sure Sir David would if he was here—that we do not have all the answers yet. This is something we are working through with the pathfinders in the Department of Health and as we build the basis for the Commissioning Board. The first and most important principle is that the Commissioning Board wants to see successful
The success of the NHS absolutely depends on the success of the consortia, and one of the Commissioning Board’s primary roles will be to support consortia to be as good as they possibly can be.

Alluding to the reference to deficits, while good management is absolutely key and critical to all NHS organisations—and we hope, through this model, to increase the economies of scale and protect the specialist expertise in terms of good management—there is no doubt that NHS resource is spent by clinicians of all kinds. In order to address deficits such as the ones we see in Cumbria, we need to see a change in clinical practice so that that clinical practice eliminates waste and delivers high quality for patients.

That is what we will be supporting the consortia to do. It will be in our interest to give the consortia the best possible start in life. Therefore, an authorisation process which looks at all the important aspects and helps them to demonstrate that they are good across the range of the things they need to do will be key, but that will then have to be followed up by an ongoing assurance process because organisations change. We all know that. We all know a lot of work to do on the detail of the elements of the authorisation process, but we are all clear that it is really important we look at six areas during authorisation. One is that these organisations are clinically focused and are really going to make a difference from the clinical point of view. Otherwise, what would be the point in having them? That is not just about general practice clinicians being engaged. It is about them demonstrating that secondary care clinicians, nurses and allied health professionals are all engaged in this process.

The second important area is that these have to be organisations that are responsible to their patients and their communities. As part of the authorisation we would want to understand that they have the right systems and processes in place to do that, not only from their own point of view but working closely with the local authority and local HealthWatch. In fact, as a step along the journey, we have announced, in the last few days, that in this year’s GP contract practices will have an increased focus on patient participation groups, which we know will help.

The third key area for authorisation will be that the organisations have a plan and can demonstrate how they are going to improve quality for patients within their allocated resource. We would need to know that they have a comprehensive capacity and capability to discharge all their functions, which are significant. As I have said here before, we are trying to create a system which gives the consortia a choice of commissioning their back office commissioning functions from organisations which are highly expert and therefore getting the economies of scale. In terms of looking at that overall capacity and capability, which is about both discharging commissioning functions but also doing the full range of corporate governance, statutory functions, safeguarding—all of those things—some of those elements might be bought in from outside the consortia itself, or shared across consortia.

The next area we would want to be clear about is that, to commission effectively, consortia need to collaborate. They need to have those arrangements in place. I go back to my earlier conversation about having to collaborate with neighbouring consortia but also with the local authority because a lot of commissioning is joint with the local authority.

Finally, they need to have the leadership capacity and capability. Again, they have to have an accountable officer and they have to have a chief finance officer. I am sure none of us here underestimates that successful organisations have very high calibre leadership.

Those are the domains, the areas we would want to see. We want consortia to be able to demonstrate to us that they have thought about these and they have thought about how they can discharge all these duties. I am sure we will try, during the course of the authorisation, not to create a bureaucracy so that they spend all their time worrying about authorisation. We will try to make sure that the documents that they are already having to produce, such as their constitution and their commissioning plans, meet the needs. Again, as Sir David mentioned last time he was here, so much of this depends on partnerships and relationships that it is our assumption that the authorisation will include an authority to consult. We would hope that the views of others locally and in neighbouring organisations.

It does seem unlikely, although we still have two years—given the enthusiasm and the number of pathfinders who are starting to look at this path already—that every single consortium would be absolutely competent in every area. I am sure that probably never happens to any organisation. They will always need support and development. But there is a range of options, as opposed to the full authorisation, which would be available. One would be that the consortia was authorised to commission some services and not others. Another would be that the consortium was authorised with support. It may well be that the Board would consider that, until it matured, some extra support in terms of management capacity needed to go into the organisation. There might be certain conditions around the authorisation. Where the consortium is not authorised to discharge all its duties, then the Board would have a choice of either commissioning those services itself or perhaps allowing a more modest consortium to commission those on behalf of those in the interim.

Broadly, that is where we are on that process which, hopefully, puts us in the position whereby, as we move through 2012–2013 and into 2014, we simply have constantly improving consortia who all become able to be more autonomous and independent. Then, I am sure, the continuing assurance process will be one which includes earned autonomy.

Mr Lansley: I would add a point or two, if I may, to that. First, we are already in a process, not least through the PCT clusters, of identifying how the right kind of staffing support and management support can be available to the new commissioning consortia. As all of us know, your predecessors, the Select Committee before the election, published a report in March last year which made it perfectly clear. I think what they said was, “The 2009 World Class Commissioning assurance process confirmed that the quality of commissioning by PCTs was largely poor to mediocre.” That disguised that there are some good
managers and good teams in primary care trusts. Our expectation is that this process will identify those and not only ensure that they are retained in PCT clusters but also have the opportunity to join commissioning consortia in future.

The other thing I might say is this. Of course, we have known for years that primary care trusts were not meeting the quality standards and capabilities that we wanted, but there was no authorisation process. We do not start down this process from, "It all worked fine, so why are we messing with it?"

Chair: One of the more implausible public campaigns is the campaign for the preservation of the PCT, as they were in April 2010.

Mr Lansley: Yes. That is exactly the right point. This process of authorisation, not least because of its transparency and rigour, is going to be something that gives people, including people who depend on the National Health Service, and the local authorities, who have an integral part in all this, a degree of reassurance about the nature of the capabilities that are managing their commissioning process that we have not had in the past. All that happened with PCTs was the World Class Commissioning process was introduced and, in the two years it was introduced, the amount of management consultancy spend by primary care trusts and Strategic Health Authorities rose by 78%, from £176 million to £314 million. The response was just to hire more management consultants.

Chair: We have, helpfully listed by Dame Barbara, six domains—I think that was your term of art—that we would like to go through, or at least some of them, in the course of the time left to us.

Q485 Chris Skidmore: I am particularly interested in what Dame Barbara said about engaging secondary care commissioners and the process of that engagement. Why not simply include secondary care commissioners within the consortia to start with? Why do they need to be engaged on a separate level? Obviously, you are talking about commission-led commissioning.

Mr Lansley: I will ask Bruce to add to this because Bruce, in particular, has been engaging with the views, as it were, of the broader clinical community in all of this. From my point of view, it is general practice-led commissioning. Why general practice? For the very simple reason that that is a unique place in the structure of clinical responsibility in the National Health Service where there is not only a responsibility for the individual patient, for whom one is responsible, but an understanding of that patient in the context of their community and their needs over the longer term in a population health context. It is built around general practice, but it is not confined to general practitioners and it is not necessarily confined to general practice as such.

Sir Bruce Keogh: Different consortia will have different needs that they will need to engage with their secondary care colleagues about. They have to have the freedom to do that.

Chris Skidmore: But they won’t be specifically included on the consortia. They won’t have a voice within the consortia senate, for instance.

Mr Lansley: We are not intending to be prescriptive about how the consortia should structure themselves. We are intending to set, as Barbara has very well set out, “tests” for authorisation that are about capability, purpose and how one goes about delivering that task, not trying to set a series of prescriptions.

Q486 Chris Skidmore: If there was a population group with a particular chronic need where secondary care commissioners would need to be involved, they could join the local commissioning board of the consortia.

Sir Bruce Keogh: Indeed, and we would expect them to.

Q487 Chair: As full members of the consortium or as members of the executive of the board?

Mr Lansley: The practices will be members of the consortia. The way in which they go about their task is something we will be asking them, through the authorisation process, to demonstrate—how they fulfil these purposes. It is purposive rather than prescriptive.

Dame Barbara Hakin: It may be that not many PCTs have secondary care clinicians on their boards and governing authorities.

Q488 Chris Skidmore: It is very welcome that you have made these statements here today. Certainly the evidence we have received, overwhelmingly, has been out of a concern that it will be, although GP led, GP dominated and that secondary care commissioners won’t have a voice. You explaining that today is certainly welcome.

Mr Lansley: Barbara will know better than I do, but I don’t know about this from places I have been. I was in Dudley last week where they were describing to me the way they are going about the design of their care pathways, and they had nursing and speech and language therapists who were leading work streams. It is not doctors leading, either. It is a range of health professionals.

Q489 Chair: Bruce, do you want to develop the theme of the broader clinical engagement?

Sir Bruce Keogh: One of the things we are trying to do through this is to give considerable freedom to the consortia and to the GP commissioners to conduct business in a way that they feel is most appropriate for their patients. When we look at the kind of issues that they and providers are having to deal with at the moment, they are having to deal with emergency admissions, which puts a load on the providers, we have patients in hospital who would be better off being handled in the community and we have growing evidence that not only patients but sometimes care can be much better delivered in the community. For consortia to set about trying to deliver services without involving secondary care clinicians would be like trying to have a fight with one arm tied behind your back. It is simply not going to work.

We want to encourage them to use their imagination. There are many different models. You have heard one from the Secretary of State. But I can see no reason why a commissioning consortium can’t commission a secondary care physician to lead on a particular type
of pathway, like rheumatology or chronic obstructive airways disease. That is the sort of thing which will help to engage them and help the secondary care organisations feel they are making a significant contribution to the delivery of care in the services. If conducted properly, that has the potential to alleviate some of the burdens on secondary care that Nadine Dorries was alluding to earlier and also relieve some of the financial burdens.

Q490 Nadine Dorries: Could you describe how that would look? How would that look, a secondary care clinician leading? Can you illustrate it slightly more? I don’t think everybody quite understands what you mean by that. Can you illustrate it how it would look—how it would work in practice?

Sir Bruce Keogh: Perhaps I can work down. One of the most successful things that has happened over the last decade, in terms of improving care, has been the development of clinical strategies in the NHS. The thing that makes them successful is that they focus on clinical outcomes, they focus on clinical leadership and they are led by a clear, declared leader. In this Committee you will have seen some of the national clinical directors. What is quite possible is to have a microcosm of that existing at a local level, either with one, two or more consortia, asking for leadership and receiving very specialist advice on how to develop pathways of care from those who are most familiar with them.

Q491 Nadine Dorries: Would it be an exchange of dialogue, of opinion, or would there be an official role on the consortium?

Sir Bruce Keogh: I wouldn’t want to stipulate that it would be one or the other. It could be all of those things. But I can quite easily see that a commissioning consortium could commission a secondary care doctor to lead the development of a particular type of service for them at a service level agreement type of approach.

Q492 Nadine Dorries: It would be that you would buy for all your rheumatology patients to come to this hospital and be seen by these doctors. “This will be the type of care and the way we will treat rheumatology. Therefore, our agreement is this much for that service.” Is that not right?

Sir Bruce Keogh: That is a bit too speculative as to the end result of how that might work. There are all sorts of ways that things could be delivered and, of course, the secondary care doctor who is leading on that would be expected to consult with all those who had an interest in rheumatology patients, ranging from the third sector right through to his colleagues. It doesn’t necessarily mean that he stipulates that all patients are seen in one place.

Mr Lansley: We have a number of examples of how this might work, generally speaking. Cancer networks in some places have already developed from what was originally simply a network of providers of cancer services to organisations, effectively, that are now capable of being a commissioning structure. What they are looking at, in effect, is determining the care pathways for cancer patients. It is a meeting place of a range of disciplines and professions to make that happen.

We have another example in the West Midlands. The West Midlands federated mental health commissioning vehicle has GP leaders and people from local authorities, from user groups and from providers of mental health services coming together in that sort of network to define what the care pathways look like. In fact, that goes on, then, to be responsible for contracting. The commissioning consortia can give that kind of contracting organisation a responsibility.

Q493 Nadine Dorries: This is one of the problems with the Bill, Secretary of State. You know of those examples because of your role and your Department knows of those examples. But the question I am frequently asked by GPs is, “How does that work?” If I had a criticism of the Department in this Bill, my main criticism would be that you have not communicated very well these examples which you and your Department know about but GPs and their consortia do not always know about. I had a conversation this weekend with a group of GPs. They can’t quite see the way through how some of it is going to work because it hasn’t been communicated to them terribly well.

Mr Lansley: It is a fair point. From our point of view, in a sense, the debate about how it is supposed to work is happening before we had expected to have created the learning network that shared precisely how people were putting these things together. In a way, when we started out, in March 2011 we expected there to be a small number of pathfinder consortia who were beginning to shape this. In fact, we have 177.

Nadine Dorries: A victim of your own success.

Mr Lansley: There is a tendency to expect the Department of Health to produce a document that tells them how to do it. The answer is that we are creating much more of what we think of as a learning network, the purpose of which is that they shape how this works.

Q494 Chris Skidmore: How is that learning network progressing so far? Is it internet advice and various officials giving advice on the phone?

Dame Barbara Hakin: Yes. The pathfinder network has taken off. We have 177 pathfinders. There is a range of things that are going on, but the key one that holds it together is the pathfinder network and website, which is growing in terms of its technical ability and its content by the day. We are very early—

Q495 Chris Skidmore: Do you have any data for how many people have logged on or clicked on to it yet?

Dame Barbara Hakin: I haven’t at the moment, but I would be happy to get you that.

Q496 Nadine Dorries: Is that just for GPs to use or is that for everybody to access, all health care workers? Who has access to that website?

Dame Barbara Hakin: Anybody could have access to the website. It is predominantly designed for pathfinders, but the pathfinders don’t have to say,
"Only our GPs can log on to the website." Some areas of the website are open to anyone because we want the consortia who are not already pathfinders to be able to use and access it. I won't pretend for one minute that that site is as we would want it to be. It is a relatively short space of time since the Bill was introduced and the enthusiasm and response is helping us create the website. Of course, to some extent, most learning comes from each other. It isn't about what we know in the Department. For us, the key is creating the linkages. Sitting around the pathfinder, which I call the hard-wiring of the system, we have a clinical commissioning network. That is much more about bringing people together and facilitating discussion—again, website, e-mail and places for people to have conversations and debate issues. Then, sitting round that, there is a huge raft of things. Again, at the behest of the frontline we are trying to make one coherent whole—not that it is all the same but that people can navigate around the system. There are an awful lot of organisations, the BMA, The Royal College of General Practitioners, The National Association of Primary Care, NHS Alliance, all doing work and having networks to help people learn from one another. I see our main role as making sure that we use the technology to best effect to connect all these people. It is those people out there on the frontline who have the answers, not us.

Q497 Valerie Vaz: With the greatest respect, one of the GP pathfinders said he was working through the PCT, so the PCTs are still in control of these pathfinders. Is that not the case?

Dame Barbara Hakin: At the moment, the pathfinders—

Valerie Vaz: They are. He said that.

Dame Barbara Hakin: The best pathfinders act with delegated authority from the PCT.

Valerie Vaz: They are working with the PCTs.

Dame Barbara Hakin: Pathfinder does what it says on the tin. It is trying to help us find the path.

Valerie Vaz: So they are working with the PCTs.

Dame Barbara Hakin: Yes, absolutely.

Valerie Vaz: The set-up is exactly the same as it is now.

Dame Barbara Hakin: They are what, sorry?

Valerie Vaz: The set-up is exactly as it is now. The PCTs are in control with GP consortia and the pathfinders.

Dame Barbara Hakin: We are in a transition period. We have created clusters in order to try and help the consortia to develop and grow into what we need them to be as soon as possible, but we still have two years.

Q498 Valerie Vaz: I was pleased to hear that Professor Sir Bruce Keogh said there were some successes over the last 10 years. I am not into party politics. I just want a National Health Service that works. What concerns me is that a number of GPs, 89%, have said that they don't want the system you are currently putting through. I know you may smile, Secretary of State, but there are people out there who are concerned about the lack of accountability of public money. It is all very well that you say, "We are just thinking things through." That is what you said five minutes ago, "We are thinking things through." But you still don't know what the triggers are where the National Health Service Commissioning Board—

Mr Lansley: We are in a transition.

Valerie Vaz: No. Let me finish.—is going to step in and take over a GP consortia. You said you don't know. You are still thinking it through. But, at the bottom of it, do you not accept that you are actually playing—

Mr Lansley: What are the triggers now?

Valerie Vaz: Let me just finish.—with public money and playing with people's lives. This isn't just a stand-alone. This is actually people's lives we are talking about.

Mr Lansley: Do you know what? The people I'm relying upon are general practitioners who are already responsible for people's lives. I am relying upon clinicians across the NHS to add not only the responsibility they currently have for providing the care to people, and doing it more successfully year on year—

Valerie Vaz: And they do it very well.

Mr Lansley: —the improvement they deliver year on year, to empower them, through this process, to put alongside that the responsibility to be able to make decisions about how resources support them.

Valerie Vaz: And they are doing it very well and they don't want the responsibility of the money.

Chair: Can we have one at a time?

Mr Lansley: There is a relationship with managers. It is not a relationship where the PCT—

Valerie Vaz: He interrupted me.

Mr Lansley: —tells general practices and commissioners what to do. It is a process by which those who are responsible for the management of care of patients are increasingly, themselves, in a leadership role with management in support.

Q499 Valerie Vaz: But that is not the evidence we heard.

Mr Lansley: I actually think that's the right way round.

Valerie Vaz: With the greatest respect, that is not the evidence we heard. We heard about some good practice around the country. I would have expected, in this time of financial constraint, that you don't spend the £5.1 billion that Sir David Nicholson said is being spent on the reorganisation and that that goes into patient care.

Mr Lansley: It's not. I just said £5.1 billion—

Valerie Vaz: That's what you said. It was £5.1 billion. Have a look at the transcript.

Mr Lansley: £5.1 billion is the current cost of administration in PCTs, strategic health authorities and arm's length bodies in the Department. We are planning to reduce it by £1.7 billion in real terms. The cost in the impact assessment of the overall reorganisation has been estimated at £1.4 billion. Most of that would be costs that would be incurred anyway in order to reduce the total administration costs. It yields a saving of £1.7 billion in each year. 10% of the overall QIPP programme for delivery of efficiency savings is happening simply because we are delivering those reductions in administration costs. Under
current circumstances, it is absolutely the right thing to take resources from the frontline—from the back office and get them into the frontline.

Q500 Valerie Vaz: “Frontline”—Freudian slip.
Mr Lansley: That is what we have done over the six months since May 2010. In the first six months for which data is currently available, there was a reduction of some 2,000 in the number of managers. I have the numbers—

Q501 Valerie Vaz: Do you think people are satisfied with—
Chair: Valerie, can we be patient—
Mr Lansley: If you want to have the actual numbers—
Valerie Vaz: I have been patient, Chair.
Mr Lansley: We had a reduction in the number of managers of 2,103.
Valerie Vaz: I am talking about exchanging e-mails at the minute.
Mr Lansley: It is a 2,103 reduction in the number of managers and, for example, an increase of 2,484 in the number of doctors. I happen to think that what we are doing is all about empowering and supporting those who are already responsible for delivering care to patients.
Chair: Andrew George has been seeking to come in on the second of Dame Barbara’s domains, which is local engagement.

Q502 Andrew George: I will begin with a broader question. How long do you think it will be before each GP practice will be subject to competitive tendering?
Dame Barbara Hakin: I don’t really understand—
Andrew George: If everything else is up for grabs, as far as tendering of services, I want to understand what is different about GP services, in terms of all other health services, that they shouldn’t be subject to a tendering process?
Dame Barbara Hakin: The current contract for general practice, the dominant contract, is the GMS contract. There are local PMS contracts. Where there is an absence and where, strategically, there is a need to attract other forms of general practice to an area because it is not possible to attract traditional general practice then, under those circumstances, there have been tendering processes.

Q503 Andrew George: Is it potentially subject to any contestation, the fact that these things are straightforward contracts with providers at a local level, straight from the NHS Commissioning Board in future?
Dame Barbara Hakin: I am sorry?
Andrew George: Will it be a matter, under competition law, of potential contestation given that these are straight contracts and it will be, in future, from the NHS Commissioning Board directly to GP practices? Is there any concern there?
Mr Lansley: I do not think this is any different a process than that which would be currently undertaken by a primary care trust. It just happens to be done by the NHS Commissioning Board centrally.
Dame Barbara Hakin: A gain, as back with the earlier conversation on competition, that process comes into being when one is creating new services, whereas the contracts that practices have for delivering primary medical care are life-long.

Mr Lansley: A lot of these are perfectly reasonable questions. In a way, it kind of illustrates how far what we are doing is evolutionary from where we are now. There are an awful lot of things people are asking questions about and saying, “How is that going to work?” Nobody has any idea how it works now. What, for example, are the triggers for intervention by the NHS executive—

Q504 Valerie Vaz: That is what is so worrying. Aren’t you concerned that nobody has any idea about our Health Service?
Chair: Valerie, please.
Mr Lansley: This is what I am saying. What do you think are the triggers for intervention in a primary care trust now, because there are primary care trusts that fail? We have lived without any such transparency, and completely without it.

Q505 Andrew George: I will move the question on to the issue of accountability, GPs coming together in consortia and not meeting in public. It was proposed at my party conference that they should do and also that they should be configured of a wider range of representation, including locally-elected representatives, which was originally in the coalition programme. Secretary of State, are you likely to take any of that on board?
Mr Lansley: I will do exactly what I have described. We are going to continue through the process of the passage of the legislation, continuing to seek to ensure that we clarify and, if necessary, improve the way in which the Bill delivers the purposes that we set out at the outset. Often, people have lost sight, in the minutiae of the detail this, of the fact that this is all about delivering better outcomes for patients and the focus on quality and outcomes is absolutely at the heart of this. It is about empowering patients. We are very clear that we are going to do that. It is about empowering frontline professionals, and we are going to do that.

Q506 Andrew George: Is the issue of accountability and transparency and the proper conduct of these statutory decisions, which were ultimately made, in conflict with that objective?
Mr Lansley: No. We are intending that there should be, and in the course of our conversations this afternoon we have illustrated a number of respects in which there is far greater transparency in the design of the NHS for the future than has been the case in the past. There is also much greater scope for accountability. You won’t want me to go on too long about this, but, for example, HealthWatch delivers a much greater formal accountability and structure for patients to exercise voice. The scrutiny processes of local authorities will be significantly empowered as compared to where they are now, because at the moment they cannot reach into private providers. The scrutiny processes, at the moment, don’t even reach directly into general practice, do they?
Dame Barbara Hakin: No.
Mr Lansley: They will in future. Wherever the NHS pound goes, the scrutiny process will follow. As you rightly say, we have in the legislation what is now intended to create a role for democratic accountability through the Health and Well-being Boards that has simply not existed in the NHS since the early 1970s. As to the Health and Well-being Boards, alongside the pathfinder consortia we have now got, as I announced last week, 134 local authorities—90% of the country—have come forward and said they want to be early implementers because they recognise this process of direct engagement with the commissioning process, allied to their responsibilities for public health, social care and beyond, has the potential to transform the quality of NHS and public health and social care services.

Q507 Andrew George: I can’t see how that is going to happen. You say—and you repeat the mantra—“No decision about me without me” and you say it is all patient-centred and it is about patient outcomes, but the crucial decisions about commissioning of services don’t have to be made by the local electorate on the basis of public opinion there on those commissioning boards. They are outside. There is no transparency. The meetings are not held in public. How can you possibly claim—

Mr Lansley: They will be transparent.

Andrew George:—that there is “No decision taken about me without me”? They are outside.

Mr Lansley: No. They will be transparent for two reasons. One, because all of those commissioning the structure of the commissioning plan must be the subject of discussion between the commissioning consortia, the local authority and the Health and Well-being Board. It is also transparent since the commissioning consortia will have, transparently, to make clear what service it is they are inviting providers to provide. Or, if they are doing so through an open competition, it will be an open competition and the contracts will be—as we as a coalition Government are doing, they are contracting and the public sector will be, except where there are specific compelling reasons for commercial confidentiality—out in the open.

Q508 Andrew George: There will be a tremendous amount of commercial confidentiality with regard to those. The ultimate decision, obviously, will be communicated.

Mr Lansley: Why would there be commercial confidentiality? Since there is a tariff, there will be a tariff.

Andrew George: A tendering process always involves commercial confidentiality. You cannot pretend that it does not.

Mr Lansley: But I made clear why I think we will see, in future, less by way of competitive tendering because, through the any qualified provider process one would establish a tariff basis and invite people, in effect, to offer to be a provider on the basis of the tariff and the quality specification. To that extent, it can be entirely transparent.

Q509 Andrew George: If a commissioning consortia came forward to you with a proposed governance arrangement that involved, as equal members of their commissioning board, clinicians from secondary care, nursing care, and elected community representatives, you wouldn’t object to that?

Mr Lansley: I will repeat what I have said before. The authorisation process for consortia is purposive rather than prescriptive. Since we are not prescribing that they should do things, it is reasonable for us not to prescribe what they shouldn’t do.

Q510 Chris Skidmore: Can I come in on that briefly and take a slightly different stance from Andrew? I am concerned if you have elective representatives from local authorities that you create a politicisation of the system. I was wondering if you have any concerns that Health and Well-being Boards might ever be at loggerheads with consortia and how that would be ironed out.

Mr Lansley: They may be. In the Coalition Agreement—and clearly it did differ—the intention originally was that we would have primary care trusts that tried to combine both things together, but it was perfectly obvious that once the commissioning responsibility was in the hands of the commissioning consortia and once the public health responsibility is in the hands of local authorities and there are good and compelling reasons for that, there was not a substantive role for primary care trusts. That was a pointless position to pursue. None the less, we were always clear, through the coalition process, that we were going to combine two things together: clinical leadership and democratic accountability. The place where that happens is in the Health and Well-being Board.

Q511 Chair: Secretary of State, it is slightly odd, isn’t it, to have the commissioning authority in the hands of the consortium without an obligation to meet in public, whereas the trust board, which in the end is simply responding to a commission placed by a commissioner with public funds, does meet in public?

Mr Lansley: Which trust do you mean by the “trust board”?

Chair: Provider trusts.

Mr Lansley: It is all part of a central proposition, which is that we want the consortia to meet and make a range of specific purposes and themselves to come forward and set out how they intend to do that. Barbara, I think very helpfully, has further illustrated to you the shape of what those purposes look like, in addition to their specific statutory responsibilities. They will come forward and they will show us what those look like. We are literally resisting, in order to ensure that we do not simply recreate, in the context of this new statutory body, all the characteristics of primary care trusts. We are going to give them the opportunity to come and show how they can meet this set of criteria.

