House of Commons

Health Committee

Report of the NHS Future Forum

Oral Evidence

16 June 2011

Professor Steve Field CBE, Sir Stephen Bubb, Julie Moore and Geoff Alltimes CBE

5 July 2011

Rt Hon Andrew Lansley CBE MP, Sir David Nicholson KCB CBE and Richard Douglas CB

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Oral evidence

Taken before the Health Select Committee

on Thursday 16 June 2011

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper	Chris Skidmore
Yvonne Fovargue	David Tredinnick
Andrew George	Valerie Vaz
Grahame M. Morris	Dr Sarah Wollaston
Mr. Virendra Sharma	

Examination of Witnesses

Witnesses: **Professor Steve Field CBE**, Chair, **Sir Stephen Bubb**, Lead, Choice and Competition, **Julie Moore**, Lead, Education and Training, and **Geoff Alltimes CBE**, Lead, Patient Involvement and Public Accountability, NHS Future Forum, gave evidence.

Q1 Chair: Good morning. Thank you very much for coming, and so quickly, after what has been a pretty eventful couple of months for all of you. On these occasions, I normally ask you to introduce yourselves and tell us where you come from. With the consent of the Committee, I suspect that is unnecessary this morning. We are probably aware of how you got to be here this morning.

Can I just say a few words by way of introduction? We intend to try to cover a very broad waterfront this morning. In doing so, we are interested, first, in asking one or two process questions. We will then, obviously, get into the meat of the policy substance. We recognise that you, as a group, are responsible for what you recommended to the Government, not the Government's policy itself, and we will ask you questions about your recommendations. We will certainly ask you questions about the Government's response to your recommendations thus far, but we will seek to draw a distinction between your recommendations and the Government's policy because the Government is responsible for that, not you.

Can I open the questioning, therefore, by introducing some questions on process? We would be interested to know what your understanding is of the future role of the people who have led the listening exercise. We would also be interested to hear about the process you went through following your appointment to produce the recommendations you published on Monday.

Professor Field: That is an open question.

Q2 Chair: Perhaps you could start with the question at large around that?

Professor Field: Thank you for inviting us and thank you for the time that you have all spent with us before. The discussion we had at the informal session was very helpful. Do you want me to take what the future role is first? I'm not sure, is the answer. We haven't had a formal sit-down to talk through what we might do. I had one short end-of-meeting discussion with David Nicholson about the fact that the feedback had been we had been doing a good job. The feeling was that the Future Forum had a place in that the active listening and the engagement with stakeholders had gone well. To be perfectly honest, as we said to you about coming here before, I have only been focused on delivering a paper. Frankly, I have not been interested in life after the Forum at all. I have been completely focused on trying to get a paper out on time in a very short timescale.

Q3 Chair: But it is true to say, is it not, that the Government has indicated it does see a continuing role?

Professor Field: The Secretary of State certainly stated that in the oral questions. He said that public health and the education and training would continue. In the very brief discussion I had with David, we talked about information management because I don't believe we can have a more integrated health system without shared records and without the public having much more access to information. I also think there was a potential weakness in our process in that most of the activity was about adult health care. Even though we tried very hard to engage from a children and adolescent area, the time we had to spend on that was prohibitive. I tried to cover that, going into how we set the Forum up, by making sure that we had people who understood child health care and social care on the Forum. If we had our chance in the future, it would be an area that we would look at together, adding to the Kennedy report of earlier last year.

The Forum was set up the week beginning 6 April. I was asked to chair the Forum and my colleagues here and Kathy—unfortunately, she has a commitment she could not get out of today otherwise she would have come—were asked, about half an hour after me, whether they would chair the workstream themes and be the leads. I came to London and worked with David Nicholson and others on the membership of the Forum over the next three or four days. Within a week we had a membership. We had a team of very good civil servants. We had the pick of who we wanted and needed. John Stewart was given the role of main civil service support. He is a very talented leader and I think he has done a fantastic job. Also, within that

week, we had been to Frimley Park and held our first meeting. That was how it was set up.

Q4 Andrew George: In view of the circumstances you now find yourselves in—and you are right with regard to the oral statement, that the Secretary of State saw a continuing role for the Forum—to what extent are you clear about the future latitude of the Forum, both as a collective body and also as individuals? For example, if you find that the Secretary of State is not remaining faithful to the gospel that you have produced for him, how much are you able to speak out either as individuals or as a Forum?
Sir Stephen Bubb: Very able.
Professor Field: I refer to what I said before, that we had one end-of-meeting discussion. It was at a briefing we were giving about progress to Una O'Brien and David Nicholson. Right at the end of that meeting, in the last minute, they were saying the feedback was very constructive and they would like to have a discussion about where we went. I can't comment on anything else because we have had no discussion. I have my personal views but I am really interested in the Government's response and how it is now implemented. With the amount of personal time I have invested in this, I will always be interested, but we honestly have not had a discussion. I don't know.