Dame Barbara Hakin: We should watch and wait to see what alternative arrangements they can come up with. The current arrangements are a number of non-executives in a meeting which, admittedly, is held in public but the public cannot intervene in that. The non-executives are there to ensure that the governance arrangements of the organisation are met. But a lot of patients, their carers and other stakeholders would like
Q512 Nadine Dorries: Secretary of State, it was fortuitous for me to be at the RCN Headquarters in Cavendish Square speaking at the beginning of the month when the press release arrived from the Department of Health announcing that the Chief Nursing Officer will sit on the NHS Commissioning Board and that there will be a director of nursing in the Department of Health with a greater public health focus. However, it did seem to take a long time and many representations to get the Department of Health to get to that position. Given that nurses today triage, prescribe and are involved in many areas of clinical administration with patients, why can it not be that nurses are commissioners alongside GPs? Why can you not go the extra step and do that?

Mr Lansley: They can be. As I said when I was in Dudley last week, if you recall correctly—

Nadine Dorries: You said nurses and various others. I wanted to jump in on that point, actually. If you did, in Dudley, can you explain in what way they are doing that? A gain, how does it look?

Mr Lansley: In that particular instance, and I recall the conversation, I said, “If you are designing care pathways, very often, it may be that nurses are in a very strong position.” Funnily enough, I was at the Royal College of Nursing having a discussion with nurse leaders about a month ago.

Nadine Dorries: You were there the day before me.

Mr Lansley: The point they made was that nurses are very often in a very strong position to see the whole care pathway, whereas doctors are very often in a position of understanding rather better the particular issue of diagnosis or treatment rather than seeing all the components of care. That is a very fair point and I entirely understand it. I was relaying that to the Dudley consortium in this conversation and they said, “Yes, we completely agree about that. For example, the community psychiatric nurse is quite often likely to be the person best placed to see the whole structure of services provided to a mental health patient, which is why a community psychiatric nurse is leading the whole process of designing the purpose of the consortia, the strategy and how it is going to meet patients’ needs.

Q513 Nadine Dorries: Is she actually sitting on the consortium board then?

Mr Lansley: They haven’t yet come to us and told us. There is this talk about what “the board” looks like—

Nadine Dorries: But will they be able to?

Mr Lansley: These consortia will be giving them space prior to the authorisation to determine what that looks like. We are not setting out “There must be a board” or what the board consists of. Indeed, there are nurse-led practices, admittedly not many, across the country who, themselves, will be members of the consortia and nurses will lead them. That happens now.

Nadine Dorries: Thank you.

Q514 Chair: There is one set of issues we have not touched on, which is the “Who commissions the commissioners?” question, which Andrew touched on, which is the relationship between the consortia and its own primary care members, GP members. When Sir David was here, and I refer back to that session, he indicated he felt it was necessary to have an engagement by the Commissioning Board at sub-national level in order to be able to be an effective commissioner of primary care. If we develop that argument—and clearly primary care, by its nature, is a local service—there is a history, isn’t there, in the Health Service of the problems caused by having separate commissioning networks for primary care and secondary care? That is how we got to where we did with FHSAs being merged into health authorities. Do you think the danger exists of that being recreated, in other words of a primary care net that is separate from the commissioning structure for secondary care? Is it not desirable, in fact, to have the primary commissioning decisions for primary care being made alongside the decisions for secondary care, in other words, in the consortia?

Mr Lansley: I am sure Barbara will want to add a little, but let me say why I don’t think that is likely to be a serious problem. First, although we are intending that the NHS Commissioning Board—in fact, it is set in the legislation—will be responsible for the contracting process with individual GP practices, of course we are looking, increasingly, at the same time, that the NHS Commissioning Board will be expecting the commissioning consortia themselves to engage with the GP practices in how they deliver the quality and outcomes that they are looking for. To that extent, performance monitoring and management can be devolved from the NHS Commissioning Board. Indeed, in so far as the NHS Commissioning Board is making decisions about the way in which it contracts—the process, for example, that Barbara was describing about determining whether they were going to commission primary medical services, or numbers of practices—that is something that would not be determined by the NHS Commissioning Board in isolation. It would be done literally as a consequence of a discussion about primary medical services in the Health and Well-being Board in a particular local authority, so seeing how the Joint Strategic Needs Assessment will govern that. This parallels, in that sense, the way in which the NHS Commissioning Board will respond to the Strategic Needs Assessment on things like pharmaceutical services or dentistry.

Can I take this opportunity to let you know something which, from my point of view, has been erroneously suggested. I know how it happened. There has been an assumption, which was made by some but not by us, that 80% of the commissioning budget of the NHS would be in the hands of GP-led commissioning consortia. Therefore, people said, if there is £100
billion in the NHS budget, that is £80 billion. It does not work like that. The total resources for the NHS are £100 billion and rising. The commissioning budget, at the moment—if you were to say it is the primary care trust budget—is £89 billion in 2011-12. Part of that is public health, and we have yet to determine how much, but part of that will become part of the responsibilities of Public Health England and the local authorities, so the comparable figure would be less than that. Of that total, about £10 billion is for commissioning specialised services—the sort of thing Bruce was talking about—the national and regional specialised services, prison health and high security psychiatric services and so on. The primary medical services, which you are just asking about, represent about £8 billion. On family health services activity, dentistry, pharmacy and ophthalmic services, are something over £3 billion. When you put all those together, the amount of resources that would be in the responsibilities of GP-led commissioning consortia—their commissioning budget to look after their patients—is of the order of £60 billion rather than £80 billion.

Q515 Chair: But there is still a requirement for the commissioning of the primary care element of that to be properly integrated—
Mr Lansley: The primary medical services delivered by general practices on their own account, yes, absolutely.

Q516 Chair: Exactly, to be integrated into the delivery of an integrated health care system.
Mr Lansley: It is.

Q517 Chair: That was the focus of my question. It seems to me essential that that should be something which has the decisive voice in a locality is with the people. There needs to be a single voice responsible for commissioning the delivery of an integrated service, both primary and secondary care, otherwise what we are doing is reintroducing, or reinforcing a division between primary and secondary care which has always been one of the fault lines of Health Service that people have tried to find their way over. There needs to be a single voice responsible for commissioning the delivery of an integrated service, both primary and secondary care which has always been one of the fault lines of Health Service that people have tried to find their way over.

Dame Barbara Hakin: The same applies.

Q518 Chair: I will bring David and Valerie in, but it would be fair to say, wouldn’t it, that these problems are easier to address if the statutory public authority nature of the consortium is reinforced through the governance structures?
Dame Barbara Hakin: You are absolutely right. Once there is confidence in the governance arrangements of the consortium, it is much easier to delegate authority for these issues. However, there are other areas outside primary medical care that the boards will be commissioning, such as dental care and optometry. The same applies.

Q519 Chair: Primary care includes, surely, pharmacy—
Dame Barbara Hakin: Absolutely, all the areas.
Chair: Yes, otherwise the fault line is simply moved somewhere else.

Q520 David Tredinnick: I want to add to what the Chairman was saying. Thinking about the county I represent, Leicestershire, my understanding is that the consortia are talking directly to primary care. Therefore, there is an informal process already that has been created that is very beneficial. I absolutely agree that there should be a formal structure, but you have already got an informal one. Certainly, my understanding of the county—and the Chairman is well qualified to comment on what I am saying as he represents the same county—is that this has to be an intimate partnership, otherwise that is happening. My question is: is it happening elsewhere in the country? Are you getting a better tuning of primary care services already because of better lines of communication?
Dame Barbara Hakin: Primary care continues to improve everywhere. PCTs across the country have made huge inroads. Your constituencies in Leicestershire is a part of my patch of the East Midlands Strategic Health Authority, so thank you. I think lots of good things went on in terms of improving the quality of primary care. But there is still variability. We have to accept that if you look at the variability in primary care it is probably greater...
than almost any other aspect of the Health Service. One of the benefits of one NHS Commissioning Board will be to rushed to the commissioning of primary care which, hopefully, reduces the variability and starts to address some of the inequalities. There is no greater mark of inequalities than availability of high quality primary care. In terms of inequalities in health care, that has a huge impact. Addressing that will be key.

Q521 David Tredinnick: In the county, as you have volunteered that you were representing the East Midlands, is it not a fact that we are getting a better line of communication through this new arrangement informally before we get to the formal structures?

Dame Barbara Hakin: Lots of things are improving the quality and consistency of primary care.

David Tredinnick: I am bowling you such a soft ball and I am hoping you are going to hit it.

Dame Barbara Hakin: There is no area in the country that could look across all its primary care and say that there were not areas where there was room for improvement, although I do think what they have done in your neck of woods is really excellent.

Chair: It will look good in the Leicester Mercury.

Q522 Valerie Vaz: I have three very quick stand-alone questions. Integrated health partners have said they want to enter into partnerships with GPs on a profit-sharing basis. Do you agree with that? Do you think that is likely to happen?

Mr Lansley: I saw press reports—I have to say only press reports—that appeared to indicate they were doing this on the erroneous belief that they and/or the consortia were in a position to profit by making savings within their commissioning budget. That is simply not true. In so far as a commissioning consortia wanted to have commissioning support from a private-sector organisation, and if they wanted, for example, to use their management allowance for that purpose, or share their quality premium—and we have designed the quality premium to make it clear that if they deliver higher quality services there is a remuneration to the consortium for that purpose—with a private sector-commissioning support organisation that is up to them. None of that money comes out of the money that is available to support services for patients. The only structure of incentives there is to deliver the highest possible quality and outcomes from within the resources that are available.

Q523 Valerie Vaz: You are comfortable with that, that GPs can?

Mr Lansley: By a roundabout way, I am saying that what I have read in the newspapers—

Valerie Vaz: Is it yes or no?

Mr Lansley:—suggests they are proceeding on a business model that is not accurate. It does not work like that. If they want to produce a different business model that corresponds to the simple fact that saving money on their commissioning budget does not yield any profit to the commissioning consortia, then they have to go away and think again.

Q524 Valerie Vaz: Is the training of doctors a national issue or is it a local one?

Mr Lansley: We published a consultation just before Christmas on the future structure of education and training.

Valerie Vaz: Is it going to be with the National Health Service Commissioning Board?

Mr Lansley: We are in the process of receiving those responses to the consultation and we will respond to the consultation in due course.

Chair: That is an early bid for another inquiry, if I may say so.

Q525 Valerie Vaz: On the Ipsos MORI poll, which apparently hasn’t been published by the Department, that was out in the autumn of last year, is it possible to put that on the website instead of the 2007 one?

Mr Lansley: You mean—

Valerie Vaz: The levels of satisfaction with the Health Service.

Chair: This is a Sunday newspaper story that apparently you have suppressed a piece of good news.

Mr Lansley: You mean I didn’t publish it in circumstances—

Valerie Vaz: We don’t always believe what is in the papers, do we?

Mr Lansley:—where my predecessors didn’t publish it either? It is that sort of allegation.

Valerie Vaz: There was an election in May, wasn’t there?

Mr Lansley: As I understand it, it is a piece of work which has been done on a regular basis for Ministers. As it was not published by my predecessors, it is not my intention to publish it.

Valerie Vaz: It was only out in autumn 2010, I understand, but I do not know.

Mr Lansley: Did you say “out”?

Valerie Vaz: I don’t know. That is the question I am asking. I don’t know what goes on in the Department. That is why you are here and that is why we are asking you the questions.

Mr Lansley: It is part of the process of development of policy advice to Ministers. It was not published by my predecessors when it was done in previous years, 2009 and 2008, and it is not my current intention to publish it. If you want to know what Ipsos MORI have done, I point you to work they did for the Nuffield Trust and which was published just a week or so ago.

Valerie Vaz: Thank you.

Chair: Does any Member of the Committee wish to have a concluding shot, otherwise I think we have probably gone quarter of an hour beyond. There is one concluding shot from a coalition supporter.

Q526 Andrew George: As I sit on the coalition benches, it is quite true. In relation to both sides of the coalition, you know that both the Liberal Democrat conference and the BMA have had a number of comments to make about the Health Bill as well as, of course, our colleague Sarah Wollaston, who is not in her place this afternoon. She was reported in the Daily Mail today, I notice, as saying “Someone needs to get a grip ... It all risks going belly-up” and is
saying that the Bill is doomed as far as the NHS is concerned. How are you reacting to those broad-brush comments and resolutions coming from—even if you don’t respect them—the Liberal Democrats and the BMA, in terms of the resolutions which they have brought forward? Is it a question of ploughing on?

Mr Lansley: I can fairly say that I respect the Liberal Democrats at least as much as I respect the BMA.

Andrew George: What about Sarah Wollaston?

Mr Lansley: Sarah, too. I said yes last week. We had an opportunity in the debate initiated by the Labour Party. To make it clear, there was no proposal and no policy coming from the Labour benches. If people have concerns, I said absolutely straightforwardly, if there are legitimate concerns, we will certainly look, discuss, listen, and if we can clarify we will do so. We have already done so. People made it very clear to us they were very concerned about the issue of price competition. We had a discussion about that here in the Committee. I made it clear that it was competition on quality when I went to the Public Bill Committee. A Labour Member said to me, “Is it competition on price or is it competition on quality?” I said it is competition on quality. That was fine. But people still looked at the legislation and said, “It doesn’t actually say that,” so we amended the Bill to make it absolutely clear that, at the point at which a patient is exercising choice, or being referred, it will be on the basis of quality alone and there will not be differentiation between providers on the basis of price at that point. We have already made clear, through amendments to the Bill, that precisely the thing that worried the BMA, and may have worried some of your colleagues, is that there could be discrimination, that Monitor could use its powers to favour private providers for the purposes of promoting competition. We have ruled that out. We didn’t think it would happen and we were not intending it to happen.

Through the legislation, we will make it absolutely clear that where there are concerns we will respond to them. We have done that through the legislation, making it clear that there is no scope for discrimination between providers on the basis of ownership.

Q527 Chris Skidmore: There are no further Government amendments to the Bill.

Mr Lansley: No. We are amending the Bill many times and for many reasons, many of which are technical and for reasons of drafting, but we have already amended the Bill—

Chair: The Parliamentary process is still open to you to propose amendments to the Bill.

Mr Lansley: Absolutely it is, yes.

Q528 Andrew George: In terms of GPs, you say that GPs are enthusiastic about it. In the recent Pulse magazine, as you are well aware, even among a survey of pathfinder GPs, who must be, obviously, amongst the most enthusiastic, it says that they found 45% of them do not support the principle of GP commissioning and half expressed no confidence in you. You earlier said that they are in a unique place. If they are in that unique place, they will have a unique perspective. You are putting a lot of expectation on them and they are not terribly impressed at the moment.

Mr Lansley: The BMA last week, among many things, said they do support the principle of general practice-led commissioning. Indeed, in the past they have made it very clear that, alongside many other organisations, the principles and purposes we are pursuing are very widely supported. The same is true, and we can see it, in the way in which general practices across the country have come together to show how they will take this responsibility and use it. I do not say this on the basis of self-selecting surveys. I do this simply on the basis of going round the country, as I and my colleagues are doing all the time, and meeting consortia and the pathfinder consortia who are taking on these responsibilities. It is erroneous to suggest they are doing it because they think it is required of them. Nobody is requiring it of them at this stage. The BMA said to them, “You don’t have to do this,” but they came forward and volunteered to do it.

Chair: On that note, we should thank all three of you for coming. Thank you very much. You have given us plenty of food for thought.
Executive Summary


2. On 31 January the Department published a Command Paper response to the Committee’s Third Report commenting in detail on each of the Committee’s recommendations, including those which form the terms of reference for the follow-up inquiry.

3. This evidence provides further information on the Committee’s topics. It should be read in conjunction with the Department’s response to the Committee’s Third Report, as it builds on our earlier response to these points.

4. As the Health and Social Care Bill was introduced after the Committee published its Third Session Report, this submission of evidence provides a suitable opportunity for the Department to demonstrate how the Bill provides a coherent framework across the NHS and social care for a new approach to commissioning that will focus on empowering patients, carers and the public; on achieving better outcomes; and on promoting greater freedom for clinicians to work collaboratively to shape services.

Introduction

5. The House of Commons Health Committee’s Third Report of Session 2010–11, Commissioning, summarised their inquiry as “How do we make commissioning effective?” In articulating our proposals, we have always identified effective commissioning as one of the cornerstones for improving the quality of patient care and the outcomes achieved by the NHS. We have also been clear that commissioning needs to be clinically led, that it needs to be more directly connected to patients’ and clinicians’ day-to-day experiences of the NHS, and that responsibility for commissioning needs to be aligned with existing responsibilities for coordinating patient care and making patient referrals. It is these principles that are at the heart of our proposals for GP-led commissioning.

6. We would draw the Committee’s attention to the consistency with which this message has been given in the successive statements of policy since the election, and how the proposals have been developed by an ordered process of consultation, engagement and discussion.

7. The Coalition: our programme for government (May 2010)1 said that GPs should be commissioners of care. Equity and Excellence: Liberating the NHS (July 2010)2 reaffirmed the Coalition Government’s commitment to devolve responsibility for commissioning most NHS services to groups of GP practices. As our response to the Committee’s Third Report emphasised, rather than representing a “significant policy shift” or “change of approach”, the White Paper proposals were foreshadowed in principle by both the Conservative and Liberal Democrat health manifestos, and represented a sensible development of the Coalition programme.3

8. The consultation documents accompanying the White Paper invited views from professionals, from the public and from other organisations to help shape policy development. Liberating the NHS: commissioning for patients (July 2010)4 sought views on the proposed framework for GP consortia and the NHS Commissioning Board. Transparency in outcomes: a framework for the NHS (July 2010)5 proposed a robust framework of transparency and accountability for the NHS, including an NHS Outcomes Framework to allow the NHS Commissioning Board to be held to account for improvements in the quality of NHS care and healthcare outcomes. Liberating the NHS: local democratic legitimacy in health (July 2010)6 sought views on proposals for patients and local communities to get a powerful voice through local HealthWatch and local Health and Well-being boards. Local authorities will have a major new role in promoting joined-up commissioning of NHS, public health and social care and they will also regain responsibility for local health improvement.

9. We have maintained the consistency of purpose articulated in the White Paper. Our proposals constitute a credible programme of modernisation, developed through extensive engagement with the public and with stakeholders across health and social care. The Government’s response to the consultations— Liberating the NHS: legislative framework and next steps —set out how we were adapting some aspects of these proposals.

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1 www.cabinetoffice.gov.uk/sites/default/files/resources/coalition_programme_for_government.pdf
2 www.dh.gov.uk/prod_consum_dh/groups/dh_digitalasset/@dh@en/@ps/documents/digitalasset/dh_117794.pdf
4 www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117587
5 www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117583
6 www.dh.gov.uk/en/Consultations/Closedconsultations/DH_117586
to reflect the views raised during the consultation and engagement process, including the announcement of the GP consortia pathfinder programme to allow early testing of the principles of GP-led commissioning.\footnote{Liberating the NHS: legislative framework and next steps (December 2010) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_122661}

10. This process of planning and public engagement culminated in the introduction to Parliament on 19 January of the Health and Social Care Bill 2011,\footnote{www.publications.parliament.uk/pa/cm201011/cmbills/132/11132.i-v.html} which sets out the proposed legislative framework for the White Paper reforms including the establishment of commissioning consortia and the NHS Commissioning Board. On 31 January, the Commons agreed that the Bill should proceed to Second Reading, and it is currently under the scrutiny of the Health and Social Care Public Bill Committee.

11. While the Bill is subject to Parliamentary scrutiny, the process of engagement and testing continues, in particular through the GP consortia pathfinder programme which now encompasses 141 pathfinders covering over half the population. The first cohort of pathfinders came together at a national event on 26 January to help shape the pathfinder programme and discuss how best to use the programme to support effective consortia development.

12. The Department launched a pathfinder learning network at the 26 January event. This is an online resource that will complement the support given to pathfinders by primary care trusts (PCTs) and strategic health authorities (SHAs). It will help spread pathfinder learning through the wider GP community and accelerate the development of GP commissioning by facilitating engagement and organisational development. It will also help design and test the approaches that the NHS Commissioning Board will use to authorise consortia and hold them to account for outcomes. This network will be supported by national primary care stakeholders to help spread learning across the wider GP community, facilitate connections between pathfinders working on similar areas, and support the development of clinical leaders. The network is supporting a systematic approach to maximise and share learning, with—for instance—specific pathfinders working on areas such as cancer services, long term conditions, mental health and involving patients and the public.

13. In order to support a managed transition to the new commissioning arrangements, the Department is establishing clusters of PCTs for the transitional period 2011–12 and 2012–13. Clusters will sustain PCT capacity and accountability during this transitional period, ensure continued pace in the delivery of quality and productivity improvements under the QIPP programme, support the development of GP consortia and ensure that consortia have access to high-quality and cost-efficient forms of commissioning support.

14. On 31 January, Sir David Nicholson wrote to the NHS with guidance on establishing PCT clusters by June 2011 and on their functions during 2011–12 and 2012–13.\footnote{www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_123933} Each SHA has been asked to ensure that by 7 January of the Health and Social Care Bill 2011,\footnote{www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122361} which sets out the proposed legislative framework for the White Paper reforms including the establishment of commissioning consortia and the NHS Commissioning Board. On 31 January, the Commons agreed that the Bill should proceed to Second Reading, and it is currently under the scrutiny of the Health and Social Care Public Bill Committee.

15. The cluster model will support pathfinders in taking on increasing commissioning responsibilities on behalf of PCTs during the transitional period, with a number of staff from the clusters assigned to consortia to work on their behalf. This will support emerging consortia in developing to the point where they are ready to be established as statutory organisations and to commission services in their own right. It will also ensure that emerging consortia play a central role in shaping local responses to the QIPP challenge and in ensuring that these plans reflect the needs of local patients and communities.

16. Each point raised by the Committee is given below in italics, numbered 1-10; the reference in brackets is to the relevant paragraph in the Third Report of Session 2010–11, Volume I: Report, together with formal minutes.

1. We intend to examine further the assurance regime which it is proposed to establish around commissioning consortia in order to satisfy ourselves that the NHS Commissioning Board has sufficient authority to deliver its objectives defined in its Commissioning Outcomes Framework. (Paragraph 89)

17. The Health and Social Care Bill 2011 creates a clear framework that will enable the Board to deliver its objectives (as reflected in its Mandate and the NHS Outcomes Framework) through the initial process of authorising consortia, through the subsequent framework for annual assessment of consortia (including the Commissioning Outcomes Framework) and through a range of powers to intervene to support consortia in defined circumstances.

18. The Board must, before granting an application for establishment as a consortium, satisfy itself as to a number of key tests, including the ability of the proposed consortium to discharge its statutory functions. This will mean satisfying itself that the consortium has appropriate arrangements in place to commission healthcare for those patients for whom it is responsible, including appropriate arrangements for managing financial disturbances.

\footnotesize{7 Liberating the NHS: legislative framework and next steps (December 2010) www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_122661
\footnotesize{8 www.publications.parliament.uk/pa/cm201011/cmbills/132/11132.i-v.html
\footnotesize{9 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PolicyAndGuidance/DH_123933}
resources, promoting quality improvement, involving patients and the public, working in partnership with local government, and securing expert advice from other health professionals.

19. The Board will also need to satisfy itself that the area specified in the constitution of the consortium is appropriate (eg for the purposes of commissioning emergency care and commissioning healthcare for patients not registered with any GP practice); that its constitution complies with the requirements of the legislation and is otherwise appropriate; that it has the right membership (eg each of its members will be providers of primary medical services on the date of establishment); and that it would be appropriate for the Board to appoint as the accountable officer the person nominated for this role by the consortium.

**Ongoing Accountability**

20. During 2011–12, the shadow NHS Commissioning Board, supported by NICE, will start to develop a Commissioning Outcomes Framework. This will enable the Board to hold consortia to account for the quality of the services that they commission, the clinical and patient experience outcomes achieved from those services, and their contribution to reducing health inequalities. The Framework will ensure that there is clear, publicly available information on the quality of healthcare services commissioned by consortia and will support Health and Well-being Boards in understanding local healthcare needs and shaping strategic priorities for improvements in health and well-being. The Department will publish a discussion document shortly, seeking more detailed views on possible features of the Framework.

21. The Commissioning Outcomes Framework will form part of a wider accountability framework that will also enable the Board to hold consortia to account for how effectively they perform their other statutory duties of consortia, including their duties relating to management of financial resources, involvement of patients and the public in commissioning, promoting patient and carer involvement in their own healthcare, partnership with local authorities and securing expert advice from other health professionals. There is likely to be an important role for local authorities, Health and Well-being Boards, local HealthWatch and other health and care professionals in feeding into this annual assessment.

22. A significant element of the Board’s oversight of consortia performance will be to ensure their financial stability. Consortia will be required to maintain annually audited accounts, and to provide financial and other data to the Board as required, to allow in-year monitoring against budgetary controls. The Board will have the power to support consortia in developing appropriate risk-sharing arrangements, for instance pooling resources with other consortia or local authorities or with the Board itself.

23. Each consortium will have to produce an annual commissioning plan, which sets out how it intends to fulfil its responsibilities to its patients, particularly in regard to improving quality and outcomes and discharging its financial duties. The plan must take account of the relevant local joint health and well-being strategy (or strategies). Each consortium will also produce an annual report, which will further support accountability.

24. The Bill gives the Board the power to make an additional payment to a consortium if it considers the consortium has performed well in the previous year. This “quality premium” will enable the Board to provide appropriate incentives and rewards for consortia that achieve high-quality outcomes for patients within the resources available to them. During 2011–12, the shadow NHS Commissioning Board will start to work with pathfinders and with patient and professional groups to design these arrangements.

**Intervention and Support**

25. The Bill gives the Board the powers to intervene to support consortia where there is evidence that a consortium is failing to fulfil its statutory duties or there is a significant risk that it will fail to do so. The Bill will enable the Board to apply a range of proportionate measures to intervene and support consortia, depending on the nature of the problem or risk. Depending on the circumstances, this could include directing a consortium to fulfil its functions in a different way, arranging for another consortium or the Board itself to undertake some functions for a time-limited period, or appointing a new Accountable Officer. Where necessary, the Board will also be able to vary the constitution of a consortium, or—after consultation with those concerned and with relevant local authorities—to dissolve a consortium and make other arrangements for the GP practices in that consortium.

26. The pathfinder programme will enable the Board to test these arrangements with emerging consortia and with other stakeholders to ensure that they provide an effective framework to anticipate and put right potential problems at a sufficiently early stage, whilst providing the freedom for well-performing consortia to decide for themselves how best to commission services to improve outcomes for patients.

2. We intend to review the arrangements proposed in the Bill for defining the lines of accountability between the NHS Commissioning Board, the Department of Health and the Secretary of State to prevent potential future conflicts arising. (Paragraph 91)

27. The Secretary of State will retain the duty to promote a comprehensive health service; and will be responsible for setting the strategic direction and legislative framework for the NHS. The Secretary of State will consult upon and set the Mandate for the NHS Commissioning Board (issued on a three-year basis with an annual update) and will hold the Board to account against it. The Mandate will include the objectives and
requirements for the Board during that period. Each year the Government will report publicly on the performance of the health service. This will give the public and Parliament a clear basis for holding the Government to account. In addition, Parliament will continue to be able to scrutinise decisions and actions in the normal way.

28. The Bill maintains the overarching duty of the Secretary of State, which dates from the original NHS Act of 1946, to promote, “a comprehensive health service designed to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of illness”. It distinguishes for the first time between healthcare and public health, laying the way for the new public health system. It also sets clear constraints on the Secretary of State’s ability to intervene in the NHS.

29. Alongside the Mandate, the Bill proposes a power for the Secretary of State to make “standing rules” through regulations, setting legal requirements for commissioners. These would, for example, provide the basis for the continuation of certain rights in the NHS Constitution that currently depend on directions to PCTs and would also give Ministers power to ensure compliance with European Union (EU) obligations.

30. The Bill proposes a limited list of areas where standing rules can be made. Balancing the need for future flexibility with proper Parliamentary scrutiny, the Secretary of State would be able to make new standing rules in additional areas only through regulations made by the affirmative resolution procedure. Furthermore, the expectation is that the Secretary of State would make changes to the standing rules only at the same time as the Mandate is set; where that is not the case, the Secretary of State would be obliged to lay a report in Parliament explaining why.

31. The overall framework proposed in the Bill is designed to give the NHS greater freedoms, improve transparency and help prevent political micro-management. The powers of the Secretary of State would be constrained and made more transparent. At the same time, political accountability to Parliament would be strengthened. This is illustrated by the use of the affirmative resolution procedure to scrutinise the Secretary of State’s powers in a number of areas, including the power to confer additional functions on the Board and to extend the existence of new Special Health Authorities beyond three years.

3. The Committee believes it is essential for clinical engagement in commissioning to draw from as wide a pool of practitioners as is possible in order to ensure that it delivers maximum benefits to patients. GPs have an essential role to play as the catalyst of this process, and under the terms of the Government’s changes they, through the commissioning consortia, will have the statutory responsibility for commissioning. They should, however, be seen as generalists who draw on specialist knowledge when required, not as the ultimate arbiters of all commissioning decisions. The Committee therefore intends to review the arrangements proposed for integrating the full range of clinical expertise into the commissioning process. (Paragraph 96)

32. We agree that effective commissioning will rely critically upon engagement and collaboration with a wide range of health and care professionals. Our proposals to root most healthcare commissioning responsibilities in the system of general practice are designed to build on the holistic overview that GPs and other practice staff have of patients’ needs and on the existing role of general practice in coordination and continuity of care, making referrals to more specialist services, and acting as patients’ advocates. Through these existing roles, GPs, nurses and other practice staff already have a network of local relationships with other health and care teams and professionals. We agree that it will be essential for them to build on and strengthen these networks so that commissioning draws on their collective clinical expertise and experience and improves clinical collaboration. This will mean commissioning that is not only clinically led, but also informed by an expert, multi-professional view of local health needs and solutions.

33. One of the key aims of the White Paper and the Bill is to liberate clinicians from the burdens which previous governments have imposed on how services are planned and provided. The Bill places a statutory duty on consortia to obtain appropriate advice from health experts, but does not seek to prescribe precisely how they meet this duty. We consider that a more prescriptive approach would risk tokenism and would not achieve the meaningful engagement and collaboration that will underpin successful commissioning.

34. The arrangements for authorisation, accountability and (where necessary) intervention described above will, however, enable the NHS Commissioning Board to satisfy itself that consortia have appropriate arrangements in place to involve other healthcare professionals and, if necessary, to work with consortia to support them in improving these arrangements if there were evidence that insufficient or ineffective clinical engagement were preventing a consortium from fulfilling its duties effectively.

35. We envisage, in particular, that the authorisation process—and the wider developmental process for emerging consortia of which it will be part—will help ensure that consortia develop effective relationships with a range of health and care professionals. We also envisage that the ongoing accountability framework for consortia will allow health and care professionals to provide their own views of how effectively consortia are developing multi-professional engagement and for this to feed into the Board’s annual assessment of consortia.
4. Although the Committee understands the value of the separation of the commissioner and provider functions it believes it is important that this function separation is not allowed to obstruct the development of high quality and cost effective service solutions. We therefore intend to review the arrangements proposed in the Bill for reconciling these conflicts. (Paragraph 102)

36. We regard it as a false dichotomy to suggest that the separation of commissioner and provider functions is in conflict with the development of high quality and cost-effective service solutions. The purpose of commissioning is to understand patients’ healthcare needs, to ensure that patients have access to services that meet those needs, and to monitor the quality of those services. It has always been—and will remain—an integral part of good commissioning to work collaboratively with providers to review services and pathways of care and identify how to improve quality and cost-efficiency.

37. The Government fully supports the development of more integrated care, for example for cancer services, emergency care, and rehabilitation and recovery. Clinically-led commissioning will support this. Commissioners will be able to “bundle” services together across a pathway where this makes most sense.

38. There have been a number of suggestions that collaborating with providers or developing more integrated care would be regarded as anti-competitive. This is simply not the case. Collaboration with providers and greater integration of care are, on the contrary, good commissioning practice.

39. Where services are commissioned through competitive tender, commissioners will need, as now, to ensure that services are specified in a way that does not give an unfair advantage to established providers. But, as now, commissioners will be expected to work with a range of providers and practitioners to develop innovative service models that contribute towards improvements in quality and productivity. This expectation is set out in existing DH procurement guidance. We expect it to remain central to the guidance developed in due course by the NHS Commissioning Board to support consortia in procuring services fairly and transparently and in ways that promote competition in the interests of patients.

5. The Committee agrees that local engagement with the commissioning of primary care services is important and therefore welcomes this development. The potential conflict of interest between consortia and local primary care providers does however remain. We therefore intend to review the arrangements proposed in the Bill for the commissioning of primary care services. (Paragraph 104)

40. We welcome the Committee’s support for greater local engagement in the commissioning of primary care services. We can reassure the Committee that GP consortia will not, however, have delegated responsibility for basic commissioning decisions such as deciding which providers should receive contracts for primary care services or dealing with any breaches of contract. These commissioning decisions will always be carried out by the NHS Commissioning Board.

41. The role of consortia will be to assist and support the Board in securing continuous improvement in the quality of primary care services. This will allow the Board to draw on the relationships between GP practices within a consortium and for the members of consortia to take a collaborative approach to raising standards in primary care. There is a considerable appetite amongst consortia pathfinders to explore how this relationship will work, building on existing good practice in peer-driven quality improvement.

42. The NHS Commissioning Board could also arrange for consortia to commission some enhanced primary care services on its behalf, subject to appropriate safeguards to ensure transparency and fairness.

43. Whilst the NHS Commissioning Board will commission primary medical care services (under the GP contract), there are a range of other community-based services that consortia could in principle commission from GP practices. We agree that it will be important to ensure that consortia have good systems to prevent conflicts of interest when practices are bidding to provide services, or where they wish to provide services that are subject to an “any willing provider” model (i.e. where patients choose from which provider they wish to receive a referral service). These arrangements can build on existing good practice.

44. Consortia will be required to set out their arrangements for dealing with conflicts of interest in their constitution. GPs are in addition bound by GMC guidelines on conflicts of interest and by the requirements of Good Medical Practice.

45. The Bill provides that the Secretary of State may make regulations that impose requirements on the NHS Commissioning Board and consortia to ensure that they adhere to good procurement practice, protect and promote patient choice and promote competition. The regulations could include a power for Monitor to investigate complaints that consortia have not met the requirements of these regulations, although we would expect that the Board would aim to resolve complaints in the first instance. GP consortia and the NHS Commissioning Board will be required to act transparently and non-discriminately in their commissioning activities.

46. The NHS Commissioning Board will develop guidance to help consortia ensure that they have good governance arrangements, including transparency of decision-making and clear procedures for declaring interests.
47. Through a series of engagement events and working groups with pathfinders and other stakeholders, we are developing scenarios and testing safeguards to inform the approach of the shadow NHS Commissioning Board and Monitor.

6. The commissioning of services that either work across [health and social care] boundaries, or are intimately linked is therefore an issue to which the Committee attaches great importance, and we intend to review the effectiveness of the structures proposed in the Bill which are designed to safeguard co-operative arrangements which already exist and promote the development of new ones. (Paragraph 107)

48. The Health and Social Care Bill provides for a Health and Well-being Board to be established for every upper tier local authority. We propose that these will be established by April 2013, although we have invited all local authorities to become part of an early implementer programme to explore the potential of Health and Well-being Boards. The Boards will increase the influence of local people in shaping services through democratically elected councillors and local HealthWatch. They will bring together commissioners from the NHS, public health and social care to agree priorities and commissioning strategies and provide the opportunity to achieve greater integration of services and joint working.

49. The proposed legislation governing Health and Well-being Boards will provide a consistent, yet flexible framework. We expect this to strengthen relationships between the different organisations represented as people can come together to discuss issues in an open manner, breaking down organisational barriers, misconceptions and historical rivalries. They can consider the total resources available and come to a joint understanding as to how resources can best be deployed to secure better health and well-being outcomes for local communities, better quality of care and better value for taxpayers.

50. Building on this platform, local authorities and GP consortia will have a duty to undertake and publish joint strategic needs assessments (JSNAs). This duty will have to be discharged through the Health and Well-being Boards. PCTs and local authorities have been under a statutory duty to undertake a JSNA since 2008. Liberating the NHS—Legislative Framework and Next Steps; Healthy Lives, Healthy People and A vision for adult social care: Capable Communities and Active Citizens underlined the importance of developing JSNAs to provide a shared understanding of the needs of the community, including health such as housing or education.

51. Having identified local needs through the JSNA, local authorities and GP consortia will be required to develop a joint health and well-being strategy for addressing these needs. This will span the NHS, social care and public health, and could potentially consider commissioning of services that cover wider determinants of health such as housing or education.

52. Local authorities, GP consortia and the NHS Commissioning Board will each have to have regard to this strategy when developing their commissioning plans. Consortia will have to seek the views of the relevant Health and Well-being Board(s) when preparing their commissioning plan as to whether the plan takes proper account of the most recent JSNA and joint health and well-being strategy, and the Board’s view must be included in the plan. Health and Well-being Boards may also write to the NHS Commissioning Board or the local authority if they feel that commissioning plans do not adequately have regard to the JSNA or the joint health and well-being strategy.

53. Both Health and Well-being Boards and the NHS Commissioning Board will be under a duty to encourage integrated working. In developing the joint health and well-being strategy and in broader conversations, the Health and Well-being Board must encourage commissioners to work in an integrated manner, and in particular encourage commissioners to make use of the flexibilities in the NHS Act 2006 where these are likely to lead to improvements. For example, section 75 of the Act supports a range of partnership arrangements, such as pooled budgets or lead commissioner arrangements. To ensure existing arrangements are sustained during transition, we are using the NHS Operating Framework to ask all PCTs to work with their Local Authority partners to ensure that a succession plan is in place for existing pooled budgets and joint commissioning arrangements.

55. In order to support local government in taking on its new roles, we will create a network of “early implementers” of Health and Well-being Boards to share learning and feed this into policy development. The emphasis of the work will be on working across local government and partners to accelerate sharing of learning and supporting the development of effective Health and Well-being Boards that can bring together partners in local areas to better serve their communities.

56. Many of the responses to the consultation on Liberating the NHS underlined the importance of developing Health and Well-being Boards—and local authority capacity more generally—alongside the development of GP consortia. The Department is working with local authorities and with SHAs and PCT clusters to align the implementation approaches for Health and Well-being Board early implementers and GP consortia pathfinders.

57. Our initial focus is on aligning communications through shared websites, bulletins and learning materials for GP consortia pathfinders and Health and Well-being Board early implementers, as well as ensuring early

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implementers and consortia are able to come together as part of regional transition events. We are also working to develop a “shared offer” on learning and support for pathfinders and early implementers. A number of pathfinders are already actively engaging with shadow Health and Well-being Boards, building on joint commissioning.

58. The government is extending the remit of NICE to social care to support the creation of effective quality standards for all those using health and social care services. This will enable NICE to approach issues covering the whole pathway between health and social care, focusing on the holistic needs of individuals. One such NHS quality standard, published in June 2010, looks at quality in relation to services for dementia—an important cross-sector issue which has resonance for both social care and healthcare services.

7. We intend to review the arrangements proposed in the Bill to enable commissioning consortia to address these issues [cross-area collaboration by consortia in reconfiguring services] effectively; this will include a review of the ability of the new system to encourage commissioning consortia to cooperate in achieving the benefits to patients which may be available from major service reconfiguration. (Paragraph 110)

59. Our response to the Committee’s Third Report of Session 2010–11 explained how GP commissioners would have unprecedented influence over how healthcare services are delivered locally, and that this brings the opportunity to lead service redesign.11 Leading any major service change is about building effective partnerships, including with other consortia where changes may benefit a wider population. We emphasised also how patients and the public will be able to influence service redesign through requirements on consortia to involve the public.

60. The scrutiny functions of local authorities will also be extended to cover any substantial changes to designated services, regardless of provider. This will bring a wide range of NHS services provided by independent providers within the scope of local authority scrutiny for the first time. We also intend to strengthen the democratic legitimacy of referrals from local authorities to the Secretary of State for Health, as we intend for these decisions to be subject to a vote of the full council, allowing every councillor to contribute to the discussion.

61. The new arrangements for commissioning will provide a strong framework for local co-operation between providers, local authorities, GP consortia and local HealthWatch. This will help make commissioning decisions more responsive to local health needs and patient views. Health and Well-being Boards will support a culture of local collaboration, centred on the joint health and well-being strategy. This will facilitate the development of more joined-up services that make better sense for patients and the public and improve quality and efficiency.

62. The Health and Social Care Bill provides wide-ranging powers to support collaborative working between consortia and with local authorities. Consortia may delegate commissioning functions to a lead consortium or local authority, commission jointly between consortia and commission jointly with local authorities, pooling funds and expertise as necessary. This will allow consortia to build on the success of existing regional commissioning networks and joint commissioning arrangements.

63. The pathfinder programme will help the NHS and local authorities to explore how these collaborative arrangements can best evolve and identify any support that may be necessary. During transition, both PCT clusters and the NHS Commissioning Board will have a role in supporting the development of cross-consortia working arrangements. However, we will not be prescriptive in the approach consortia should adopt, as we want to encourage successful arrangements to emerge locally through the work of pathfinders.

8. The Committee intends to review the arrangements proposed in the Bill for enabling consortia to reconcile this potential conflict [between patient choice and commissioning] by enhancing patient choice at the same time as delivering the consortium’s clinical and financial priorities. (Paragraph 115)

64. Giving patients choice and control over the care they receive should not be a luxury, but a routine element of the service which the NHS provides to patients. There is evidence that giving patients choice and control can improve both quality and efficiency of care— and should not, therefore, be seen as being at odds with clinical and financial priorities.

65. It may be helpful to address here some common misunderstandings about how choice of provider will work under the “Any Willing Provider” model, which are inhibiting an honest assessment of its value to patients and commissioners.

66. The “Any Willing Provider” model is not new: patients have been able to access a free choice of any qualified provider for routine elective care since April 2008. The proposal is to extend this to most NHS services by 2013–14. This will mean that, when a patient requires a referral, they will be able to choose from a range of providers who are qualified to provide safe, high-quality care and treatment and select the one that best meets their needs.

67. Giving patients this choice will not conflict with a consortium's clinical priorities, as it will still very much be for commissioners to decide on the services to which they want to be able to refer their patients to have access and to establish quality criteria for these services. Only providers that meet the commissioner’s quality criteria will be eligible to provide these services. Not does it conflict with financial priorities, as consortia will set a fixed price that will then apply to all providers (so the patient’s choice of provider does not affect the price paid) and the model does not alter the decisions that GPs and other clinicians reach with patients about whether a referral is needed. Allowing patients this choice of provider should help support effective commissioning, as commissioners will know that a range of safe, good quality and affordable providers are available. It will also avoid the cost, time and effort involved in competitive tendering.

68. Obviously not all services will be suitable for the “Any Willing Provider” model. Tendering will be appropriate in some cases, including where a free choice of provider would clearly not be appropriate (eg for a range of emergency care services), or to provide complex, integrated packages of care (eg for frail older people with multiple complex conditions), or where commissioners need to provide income or activity guarantees in order to ensure a guaranteed service. Consortia will be responsible for determining which is the most appropriate approach.

69. The Department is aiming to issue guidance in March about how the initial implementation of the “Any Willing Provider” model for community services will work, including how to select providers. The aim is to promote national consistency in terms of quality and safety and ensure, where possible, that a provider who is registered in one locality does not have to go through a full application process again for that service in another locality. This should maintain standards, whilst reducing duplication and bureaucracy. We will be working with commissioners and providers to decide how best to do this. We want to build in sufficient flexibility for the “Any Willing Provider” to work in the best interests of patients and fit local needs.

70. Our consultation on information and choice, Liberating the NHS: greater choice and control, closed on 14 January 2011 and we expect to report back shortly on the results of that consultation, drawing on the public’s responses to inform further proposals for enhancing patient choice and control.

9. The Committee does not find the current stance on patient and public engagement in commissioning persuasive. The National Health Service uses taxpayers’ resources to deliver a service in which a high proportion of citizens take a close interest both as taxpayers and actual or potential patients. While the Department may be right to point out that there is no special virtue in uniformity of structure, the Committee regards the principle that there should be greater accountability by commissioners for their commissioning decisions as important. We therefore intend to review the arrangements for local accountability proposed in the Bill. (Paragraph 118)

71. In our response to the Committee’s Third Report we considered the range of ways in which the public could influence local commissioning. Without repeating our earlier comments, we would like to emphasise the clear lines of accountability which will support patient involvement and ensure commissioners are answerable for the outcomes they achieve.

72. The NHS Commissioning Board will be responsible for holding GP consortia to account annually for the outcomes they achieve, their stewardship of public resources and their fulfilment of other statutory duties. Paragraphs 18–26 above set out the proposed arrangements for authorisation and ongoing accountability and for intervention to support consortia where they are not carrying out their functions effectively.

73. Under the Bill, consortia will have a clear legal duty to ensure patients and the public are involved in the planning of commissioning arrangements, in developing and considering proposals that will significantly affect how services are delivered or the range of services available, and in making decisions that will have a similar impact. The NHS Commissioning Board will need to satisfy itself both at the point of authorisation and on an ongoing basis that consortia have effective arrangements in place to meet this duty. We envisage that the Board will wish to draw on the views of local HealthWatch, local authorities and other community groups to enable it to assess how effectively consortia are involving patients and the public.

74. Arrangements for public accountability will be further enhanced through the introduction of a Commissioning Outcomes Framework that enables local communities to understand and compare the outcomes that consortia are achieving for patients and the progress they are making in improving quality and reducing inequalities.

75. Health and Well-being Boards will further enhance accountability arrangements by enabling local authorities and local HealthWatch to work alongside consortia in reviewing local healthcare needs and in deciding strategic priorities for improvements in Health and Well-being. Boards will be required to include in its membership elected representatives, commissioners of NHS, public health, social care, and children’s services, and representation from Local HealthWatch. They will also, if they wish, be able to involve others such as providers and voluntary sector organisations.

76. The January event for pathfinders highlighted the enthusiasm amongst emerging consortia to build on what works well locally to engage with patients and the public, including Patient Participation Groups, local authority citizens panels and PCT membership schemes. One pathfinder had a representative from the patient participation group of every GP practice sitting on a locality group with representatives from the local authority,
voluntary organisations and local special interest groups, to constitute a stakeholder forum which the consortium could use to gauge patient and public views.

77. We want to see all consortia develop robust arrangements that are tailored to local circumstances and driven by local initiative, rather than prescribe a single central approach. The pathfinder learning network will provide a platform for consortia to share best practice on this. Ultimately, however, it will still be for the NHS Commissioning Board to satisfy itself that a consortium has effective arrangements to meet its statutory duty of public and patient involvement.

78. The Department’s Voluntary Sector Strategic Partners have been in early discussions to inform and develop the arrangements for GP commissioning consortia and the NHS Commissioning Board. Dame Barbara Hakin, the Managing Director of Commissioning Development recently met with ten leading patient organisations, including the Chair of National Voices and representatives from Age UK. This group will provide a link back into the broader voluntary and community sector.

10. The Government must support consortia and existing commissioning organisations to form clear and credible plans for debt eradication and for tackling structural deficits within their local health economy. The Committee intends to further review this issue in its further work. (Paragraph 123)

79. The 2011–12 NHS Operating Framework establishes that GP consortia will not be responsible for resolving PCT legacy debt that arose prior to 2011–12. We expect pathfinders and emerging consortia to work closely with PCT clusters during the transitional financial years 2011–12 and 2012–13 to ensure that no new deficits are created and that appropriate control and balance are maintained, so that from 2013–14 consortia will commence full responsibility for commissioning on a robust financial basis. GP consortia will otherwise be responsible (from 2013–14 onwards) for any unresolved debt that arises during these two years.

80. Where consortia carry out commissioning functions during 2011–12 and 2012–13, they will do so on a delegated basis. In other words, the relevant PCT(s) will remain statutorily accountable for expenditure and service outcomes, but will delegate responsibilities to consortia (either as sub-committees of the PCT or, once consortia are statutorily established, as bodies in their own right). The Department is working with pathfinders to develop best practice guidance on the arrangements for delegating commissioning responsibilities and associated budget provision. These arrangements will support emerging consortia in taking an increasingly active role in shaping QIPP plans and ensuring that improvements in quality and productivity are based on a good understanding of patient needs.

81. To support the transition, the NHS Operating Framework 2011–12 sets out our intention increasingly to deliver business through PCT clusters. They will in essence work as transition vehicles for overseeing and accounting for delivery of financial and service priorities, supporting the development of the new commissioning system, ensuring that emerging consortia have access to good commissioning support, and directly commissioning those services (such as primary care and specialised services) that will in future be commissioned by the NHS Commissioning Board.

82. Some regions of the NHS have already developed clusters of PCTs. In order to secure the capacity and flexibility needed for the transition period, we shall undertake a managed consolidation of PCT capacity to create clusters across all regions of the NHS. As part of this transitional process, PCT staff will be increasingly assigned to emerging GP consortia to support their development and support them in taking on delegated commissioning responsibilities.

83. In creating clusters, our aim is to maintain the strength of the commissioning system in light of the significant financial challenges ahead and to provide maximum opportunities and support for emerging consortia to grow their capacity and capability. Clusters of PCTs will have greater resilience to manage the demands of the service during transition, whilst supporting the development of emerging consortia.

84. SHA’s will oversee the development of PCT clusters and ensure local coherence across the local development of the new architecture, such as relationships between GP consortia pathfinders and local Health and Well-being Board early implementers.

**Improving Health Outcomes**

85. Equity and excellence: Liberating the NHS expressed the intention that in giving the NHS a stable, enduring framework for quality and service improvement, the focus of debates on health should move to priorities and progress in health improvement. With the new arrangements for commissioning still in development, we have not reached that stage yet. But as those new arrangements for commissioning and accountability take greater shape, we hope to reinforce the fact that these changes are not an end in themselves, but are designed to allow a renewed focus on improving health outcomes and reducing health inequalities.

86. The Government has made it clear that tackling health inequalities is a priority, with a determined focus on equity and fairness. Everyone should have the same opportunities to lead a healthy life, no matter where they live or who they are. As well as helping people live longer, healthier and more fulfilling lives, we aim to improve the health of the poorest fastest.
87. Tackling health inequalities and unacceptable variations in service outcomes is an important aspect of our drive to improve service quality and health outcomes of services across the board. People in many disadvantaged groups and areas live shorter lives and experience poorer health throughout their lives. The more devolved health system we are developing will support a sharper focus on the pockets of disadvantage that exist across the country.

88. Reducing health inequalities will be embedded into the reformed systems of accountability for both the NHS and public health. Subject to Parliamentary approval, the Secretary of State for Health, the NHS Commissioning Board and GP consortia will each have specific duties as regards reducing inequalities. GP consortia and Health and Well-being Boards will need to look strategically at the needs of local populations when developing JSNAs and identify strategic priorities for reducing health inequalities.

89. The Department has developed an NHS Outcomes Framework to provide national accountability for the outcomes that the NHS delivers. The framework will not only be a mechanism to hold the NHS to account, but will act as a catalyst to drive quality improvement and delivery of better outcomes across the system.

90. One of the underpinning principles in developing the NHS Outcomes Framework has been the need to promote equalities and reduce inequalities in health outcomes. To encourage this, the outcome indicators, as far as possible, will be chosen according to whether data can be disaggregated by equalities characteristics and by geography so that outcomes for disadvantaged groups can be measured.

PUBLIC HEALTH

91. Action to tackle health inequalities is also at the centre of our approach to public health. The Public Health White Paper, Healthy Lives, Healthy People: our strategy for public health in England (November 2010),12 sets a radical new vision for improving the health of the nation. The public health budget will be ring-fenced and allocated to reflect relative population health needs, with a new “health premium” to promote action to reduce health inequalities. Public Health England will lead national action to protect and improve health, with local authorities given new responsibilities and ring-fenced funding for health improvement in local communities.