Q5 Andrew George: The question is about your freedom to comment on where the Government goes from here.
Professor Field: I was independent. I have had no political pressure before and I don't feel any political pressure now. Just as I felt it appropriate to do an interview with *The Guardian* to raise some of the issues in the middle of the process, I see myself free to speak out. Those of you who know me know I am not shy to speak out. The reason I did *The Guardian* interview right in the middle was that some people were saying this was a publicity stunt and not real. Frankly, I know it was real and I wanted to put a marker in the sand so that people understood—it might not have made people happy—that we are independent.

Q6 Valerie Vaz: You did not actually mention the name of the person who appointed you. Who was it you had the discussion with? Who tapped you on the shoulder and said, "Sir Steve, will you be"—
Professor Field: He's Sir Steve.
Valerie Vaz: I know.
Professor Field: I am plain "Steve" and a GP.

Q7 Valerie Vaz: Hopes for the future. Who actually tapped you on the shoulder and asked you to start off the Forum?
Professor Field: I was asked to be available for a telephone call from the Secretary of State. In the end, because I was in meetings and racing around, Simon Burns called me. His words were, "The Government has decided to have a pause. We are going to do this exercise. There are going to be four workstreams. We'd like you to lead it. Would you like to do it?"

Q8 Valerie Vaz: So it was very much Department of Health orientated.
Professor Field: Simon Burns, who is the Health Minister, asked me.

Q9 Valerie Vaz: I know that. The other thing is that, obviously, we are very disappointed you felt you could talk to *The Guardian* and not to the Health Select Committee. I know you said you had a very good conversation but it would have been nice, I would have felt, if you could have come to the Health Select Committee to talk to us about all this. I think the Department of Health refused on your behalf but, anyway, you talked to some of us.
Professor Field: I apologise for that. To be honest, as I said before, I was just completely focused on where we were going.

Q10 Valerie Vaz: Absolutely. I know you do a number of jobs. How did you set up your team? I am thinking of how you got the expertise. I am looking at the lovely pictures you have, and it is not exactly diverse. There are only 12 women, aren't there?
Professor Field: Which team?

Q11 Valerie Vaz: This whole team.
Professor Field: That team. Yes.

Q12 Valerie Vaz: You have seen the pictures in there, haven't you?
Professor Field: I have seen the pictures. Of course I have. I have read it as well.

Q13 Valerie Vaz: I am coming on to that. That may be funny, but there are some inconsistencies.
Professor Field: I know.

Q14 Valerie Vaz: I will ask you about that later.
Professor Field: There will be because there were four different reports.

Q15 Valerie Vaz: Of course. But you are in overall charge, aren't you?
Professor Field: Yes—or was.

Q16 Valerie Vaz: Good. So how did you set up your team?
Professor Field: I went into the Department of Health the day after, I think it was, I was asked to do this. Within 48 hours a list of people who had been put forward to be Forum members was given to me.

Q17 Valerie Vaz: By?
Professor Field: By the Department of Health; by David Nicholson's team. I met with John Stewart, who David had asked to be the civil service lead. I went through the list, and I didn't know all of them. I still have not asked about how the nominations came forward for it but, for example, a number of the doctors were nominated by Bruce Keogh, the Medical Director. I didn't know who they were but it covered a spread. Looking through their job titles, it looked as though the Forum members covered a large part of what I needed. However, I felt what was missing was mental health representation and there was no one

from the children's health area. I wanted someone who had good expertise and would also understand the college networks for education—Terence Stephenson from paediatrics, Peter Nightingale from intensive care medicine but also the academy. I looked at it and I thought it was not a very diverse group ethnically.

Q18 Valerie Vaz: Or in relation to women.
Professor Field: And women. Therefore, I suggested we look for someone who understood BEME—racial equality issues—and who would be able to speak forcibly in those areas, we looked at the nursing component and we came up with a list. If there was a weakness, it was that there was not a member from industry, from the private sector, on that Forum. We had a series of meetings with the private sector but we did not, in the end, get round to appointing someone. We had a problem with public health because the person suggested, Ruth Duffy, who was fantastic, had just been appointed to the Department of Health to lead on public health, and I didn't want any employees of the Department of Health. I took Frank Atherton, because I knew he would speak out for the Directors of Public Health and was independent, but we could not get hold of him. When we had announced the names and his name was not on the list, it caused a bit of a problem with public health. There wasn't a pharmacist on the original board. I wanted a pharmacist because I think the future of health care will involve pharmacy and others but, unfortunately, the person I asked for was on holiday. Eventually I found him—not personally—via the telephone, on a beach in Turkey. It took about two weeks.