92. The Department is consulting on the funding and commissioning routes for public health. We are also consulting on a public health outcomes framework, which will contain indicators designed to allow progress to be measured towards a number of public health outcomes and provide incentives for local health improvement and reductions in inequalities. A key criterion in choosing which indicators to include in the final outcomes framework will be whether or not they can be measured at the local authority level.

93. Public Health England will publish progress against the outcome indicators for each local authority. This will enable the population locally to hold their council to account for local performance, and for Directors of Public Health and colleagues to assess their performance against comparator authorities.

94. The Public Health White Paper responds to the report of the independent review, chaired by Professor Sir Michael Marmot, to explore the impact of the wider social determinants of health and advise on future action to reduce health inequalities in England. The White Paper adopts the review’s life course framework to provide a focus for tackling the wider social determinants of health.

NICE

95. Under the proposals in the Health and Social Care Bill, NICE will be re-established on a statutory footing and its remit will be extended into social care. NICE is at the heart of the Government’s plans for promoting quality in the NHS, and the extension of its role into social care will help to create a seamless and integrated approach to health and social care. Our plans for NICE build on its strong track record, and NICE as re-established will continue to support the delivery of high quality health and social care through the production of robust, evidence-based advice and guidance.

96. The Bill also sets out the key role of NICE quality standards in supporting the overarching duty of quality and improving outcomes. NICE quality standards describe the core elements of a high quality service or care pathway and, under our plans, the NHS Commissioning Board and the Secretary of State will be required to have regard to them in carrying out their functions. We envisage, for example, that the NHS Commissioning Board will draw on quality standards in developing indicators for the Commissioning Outcomes Framework and in developing appropriate incentives for healthcare providers through model contracts for secondary care providers and through the Quality and Outcomes Framework for GP practices.

97. The Government wants to give NHS patients better access to effective and innovative medicines and we are currently consulting on plans to introduce value-based pricing for medicines. Our intention is to introduce the new arrangements from 2014, on expiry of the current Pharmaceutical Price Regulation Scheme. Through value-based pricing, our aim is to ensure that a drug’s price appropriately reflects the value it offers, so that clinicians and commissioners can have greater confidence that medicines are cost effective as well as clinically effective. NICE’s role will evolve under value-based pricing, but, as an international leader in the evaluation

of drugs and health technologies, it will continue to have a crucial part to play through the provision of authoritative and expert advice to support clinical decision-making.

**Cancer**

98. On 12 January we published Improving Outcomes: A Strategy for Cancer. It sets out how the Coalition Government’s reforms of health and care services will drive improvements in cancer outcomes and put patients and the public at the heart of cancer services.

99. Commissioning for cancer is complex and needs to be coordinated across the care pathway involving teams in general practice, community services, social care, acute general hospitals and specialist centres.

100. The NHS, public health and social care outcomes framework will set the direction and provide clear accountability. The Secretary of State for Health will hold the NHS Commissioning Board to account for delivering national outcome goals.

101. The NHS and Public Health England (PHE) will need to work together closely, offering integrated advice and care to the public and patients with many shared areas of accountability for cancer services. While the NHS Outcomes Framework has cancer survival as an improvement area, Healthy Lives, Healthy People: Transparency in Outcomes proposes that cancer mortality should be an improvement area for PHE as this covers improvements in prevention as well as in diagnosis and treatment. Key indicators spanning a number of domains will drive prevention and earlier diagnosis of cancer as well as improvements in NHS outcomes.

102. The Coalition Government’s proposed Health and Well-being Boards will provide a forum for the development of cross-cutting commissioning approaches to improve cancer services, providing more effective engagement between NHS, public health and social care commissioners.

103. GP consortia are well placed to commission the majority of cancer services. Those cancer services best commissioned for larger populations may require consortia to group together to commission services and some services will continue to be commissioned at a national level, including specialised surgical services and services for some rarer cancers (e.g., children’s cancers).

104. The Strategy sets out how choice for patients in their cancer care will be extended and identifies the gaps in information on health outcomes which are crucial to ensuring patients are empowered.

105. Although we have made considerable progress on cancer over the past 10 to 15 years, we know from available data that our survival rates lag behind those in comparable countries. The main reason for this is late diagnosis of many patients. The Strategy therefore has a significant focus on earlier diagnosis, which will be achieved through raising the public’s awareness of the signs and symptoms of cancer and providing better access to diagnostic tests. To support the NHS to achieve earlier diagnosis of cancer alongside efficiency savings, the Strategy is backed up with over £450 million investment over the Spending Review period.

106. The Strategy sets out our aim to save an additional 5,000 lives every year by 2014–15 and improve cancer outcomes through:

- reducing the incidence of cancers which are preventable, by lifestyle changes;
- improving uptake of screening and introduce new screening programmes where there is evidence to justify them;
- achieving earlier diagnosis of cancer, to increase the scope for successful treatment; and
- making sure that all patients have access to the best possible treatment, care and support including improving access to innovative treatments such as proton beam therapy.

107. Improving outcomes for people with cancer is also about improving patients’ experience of care and improving the quality of life for cancer survivors. The Strategy therefore also sets out a range of actions to deliver improvements in those areas.

108. The Strategy highlights that information will be central to the drive for better outcomes, underpinning stronger commissioning and patient choice. Commissioners will need better information to drive up the quality of services and outcomes and to make efficient use of resources. We will ensure that we have better activity information and full clarity about costs for different services, and the right incentives to reward quality and efficiency. In addition to taking forward the tariffs for chemotherapy and radiotherapy, during 2011–12 we will investigate the potential development of a range of tariffs to incentivise high quality, cost-effective services.

109. It is intended that the Commissioning Outcomes Framework will incentivise high quality commissioning and will be closely aligned with NICE Quality standards. The library of Quality Standards being developed by NICE will be an important resource for commissioners in identifying issues to prioritise and will enable scrutiny of the extent to which they are commissioning high quality care.

110. The Department of Health and the National Cancer Action Team have provided guidance and support to commissioners through the Cancer Commissioning Toolkit and the Cancer Commissioning Guidance. We
will now work with GP consortia to identify their specific needs for commissioning support. The Cancer Networks will support pathfinder consortia through transition.

**Mental Health**

111. On 2 February the cross-Government strategy for mental health, No Health Without Mental Health,\(^{14}\) was published. The strategy is based on outcomes, giving mental health “parity of esteem” with physical health issues as central to priorities across Government and in the mainstream of health and social care services.

112. The strategy has the twin aims of promoting and sustaining good mental health and well-being in the wider population, and improving the quality of existing services for people across the full range of mental health problems. It looks at the prevalence of problems and effective approaches at different stages across the whole life course and stresses the importance of prevention and early intervention. The Strategy makes clear that our approach is based on the principles that the Government has laid down for its health reforms, such as focusing on measurable outcomes and the NICE Quality Standards that deliver them rather than top-down process targets.

113. In support of the strategy, on 2 February the Department published Talking Therapies: a four year plan of action.\(^{15}\) The plan sets out how the NHS will complete the nationwide roll-out of the Improving Access to Psychological Therapies programme, ensuring older people get good access to talking therapies and:

- initiating a stand alone programme with the ambition of making the same step forward for children and young people as has already been made for adults;
- achieving other NHS savings by offering talking therapies to people with long-term physical conditions or medically unexplained symptoms; and
- developing ways to expand access to talking therapies to people with serious mental illness.

**Kidney Disease**

114. A greater focus on the outcomes that matter most to patients, and in particular more attention given to patients’ experience, has the potential to yield great benefits for people with kidney disease. For example, GP consortia will be well placed to maximise opportunities for the efficient integration of primary and secondary care for people with chronic kidney disease, meaning that people are seen at the right place and time without the frustration of unnecessary referrals and duplication. A Quality Standard on chronic kidney disease is in the final stages of preparation by NICE and will help to guide commissioners and providers of services in this area.

115. Similarly the explicit emphasis on effectiveness and patient safety set out in the first Outcomes Framework, together with clinical leadership, lend themselves to a more systematic approach to the prevention, detection and management of acute kidney injury, which research suggests may affect up to 20% of emergency admissions—resulting in significant morbidity and mortality. This is primarily a matter of consistently providing good quality basic and generic care for the acutely unwell, which will benefit from a clear and unfettered drive by commissioners to yield improvements in all the domains of quality.

116. Preparation for and delivery of renal replacement therapies—dialysis and transplantation—will be commissioned by the NHS Commissioning Board with due regard for patients’ needs to maintain their day to day lives. Patient choice and control—“no decision about me without me”—will be the watchwords of quality services after the transition, with informed choice of treatment modalities including care at home; conservative care in the community and, at an appropriate time, good end of life care. For example, an increase in the availability of dialysis at home—which is known to be more clinically and cost effective than in-centre treatment—will mean that patients will be able to plan their treatment around their lives rather than vice versa. For dialysis patients of working age, this treatment modality will help them to continue in employment with benefits to themselves and the wider community.

**Diabetes**

117. Diabetes is a life-long complex condition that affects every part of the body and throughout the course of their lifetime people with diabetes will need to engage with a range of healthcare professionals. There is no single care pathway for people with diabetes and it is essential that they receive the relevant care and attention as and when they need it. The NHS reforms present the opportunity for stronger, closer partnership working between GP consortia and secondary care specialists, ensuring that evidence-based multi-disciplinary care is commissioned and is focused on the needs of the individual patient sitting in the GP practice.

118. Engaging patients in a better understanding of their condition and educating them how to manage their own condition results in better outcomes. These reforms offer the potential to provide more tailored treatment for people with diabetes so that they can access specialist care from the primary, community and acute sectors.

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119. We know that there is significant scope for improvements in primary care in terms of managing people with diabetes in the community. Because the performance of local health services will increasingly be measured on whether or not patients are in good health and able to live active, fulfilling lives, it will become more apparent where people with diabetes are not receiving good primary care and community services to help them manage their condition, and there will be a greater onus on GP consortia, health professionals and Health and Well-being Boards to address this.

120. Strengthening the relationship between primary and specialist care can only be a good thing for improving care for people with diabetes. In anticipation of these changes, the diabetes team in Portsmouth NHS Trust have already proposed a solution that will drive specialist diabetes care into the community cutting across the divide of primary and specialist care. This not only provides more convenient services for people with diabetes, but also ensures the integration of specialists into primary care.

**Heart Failure and Cardiac Rehabilitation**

121. The focus on patient experience, empowerment and long-term conditions envisaged in the new arrangements should give a welcome emphasis to the commissioning of services for heart failure and cardiac rehabilitation. Moving commissioning decisions closer to patients should ensure they are better able to influence their care through direct discussion with their GP. This is of particular importance to people with long-term conditions. GPs should become more aware of the full menu of services available and will be able to offer greater choice and control to their patients to manage their own condition more effectively, with specialist medical support only where necessary.

122. Facilitating the entry of new and different local provider organisations will help people tailor their care to meet their needs. For cardiac rehabilitation, this would mean that patients not only have a choice of services from a variety of providers in a range of settings, but also that they could select only the components of the services that meet their individual needs.

123. The NICE Quality Standard on Chronic Heart Failure (due in summer 2011) will provide a robust evidence base to enable GP consortia to understand the benefits and cost-effectiveness of alternatives to hospital provision, through telemedicine and community teams, in addition to the importance of self-care and cardiac rehabilitation in preventing hospital admissions. It is also likely to help the NHS Commissioning Board develop suitable indicators as part of the Commissioning Outcomes Framework to hold commissioners to account for delivering the outcomes that people want.

**Commissioning for Stroke Care**

124. The focus on improved stroke linkage between primary and secondary care will offer opportunities to focus on prevention through, for example, better management of patients with atrial fibrillation and consequent reduction in the risk of stroke. Patients with atrial fibrillation have worse strokes with worse outcomes, so improving atrial fibrillation management can improve overall outcomes.

125. As with cardiac services, the new arrangements will support a strengthened focus on patient experience and patient empowerment. GPs should become more aware of the benefits of continuing rehabilitation, including understanding how best to deliver it most effectively for most patients (eg via telemedicine facilities) for as long as patients are able to benefit from it. By offering greater choice and control to their patients to manage their own condition more effectively, GP consortia should be able to commission specialist medical support only where necessary.

126. The acute phase of stroke is a very small part of the overall patient pathway. By providing improved focus on post-acute and social care, patient experience and outcomes will improve, enabling better integration into the community and reduced social isolation, which will also benefit carers. Improved understanding of the importance of high quality stroke care including rehabilitation should reduce the numbers of people who are admitted to residential care.

127. The NICE Quality Standard on Stroke provides an evidence base to enable GP consortia to understand the benefits and cost-effectiveness of high quality stroke care. It will also help the NHS Commissioning Board develop suitable indicators as part of the Commissioning Outcomes Framework to hold commissioners to account for delivering the outcomes that people want.

**NHS Health Check Programme**

128. The NHS Health Check programme is a national public health programme aimed at preventing heart disease, stroke, diabetes and chronic kidney disease. The Government made clear its commitment to the continuation of the programme in the Public Health White Paper. The programme aims to prevent disease and help people stay well for longer. As such, it is proposed as an indicator in the Public Health Outcomes Framework.

129. The NHS Health Check programme is a clinically and cost effective programme with a robust evidence base. It is for everyone in England between the ages of 40 and 74 that does not already have one of these diseases. Everyone having a NHS Health Check will have an individual assessment to determine their risk of
having a heart attack or stroke, or of developing diabetes or chronic kidney disease in the future. Each person will be offered a tailored package of lifestyle advice and support to help them reduce or manage that risk. For those at low risk, this might be no more than general advice on how best to stay healthy. Others may be assisted to join a weight management programme or a stop smoking service. Those at the highest risk might also require preventive medication with statins or blood pressure treatment.

130. Six Carers Strategy demonstrator sites, focusing on health and well-being checks, are testing different ways of reaching out to carers, including those in ethnic minority communities. The findings from the independent evaluation of the demonstrator sites, particularly around accessibility for carers will be fed into the ongoing policy considerations for the NHS Health Check Programme.

131. There is also a related annual health check programme for people with learning disabilities that has been running since 2008–09. The Government has confirmed it is keen for this programme to continue in 2011–12, and is currently looking at the most cost effective way of ensuring that. Evidence shows people with learning disabilities value annual health checks. Evidence also shows people with learning disabilities have greater health needs than the general population, and that such checks lead to earlier diagnosis and earlier treatment. Annual health check data is analysed and published by the Public Health Observatory in relation to people with learning disabilities.16

132. Vascular conditions (mainly coronary heart disease, stroke, diabetes and chronic kidney disease) are the largest contributors to the gaps in health between deprived and better off, and between different ethnic groups. This programme, if implemented sensitively, offers a real opportunity to make significant inroads in tackling health inequalities and fits with the wider agenda for improving public health.

March 2011

Written evidence from NHS Confederation (CFI 06)

Executive Summary

— The government’s proposed reforms present an important opportunity to create a meaningful link between the decisions taken in the GP’s consulting room and their implications for the use of NHS resources. PCTs were not always able to translate commissioning intentions into changes in GP behaviour. It will be important that GP consortia are able to do this.

— Whilst we support the objectives of the reforms and are pleased the government has addressed some issues we raised in response to the White Paper, we still have some concerns.

— Crucial to the implementation of the reforms will be the success of new GP consortia leaders in attracting GP followers and achieving genuine improvements in general practice. GP commissioners must be provided with the right tools to deliver improvements in quality and performance in primary and secondary care and to ensure good practice in commissioning and provision.

— There is not yet sufficient clarity or consensus about what in the new system will drive quality improvement, and who will intervene when things go wrong. Further clarity is needed about the mechanisms to enable consortia to support the Board in securing continuous improvement in primary medical services.

— Legislation, regulations and guidance must strike a balance between strong accountability and assurance and local organisations’ autonomy. The decisions and behaviours of the Secretary of State and the NHS Commissioning Board in exercising their powers will also be crucial.

— A balance will need to be struck in how conflicting or competing duties are applied in practice. This makes it all the more important to ensure the accountability mechanisms in the Bill are clear and powerful. Proposed mechanisms for ensuring consortia and the NHS Commissioning Board are accountable to, and effectively involve, patients and the public require further development.

— It will be important for consortia to involve a wide pool of health professionals in commissioning. We remain concerned about the potential loss of public health expertise as public health responsibilities transfer from PCTs to local authorities and Public Health England. The Government should also explain its plans for clinical networks.

— Greater clarity is needed about how patient choice will be enabled in practice, both in terms of choosing a provider when requiring treatment and in choosing a commissioning organisation to arrange care more generally.

— The legislation must make clear that the promotion of competition is a key element of providing protection to patients and taxpayers. At the same time, the implementation of competition law in healthcare should be tailored to recognise and encourage cooperative and integrated arrangements where these are clearly in patients’ and taxpayers’ interests.

16 www.improvinghealthandlives.org.uk/numbers/checks/
— Safeguards will be needed to ensure the independence of local Healthwatch, given the powers of funding and accountability that local authorities will hold over the bodies.
— PCT staff are central to achieving a successful transition to the new system. We regret that we continue to see rhetoric used in public which is both unnecessary and counterproductive in this regard.

1. About the NHS Confederation
1.1 The NHS Confederation is the independent membership body for the full range of organisations that make up the modern NHS. We have over 95% of NHS organisations in our membership including ambulance trusts, acute and foundation trusts, mental health trusts and primary care trusts plus a growing number of independent healthcare organisations that deliver services on behalf of the NHS.
1.2 We are uniquely placed to consult with and speak for the health system as a whole. To enable us to advise the government on the proposed reforms to the NHS, we have been consulting extensively with our members across the country since July 2010 through engagement events, consultation, and other formal and informal mechanisms, to hear about their views on the planned changes.
1.3 We welcome the Health Committee’s careful consideration of the NHS White Paper, Equity and excellence: liberating the NHS, and its desire to scrutinise the implications of the Health and Social Care Bill.
1.4 Our evidence includes the key points from our response to the consultation on the white paper and our recent briefings for the Bill’s Second Reading and Committee stage, as they relate to the Health Committee’s identified questions.

2. The assurance regime for commissioning consortia and authority of the NHS Commissioning board to deliver its objectives
2.1 We welcome the stated intention of the Bill to loosen central government’s day-to-day control over the commissioning and delivery of NHS services. However, there is not sufficient clarity or consensus about what in the new system will drive quality improvement, and who is going to get a grip when things go wrong.
2.2 Commissioning consortia will have a duty to promote quality improvement and will also be required to maintain financial balance. However, the Government still needs to clarify the influence consortia will have over individual practices to enable GP commissioners to deliver these duties. In addition, it is still unclear how it will be ensured that consortia governance arrangements are adequate.
2.3 The Government should put in place an assurance system for consortia. The NHS Commissioning Board should apply tests to ensure consortia maintain strong governance arrangements with clear, transparent and robust decision-making and audit procedures. Detailed, prescriptive guidance should be avoided to provide local organisations with the freedom to innovate and establish their own ways of working whilst providing some assurance that organisations are suitably constituted. We would like the Government to clarify at an early opportunity the tests it would apply to consortia governance arrangements.
2.4 The Bill sets out a clear intervention regime for consortia that are failing or deemed at risk of failing, but there is no indication of how performance is monitored and managed prior to that point. Will the Board evaluate the performance of consortia, negotiate specific areas or levels of quality improvement with individual consortia, and determine failure or potential failure? If so, how will it do so?
2.5 Within the legislation and subsequent regulations and guidance, a careful balance must be struck between accountability and assurance mechanisms. They need to be strong enough to ensure the system achieves its objectives, whilst avoiding over-empowering top-down structures at the expense of local organisations’ autonomy to set local Priorities and to make their own commissioning decisions.
2.6 The decisions and behaviours of the Secretary of State and the Board in exercising their powers will also be crucial. As the Bill stands, the potential for the Secretary of State to direct the NHS Commissioning Board and for the Board to direct commissioning consortia through regulations remains significant.

3. Arrangements for defining lines of accountability between the NHS Commissioning Board, the Department of Health and the Secretary of State to prevent potential future conflicts arising
3.1 The Bill sets out a clear line of accountability between the NHS Commissioning Board and the Secretary of State, with a national mandate agreed annually. The Secretary of State has powers of intervention which seem appropriate. However, the Bill places a number of duties on different bodies. Sometimes these are unavoidably conflicting or competing.
3.2 A balance will need to be struck in how conflicting or competing duties are applied in practice. This makes it all the more important to ensure accountability mechanisms in the Bill are clear and sufficient, and those organisations or individuals that are responsible for holding others to account have sufficient powers to take appropriate action where they have concerns.
4. Arrangements for integrating the full range of clinical expertise into the commissioning process

4.1 We agree that it is essential for clinical engagement in commissioning to draw from as wide a pool of practitioners as is possible. We have previously highlighted the apparent omission of any consideration of the role of specialist doctors or of the wider clinical community. In our view, it would not be appropriate to specify in primary legislation exactly how commissioners should involve these professionals. Individual consortia should nevertheless make appropriate arrangements to involve a wide pool of health professionals in commissioning.

4.2 We remain concerned about the potential loss of public health expertise as public health responsibilities transfer from PCTs to local authorities and Public Health England. PCT public health teams currently provide expert support to the PCT’s commissioning of health services. The Government has not yet been clear whether it expects public health professionals in local authorities to provide this support to GP consortia in future. If this is the expectation, the Bill needs to clarify that public health professionals in local authorities should be required to provide this support. Adequate funding will also be required.

4.3 We would like the Government to explain its plans for clinical networks. Clinical networks have helped integrate care pathways and improve the quality of care, providing valuable local support and clinical expertise. We were pleased to hear the future chief executive of the NHS Commissioning Board, which would be responsible for ensuring these networks’ expertise remains after 2012, recently reassuring cancer networks that he, “cannot imagine a period where we would not have vibrant cancer networks operating in the system”\(^ {17}\). However, does the Government intend all clinical networks (for example, trauma and stroke networks) to survive in present form and, if not, what other arrangements would ensure necessary collaboration between specialists?

4.4 PCTs contain many examples of effective mechanisms for securing multi-professional involvement in commissioning. These would take significant time, effort and resource to re-build if they are lost in the transition to the new system. PCT staff have many years’ experience of developing these arrangements. They will have a vital role to play in helping to sustain and develop them in a period of change. We would welcome a conversation involving all parties—including existing PCT staff—about the role of clinicians, health and public health professionals from all sectors in the new commissioning arrangements.

5. Arrangements for ensuring that separating the commissioner and provider functions does not obstruct the development of high quality and cost effective service solutions

5.1 The separation of commissioning and provision is intended to promote competition between providers and increase choice for patients. We believe choice and competition are critical components of creating a patient-centred and patient-led NHS. However, there is consensus in the health sector that cooperation and integration will often be beneficial to patients and taxpayers.

5.2 The legislation must clarify that promoting competition is a key element of protecting patients and taxpayers. At the same time, the interpretation of competition law in healthcare should be tailored to recognise and encourage cooperative and integrated arrangements where these are clearly in patients’ and taxpayers’ interests.

5.3 Some fear that competition will undermine integration, but this is not intrinsic to the competition regime. Lack of integration is more likely to be the result of poor management, culture, and the way that procurements are carried out than a direct result of markets or the application of competition law. There are ways of organising care so competition is between integrated services that provide the whole package a patient needs. Services can also be procured in this way.

5.4 The Government has said that, “the Bill will ensure that NHS commissioners will be subject to comparable prohibitions of anti-competitive conduct as those for providers under national competition law. The legislation will help prevent commissioners from taking individual actions or reaching agreements which restrict competition against the public interest.”\(^ {18}\) Clauses 63 and 64 are intended to ensure good procurement practice by the NHS Commissioning Board and by GP consortia. It is important to ensure these clauses achieve the government’s aim.

5.5 It is unclear whether clauses 60 and 61 which give Monitor functions under the Competition Act 1998 and the Enterprise Act 2002 in relation to activities which concern the provision of health care services in England, are also intended to apply to the commissioning of health services. If so, it may be significant that clause 62(2) states that the general duties of Monitor (section 52) and the matters to which Monitor must have regard (section 54) do not apply when Monitor is carrying out its functions in relation to the Competition Act and the Enterprise Act. The implications of this should be clarified.

\(^ {17}\) Sir David Nicholson, NHS Chief Executive, giving evidence to the Public Accounts Committee’s evidence session on Health Landscape Review, 25 January 2010 (Q209).

\(^ {18}\) Liberating the NHS: Legislative framework and next steps (15 December 2010). Paragraphs 6.87–6.89.
6. Arrangements for commissioning of primary care services

6.1 Delivering improvements to the quality and cost effectiveness of general practice and other primary care services is critical to the reforms' success. This has probably been under-emphasised in the debate about the Government's plans.

6.2 There is not yet sufficient clarity or consensus about what in the commissioning arrangements will drive quality improvement in primary care services. Further clarity about the structure and approach of the NHS Commissioning Board will be required here. In particular, what mechanisms will be available to consortia to enable them to support the Board in securing continuous quality improvement in primary medical services, as set out in clause 22/14M of the Bill? We fear consortia would be underpowered to fulfil this role at present. In addition, what mechanisms will be available to ensure patient concerns and complaints about primary care services are reflected in the commissioning of these services?

7. Effectiveness of the structures proposed in the Bill which are designed to safeguard existing co-operative arrangements between services which work across health and social care boundaries or are intimately linked, and promote the development of new ones

7.1 Health and Wellbeing Boards could be an important part of the NHS system architecture, with the potential to plan services and bring the local system together. However their powers to influence GP commissioners are relatively weak. In practice, this will depend upon the capacity, resources, relationships and behaviours developed at a local level.

7.2 GP consortia will not necessarily be co-terminus with local government boundaries. This will add complexity to the working relationships between Health and Wellbeing boards and GP consortia. It will be important for pathfinders to find effective ways to manage these relationships.

7.3 Local Healthwatch will be funded by and accountable to local authorities, but they will also be responsible for scrutinising local authority functions in relation to social care. Safeguards will be needed to ensure that the local authority does not use its powers of funding and accountability to penalise a local Healthwatch that is critical of the local authority when exercising its scrutiny functions.

7.4 In addition to safeguarding cooperative relationships between the NHS and local government, it will also be important to protect cooperative arrangements between different parts of the NHS, such as primary, community and secondary care. As we have already suggested (5.3) the proposed new structures do not preclude such relationships, but new approaches will be required to protect and develop them.

8. Cross-area collaboration by consortia in reconfiguring services effectively where appropriate, and the ability of the new system to encourage commissioning consortia to cooperate in this

8.1 It is unclear from the Bill what expectations will be placed on consortia to co-operate when reconfiguring services. As the Committee has identified, it is likely consortia will need to collaborate at times to make strategic decisions about large scale service change. It will clearly be in the interest of GP consortia to work together effectively. The powers of the Commissioning Board to intervene in failing consortia will probably be sufficient without any further legal requirements on consortia being placed in the Bill.

8.2 The Bill places much more emphasis on individual organisations driving quality improvement in a competitive market. This is welcomed by providers who want trust Boards to have the freedom to run their organisations. However some of our members have concerns about the removal of regional and local system management and quality improvement support infrastructure.

9. Arrangements for reconciling the potential conflict between promoting patient choice and enabling consortia to deliver their clinical and financial priorities

9.1 Clause 19 of the Bill is clear that both the Board (13F) and consortia (14N) will be under duties to enable patients to make choices about provision and to promote patient involvement in decisions about their care. But it is not clear what shape these choices will take and how patient wishes will be reconciled with GPs' clinical and financial decisions, where these are not aligned.

9.2 In theory, individuals will have a choice of commissioner in that they will be able to move to another commissioning consortium by registering with a different GP. In reality, many will be either unable or unwilling to exercise this right, and will not see this as a satisfactory mechanism for registering their concerns about the behaviours and decisions of a consortium or an individual practice within it.

9.3 We would like to see greater clarity about how patient choice will be enabled in practice.

10. Arrangements for local accountability and public and patient engagement

10.1 We have some concerns about the proposed mechanisms for ensuring the accountability of commissioning consortia and the NHS Commissioning Board to patients and the public.
10.2 Expectations of what health and wellbeing boards will be able to deliver, particularly the extent to which they will strengthen local democratic accountability, appear unrealistic. Whilst elected local authority members and a representative of local healthwatch will be Board members, it remains unclear how the Health and Wellbeing Board will be held accountable by the local community.

10.3 The scrutiny function and powers will rest with local authority, which may discharge these responsibilities through either new arrangements or existing overview and scrutiny committees (OSC). We support the continued operation of OSCs, but it will be important to ensure that scrutiny does not focus entirely on the proactive decisions taken by commissioners, but takes a broader perspective.

10.4 With the continuation of the local authority OSC and the creation of the local Health and Wellbeing Board and Healthwatch, there is the potential for duplication of information requests to local providers. The government should consider placing a duty on health and well-being boards, local healthwatch, and overview and scrutiny committees to avoid duplication of information and inspection requirements on local providers.

10.5 It is vital that commissioning decisions are informed by systematic feedback and input from patients and the public. This should include engagement with groups of the community that do not traditionally use GP services.

10.6 Many PCTs have made real progress in developing effective patient and public involvement in commissioning. GP commissioning consortia and the NHS Board must build on this work when they take on commissioning responsibilities. Both the local GP commissioning consortia and NHS Commissioning Board should be required to provide a published annual statement of how they have involved patients and the public in commissioning.

11. Support to consortia and existing commissioning organisations to form clear and credible plans for debt eradication and for tackling structural deficits within their local health economy

11.1 The Committee is correct to highlight that debt eradication and structural deficits present a significant challenge to the NHS, which current and future commissioning organisations will need to address. PCTs are at present working with emerging GP commissioners to develop strategies which will assist them in delivering the “Nicholson challenge”. In many areas, difficult decisions around service configuration will be necessary to address this issue adequately.

11.2 The government has high expectations of PCT staff, requiring them to deliver significant efficiency savings, while helping to establish new commissioning arrangements and winding up their own organisations, at a time of considerable personal uncertainty. PCT staff are central to achieving a successful transition to the new system and this must be recognised at all levels of government. We regret that we continue to see rhetoric used in public which is both unnecessary and counterproductive in this regard.

11.3 The steps introduced by the Government to cluster PCTs to work together are a pragmatic approach to maintaining effective commissioning capacity during the transition. However we are concerned that the implementation of such changes must not be allowed to divert attention to structural change rather than focusing on delivering the “Nicholson challenge”. Also care must be taken to ensure that proper governance in PCTs is not disrupted and that effective integration with local government is not damaged as a result of the clustering.

February 2011

Written evidence from Professor Calum Paton (CFI 07)

SUMMARY

— The Health Bill is likely to return commissioning to a worse version of the often-chaotic state which prevailed from 2001 to 2006.

— The new “reforms” are not evolutionary in terms of NHS structure and organisation; indeed, they are highly disruptive. But they are not likely to be revolutionary in the medium- or long-terms: it is likely that “devolution to the frontline” will be a mirage, as before. “Meso-level” institutions for performance management will have to be reinvented.

— The Government is fudging the conflict between collaboration and “competitive markets” in the NHS: it has failed to answer the sceptics concerning the possibility of local cooperation between GPs and hospital doctors. Integrated services are only possible under the “any willing provider” regime if they are not local “monopolies”. This will lead either to the abandonment of integration or untenably high costs (to create the capacity for local competition.)

— The NHS has recently seen a proliferation of “policy by euphemistic slogan” eg World Class Commissioning (WCC), which the Committee rightly labelled “ridiculously named” in its 2010 Report. The latest slogan, “the Nicholson challenge”, has an equal capacity to rebound on its authors.
Choice and commissioning are intrinsically opposed, unless the latter is a synonym for planning services by region, area and locality (among which patients or non-budget-holding GPs are free to choose) as opposed to the "market" function it has become, where criteria other than choice come to dominate (despite much rhetoric.)

1. The Health Bill—Radical or Cyclical? Earlier comment focussed upon whether the Bill was revolutionary or evolutionary. For example, Chris Ham originally implied the former, commenting on last summer’s White Paper, Equity and Excellence. More recently Julian Le Grand described the latest "reforms" as evolutionary, building upon the Blairite agenda. To me, the new reforms are neither revolutionary nor evolutionary, and indeed these words may blur their real likely effect.

2. Most certainly the Bill is not evolutionary in terms of NHS organisation and structure. It drives a coach and horses through what we academics like to call the "meso" level tier (ie between the centre and localities), in abolishing both PCTs and SHAs. The latter had only recently (in 2006) been reconfigured into regional organisations— as had existed before the 2001 re-organisation, Shifting the Balance of Power (StBoP), created nearly 30 smaller SHAs. PCTs had been created (as a country-wide system, as opposed to a "voluntary" option) also in 2001; and then themselves reconfigured into a smaller number.

3. Yet neither is the Bill revolutionary. Even were "power to frontline GPs" considered revolutionary (about which we might debate), it is already clear that the "new New NHS" will have as its commissioning agencies (in some cases already) large consortia of GP practices which are likely to grow larger over time. That is one of the reasons the reforms can be seen as cyclical. Like StBoP, their ill-fated predecessor sponsored by former Secretary of State Alan Milburn, they are born in the rhetoric of "devolution", "decentralisation", "power to the frontline" and the like; yet the reality may well be very different. Indeed it will have to be, if loss of control at "local health economy" level is not to make the "Nicholson challenge" not so much a pipedream as a nightmare.

4. We are likely to see a cyclical pattern. Just as StBoP was short-lived (but long-lived enough to underpin much dysfunction, including the "financial deficit crisis" of 2005–06), the brave new world (again) of "local" commissioning will have to be quietly abandoned. In organisational terms, this will mean re-creating meso-level institutions which sit between GPCC and the "centre" in whatever guise (ie the NHS Commissioning Board, the Department of Health and the Secretary of State.) Otherwise, local health economies will lack the control and accountability required to achieve strategic objectives efficiently.

5. Thus to provide continuity (of the desirable sort), the reforms will have to betray themselves in the implementation phase. The question arises, then: why the upheaval?

6. In a nutshell, even more than with StBoP, these reforms—through stripping away the meso-institutions—may force both the inappropriate devolution of certain functions and the inappropriate centralisation of others. All is not as it seems—which is not to suggest conspiracy so much as a failure to learn from even the most recent history.

7. Future Institutions. New institutions will have to fill the lacuna in performance management left by the reforms. The intention— that external "regulation" will replace internal "performance management"— will only come to fruition if (for example) Monitor becomes a system performance manager rather than a "market regulator."

8. It is not only performance management which will be required. While "consortia of consortia" can do some strategic commissioning (ie for services which are too complex or "cross-boundary" for individual GPCC, yet slipping the net of national commissioning by the Board), agencies will be required to reconfigure and plan services at regional/area level. Whether these are regional offices of the Department of Health ("back to the future") or management agencies acting on behalf of groups of consortia, the function will be required. These management agencies will require the usual functions (strategic planning; finance; et al) which are barely mentioned in the Bill.

9. In terms of the reforms being part of a cyclical process of "re-disorganisation", the ambition that GPs be at the heart of commissioning was also at the heart of StBoP, which proposed the Professional Executive Committee (PEC) for PCTs. These mostly lost influence, and GPs mostly lost interest, over time. This is because the scale and scope for effective commissioning meant either that unrealistically large numbers of GPs would have to be involved (except for the most local, community services and most simply-defined hospital services) or management agencies would take over.

10. It can be argued that, this time, as did not happen even with Practice Based Commissioning (PBC), the GPs will control the process, instead of being controlled as in the past. There is some truth in this. But, over time, the vast majority of even these GPs who stay interested will be "non-executives." Two questions therefore arise: how powerful are non-executives? and how legitimate is it that the governance of GPCC (and their larger collaborative "joint commissioners") is not in the hands of a public body but in the hands of one part of one profession?

11. The guts of commissioning "9 to 5" (or "8 to 8" one hopes!) will have to be done by professional managers. The real question is whether these come from the private sector or the public sector. If much of the latter cadre melts away, then the hope of saving management costs may well be dashed.
12. The Government's response to the Committee's earlier reports on management costs is deeply unconvincing. It is not based upon analysis but upon a "flat." Additionally, in gauging transitional costs, no account is taken of "opportunity cost" (bluntly, lost benefit from spending scarce management time on "non-strategic" things instead of—for example—the three components of the "Nicholson challenge" (ie developing extra-hospital care; a lower tariff; and controlling the pay bill.)

13. Integrated services? Just as unconvincing is the Government's response on the issue of whether the "market" (Any Willing Provider; Monitor as an "anti-trust", pro-competitive regulator) is compatible with the prospect for meaningful collaboration between GPs and hospital doctors. Any such collaboration will have to go "against the grain" rather than with it. The Government's response to the Committee in effect states that, even although tenders for hospital services cannot be written to favour any one (eg local) provider, the local hospital doctors can still help the GP "commissioners" write the tender (to enable "integrated care" designed along "pathways"). One has to ask: has whoever drafted this facile response ever talked to a busy hospital doctor? Why would the latter labour collaboratively to service a system which is suspicious of collaborative relationships? We may note that some of the most respected commentators who believe in aspects of the new policy also point to the dangers of the "purchaser/provider split" being too rigid or doctrinaire (eg David Colin-Thomé; Michael Dixon.)

14. It is also argued by the Government (quoting the King's Fund, 2010) that "integrated providers" (one assumes they mean systems including hospital care, community services and GP services) can flourish in the market-place as long as they are not local monopolies. Has anyone in the Departmental "silo" working on integrated care talked to a colleague working on costs-saving? How much would it cost to replicate an English version of California-style Health Maintenance Organisations in the NHS?

15. Hard Choices and Dilemmas. If the national Board is to commission primary services, then having GPCC commission "extended primary services" which collaborate with hospital services is not likely to be efficient or to lead to an alignment of incentives: the two should be complementary and commissioned holistically.

16. The national evaluation of past policy most relevant to the "new commissioning" is the evaluation of the "total purchasing pilots" (TPP) (Mays et al, 1988.) There are many differences, but a key result—as also from some US and European comparisons—was that, to be effective, GP commissioning will be expensive and will need long-term nurturing. One cannot think of a less propitious environment than the current fiscal climate against which to banish the cynicism which is so prevalent at "street level" in the medical profession. Additionally, TPP seemed to work better for "extended primary care" (see 16. above) (ie an amalgam of traditional primary services and wider, extra-hospital services)—ironically, almost the antithesis of GPCC's responsibilities. Budgets to GP groups may be less suitable, on the other hand, for population imperatives such as reducing health inequalities: GPs get involved in commissioning, in the main, as a result of local enthusiasms and "pet projects", not wider goals. Here again, there is a danger of repeating 2001-06 in a worse form as the local enthusiasms of small commissioners come into conflict with system imperatives.

17. The division into centrally-commissioned services and GPCC-commissioned services is not as convenient as it seems (see 8. above) A flaw with both the 1990s "internal market" and the post-2001 commissioning regime was that different commissioners made commissioning decisions which were not coherent in the aggregate ( not "[joined up]"). For example, specialised services commissioned from particular hospitals may require a "critical mass" of complementary services, which themselves depend upon GPP decisions. Local GPCC decisions concerning the scale, scope and location of secondary services may require coordination with other GPCC decisions. Between 2001 and 2006, the need to reinvent this wheel (slowly) saw much waste and "planning blight." If this is to be avoided this time around, we will require a system which is devolved in rhetoric and centralised in reality. Since the meso-level institutions are abolished, the centre will have to do what regions/SHAs were doing or should have been doing in the past ie managing performance and not just monitoring it.

18. Choice and commissioning are awkward bedfellows. Some of this is inevitable. For example, under the last government, the "Darzi reconfigurations" put quality and appropriate scale and scope of services above choice, in reality if not in rhetoric. "Choice" is a politician's sine qua non; whereas, in implementation, the hard reality of combining it with fiscal realities and clinical necessities often reduces it to merely one goal among many. Ongoing evaluation suggests that the differences "on the ground" between the "market choice" regime in the English NHS and the very different approaches elsewhere in the UK are minor. Overt "commissioning" moreover is in clear tension with individual choice (ask an American who is suspicious of the NHS!).

19. GPCC are likely to push hard for "price competition" (ie the—reduced—tariff as a maximum, not a regulated norm), as they face new responsibilities in a cold fiscal climate. This holds out the danger of quality lapses. A previous evaluation of the 1990s internal market suggested this is not just an abstract worry. A major priority for the NHS ought to be to learn from the current Public Inquiry into Mid Staffordshire NHS Foundation Trust. The weakness of internal performance managers (including the SHA regime) may be an important lesson. It is difficult to see how abolishing such tiers completely might help.
20. The Hardest Choice of All. Bluntly, there are three objectives of which two are attainable: cost-savings of 4% a year; integrated services for a wide range of "clinical pathways"; and competition. The Government asks for all three—without any evidence that they are jointly attainable, and much to suggest that they are not.

21. An Alternative. There is much myth about the inevitability and desirability of the "purchaser (commissioner)/provider split." The Committee's 2010 Report rightly drew attention to the fact that this may have produced lots of cost without commensurate benefit. The usual response however is to call for "improved commissioning" or the like (as with WCC.) This mirrors the call for "improved purchasing" during the 1990s internal market. Yet the fundamental direction of travel may be flawed.

22. Integrated organisations organised at district or area levels containing both primary/community services and hospital services are attacked on two grounds—that they are "anti-competitive", "Old Labour" (ie the "forces of conservatism" in Blair's term) or both. Yet the pre-1991 NHS did not have integrated organisations: the GP service was separate from both hospital and community services. No-one is suggesting a retreat to a golden age.

23. It is possible to have "choice without (much) market", just as it is possible to have "markets without (much) choice"—the prevailing situation post-1991 and post-2001, despite prevailing perceptions based upon ideological closure. With this approach, GPs are non-budget-holding, and are free to refer patients in line with patients' preferences. Where patients choose non-local services, money flows with them (the partial absence of this being a problem with the pre-1991 NHS, although not as severe as advocates of the "internal market" implied.)

24. "Commissioning" then becomes a synonym for needs assessment and the provision of services to meet these needs. Ironically the best scale/population size for this function is probably the sort of Health Authority we had from 1997 to 2001, with a regional tier (lean but strategic) to "performance manage" the system as well as to coordinate the provision of regional specialist services. But such a Health Authority would be an integrated organisation, with GPs sharing executive (and perhaps non-executive) authority with other professions. GPs are neither heroes nor villains, so to deliver 80% of the NHS budget to them (mostly as non-NHS employees) is surely bizarre.

25. For the marketers to argue that such a system would be "inefficient" invokes images of motes and beams. I am under no illusion that this approach is on the political table in England (as opposed to the rest of the UK.) But the "development needs" of such a system would be parsimonious by comparison with the bloated and often wasted investment in failed market systems.

Calum Paton
February 2011

Written evidence from Monitor (CFI 08)

1.0 Introduction

1.1 Monitor welcomes the Health and Social Care Bill. We strongly support the Government's plans to modernise the NHS and make Monitor the economic regulator for health and adult social care. We believe it is right to have an economic regulator which is independent of political influence, can build specialist skills and is transparent in the way it sets prices, promotes competition where appropriate and deals with failure, both of markets and of institutions.

2.0 Monitor and NHS Foundation Trusts

2.1 Monitor's current role is as the Independent Regulator for NHS foundation trusts. Our mission is to provide a regulatory framework which ensures that NHS foundation trusts are well led and financially robust so that they are able to deliver excellent care and value for money.

2.2 NHS foundation trusts are a key component of the purchaser/provider split that was established following the Health and Social Care Act 2003. When an organisation achieves NHS foundation trust status it is no longer accountable to Strategic Health Authorities and the Department of Health (who have ongoing responsibilities for commissioners). Instead NHS foundation trusts are accountable to their local communities.

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19 Professor of Health Policy (1993-2009) and Professor of Public Policy (2009-date), Keele University; Chairman, University Hospital of North Staffordshire NHS Trust, 2000-2006; Editor-in-Chief, International Journal of Health Planning and Management (Wiley Blackwell)
2.3 Monitor considers that the purchaser/provider split aims to ensure that the funding that is provided to the NHS achieves the best possible value for money, and that the NHS allocates the resources that it receives efficiently to meet the expectations of the public.

3.0 Commissioning in the Health and Social Care (2011) Bill

3.1 Monitor believes effective commissioning is integral to the success of proposals in the Health and Social Care Bill. GP consortia will be responsible for 80% of the NHS budget—around £88 billion for 2010-11. They will be expected to use this resource to improve the quality of care for their patients by bringing greater clinical expertise to commissioning activities.

3.2 The Health and Social Bill continues and enhances the policy of patient choice in the NHS so that there is greater competition among providers. For some services patient choice will not be appropriate, but there will be an expectation on commissioners to look to contract for services via competitive tenders (competition for the market), rather than issuing contracts non-competitively to incumbent providers.

3.3 Monitor is aware that interested parties have raised questions on the impact of the Health and Social Care Bill on commissioners’ activities. It is therefore important to clarify the current status of proposals with regard to procurement.

3.4 Monitor agrees with the Department of Health that there is potential for commissioners to act in ways that might not promote competition, or to act anti-competitively, particularly if they are able to provide services and self-supply. For example, a consortium might decide to continue to roll over contracts for services delivered by their practices, rather than allowing other providers to bid for them through competitively tendering.

3.5 The Department of Health currently requires commissioners to follow the Principles and Rules for Cooperation and Competition (PRCC) when procuring health services. The PRCC contains 10 principles which help to ensure co-operation, while protecting competition, in NHS services. This includes the prevention of anti-competitive behaviours by commissioners. The Cooperation and Competition Panel (CCP) can investigate complaints where there has been a failure to comply with the PRCC, and it can make recommendations. However, it has no power to require that the recommendations are followed.

4.0 Monitor’s role on Commissioning Behaviour

4.1 The Health and Social Care Bill sets out that commissioners may be subject to procurement and competition regulations—developed by the Department of Health but enforced by Monitor. These would require the NHS Commissioning Board and commissioning consortia to:

— adhere to good procurement practice;
— protect and promote patient choice; and
— promote competition.

4.2 According to clause 64 of the Bill, Monitor may be given new powers to take action against, amongst other things, anti-competitive behaviour by commissioners. These powers will be set out in regulations and would enable Monitor to:

— investigate a complaint against the NHS Commissioning Board and/or commissioning consortia for failing to observe these requirements.
— require information from the NHS Commissioning Board and/or commissioning consortia; and
— require explanations from the NHS Commissioning Board or a Commissioning Consortium.

4.3 Monitor would only be able to use these powers under specific circumstances as outlined in the Bill. For example, if the NHS Commissioning Board or a commissioning consortium were to fail to comply with the regulations (under clause 63). However, the failure would have to be serious and Monitor would have to consider that the person making the complaint has “sufficient interest” in the arrangement.

4.4 The Bill does not specify whether this applies to individual health service users. Nor does it define serious failure or sufficient interest.

4.5 Also according to clause 63 of the Bill, Monitor may be given powers to require, if the investigation were to be upheld, the NHS Commissioning Board or commissioning consortium to:

— remedy the failure;
— put in place measures to prevent failures to comply with the requirements or to mitigate against the effects of failures;
— vary or withdraw an on-going tender process; and
— render an arrangement ineffective.
4.6 The Bill does not give Monitor the right to award damages to a claimant or compensation if a contract is declared ineffective.

4.7 Monitor considers that it is important that the new framework under which we will operate should go further than the protection against anti-competitive behaviour that is provided in the PRCC. We therefore support the proposal in the Bill that Monitor should have oversight relating to procurement of health and social care services, co-operation and agreements between providers and commissioners, the conduct of commissioners (from a competition perspective), and mergers and vertical integration between providers and commissioners.

4.8 When exercising these functions, Monitor would have to have regard to factors such as patient safety.

4.9 The Department of Health will consult on the regulations before they are made. The regulations would also need to be interpreted alongside existing EU and UK procurement law.

4.10 However, the extent of Monitor’s remit in this area will only be clear once we have further detail from the Department of Health about the regulations to be brought forward. This includes details such as the criteria Monitor will have to apply in deciding whether to render a contract ineffective, the rights of appeal available to the NHS Commissioning Board and commissioning consortia, and the time limit for bringing a claim. Monitor is unable to provide clarity on how it will exercise these functions until the Department of Health has set out this detail.

4.11 Once Monitor has this information, we will carry out a full analysis of the situation. Before any decisions are taken, there will be full consultation and involvement of interested parties. This is paramount. We will only make the final decisions after careful consultation and analysis.

February 2011

Written evidence by the Medical Practitioners’ Union (CFI 09)

ABOUT THE MEDICAL PRACTITIONERS’ UNION—UNITE

MPU, founded in 1914, is a small group of doctors (compared to the BMA) currently mostly GPs in deprived areas. MPU merged with another trade union that has resulted in becoming part of Unite. We participate in the representative machinery of the medical profession through agreements reached with the BMA in 1950. As part of the Health Section of Unite MPU’s policies are informed by other professional groups, particularly health visitors, sexual health workers, mental health and school nurses. It has a track record of influencing national policies such as: the GPs’ Charter, Junior Doctors’ hours, and of influencing the medical profession—exposing racism in the profession, the vulnerable position of sub-consultant grade doctors, campaigning for a salaried option for GPs and for better health services for asylum seekers.

Of particular relevance is that MPU produced proposals for locality commissioning (1991) which became Labour Party policy in 1992 and the policy of the BMA by the mid 1990s.

STATEMENT OF CURRENT ATTITUDE TOWARDS THE NHS AND SOCIAL CARE BILL

(References: “Clause ...” refers to the Bill; “IA ...” refers to the Combined Impact Assessment. Other references will be supplied on request)

1. CONTEXT: The National Health Service is not perfect but has improved particularly since its funding was increased. It had its highest patient satisfaction rating recently. Its outcome figures do compare well with other health systems in spite of government assertions to the contrary. The NHS provides access to health care rated as the best in the developed world.

Whilst it is possible to agree with elements of the Bill, we oppose the Bill as a whole because of the creation of competitive markets, the powers of Monitor, the wholesale dismantling of organisational structures, the privatisation of NHS assets and the conversion of Directors of Public Health into local government officials with perceived loss of their important independent voice.

The basic ethos of the NHS may not be directly undermined by the Bill but indirectly the “free at the point of use” principal could be undermined by the uncritical adoption of market principles. As profits become the benchmark of “good health services” some services could be seen as not cost efficient merely because they are complex and expensive rather than inefficient.

Marketisation and commodification of health services reduce the high ideals of the NHS to that of simple trading. The ethos of the NHS and of those who working in the Service are crucial to its success and mirrored by the high value which the population ascribe to it. Knowing the price of everything and the value of nothing sums up this concern.

The experience of Independent Sector Treatment Centres (ISTCs) is that they offered services (often at 11% above NHS Tariff) to patients with uncomplicated medical histories (‘cherry-picking) leaving the NHS to deal with patients with complex, multiple diagnoses.
The evidence from PFI projects is that they are more expensive than publicly financed builds, are poor value for money and distort the funding allocations to PCTs with PFI projects.

The Health Services of Wales, Scotland and Northern Ireland have not introduced the purchaser-provider split nor competition as drivers for cost efficient, quality services.

2. No democratic mandate: the reorganisation of both the provider and commissioning side was five years in the planning according to the Secretary of State but barely mentioned in his Party’s Manifesto and specifically ruled out in the Coalition’s Agreement—no top down, major reorganisation of the NHS. There should be trust between the people and its government—such trust has been jeopardised with regard to the future of the NHS in England.

3. Commissioning is defined by MPU as the process of gathering and analysing the wants and needs of a population, identifying the services required to meet those needs and of monitoring those services and their outcomes as they are delivered.

4. There is nothing against and everything for the involvement of GPs and other professions in the commissioning of care. There is however no need to abolish PCTs or SHA to achieve this, nor to establish competition within the provider setting.

5. Privatising the Commissioning Function: the abolition of PCTs and SHA to be replaced by GP Consortia opens the door to private sector involvement in the commissioning process. This is of course government policy and MPU is totally opposed to it. There has been confusion as to whether GPCCs will be NHS Bodies (Clause 6 1E (1))—they should be.

GP Principals are independent contractors to the NHS under one of three contractual arrangements: General Medical Services (GMS) a UK wide, national contract; Personal Medical Services (PMS) a locally held contract with a PCT and; Alternative Personal Medical Services (APMS) which is a proper commercial contract with a PCT. GMS and PMS are the norm and GPs and their staff have access to the NHS Pension scheme and regard themselves very much as “part of the NHS”.

APMS contract holders do not have to be GPs and have fully commercial contractual arrangements with PCTs. They are more distant from “the NHS family”. The GPs working in APMS are usually salaried to the company and are usually not GP Principals.

Two or more APMS practices could form a “private” consortium with confused allegiance to either private employer or NHS, yet with access to NHS funds. As with all consortia it can write its own constitution, raising issues of accountability and conflicts of interest.

6. Price competition: within the NHS as indicated by supplementing national tariff with a “maximum price” (Clauses 103 and 104), has been shown to lower the quality of health care provided. Improving the quality of health services should be by sharing good practice and outcome data, thereby using peer pressure rather than market competition. This method has been successful in rationalising prescribing by GPs and would work in a similar way for inappropriate GP referrals.

Recent “clarifications” by the Secretary of State that competition will be based on quality not price will remain unconvincing whilst “maximum price” is on the face of the Bill and whilst Monitor’s role is specifically stated as promoting competition (Clauses 52 (1) (a) and 63 (1) (c)) and enabling easier entrance to and exit from the “health market” (IA B 106 and 112).

We would ask for the evidence that market competition improves health outcomes. (The Impact Assessment rests its case for the success of market competition on examples from new car sales, replica kits, the air travel industry and opticians). We question the current rhetoric that investment over the last 10 years had not improved health outcomes as they are delivered.

7. If the Any Willing Provider policy (AWP) is pursued as currently envisaged GP Commissioning Consortia (GPCCs) will actually do very little commissioning as defined above. Services are likely to be commissioned as follows:

(a) Special Commissioning by NHS Commission Board

(b) A&E, ITU and so on—no tendering as they are likely to be located at the local hospital (whether NHS or privately run). Any reconfiguring will have to be done at a supra-Consortia, “regional” level.

(c) Elective Services—AWP will be selected by the patient with GP support from a national list perhaps trimmed to more local providers

(d) Long term conditions (eg diabetes, heart disease) “off the peg” packages of care will be designed by providers and offered to consortia. It is likely that any “tweaking” of the package will only be possible at the margins since providers will want to minimise different services for different (neighbouring) consortia. This “provider dominance” is commissioning the wrong way round and leaves the tail wagging the commissioning dog. If led by the private sector and uncoordinated it risks further weakening the comprehensive nature of current NHS services.
Consortia are the bill payers for most of these services and will have limited choice over providers. The patient chooses elective care, not the host consortium. The Secretary of State has recently said that competition rules will not apply if the Consortium can show their decision is in the best interests of patients. Once the Bill is law, the present or any future Secretary of State could change this interpretation.

How will GPCCs manage demand with such limited control over service provision? Demand management of appropriate GP referrals has historically proven difficult. As noted above, peer pressure could reduce inappropriate referrals.

8. The AWP policy is likely to be detrimental to NHS hospitals and to the provision of comprehensive acute services. Commercial providers have to date provided straightforward procedures only—hip replacements, hernias and cataracts. The Impact Assessment makes explicit that there should be easier entrance to and exit from NHS provision and that competition between providers should be stimulated (IA B4). As private providers take more procedures from NHS hospitals the following may result:

- Acute hospitals rely on “cross-subsidies” to support over tariff services from services provided under tariff. Less income to NHS providers leads to financial instability and pressure to increase non-NHS income; for example, exploiting the removal of the cap on earnings from private patients (IA B72) resulting in longer waiting lists for NHS patients (IA B156).
- A&E and ITU unable to call on a complete range of services 24 hours a day if some departments have “failed” and closed (IA B149).
- NHS left with more complex (IA B54) and expensive case mix due to “cherry-picking”.

“Designated Services” as laid out in the Bill (chapter 3) will attract a premium payment (Part 3 chapter 7) from the provider and so there will be a disincentive to designate services. Again A&E may not have a full range of services to call on 24 hours a day unless all relevant services are “designated”, the direct opposite of the Government’s intention to apply the rigour of the market.

9. Postcode lottery of services: Consortia are to have autonomy, can construct their own constitution and decide which services will and will not be provided for their patients. Patients in neighbouring consortia could therefore receive a different menu of services provided to different service specifications. Whilst adapting services to local need is acceptable this policy tends to remove “National” from the NHS and puts at risk the equitable provision of services for the English population as a whole.

10. Fragmentation of Community and Primary Care Services: The NHS delivers care in teams—obvious in the hospital setting but less so in the community. During the 1980’s primary health care teams (PHCT) were common—health visitors, midwives, district nurses, GPs, practice managers and often social workers. The move away from practice alignment of community staff and increasing work load as more services are provided in the community, has led to the decline of PHCTs and poorer coordination and integration of services (IA B44). The best primary care relies upon good systems, good relationships between colleagues and, crucially, trusting and long-term relationships with patients. Any attempt to re-introduced PHCTs to promote integration of services will be hampered by multiple, community providers competing for business rather than cooperating for care.

Multiple providers in competition with each other has already proven problematic for primary care as residential care services have been privatised—one company employing the staff, another providing care packages to residents and community staff who now have little contact with the practices serving the residents.

11. Conflicts of Interest:
   - GPs and/or private companies as both commissioners and providers
   - GPs having to consider the Consortium’s budget versus the needs of the individual patient coupled with rewarding practices for referring less (Clause 23 223L). This fundamentally distorts the trust embedded in the doctor-patient relationship and the GP’s role as patient advocate.

12. MPU also has concerns similar to those raised by other groups and organisations:
   - the haemorrhage of talent from PCTs and SHA’s at a time of massive reorganisation;
   - resources diverted to reorganisation rather than patient care;
   - costs of redundancy pay, the reorganisation itself and rising transactional costs;
   - risk of organisational dysfunction or collapse;
   - lack of evidence that the new system will benefit patient care;
   - weak accountability and democratic structures proposed; and
   - knock on effect on teaching and training as private sector absorbs more trained staff.
13. RELEVANT CV OF DR SINGER, PRESIDENT

1982 to Date  Member Enfield and Haringey (now Enfield) Local Medical Committee
1982 to 2004  Member of various NHS Bodies representing Enfield Local Medical Committee or Edmonton GPs: Enfield and Haringey DHA, Enfield DHA, Edmonton Primary Care Group, Enfield PCT’s Professional Executive Committee
1992 to 2003  Founding and Executive member of National Association of Commissioning GPs (which later became the NHS Alliance)
1996 to Date  Member of General Practitioners’ Committee of BMA (representing MPU)
1996  Author/editor: GP Commissioning: an inevitable evolution (Radcliffe)
2003 to Date  President, Medical Practitioners’ Union—Unite

Dr Singer is not a member of a Political Party but contributes indirectly to the Labour Party via Unite’s political levy.

February 2011

**Written evidence from The King’s Fund (CFI 10)**

The King’s Fund is a charity that seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

**Summary**

— Many GP commissioning consortia will need considerable support from the NHS Commissioning Board, particularly during the first years after formal establishment. Unless there is a robust process of self-assurance and an accompanying developmental programme, the Board may be drawn into top-down performance management.

— The Secretary of State retains considerable powers of intervention under the Health and Social Care Bill. The pressure to use these will be intense unless consortia and the NHS Commissioning Board perform consistently highly.

— Consortia must be given stronger requirements to involve other professionals in commissioning, and in doing so should be encouraged to work with clinical networks.

— The Bill creates insufficient mechanisms and incentives for integrating commissioning across health and social care. Monitor should be given a specific duty to promote collaborative working as well as competition.

— Commissioning processes must be transparent if consortia are to manage conflicts of interest without creating unnecessary bureaucracy.

— Stronger obligations are needed to guarantee adequate patient and public involvement in commissioning.

— We remain highly concerned that it will be difficult for commissioning consortia to drive much-needed large-scale reconfiguration within secondary care.

— Choice of “any willing provider” may be appropriate in some clinical areas but not in others, and should not be allowed to undermine commissioner purchasing power.

**The Assurance Regime for Consortia**

1. The Committee’s previous Report on commissioning highlighted the critical importance of creating a sufficiently robust assurance regime for GP consortia, and we would strongly endorse this point. Consortia will be held to account principally by the NHS Commissioning Board (NHSCB), through an annual performance assessment, and rewarded for good performance with a “quality premium” incentive payment.

2. The Health and Social Care Bill allows some flexibility in terms of how the NHSCB interprets its relationship with consortia. Its most direct powers of intervention can only be deployed in two circumstances:
   — When a consortia is failing to discharge any of its functions.
   — When a consortia is at “significant risk” of failing to do so.

3. However, the Bill also confers broader powers which could see the NHSCB become much more than a safety-net for isolated cases of failure, and it is highly likely that it will need to do so. For example, it has powers to issue commissioning guidance which consortia would be legally bound to have regard to. David Nicolson has indicated his preference for the NHSCB taking a wider role in offering proactive support, writing in a recent letter to the NHS that the NHSCB “will offer a spectrum of support, from empowering and facilitating success, to intervening to support consortia in difficulty”.

**Ev 138 Health Committee: Evidence**
4. While we believe the overall relationship between the NHSCB and consortia should be “supportive” rather than managerial, it may be necessary and appropriate for the NHSCB to assume a more hands-on role in the first few years after consortia formally take on their responsibilities, potentially working with or through PCT clusters. This could include directly commissioning those services which consortia are not yet ready to accept financial responsibility for. It is likely that there will be a substantial number of consortia which perform relatively poorly but which do not meet the threshold for formal intervention by the NHSCB. There will need to be an appropriate developmental programme in place to help these consortia make improvements, perhaps including ‘mentoring’ from more advanced consortia.

5. The annual performance assessment process developed by the NHSCB, along with any commissioning guidance it publishes, must be designed to be of use to consortia themselves. The assessment should be a developmental aid more than a performance management tool, the aim being to help consortia to clearly identify what their weaknesses are, and what developmental support they might need to address these weaknesses. Consortia must be able to translate their performance in the annual assessment into practical action. Focusing the assessment process exclusively on outcomes may not be sufficient to give consortia a detailed diagnosis of how they need to change. An assessment of core commissioning competencies would be of much value to consortia, particularly in the early years when they are developing skills and capacity.

6. If the assurance regime fails to enable consortia to assess and respond to their skills gaps and organisational weaknesses themselves, a return to top-down performance management may be inevitable. Our view is that a wholesale reversion to performance management would be regrettable—but that there are some functions that the NHSCB should be performing on an ongoing basis, such as the development of national standards and template contracts.

7. The authorisation process for consortia will be a key part of quality assurance for GP commissioning. Getting this process right will be an early challenge for the NHSCB. In stark contrast with the authorisation process developed by Monitor for aspiring Foundation Trusts, consortia will be new organisations with no track-record they can be judged against. The skills they need will also be new—and different to those required in the past by PCTs. This leads to the conclusion that for some consortia, authorisation may need to be a phased process rather than a one-off event, with responsibilities being transferred incrementally over time.

8. Given the relatively small scale of many consortia, it is highly likely that some services will need to be commissioned collaboratively by inter-consortia partnerships, potentially at multiple co-existing levels. This introduces another element of complexity into assurance arrangements. It is not clear how the quality of inter-consortia commissioning will be assured, and how good or poor performance will be attributed to actions taken at this level versus the individual consortia level.

9. A priority for the NHSCB will be to develop a clear failure regime for consortia whose performance is poor enough to warrant intervention. The Bill gives the NHSCB power to intervene in a range of ways, including ultimately the power to dissolve a consortium and pass its functions to other consortia or take them on itself. The NHSCB will need to establish a rules-based system describing with greater precision how and when its various powers will be used.

Accountability at the National Level

10. The Committee raised concerns about the potential for conflict between the NHSCB, Department of Health and Secretary of State, and the need for clear lines of accountability to prevent this.

11. Under the Bill, the Secretary of State retains considerable powers over the NHS. For example, in the annual mandate between the Secretary of State and the NHSCB, the former is able to specify not only the objectives that the NHSCB should seek to achieve, but also “any requirements that the Secretary of State considers it necessary to impose on the NHSCB for the purpose of ensuring that it achieves those objectives”. The Bill also allows for secondary legislation which would allow the Secretary of State to set a number of other requirements relating to the operation of the NHSCB, and with Parliamentary approval could require the NHSCB or consortia to do anything considered “necessary for the purposes of the health service”.

12. The Bill therefore leaves room for the relationship between the Secretary of State and the NHSCB (as well as that between the NHSCB and consortia) to have managerial elements. The Department of Health has indicated that some of the powers granted to the Secretary of State would only be used in exceptional circumstances. However, if consortia or the NHSCB do not perform consistently well, the pressure on the current or future Secretaries of State to use the powers invested in them could be very strong. In such a circumstance, the removal of the intermediate tiers of NHS management (PCTs and SHAs), leaving national bodies interacting directly with (potentially weak) local bodies, could result in increased centralisation—in spite of the prevailing political preference for the opposite.

13. Just as there is a potential for these arrangements to lead to tensions between the NHSCB and Secretary of State, there is also a lack of clarity in the relationship between the Care Quality Commission and Monitor. The two regulators are charged with safeguarding different aspects of system performance, and it is not yet clear what the preeminent consideration will be in situations where these diverge—for example, where promoting competition and contestability is at odds with promoting quality. Greater clarity is needed on how the two organisations will relate to each other in the new system—and how both will relate to the NHSCB.
MULTI-DISCIPLINARY INVOLVEMENT IN COMMISSIONING

14. We are concerned that the requirement in the Bill for consortia to “obtain appropriate advice” from other health professionals will not guarantee sufficient multi-disciplinary involvement in commissioning. The government must set out clear expectations that consortia will fully involve hospital specialists, other clinicians and health and social care professionals in their work. This could be through a legal duty to involve such professionals, or a duty to report annually on how they have been involved.

15. With real multi-disciplinary involvement, commissioning consortia could become the focus for improved collaboration and closer working between services and professionals. If, however, commissioning is seen principally as the prerogative of GPs, there is a risk of it widening the divisions that already exist. Research shows that practice-based commissioning had exactly this effect in areas where specialists and other professionals were not adequately involved (Curry et al 2008).

16. Consortia should be encouraged to work closely with existing clinical networks created as forums for multi-disciplinary work. These broker care across providers for patients with particular conditions, for example in cancer, cardiac and stroke care (Curry & Ham 2010). Evaluations have demonstrated that such networks can succeed in supporting professionals to build collaborative relationships across organisational and professional boundaries (Guthrie et al 2010). The NHSCB could set out expectations for how consortia should work with multi-disciplinary networks in core clinical areas.

17. Over time, some consortia may choose to go further than this and develop into multi-professional organisations which span the divide between commissioning and provision, on a similar model to multi-specialty medical groups in the US. Some of these groups have successfully taken on a budget for a defined population, on behalf of the insurance companies with whom the patients are enrolled. The groups consist of a network of specialists and primary care doctors who are either directly employed by the group, or contracted to work with them. The experience of these groups suggests that multi-disciplinary commissioning could only succeed in the UK if payment mechanisms were re-designed to support such collaboration (Thorlby et al 2011, Ham and Smith 2010).

18. If consortia are to have sufficient focus on the health of their local population as opposed to individual clinical encounters, it is essential that public health specialists are involved in their commissioning activities. We are concerned that Health and Wellbeing Boards will have limited powers over GP consortia, and that there may not be sufficiently close relationships between consortia and public health specialists based in local authorities. The lack of co-terminosity between local authority and consortia boundaries will introduce a further barrier here, making it harder for consortia to get access to the high-quality public health data they will need to commission effectively.

INTEGRATION WITH SOCIAL CARE

19. The Bill places duties on the NHSCB and Health and Wellbeing Boards to promote integration between health and social care and includes provisions to enable the NHSCB or consortia to establish pooled funds. These provisions are welcome and should encourage joint working across health and social care. We would encourage the definitions of “health-related services” and “social care services” in clause 179 to be widened to capture the full range of health and wellbeing services. There should also be an equivalent duty on GP consortia to promote integration.

20. However, integration across health and social care will be compromised if the policy drivers of choice and competition produce an increasingly fragmented array of competing public and private providers (see also our response to the Greater Choice and Control consultation). There is a duty on Monitor to promote competition “where appropriate”; the definition of “where appropriate” will be critical to ensuring that promoting competition does not impede efforts to advance integration. Monitor should also be given a specific duty to promote collaborative working across health and social care.

21. The NHS, social care and public health outcomes frameworks need to go further to support integration between the sectors. Further work is needed to ensure that the outcomes frameworks align. In the longer term, the creation of a single outcomes framework across the three sectors would more effectively support integrated working.

22. Under the current arrangements, PCTs and local authorities have developed numerous ways of working in partnership, resulting in better co-ordination of services. Ensuring good practice is carried forward through the transition will be critical, but it is unclear how realistic it will be to achieve this given the speed and scale of the reforms. The loss of the co-terminosity between local authorities and commissioners may create practical barriers to joint working (see our response to the Information Revolution consultation) and we fear that progress made to date in improving integration could be reversed.

23. It is difficult to interpret what impact the changes to the legislation on Care Trusts (clause 184) will have on integrated working. However, we caution against any provisions which might lead to dissolution of arrangements in those places where Care Trusts have worked well, such as Torbay—the benefits of which are described in a forthcoming report by The King’s Fund.
Conflicts of Interest

24. The Bill requires that consortia include in their constitution details on managing the conflicts of interest which will inevitably arise from GPs’ dual position as commissioners and providers of services. What should be included in this is not specified in the Bill, although the Government’s response to the Committee’s previous inquiry suggests that there is likely to be secondary legislation and/or guidance on consortia’s internal governance arrangements in due course (paragraph 68).

25. It would not be in patients’ interests for regulations/guidance on conflicts of interest to be unduly restrictive. A major benefit of GP involvement in commissioning is the potential for GPs to design and commission innovative forms of expanded primary care provision and new models of care in the community. An appropriate balance needs to be struck which does not risk stifling this potential for creativity under the burden of highly bureaucratic processes or complex procurement and tendering rules.

26. What is imperative is that the arrangements that are developed maximise transparency. Transparent reporting of the commissioning decisions taken, and how these are reached, will provide the strongest safeguard ensuring public money is used appropriately. There are several practical ways this could be implemented (see Ham et al 2011):

- Requiring consortia to have public representation in their boards or other management structures.
- A requirement to publish commissioning decisions above a defined value.
- Establishing processes through which aggrieved parties can ask for commissioning decisions to be reviewed.
- A requirement for GPs to declare financial interests in provider organisations.
- Development by the NHSCB of a list of enhanced services that consortia are able to commission from practices without using tendering processes.

27. In the context of this need for transparency, the limited requirements being placed on consortia are a cause for concern. The Bill requires that consortia publish their constitution, commissioning plans and remuneration arrangements, and that they hold an annual general meeting open to members of the public. These requirements are helpful but do not go far enough—particularly with respect to patient/public involvement (see below).

Patient/Public Involvement in Commissioning

28. Arrangements for patient/public involvement in commissioning are already weak under the existing system, and there is a significant risk that the reforms will weaken them further. By placing no specific obligations on consortia, the Bill fails to give patients and members of the public meaningful powers within the commissioning system. Consortia are to have a duty to involve patients in decision-making, but involvement here can mean as little as “being consulted or provided with information”. The power of local HealthWatch groups over consortia will be limited to a scrutiny function, and Local Authorities’ ability to refer reconfiguration decisions to the Secretary of State is to be restricted to designated services.

29. The Bill does permit the NHSCB to publish further guidance on patient involvement, to which consortia will be obliged to have regard. The NHSCB should be encouraged to do so, and as stressed above, the most important principle in such guidance should be that of transparency. Patients and members of the public must be able to see how and why decisions relating to the commissioning of services in their area are reached.

30. Without meaningful accountability to local people, we can anticipate many legal challenges being made to commissioning decisions. This can be pre-empted, and the associated expenses reduced, through effective patient/public involvement from the outset.

31. Patient/public involvement should build on examples of good practice developed by practice-based commissioning consortia. For example, the constitution of “Principia Partners in Health” in Nottinghamshire guarantees that half of the members of the company’s Board of Directors are members of the public, and “lay” members have voting rights at the annual meeting (Parsons et al 2010). The community membership models developed by Foundation Trusts may provide further examples of good practice (Ham & Hunt 2008). Involving local condition-specific groups and community organisations in the commissioning process may also provide an effective mechanism for giving patients and members of the public a stronger voice (NHS Alliance 2010).

Service Reconfiguration

32. We remain concerned that it will be difficult for commissioners to drive major reconfiguration within secondary care in the absence of PCTs and SHAs or equivalent local system leadership. The Bill enables consortia to collaborate in order to address issues too large for any one consortium to tackle alone. However, there is a danger that allowing such collaboration to happen organically will mean that the pressing need to reconfigure hospital provision in some areas will not be addressed quickly enough, if at all.

33. A related concern is that consortia will pursue commissioning strategies which make financial sense from their own perspective but could represent very poor value for money for the local health economy as a whole. This could risk de-railing crucial efforts to improve productivity in the NHS.
34. The Government’s response to the Committee’s previous inquiry indicates that there may be a role for the NHSCB in supporting consortia in service reconfiguration (paragraph 93). It is possible that regional tiers of the NHSCB will provide the local system leadership that currently appears to be lacking in the proposals. In the more immediate future, it seems likely that reconfiguration will be driven principally by secondary care providers themselves, seeking to make efficiencies in response to the intense financial pressure they are under.

35. The designation process, by which Monitor will ensure the continuity of certain “essential” services, may complicate attempts to reconfigure hospital services. The financial and practical interdependency of different service clusters means that designation can be expected to have knock-on effects on other services, whose removal would make the designated services unsustainable. Designation is expected to be led by consortia, which will apply to Monitor for local services to be granted designated status. This process could have a major impact on the range of services available in local areas, again underlining the importance of giving patients and members of the public a strong voice within consortia. Both consortia and Monitor will need to strike a careful balance between maintaining access to essential services and avoiding creating a system with undue barriers to beneficial change.

TENSIONS BETWEEN PATIENT CHOICE AND COMMISSIONING

36. Giving patients choice of “any willing provider” has the potential to weaken commissioners’ hands in negotiations with service providers. A commissioner’s power is based to some extent on their ability to negotiate and select a provider with certain providers to deliver services under defined terms. Under the any willing provider model, a provider’s income is determined by the sum of individual patients’ choices rather than by agreements with commissioners (which could not specify contract volume or expected income). There is some risk that this could weaken commissioners’ ability to influence provider behaviour or specify innovative service models. Patient choice could also compromise the commissioner’s ability to control their budget. There is therefore a need to strike a balance between commissioning and patient choice as two alternative means of driving service improvement.

37. We recognise the benefit of offering greater choice to patients in elective care and would like to see greater choices being offered to patients with long term conditions, as well as in mental health, maternity and end of life care services. We would recommend that the extension of choice in these areas is managed carefully by the NHSCB and Monitor, and have suggested ways that this could be achieved in our response to the Greater choice and control consultation. However, we also stress that complex services such as those for trauma or cancer need a co-ordinated approach across providers. Quality has been demonstrably improved by focusing care within centres of excellence and creating networks of providers—an approach which necessarily reduces the extent of choice for patients. A market that encouraged multiple new entrants to offer such services would not be good for patients, or financially beneficial for commissioners. GP consortia should be supported to develop integrated care networks with acute and community providers. Patients could then be offered choice between integrated delivery systems—although this scenario may take some years to develop (Curry & Ham 2010).

38. The devolution of commissioning budgets to GP consortia, combined with free choice of GP, will mean that for the first time in the NHS patients will have de facto choice of commissioner. If consortia make significantly different decisions about their clinical and financial priorities, patients may decide to register with a different practice in order to access a different range of treatment options. It is uncertain whether this will impact positively or negatively on equity of access, or on health inequalities—there is a risk that those who are more able to navigate the system may be able to get greater access to their preferred treatment options. Choice of commissioner could also have other implications such as the potential for adverse selection or “cream skimming”.

39. An additional dimension to this debate relates to GP consortia assuming the drug rationing responsibilities previously held by NICE. There is a risk of the patient-doctor relationship being compromised by this arrangement if a patient suspects their GP is making prescribing decisions based on financial rather than clinical considerations. There is a strong argument for retaining a central mechanism for evaluating the cost-effectiveness of interventions and issuing guidance on this, on the grounds that devolving all rationing decisions to the local level would be inefficient, impose significant burdens on consortia, and could exacerbate the “postcode lottery” in availability of treatments.

REFERENCES


1. Summary

1.1 The Bill must make a clear distinction about different types of accountability within the Health Service: accountability to patients as individuals is one thing, accountability to the public as the “moral owners” of the service is another. The ways in which people should be involved in decision-making are different in each case.

1.2 Patient and public engagement should begin where the people are: in GP practices and information gathered there should be aggregated up to higher levels as required.

1.3 Patient and public engagement has value and credibility only if it can be clearly shown that it has a direct impact on the provision of services. It must not become a tickbox exercise and an end in itself. In their role as commissioners GPs now have a new duty to involve the public as well as patients and this means talking to the well, the young and those who are not well known to the practice or frequent users of its services.

1.4 Patient participation groups in practice can be very useful but require an ongoing investment of time and energy if they are to be sustainable. There are many other ways to find out what people are thinking.

1.5 Consortia board membership needs to include representatives of both patients and the public. It is important that they represent a significant proportion of the membership and that the culture of the board ensures that they do not play a tokenistic role.

1.6 Local HealthWatch must have a central role in commissioning but should not be seen synonymous with effective patient and public involvement which can only be achieved through practices and consortia working directly with their own patients and users of their services. We strongly oppose HealthWatch taking on direct responsibility for complaint handling or complaint advocacy.

1.7 In order to address health inequalities it is vital that commissioners at all levels find ways of involving people who are on the margins and whose voices are not easily heard. This challenge will be met only by close partnership working in localities.

1.8 We fully support calls for an independent health scrutiny function separate from whatever scrutiny powers are taken on by the HWBB. This LA function should involve not just elected councillors, but independent lay people appointed as “assessors” to the scrutiny committee.

1.9 Joint working between health services and councils will only work if there is an acknowledgement of the culture differences between them and a determination to change the culture of both.

2. Background to The Moore Adamson Craig Partnership LLP (MAC)

We are an independent consultancy which specialised in user and public participation in a range of areas where decisions are made that have a direct impact on peoples’ lives. At present we have a particular focus on health and education.

We train lay and user participants and we support service providers in increasing and improving public involvement in the design and delivery of public services. In recent years we have worked with Primary Care Trusts, GP practices, GP consortia, Foundation Trust governors and a wide range of patient groups including Local Involvement Networks (LINks) to promote effective user and public engagement in health service delivery.
As individuals, all our partners are active participants as well as consultants, investing their time in membership of participatory bodies such as a GP patients’ liaison group, a community health services Provider Board and a residents’ right to manage company, and as a lay member on the PEC of a PCT.21

3. Accountability in the Health and Social Care Bill

With our focus on user engagement in health services, we welcome the stated aim of the Bill to increase and improve public and patient involvement in the design and delivery of services. However, we remain unconvinced that the Bill as currently framed will in fact bring this about. We support the principle of “no decision about me without me” but would like to see it extended into “no commissioning for me without me”.

The NHS Constitution says that the NHS belongs to the public but fails to elaborate on what this ownership means in practice. The fundamental confusion about what accountability means in relation to the health service is reflected in the Bill and as a result GP consortia stand to be pulled in numerous different directions by the National Commissioning Board, the local health and wellbeing board, possible overview and scrutiny and (lest we forget) the patients and the public.

The Bill fails to make a clearer distinction between the accountability of a clinician to a patient and the accountability of the NHS to the public. Although inter-related, they are not the same thing and people will respond differently depending which role they are fulfilling.

In our work with practices we increasingly find it useful to encourage service providers to think of patients and their families as customers and to develop their services with the needs of these customers in mind. This takes the relationship away from one of dependency to one of service and quality in which patients have choice and influence: one where what matters to the patient matters to the doctor whether it is the colour of the wallpaper in the waiting room or the quality of end of life care.

The relationship between GP commissioners and the public they service is entirely different. This is a relationship in which the public should be seen as the “moral owners”22 of the service as a whole and where the governance relationship is about commissioners making decisions about how money is spent in partnership with, and on behalf of, the public.

4. Start at the Bottom: in GP Practices

The emphasis on responding to the views and needs of patients means that we have to start where the patients are. GP practices provide one of the most useful proxies for the local patient population and it is our view that both patient and public involvement in the health service needs to start in practices.

Bearing in mind the caveat mentioned above about the interests of patients and the public often being different, new commissioning arrangements mean that practices will need to start seeing the people on their lists as both patients and members of the public. It will therefore not be enough to engage only with the sick, those with long term conditions and those who regularly attend the practice. Practices will also need to find ways to engage with the well populations on their list, the young and those who seldom visit their GP, and to talk to them in their role as moral owners of the service as well as recipients care.

Information gathered in practices should be aggregated up to consortium level and to higher levels such as the local authority or nationally as required by the different needs of commissioning.

5. Involving Patients and the Public in Decision-Making at all levels

The key to all successful involvement in decision-making is for the focus to be on the ends rather than the means. There is a tendency in the NHS to focus on processes and new initiatives without measuring their impact. This has been particularly noticeable in the area of patient and public involvement/engagement in recent years. Unless public and patient involvement can be shown clearly to have influenced outcomes then it should be deemed to have failed. It is vital to demonstrate clearly to people that their input has been taken into account. Conversely, repeatedly failing to act on the intelligence which patients and the public provide has the effect of making people cynical.

“Involvement” activity becomes a “tickbox” exercise and an end in itself resulting in initially highly committed people becoming disinclined to engage and more likely to be publicly critical. As these people often have complex and influential networks within local communities this can be very damaging both to reputation and morale for providers and commissioners.

6. Looking Beyond Patient Participation Groups

Debate about how best to involve patients (and the public) in GP practices often focuses on patient participation groups (PPGs). Our experience has shown us that such groups can work well but they are few and far between and those which succeed depend very heavily on the support of key individuals within the

21 For further information about MAC partners and to read our blog, visit www.publicinvolvement.org.uk
22 We borrow this term from Carver Policy Governance® model which aims to promote owner accountable, ethical and effective governance.
practice, usually a practice manager or one committed GP. On the whole however practices find these groups hard to sustain and demanding of time and energy.

Many GPs are resistant to setting up such groups because they believe that they are unrepresentative of patients and a whole and that they focus on the “wrong” issues. Whilst we would not necessarily agree with this analysis we recognise that such perceptions take time and effort to overcome.

We are in favour of such groups where they can be made to work well: group members are often highly committed and have much to offer representing not only their own interests but those of others very effectively. With the right support and investment in their capacity to deliver, PPGs are capable of informed debate and of making important contributions on a wide range of issues from the day-to-day delivery of care to high level commissioning decisions.

However, without considerable ongoing support and the dedication of significant resources such groups can become and both expensive and unproductive. We are well aware of the frustrations often felt by patients and members of the public who are members of groups that do not function well and where their input is not valued and used.

It is vital that the processes which are established ensure “penalty free” participation and that people are able to see how they are making a difference. The question of reward and recognition for lay people needs serious consideration. Although some people prefer to contribute their time on a voluntary basis, others are unable to take part unless their basic expenses are covered. At some higher levels payment should be considered both because it demonstrates that the individual’s input is valued as highly as that of the other paid people in the room and because it increases the likelihood of attracting high calibre individuals and those not in the sort of paid employment that allows them paid time off work for such activities. Another important benefit in kind which should be afforded to lay people is high quality training and opportunities for personal development including appraisal and feedback. Lay people contributing to practice groups and other time-consuming activities such as focus groups should be treated as valued members of the team whether they are paid or acting in a voluntary capacity.

Although patient groups will have their place in some practices, the onus should be on practices both as providers and commissioners to develop other and different approaches to seeking patient input such as texting, virtual groups, social networking and other simple methods for staff to gather feedback directly from patients.

7. Governance Arrangement in Consortia

The governance models adopted by commissioning consortia should start from the basis that patients and the public are the moral owners of the services. We therefore support the views put forward by other respondents that the boards of consortia need to be constituted in such a way as to ensure that the interests of the wider population are foremost. We are concerned that, as with current NHS governance arrangements, there is a risk that board decision-making will be dominated by clinicians and managers keen to ensure that their particular specialisms and interests are represented. If this happens the public interest will inevitably take second place.

We are strongly of the view that the boards of consortia must not have tokenistic representation of patients and the public. There is little value in having one “lay” person at table full of professionals and it is an invidious position for any individual to be in. But even with a majority of lay and public members (such as on PCTs) it can be seen that clinical and executive status and expertise trumps lay and public status in very many cases. This will only be changed if there is a significant shift in attitudes and behaviours of boards and as this will be new territory for many GP commissioners there are opportunities to make such changes from the outset.

In our “bottom up” model described above, we would see public and patients in practices represented on the board. There has been much emphasis on clinical and managerial leadership in GP commissioning and we would like to see this complemented by strong lay leadership which is valued and supported by commissioners and nationally. Lay leaders will need recognition, support, training and rewarding—just like their opposite numbers.

No matter how boards are constituted in terms of the individuals who sit on them, the important thing is that there is an constant onus on the whole commissioning process to make decisions based on proper health intelligence gathered from a range of sources of which public and patient views and experiences form an important part.

While many methods can (and should) be used to gather this information it is what is done with the data that matters most. Patient experience data and patient and public views should be gathered systematically both by providers and by commissioners.

8. Integration Between HealthWatch and other Patient/Lay Involvement

Local HealthWatch is important but it is essential that it is not by default seen as a synonym for effective patient and public involvement. There must be much more than simply a viable Local Health Watch. More work needs to be done as to how the new HealthWatch bodies will be integrated into GP commissioning structures. At a local level, we would like to see a stronger and more diverse membership of HealthWatch
properly engaged in commissioning decisions as of right. However we think that this needs to be complemented by GP practices and consortia having direct “listening” relationships with their own patients.

We have argued strongly against Local HealthWatch (LHW) taking on a direct responsibility for complaints handling or complaints advocacy, as such functions would skew LHW’s main purpose.

HealthWatch England as a subset of the Care Quality Commission needs to have a strong and clear remit—complementary to that of the National Commissioning Board—to ensure that effective patient and public involvement happens in each consortium and HWWB in England.

9. Involvement to Address Health Inequalities

HealthWatch, GP practices, local commissioning consortia and local authorities should all be finding new and better ways of gathering the views of those whose voices are seldom heard. Many of these will be the people most affected by health inequalities. There should be a requirement to demonstrate that this is happening and that these people are having a direct impact on service planning and delivery. This work presents real challenges but this is an area where close working with other agencies (social services, education and 3rd sector bodies etc) will pay real dividends.

10. Local Government Scrutiny of Health Service

We fully support calls for an independent health scrutiny function separate from whatever scrutiny powers are taken on by the HWBB. This LA function should involve not just elected councillors, but independent lay people appointed as “assessors” to the scrutiny committee. These assessors should be publicly recruited to a uniform job description rewarded on a national basis consistent with local authority best practice. They should be accountable to their appointing Council for discharging their function fairly and impartially.

11. GPs Commissioners and Local Authorities Working Together

There are significant cultural differences between Councils and health services and although there are examples where LAs and PCTs have worked well together they are still the exception because of differing cultures. Joint strategic planning will have no impact unless the culture can be changed. Where GPs are concerned, for many, their Council is foreign territory even though they depend on its social care and other social services functions every day. It is therefore going to be very important for Councillors to get out and visit the new commissioners.

The JSNA process will act as a unifying experience and the positioning of public health with LAs will assist the process, since nothing can be achieved without public health intelligence. This is the key ingredient to put with user-led intelligence to achieve intelligent commissioning.

February 2011

Written evidence from the Royal College of Nursing (CFI 24)

1.0 Introduction

With a membership of more than 410,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The RCN responded to the Health Select Committee’s initial call for evidence for its inquiry into Commissioning in October 2010. Following the publication of the Health and Social Bill, we welcome this opportunity to submit further evidence to the Committee.

2.0 Executive Summary

— The RCN welcomes the underlying principles of the Bill to place patients at the centre of care; to reduce inefficiency in the NHS; to involve clinicians in the commissioning of services; and to improve standards across all aspects of the health service. However, the RCN has repeatedly expressed major reservations that the policies set out in the Bill will actually deliver on these underlying principles.

— The RCN is deeply concerned that the Bill does not make sufficient provisions for the role of nursing leadership within the new commissioning framework. This will be to the detriment of care and quality across the service. As the lead in the patient journey, nursing staff understand the holistic needs of patients, their carers and families.
The RCN does not believe that the Bill has sufficient detail around assurance and governance, particularly in light of the proposals to significantly increase private sector involvement in delivering services on behalf of the taxpayer. There is potential for significant variation in quality, scope and access across localities if commercial sensitivities and weak national governance prevent the appropriate sharing of service and patient level data.

In its submission to the Committee’s initial inquiry into commissioning, the RCN highlighted the need to pilot the proposed changes. Although Commissioning Consortia pathfinders have now been established, there is concern that these will not undergo any formal evaluation. The RCN would like assurances that these pathfinders will undergo stringent evaluation to ensure best practice is shared across the country.

The RCN does not believe that the Bill delivers a consistent message around patient and public engagement. There is no requirement for the NHS Commissioning Board, Commissioning Consortia or HealthWatch England to have a public representative on their boards. In addition, the RCN is concerned that there is no provision in the Bill for Commissioning Consortia to make public annual financial reports or to hold open board meetings.

3.0 ASSURANCE REGIME

3.1 Will the assurance regime ensure that the NHS Commissioning Board has sufficient authority to deliver its objectives defined in its Commissioning Outcomes Framework?

3.1.1 The RCN supports an outcomes framework that is sufficiently flexible to allow for local responses. However, it must provide a robust national framework to allow for comparisons and bench-marking. It must also ensure populations across England are not disadvantaged through poor commissioning, poor delivery or inappropriate allocation of resources. Without this, areas that could potentially be disadvantaged include offender health, sexual health and public health services, as well as those groups who are hard to reach. Whilst the RCN supports a system allowing for some locally sensitive outcome measures, we have also stressed the need for consistency across England to prevent inequity of access or service quality developing for certain population groups or health needs.

3.1.2 It is important to note the vital and unique contribution that nursing plays to the delivery of health outcomes. There is a wealth of evidence on the role nurses, midwives and health visitors play in improving outcomes by safeguarding patient safety, for instance, through infection control and preventing errors.

3.1.3 Nursing input is key to the development of a clinically meaningful outcomes framework, which incorporates insight and understanding of the patient experience and the delivery of high quality, safe care. It is important to recognise that outcomes are influenced by issues such as staffing and skill mix; internal processes such as team work; safety systems and supervision; and particular patterns of behaviour. It is therefore disappointing that there is so little detail on the role of nursing within the Government’s wider vision for a future NHS.

3.1.4 The RCN sees a crucial role for regulators in the NHS as part of the system of checks and balances. The proposed changes that will give greater freedoms, and potentially more involvement from a plurality of providers, necessitate a very clear set of standards and credible checks and balances in the system. Regulators need to respond to a more diverse range of providers and plan for the longer term. If the number and type of providers increases, it is important to ensure that they operate in ways that deliver high quality, safe care. The Care Quality Commission (CQC) (and others) has a role to play in setting standards and monitoring providers. In particular, the CQC has a number of enforcement powers and can therefore bring to bear strong incentives for providers to ensure that they deliver high quality, safe care. It is essential that the CQC has effective powers and the resources required as a robust and effective regulator.

4.0 PROPOSED ARRANGEMENTS FOR LINES OF ACCOUNTABILITY

4.1 Will the arrangements proposed in the Bill for defining the lines of accountability prevent future conflicts arising?

4.1.1 It is imperative that there remains a clear line of political accountability between the general public and national politicians for NHS-funded services and outcomes. The NHS consumes significant public resources and will inevitably always be a political issue both at national and local level (for example, by local MPs campaigning to keep open their local hospital). Politicians should scrutinise the NHS and decisions made by the Secretary of State for Health on behalf of the public and patients. The RCN does not see removal of the political involvement as credible, realistic or desirable. There must be clear and transparent accountability for public funds and outcomes.

4.1.2 The RCN has a particular concern regarding accountability in terms of health inequalities. Clause 3 of the Bill states that the Secretary of State “must have regard to the need to reduce inequalities”, but leaves this open-ended as to how the Secretary of State has to demonstrate this and how his progress will be held into account. The RCN believes that the NHS is currently well placed to take a strategic overview of health inequalities and identify need across a wide area. The RCN has concerns that the proposals as they stand will not allow for this strategic oversight.
5.0 **Integrating the Full Range of Clinical Expertise**

5.1 Will the arrangements in the Bill ensure that the full range of clinical expertise is integrated into the commissioning process?

5.1.1 The RCN was disappointed to see that the Bill does not include any provisions for the important role of nurse leadership within the new commissioning framework. The RCN believes that this will be to the detriment of care and quality across the health service.

5.1.2 The Bill states that the NHS Commissioning Board and the Commissioning Consortia only have to “make arrangements with a view to securing that it obtains advice appropriate... from persons with professional expertise relating to physical and mental health of individuals”. By leaving this option open for commissioning bodies, it does not go far enough in prescribing for the needs of patients as a whole. No single profession can have sole responsibility for commissioning services and if the appropriate range and mix of health and social care professionals are not involved in the commissioning process, the proposed new models will fail.

5.1.3 The RCN will be seeking amendments to the Bill, which will include designated nursing posts on the NHS Commissioning Board and the Commissioning Consortia. It is also important for there to be nursing input at the Department of Health. The RCN therefore calls for the Chief Nursing Officer to hold a prominent position in regard to national commissioning and oversight of this process.

5.1.4 The RCN believes that these amendments are vital, as nurses that sit on Primary Care Trusts (PCTs), Strategic Health Authorities (SHAs) and provider organisation boards, provide an invaluable insight into the practical issues of service delivery. They have a pivotal role in being able to stand back and view the whole care pathway, take a holistic perspective to look above the day to day clinical issues and effectively support the development of new and improvement of services. Bodies such as the National Patient Safety Agency and the NHS Institute for Innovation and Improvement, which helped to foster the sharing of information and best practice, have been abolished. The RCN is concerned how the sharing of information and best practice across an increasingly competitive health and social care market will be supported.

5.2 Internationally, commissioning consortia are able to work effectively, as has been shown in the USA. \(^{23}\) It is also important that the boards of Commissioning Consortia contain a range of healthcare professionals, including nurses, to ensure different professional perspectives are taken into account when examining conflicts of interest.

5.3 Where competition is introduced, it is inevitable that there will be conflicts of interest. The most important factors in mitigating these conflicts are open and transparent processes and timely resolution by external parties.

5.4 It will be important for there to be significant investment in the leadership skills of the new commissioning consortia, who will not have existing expertise in conflict resolution at a strategic level. This investment in skills beyond the usual clinical expertise will be necessary to ensure the new commissioning consortia are able to work effectively, as has been shown in the USA. \(^{23}\) It is also important that the boards of Commissioning Consortia contain a range of healthcare professionals, including nurses, to ensure different professional perspectives are taken into account when examining conflicts of interest.

5.5 The proposed reforms, if fully realised, will fragment the present service into many different and competing services. Bodies such as the National Patient Safety Agency and the NHS Institute for Innovation and Improvement, which helped to foster the sharing of information and good practice, have been abolished. The RCN is concerned how the sharing of information and best practice across an increasingly competitive health and social care market will be supported.

6.0 **Separation of the Commissioner and Provider Functions**

6.1 Will the new arrangements reconcile conflicts?

6.1.1 Where competition is introduced, it is inevitable that there will be conflicts of interest. The most important factors in mitigating these conflicts are open and transparent processes and timely resolution by external parties.

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6.1.4 The RCN was disappointed to see that the Bill does not include any provisions for the important role of nurse leadership within the new commissioning framework. The RCN believes that this will be to the detriment of care and quality across the health service.

6.1.5 The Bill states that the NHS Commissioning Board and the Commissioning Consortia only have to “make arrangements with a view to securing that it obtains advice appropriate... from persons with professional expertise relating to physical and mental health of individuals”. By leaving this option open for commissioning bodies, it does not go far enough in prescribing for the needs of patients as a whole. No single profession can have sole responsibility for commissioning services and if the appropriate range and mix of health and social care professionals are not involved in the commissioning process, the proposed new models will fail.

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7.0 **Arrangements for the Commissioning of Primary Care Services**

7.1 How does the Bill make arrangements to address the potential conflicts of interest between Commissioning Consortia and local care providers?

7.1.1 The RCN sees a crucial role for NHS regulators as part of the system of checks and balances. The proposed changes that will give greater freedoms, and potentially more involvement from a plurality of providers, necessitate a very clear set of standards and credible checks and balances in the system. The Commissioning Consortia will need to be open and transparent in their decision making processes, and ensure that full and adequate consultation is undertaken with local communities, patient organisations and other local representative bodies when awarding, reviewing, or decommissioning services from local care providers.

8.0 **Integration of Health and Social Care Services**

8.1 How effective are the structures proposed in the Bill, which are designed to safeguard existing co-operative arrangements and promote the development of new ones?

8.1.1 The RCN fully supports the Government’s desire to better integrate health and social care services, but believes that there is a need to learn and take the best from current integrated programmes. The RCN also believes that cooperation is best achieved by good relationships between healthcare professionals.

\(^{23}\) Nuffield Trust report GP commissioning: insights from medical groups in the United States
The RCN believes that the development of better integration of health and social care would be significantly helped by nursing involvement at all parts of the commissioning process.

RCN members’ experience shows that NHS staff are currently frustrated by the implications of unmet social care needs. A recent survey of RCN members highlighted a number of examples where they had cared for a patient, who left the surroundings of a ward offering social interaction, well-fed and in good health to be cared for in the community. However, the patient was soon readmitted due to inadequate social care provision and having developed health problems subsequently. The result is the “revolving door”, where patients leave hospital time and time again only to be let down by the lack of social care at home.

Nursing involvement in the commissioning process is important in any reform of the social care system as they have to manage the many daily challenges of the current system. These include carrying out needs assessments, form-filling, and discharge planning, in addition to dealing with healthcare needs that result from unmet social care needs.

There has been a lack of integrated workforce planning across health and social care in the past. It is important the Government’s proposals will ensure sufficient resources and infrastructure to provide national and regional oversight, as well as a multi-professional approach to workforce planning. This is particularly important as changes in the type of demand with regards to care take place, for example, a greater emphasis on moving care into the community. The RCN believes that there should be greater use of scenario-based planning for health and social care workforce planning.

The lack of coterminosity in the new system between Commissioning Consortia and Local Authority boundaries may also hinder integration. The current pathfinder programmes, which cover 50% of the population, vary widely in size. They will not undergo parliamentary scrutiny and there will be no formal evaluation of the impact of not matching up to Local Authority boundaries. The RCN is concerned that the lack of coterminosity may lead to patients falling through potential cracks in services.

Do the new arrangements encourage Commissioning Consortia to cooperate in achieving the benefits to patients which may be available from major service reconfiguration?

The RCN is supportive of the reconfiguration of acute hospitals, where this will deliver better, more efficient services for patients. However, these decisions have proved difficult in the past for SHAs and PCTs, as well local MPs. Local hospital closures have become extremely political around local and national elections, which has consequently skewed local decision making on some occasions.

The Bill will not necessarily encourage Commissioning Consortia to look at undertaking these difficult decisions collaboratively. It is unclear how the new Commissioning Consortia will have the capacity to consider and consult on major configurations alongside their other new responsibilities. There will also be significant pressure from their individual populations. The RCN therefore believes that there should be regional boards, which can provide strategic oversight to better facilitate major reconfigurations, which will deliver benefits to patients.

However, it is important that national political accountability is not lost in the new system. There will be possible conflicts of interest between the Commissioning Consortia’s role of providing personal clinical care to patients and their new remit, which may require them to make difficult decisions. For example, to decommit services due to either financial or clinical reasons.

There remain significant concerns that these reforms will put clinicians in a difficult position if and when cuts are made to those services and that they will be perceived as the raters of patient care. Commissioning Consortia will need support in making such decisions as they will lack experience and take time to develop the necessary infrastructure and skills. Success will be strongly dependent on how effectively Commissioning Consortia control their finances and are prepared to make difficult decisions.

The RCN also has some concerns regarding the Commissioning Consortia’s ability to manage public expectations. The Bill rightly highlights the importance of patient choice, but it will raise people’s view that they have a right to demand. This will be particularly difficult for Commissioning Consortia, which cover a more informed community. It may put pressure on how the Commissioning Consortia can demonstrate enhanced patient choice whilst also delivering clinical and financial priorities.

10.1.5 Another area of concern regarding patient choice is that the public will be able to register with any GP they choose, whilst also being able to change as frequently as they want to. If a patient can change to a GP outside of their geographical area, the GP is no longer responsible for just their local community, but also those who may use the practice for convenience. For example, those working in London, but living outside and commuting in, may opt to have a GP near to their place of work, but may need care delivered nearer home. It is not clear how this will be joined up and could lead to fragmented services.

11.0 Arrangements for Patient and Public Engagement

11.1 Are the arrangements for local accountability proposed in the Bill sufficient?

11.1.1 The RCN does not believe that the Bill delivers a consistent message around patient and public engagement. For example, there is no requirement for the NHS Commissioning Board, Commissioning Consortia or HealthWatch England to have a public representative on their boards.

11.1.2 The RCN believes that a further example of where the Bill does not go far enough is Clause 170, which instructs Local Authorities of their duty to provide a channel for patients and individuals to lodge a complaint about a healthcare service. However, it clearly states that it is up to Local Authorities to “make such arrangements as it considers appropriate”. The RCN fears that this open ended clause will lead to an even further fragmented coverage of services, and in some areas will make it far more difficult for serious concerns to be aired. There should therefore be a degree of basic standardisation of the complaint procedure across Local Authorities to ensure that all patients have the same ability to lodge complaints.

11.1.3 A Local Authority’s duty to host a Health Overview and Scrutiny Committee is amended by Clause 176, which shifts the scrutiny responsibility directly to the Local Authority. The Local Authority will have the option to form an Overview and Scrutiny Committee but will no longer be required to do so by law. The RCN has concerns that in the current climate, with extreme pressures being placed upon Local Authorities through budgetary cutbacks, the opportunity not to run a service will be seized upon due to financial necessity. This may have a disproportionate effect on those hard to reach patient groups, who are unlikely to speak out if it is proposed that their service may be decommissioned. The RCN believes that Health Overview and Scrutiny Committees carry out an important role at a local level, bringing to light areas of concern affecting local communities’ healthcare services, and encouraging joined up working between health and social care services.

11.1.4 The RCN welcomes the intent by sections of the Bill such as Clause 19, subsection 13L, and Clause 21, subsection 14P, which state the need for the NHS Commissioning Board and Commissioning Consortia to ensure that service users are consulted on changes to the commissioning of services which affect them as well as in the planning of any commissioning arrangements. The RCN believes that it is important that this consultation and supplying of information is sufficiently robust to satisfy the needs of service users and provide the service which they require.

11.1.5 Under Clause 21, Subsection 14P, the NHS Commissioning Board “may” publish guidance for Commissioning Consortia on the discharge of their functions under public involvement and consultation. The Bill goes on to state that a Commissioning Consortia “must have regard” to any guidance published. However, the RCN believes that this is too weak and that there is no mandate for Commissioning Consortia to adhere to any guidance from the Board.

11.1.6 In addition, the RCN is concerned that there is no provision in the Bill for Commissioning Consortia to make public annual financial reports or to hold open board meetings. This raises concerns about transparency and accountability of these new bodies to their local populations.

12.0 Arrangements for Debt Eradication and Tackling Structural Deficits

12.1 What are the proposed arrangements for debt eradication and tackling structural deficits?

12.1.1 In December 2010, the NHS Operating Framework confirmed that Commissioning Consortia will not be responsible for resolving PCT legacy debt that arose prior to 2011–12, and this clarification is welcome. However despite these assurances the RCN remains concerned whether PCTs and SHAs will be able to eliminate their structural deficits over the next two years.

12.1.2 The Government needs to acknowledge that they must support Commissioning Consortia and existing commissioning organisations to form transparent and realistic plans for debt eradication and for tackling structural deficits within their local health economy. The target of 4% efficiency gains for four years running is unprecedented and the RCN’s Frontline First campaign has identified that many PCTs are already struggling to maintain financial balance, and resorting to short term cuts to jobs and services.

12.1.3 Overall the proposed arrangements for debt eradication and tackling structural deficits are not sufficient. It appears that an adequate risk management regime has not been thought through, which could result in serious consequences for patient services and healthcare staff.

February 2011
1. The Royal College of Surgeons is committed to enabling surgeons to achieve and maintain the highest standards of surgical practice and patient care.

2. The College is pleased to provide written evidence to the Health Select Committee's follow-up inquiry into commissioning and would be willing to provide oral evidence if required.

3. We have focused on those areas which are of most relevance to the College's role.

**Key Points**

- The College welcomes the essential focus on clinical involvement in commissioning; however, we have several unresolved concerns about the proposed arrangements for system reform.
- We would like to see a formal requirement to involve specialists in commissioning decisions both locally and nationally.
- Within specialties, many surgical services require commissioning and oversight on a regional or supra-regional basis and we remain unclear as to how this will be delivered.
- There is a need for effective collaboration across primary and secondary care in order to improve services and we are concerned that the requirements of competition law may hinder this process.
- We are concerned that patients do not have access to sufficient, high quality information to support treatment choices.
- Patient choice, coupled with the policy of any willing provider and price competition will lead to unused capacity and waste in the NHS.
- We have significant concerns about the future provision of training in an environment where any willing provider can deliver NHS funded care.
- The potential for inconsistent application of national standards is concerning.
- The College and surgical Specialty Associations are well placed to offer advice on national and local issues.

**Clinical Engagement**

4. The College welcomes the intention for greater clinical involvement in commissioning and we sincerely hope that the provisions made in the Health Bill will be sufficient to ensure this. We agree with the Committee that both national and local commissioning bodies will require specialist clinical input in order to achieve high quality, innovative and cost effective commissioning decisions.

5. The College welcomes the provision for the Commissioning Board to obtain advice and professional expertise in discharging its functions. While we appreciate that not every specialty can be represented at board level, we would expect to see representation from major secondary care specialties so as to give a balanced and knowledgeable perspective on commissioning decisions. The College, with the support of the surgical Specialty Associations, hopes to have the opportunity to provide advice and support to the Commissioning Board on the standards to which surgical services should be commissioned.

6. Similarly, we would expect a requirement for commissioning consortia to seek advice from specific secondary care groups within their governance arrangements, and also expect that they will consult relevant guidance from professional bodies on key aspects of their work.

7. We welcome the development of a commissioning outcomes framework (to be led by the Commissioning Board) in order to hold commissioning consortia to account. Having a specification for secondary care clinical engagement within the framework would provide a key safeguard for the standards of patient care.

**Education and Training**

8. It is vital that consideration of education and training needs runs alongside service commissioning decisions.

9. The intention to open the provision of NHS-funded care to any willing provider raises concerns about the delivery of education and training. Even where contractual arrangements are in place, experience shows it is extremely unlikely that non-NHS providers will prioritise the training of the future generation of doctors and other healthcare professionals.

**Separation of Commissioner and Provider Functions**

10. It seems clear that a separation of provider and commissioner functions will remain. The College would like to see closer alignment and formal collaboration between providers and commissioners in order to bring about improvements to patient care.

11. Current proposals suggest that the NHS Commissioning Board will purchase specialised services, which we assume to be those currently defined by the National Specialised Commissioning Group, and this we would
agree with. It has been suggested that commissioning consortia might join together to commission those services which require regional oversight. We have significant concerns about this arrangement.

12. In addition to services like trauma, general paediatric surgery and vascular services, there are a number of other services within specialties that require a broader geographical focus, which will require a critical mass of patients to enable effective delivery, both in terms of efficient use of resources and maintenance of clinical skills. Service networks will require professional support as they develop, and will require a continued coordinated approach across a number of consortia and providers as they come on stream. Our concern is that the competitive environment, particularly between foundation trusts, may create a problems leading to inefficiencies and possibly failure of the service.

13. The creation of "PCT clusters" appears to be a pragmatic method of dealing with the transition. The commissioning support functions of PCT clusters could usefully have a continuing role for commissioning those services that require a broader regional perspective. The concept appears attractive in terms of maintaining the skills of high quality commissioners, reducing back office costs and enabling oversight/engagement with regulators and professional bodies on a manageable scale.

14. The NHS Commissioning Board can intervene if a consortium does not (or cannot) carry out its statutory functions. We would question how disputes (either between providers and consortia or amongst consortia groups) in relation to clinical aspects of service commissioning/delivery will be resolved. There appears to be no mechanism (other than via local scrutiny committee, which we doubt would be competent or effective) to intervene. The College is in a position to provide advice and support to mitigate conflict at an early stage and would welcome interaction with the NHS Commissioning Board to discuss this area and develop a formal pathway.

15. Currently, proposals in the Health Bill permit competition based on price. We consider this to be inappropriate as there is no evidence to suggest that competition on price in health services provides better quality. If anything, the opposite appears to be true. In a financially challenged NHS we would strongly urge against competition based merely on price, in order to avoid a “race to the bottom”, where clinical quality is compromised and essential services become fragmented and unsustainable.

16. The College remains concerned that the drive to localise the NHS may result in different interpretations of standards and that this could be to the detriment of patients.

Commissioning of Primary Care Services

17. We would agree with the Committee that there is potential for conflict of interest where a commissioning consortium purchases services from general practice (particularly services which might be considered over and above the general range of services provided at primary care level). We have particular concern about the provision of surgical services at primary care level. While the College understands the need, in certain circumstances, to shift services from secondary to primary care where this might benefit the patient and be more cost efficient, we would wish to see adequate safeguards in place to ensure the requisite standards and outcome measures.

18. We feel it is important for those practicing surgery to demonstrate that they meet the requirement competencies of the speciality, are up to date, participate in audit and practice in an appropriate clinical governance environment.

Co-operative Arrangements

19. We are concerned that the legislative requirements of a competitive environment may significantly hinder collaboration between clinical services. Provider units must be willing to allow their clinicians time to work with commissioners on designing care pathways. The balance between the requirements of competition law and the need to share expertise to bring about improvements in care requires clarification.

20. The ability to deliver major service change may be hindered by the limited experience and parochial views of commissioning consortia. While the maintenance of local authority scrutiny arrangements is a welcome change to the government's original proposals, we remain concerned that the NHS will suffer from a lack of leadership and management with regard to major service change. We would like to see appropriate involvement of the professional bodies, the benefits of which are twofold—demonstrating impartiality and an adherence to standards, while providing professional leadership to doctors involved in service transformation. The College, working with the surgical Specialty Associations, is able to offer advice and support to commissioners and providers where major service reconfiguration is being considered.

21. It will be important to ensure that commissioning decisions are transparent, take into consideration the long-term effects and avoid reactive steps to rectify short-term financial concerns. The recent media coverage on so-called “procedures of limited clinical value” is a case in point. Once again, the professional bodies are well placed to provide advice, on a national level to ensure consistency and an evidence-based approach.
PATIENT CHOICE AND COMMISSIONING

22. While we agree that patients must be involved in decisions about their care, we feel it is disingenuous to suggest that the choice agenda will be cost neutral.

23. As patients are offered choices about their treatment, coupled with the policy of any willing provider and competition based on price, it is inevitable that there will be unused capacity within the NHS, leading to inefficiencies and waste. Evidence suggests that patients do not make choices based on best outcomes; often choices are made for more mundane reasons (e.g. car parking or next available appointment).

24. There is good evidence to suggest that choice in healthcare benefits those who are sufficiently informed and socially mobile and may therefore disadvantage the poor, the elderly and less mobile members of society.

25. The provision of high quality information is key to enabling choice. We have responded to the government’s consultation on the “information revolution” and welcome the principles enshrined within that document. A number of government agendas rely on high quality information in the NHS and it will be important for the government to capitalise on these to bring about economies of scale. Much work is required to ensure both commissioners and patients have access to information that is high quality, accessible and of sufficient depth to support true choice. The College is keen to work with government and with local providers and commissioners on this important topic.

26. While we welcome Monitor’s role in ensuring the provision of essential services (though the criteria for such services has yet to be defined), we would caution that extending patient choice threatens to undermine and destabilise those local services upon which some patients will rely.

27. We are pleased at the government’s intention to allow referral of patients to a named consultant-led team. We would also urge the government to reconsider its views on consultant-to-consultant referrals which, in the main, are made to ensure the most effective treatment pathway for patients.

28. We would urge commissioners to engage local surgeons to ensure referral management arrangements are suitable, and also that decisions are audited to ensure effectiveness.

29. As services are reconfigured and streamlined it is important that the risk of “postcode lottery” is guarded against.

30. Safeguards are required to ensure that general practitioners continue to treat and refer patients based on their individual clinical need and accepted best practice.

31. We welcome forthcoming guidance from the Commissioning Board on patient involvement in commissioning consortia decisions.

February 2011

Written evidence from Professor Margaret Whitehead (CFI 50)
(WH Duncan Professor of Public Health, University of Liverpool)

Public Health Implications of the Shift in Commissioning from PCT Geographical Populations to GP Consortia

1. The session is specifically concerned with how the NHS reforms will affect resource allocation, given that there is to be a shift from PCT weighted capitation allocations, based on geographic populations, to consortium allocations, based primarily on patients registered with GP practices. The concern from a public health perspective is that the shift from PCT commissioning to GP consortia commissioning raises potential problems that include, but are much wider than, the resource allocation issue. The switch to commissioning through GP Consortia will undermine one of the fundamental mechanisms by which the NHS strives to ensure good geographic access to a full range of services wherever people live. Currently PCTs have responsibility for all the people resident within defined geographic areas, not just the patients registered with specific health services. This allows for long-term needs assessment, planning and commissioning of services to match those needs, as well as accountability of public employees for the use of the resources allocated for that population, measured against outcomes that are also population-based. The proposals in the Bill abandon the population-based principle for the first time in the NHS’s history. With GP Consortia, the basis of commissioning is for registered patients only, within the patchwork boundaries of each consortium, which have no well-defined geographical footprint. The ability to assess needs of people living in each area and plan for the proper geographic distribution of services for communities and local populations will be lost if this essential requirement is not met (Whitehead et al., 2010).

2. The technical difficulties of monitoring GP Consortia for performance, governance and accountability for health and health service outcomes will be immense without a well defined geographic population denominator, but there has been little or no consideration of this, at least not in the public domain. The focus so far seems to have been largely on financial accountability mechanisms. Consideration now needs to the given to how GP consortia will gain the necessary public health input that they require in the commissioning process, as well as how this specialist expertise should be funded.

**Resource Allocation for GP Consortia Commissioning**

3. Since its inception, the NHS has been based on the principle of “equal access for equal need”. This principle is embodied in two longstanding objectives for resource allocation from the centre to local health services:

(i) To distribute resources based on the relative need of each area for health services. Currently, this objective is to enable PCTs to commission the same levels of health services for populations with similar needs;

(ii) In addition, to contribute to the reduction in avoidable health inequalities (DH, 2011).

The resource allocation formula devised to meet these objectives includes the age profile of the population (localities with more elderly populations have higher needs, all else being equal); additional need based on the relative need of each area for health services; and unavoidable geographical differences in the cost of providing services—the Market Forces Factor (MFF) (it costs more to provide the same level of services in high cost areas such as London and the South East). From 2008 onwards, a separate component has been included in the formula to meet the objective of contributing to avoidable health inequalities. The indicator used was disability-free life expectancy (DFLE), which is the number of years from birth a person is expected to live which are free from limiting long-term illness and disability. DFLE exhibits a strong socio-economic gradient, decreasing with increasing deprivation, making it a reasonable choice of indicator in relation to health inequalities.

Both these objectives need to be embodied in the new NHS system, but it is made extremely difficult by the loss of responsibility for a defined geographic population. It is unclear, for example, if and how a measure such as DFLE could be derived for GP Consortia, given their irregular, non-geographic footprints.

4. In this and any future resource allocation formula, it is essential to take deprivation into account not only because the prevalence of ill-health increases with increasing deprivation, but also because of the higher likelihood of patients having multiple, interacting health problems which makes their treatment more complex and costly. In addition, living in poorer socioeconomic circumstances may impede recovery and make it “harder to reach” them with the services they need. Some geographic population basis needs to be retained.

**Cream-skimming and Perverse Incentives**

5. The fact that more disadvantaged populations have a higher disease prevalence and more complex conditions means that caring for them may be more difficult and costly. There are significant implications stemming from this in the move towards a more market-driven NHS system, not least the issue of cream-skimming (the practice of selecting “easier to serve”/less costly/more profitable patients). There is a danger of cream-skimming in the new NHS structures which was not present with PCT commissioning. PCTs are responsible for a population allocated to them within a defined geographic boundary—there is no possibility of picking and choosing the people within that designated area. GP Consortia, however, will not have that constraint. They can pick and choose which practices are members of the consortium: those practices based in disadvantaged communities could be shunned, for instance, while those in more affluent areas could be encouraged to join. There may be practices that no consortium is keen to take on board, simply because of the socioeconomic profile of their patients.

6. There is also the possibility of increased cream-skimming by GP practices when practice boundaries are removed and patients are able to register with any GP practice, theoretically anywhere in the country. There will be no obligation on practices to accept patients from the local area in which the practice is based if other, “easier to serve”, patients from elsewhere come forward for registration. One consequence of such a process could be the creation of the converse: “sink practices” which contain the less profitable patients with the more complex conditions. There is evidence that cream-skimming of this nature went on under the GP Fund-holding initiative in the 1990s, and any perverse incentives to do so in the new NHS reforms need to be addressed, presumably by the NHS Commissioning Board.

7. A related challenge for the NHS Commissioning Board will be to do something about the distribution of GPs, which has become less equitable, year-on-year, since the early 1990s, made even worse since the abolition of entry controls in 2002 (Goddard et al, 2010). These controls regulated the setting up of new GP practices in over-served areas, with the aim of encouraging more provision in under-doctored, more deprived areas. Remediying this will require targeted area-level policies.
8. The accelerated drive to “cleanse” GP lists of “ghost” patients in preparation for the switch to GP Consortia Commissioning could result in another form of cream-skimming. Reports in the GP journal Pulse claim that up to 40% of patients could be stripped from practice lists under tough new measures to clean the databases of registered patients on which resource allocation to Consortia will be based (Pulse, 2 March 2011). In one pilot scheme in NHS Brent, every patient who has not visited their surgery within six months and who fails to respond to two written notices will be wiped from targeted practices’ lists. This exercise was designed to cut costs by stripping out patients who have died or moved, but it also risks removing whole swathes of the local population who have very real and on-going needs for health care but who have not used the primary care services in the previous few months. This could affect, in particular, elderly people, those who are disabled or mentally ill, ethnic minorities and people in high deprivation, high turn-over areas. Lists of some GP practices with a high proportion of patients from high deprivation, high turn-over areas could be particularly hard hit by this cleansing and could face closure as registered numbers fall. Much of this is currently speculation, but requires further investigation.

PUBLIC HEALTH ALLOCATIONS FORMULA TO LOCAL AUTHORITIES

9. The current resource allocation formula contains a component to address the second NHS resource allocation objective: “to contribute to the reduction of avoidable health inequalities”. There is debate about whether this element should be removed from the formula that will distribute resources to GP Consortia and instead be covered by the formula currently being developed for the transfer of the public health budget to local authorities and the proposed “Health Premium”. The first point to be made about this proposal is that even if the health inequalities objective were to be built into the local authority public health resource allocation formula, the move would still only partially address that second objective. There would still be a need for an element in GP Consortia Commissioning formula for reducing inequalities in access to GP commissioned services that may contribute to the observed inequalities in health status. In addition, the NHS Commissioning Board would need to ensure the continuation of public health activities carried out by GPs as part of the essential services they provide for all patients.

10. Under the Public Health White Paper, local authorities will have a new statutory duty to improve the health and well-being of their local population, and possibly for other duties, such as elements of health protection. A ring-fenced budget, weighted for health inequalities, will be allocated to upper tier and unitary authorities in local government for this purpose, based on target allocations determined by an allocations formula and drawn from the former NHS budget for such public health activities. The development of a formula for this purpose will have the advantage over the formulae for allocation of funds to GP Commissioning Consortia in that it will have a defined geographic population base: people residing within local authority boundaries. The consultation document puts forward three general approaches for establishing the public health formula: a “utilisation” approach based on current patterns of public health activity and indicators of need; a “cost-effectiveness” of public health spend approach, and one based on “population health measures” within the LA areas. The utilisation approach is inadequate because variations in spend on narrowly defined public health activities are likely to be poor indicators of relative need across local authorities, as well as there being a lack of comprehensive data on activity and costs at the required spatial level. Likewise, the cost-effectiveness approach suffers from a paucity of evidence on the cost-effectiveness of public health interventions, as well as being fraught with data and methodological issues. The third approach is the only sensible choice from a conceptual and practical perspective. Measures such as standardised mortality rates and ratios, life expectancy and disability-free life expectancy are all available at the LA level and are indicators that demonstrate a strong socioeconomic gradient. If incorporated into the formula, one or other of them could indicate increased need requiring additional resources for public health activities.

THE HEALTH PREMIUM AS A PERVERSE INCENTIVE

11. In addition to the above public health allocation, there is a proposal in the Public Health White Paper to introduce a new “health premium” to incentivise action to reduce health inequalities. This will only apply to that part of the local public health budget that is for health improvement. The proposal is for local authorities to receive an incentive payment, termed a “health premium”, depending on the progress they have made in improving the health of the local population in general and of improving the “health of the poorest fastest”. Possible public health outcomes indicators have been put forward for consultation on their potential to measure the required progress. Over and above problems of availability and robustness of the data at the required spatial level, there is a fundamental problem with the proposed indicators, related to the purpose to which they are put. While several of the proposed indicators might work as indicators of increased need in an area, if used as indicators of improved outcomes they could simply deliver the premium to areas where it is easier and faster to make progress, which may well be the more affluent areas around the country. There needs to be a re-consideration of the use of financial incentives for public health outcomes from both practical and ethical perspectives.

March 2011
At the evidence session on 8 March, Dame Barbara Hakin promised to send to the Committee maps of GP pathfinders and PCT clusters.

Attached is a map of the GP pathfinders. However, to get the full benefit of the map, which is interactive, it needs to be viewed online at: http://healthandcare.dh.gov.uk/gp-consortia-map. You can click on a marker to find out more about each consortium. The markers are colour coded by SHA region.

Regarding PCT clusters, SHAs are working with local partners on proposals for clusters in line with the guidance at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123933. Final cluster arrangements will not therefore be in place in all regions until 1 June in line with the OF requirement.

March 2011

I am writing to clarify my remarks when I gave evidence to the Committee on 22 March.

Valerie Vaz asked me at Q525 about the publication of the surveys of public attitudes towards the national health service and social care, and in particular one that was “out in autumn 2010”.

These surveys have been commissioned since 2000 and reports up to 2007 were on the Department’s website. Subsequent reports were not placed on the website by my predecessors. Reports from 2008-March 2010 are however in the public domain as we placed them in the Library of the House on 3 December in response to a Parliamentary question from Liz Kendall. I have arranged for these to be placed on the website as well.

We have subsequently commissioned a further survey which was conducted during November and December. The final report of that survey has not yet been completed and when it is I will consider publication in the normal way.

I hope this clarifies the position.

Rt Hon Andrew Lansley CBE

March 2011

I am writing further to my attendance at the Health Select Committee on 22 March, when I agreed to provide further information on the Government’s proposals, outlined in the Health and Social Care Bill, for developing Monitor’s role as an economic regulator for the healthcare sector.

I think it may be helpful to begin by reiterating the Government’s aim in developing Monitor’s role as an economic regulator for the healthcare sector, which is to improve outcomes for patients and make best use of NHS resources by ensuring that the regulated market operates effectively and by strengthening incentives.

It is important to stress that Monitor’s role and its functions are specifically designed to protect the interests of patients from the unrestrained operation of market forces in healthcare. This is because the Government recognises that the equilibrium mechanisms which operate in a normally-functioning market—such as the balancing of supply and demand through competitively-determined prices—would not safeguard patients’ interests in the absence of robust regulation. It is because the Government expressly rejects the assertion that an unregulated free market in healthcare will improve patient care that the Government’s policy is to establish a regulated market, overseen by an economic regulator. The Health and Social Care Bill makes clear that Monitor must only promote competition where appropriate, and that it should regulate where necessary.

Monitor’s overarching duty would be to protect and promote patients’ interests. Monitor would be expected to fulfil this duty in carrying out its regulatory functions, which would include:

- licensing providers of NHS services;
- regulating prices; and
- imposing additional regulation, where necessary, to secure continued access to services in the absence of alternative providers.

The map is not reproduced here as the benefits of the colour-coded markers would be lost in the monochromatic printing of this Report.
In addition, Monitor would continue to perform some of its existing functions in relation to Foundation Trusts, including its function in authorising Foundation Trusts, which would be particularly important during transition, and as the registrar of Foundation Trusts.

The Committee asked for clarification as to the estimated costs of these functions.

The Government’s estimate of Monitor’s future annual budget was set out in the impact assessment published alongside the Bill and quoted a figure of £72 million, by 2015–16.

This figure includes funding for Monitor’s residual functions in relation to Foundation Trusts, which cost £17 million in 2010–11.

The £72 million figure is derived from a range of benchmark estimates, which, in turn, were based on the costs of other economic regulators, their staff numbers and the average cost per whole-time equivalent member of staff.

The benchmarks included data from the Dutch Healthcare Regulator. This organisation undertakes a similar role as Monitor would, albeit in a different country. After undertaking this analysis, the upper limit for the annual costs was considered to be £130 million, as my Rt Hon friend the Minister of State for Health said to the Public Bill Committee on 15 March.

The Department of Health has continued to refine these estimates since the impact assessment was published. On 8 February, we provided a written answer to a parliamentary question from the Hon Member for Easington, which estimated a range of £50 million–£70 million, over the next 10 years.

Work on estimating Monitor’s future running costs will remain ongoing in 2011 and we would be able to provide further refinements of our estimates in due course. In the meantime, the impact assessment we have published alongside the Bill sets out how the costs of implementing the reforms would be far outweighed by the benefits to patients and taxpayers.

The Committee also requested further information about Monitor’s role in promoting competition in relation to commissioning of NHS services.

First and foremost, Monitor’s duty would be to protect and promote patients’ interests. Monitor’s role in promoting competition would be a means to that end, not an end in itself, as the Bill makes clear (Clause 52(1)).

Our vision is that commissioners would decide how best to improve services and increase choice for their patients, including how best to utilise competition as a means to that end. Procurement would be transparent and non-discriminatory and patients would choose their preferred provider, wherever possible, with money following patients’ choices.

The purpose of competition law is to protect consumer interests, which in its application to the health care sector means protecting patients’ interests. Monitor would have concurrent powers (with the Office of Fair Trading) to apply competition law, within the healthcare sector, to address restrictions on choice and competition that acted against patients’ interests. The Health and Social Care Bill does not extend competition law; it merely creates concurrent jurisdiction between OFT and Monitor. This would be consistent with Monitor’s overarching duties and the role of competition as a means to an end, not an end in itself.

Competition law would apply to the actions of “undertakings”, which would include the activities of NHS Foundation Trusts and other types of organisation providing services within a market. However, case law suggests commissioners of NHS services, including GP consortia, would not be considered “undertakings”, for the purposes of competition law, in relation to their purchasing activities. That is why we have proposed powers in the Bill to introduce regulations on commissioners of NHS services, which would provide appropriate protections for patients and taxpayers’ interests and an effective mechanism for enforcement. This mechanism would be important, for example, in ensuring compliance with the national tariff as a fixed price.

Our aim is to ensure that commissioning processes are transparent and non-discriminatory such that NHS services are commissioned from the best providers and patients are given choice wherever possible. Our proposed approach would involve setting out clear requirements on commissioners in the form of regulations, which would be legally binding and independently enforceable.

We have amended the Bill to clarify that the scope of these regulations would be limited to requirements as to due process, managing conflicts of interest and prohibiting anticompetitive conduct that acted against patients’ interests. We do not intend to introduce requirements on commissioners to promote competition for competition’s sake, or for Monitor to have power to impose compulsory competitive tendering requirements on commissioners, and the amendments we have made to the Bill make this clear (see Clause 63 and 64, as amended).

We have also made amendments to clarify our proposals for Monitor’s investigative and enforcement powers, which would underpin these regulations. In summary, Monitor would have power to investigate potential breaches of the regulations, either on its own initiative or in response to complaints. Monitor would be able to require commissioners to take action to prevent or remedy a breach of the regulations, including, potentially, by setting-aside a contract where due process had not been followed. However, Monitor would have no power to impose fines on commissioners, as was discussed by the Committee.
In this way, our proposed approach would build on the existing system of Principles and Rules for Cooperation and Competition, which would provide a starting point for the regulations, and the role of the Cooperation and Competition Panel in investigating potential breaches. However, we would bring forward detailed proposals on the scope of these regulations, for consultation, in due course.

In the meantime, I trust that this letter will address the points raised by the Committee and clarifies our proposal that Monitor’s role in promoting competition would be a means to an end, not an end itself. Monitor’s overarching duty would be to protect and promote patients’ interests, as the Bill makes clear.

Rt Hon Andrew Lansley CBE
March 2011