Q19 Valerie Vaz: You couldn't find any pharmacist at all other than the one you wanted.
Professor Field: No. I didn't know Ash. I wanted someone who was not just a pharmacist but understood multi-professional working. We asked for someone outside the Department. Ash Soni had been a PEC chair of a PCT and therefore understood a broader remit than just being a pharmacist. It is not perfect.

Q20 Valerie Vaz: I understand. I have one other question on process. Had you read the Bill and were you working towards the clauses in the Bill, or was it all just going out and listening?
Professor Field: I have sat down and read the Bill in its entirety three or four times and I have had it read to me, like having a bedtime story read. As a GP—I don't know what Sarah thinks—it is very difficult when you come into this world and you read stuff which isn't the same narrative or speak that we are used to.

Q21 Valerie Vaz: What about your team? Have you all read the Bill and were you working towards the Bill as a set of criteria?
Sir Stephen Bubb: I wasn't.
Professor Field: No.
Julie Moore: No. I have read it, but I was given the brief of education and training which was not in the Bill. I felt obliged to read it in my day job, anyway.

Q22 Valerie Vaz: Did you read our Select Committee reports?
Sir Stephen Bubb: Yes.
Professor Field: Yes. I follow your reports because I am a nerd. I am interested in the Health Service, so I read what you have been doing. I have spoken to Stephen on and off for the last few years. I am passionate about the NHS and I thought your reports were very helpful. I am not just saying that. I thought they were very helpful, and particularly the more recent one that added to the debate. We have spoken about the Nicholson challenge on and off for a long time. I found your reports very helpful.
One thing I was conscious about was that we were not the Health Select Committee and our job was not to be the Health Select Committee. We were different and our remit was different. I have been conscious of not doing what you have to do, which is to interrogate a Bill forensically. This was about listening to stakeholders. As I and we have gone through the Bill—probably me more than most—I have asked for departmental legal opinions on things to see whether I was right or wrong; I met with Monitor, as Stephen did a number of times, and talked through the intricacies of European law—at times, Dutch law as well as English law—to see whether my interpretation of what was happening was accurate; and I think I have a reasonably good understanding. However, I am sure you can pick holes.

Q23 Valerie Vaz: It is a Bill committee which goes through the forensic process. It is not us, as such.
Professor Field: Yes. It is not us.

Q24 Rosie Cooper: Did you have any contact with the Prime Minister during the process? Did anybody from Government or advising Government ask you for interim reports? What kind of connection did you have as you went through your work?
Professor Field: I met with the Secretary of State formally once, but I was out on visits with him many times. It was the same with Nick Clegg, the Deputy Prime Minister. I met Nick twice and talked through some of the issues he was interested in, but we never covered the whole thing because it is too broad. I had extraordinary access to the Prime Minister. I spent a lot of time talking to him before and after listening events, many of which were without the press, but none of them had a formal update about where we were on issues. When I met with the Secretary of State it was about some of the key issues that he was interested in and we talked through it, but they did not have a copy of the report before about half-past 6, or 6 something, on the Friday evening. Indeed, two of the recommendations were only inserted the day before that. I had a promise from No. 10 that they wouldn't leak and we promised that we wouldn't leak the document because we wanted to make sure that everything was above board and without interference. I honestly believe I have not had any political interference at all at any stage. I have been really

encouraged about the political process and how politicians act with the public. It has been hugely encouraging watching the Prime Minister test out things that he has heard at a meeting a week before and then moving his position on how he is questioning and responding a week later. It has been really fascinating.

Rosie Cooper: Welcome to our world, I suppose.

Chair: Can I suggest that we move on from process? Are people content with that?

Q25 Rosie Cooper: In that case, I wanted to ask you a question about the press launch of the report where you emphasised widespread worrying demoralisation among managers. One of your colleagues said that manager bashing must stop. Yet, at the press launch of the Government's response to your report, the Prime Minister continually talked about bureaucrats and management as bureaucracy. What signals does that send to you, as the Forum, and to hardworking NHS managers that, after all this, the language is not changing?

Julie Moore: Could I answer that because I was the one who said it? I have absolutely no issue with restructuring—it is the perfect right of an elected Government to do so—and for bodies to go. However, the people in those jobs didn't just make the job up themselves. They were employed to do a job. They are your constituents, they are somebody's mother and they are somebody's father. They are people who have done the job they were asked to do and done it to the best of their ability in 99.9% of cases, obviously. The people need to be treated with respect. I have no issue with people saying that an organisation or bureaucracy itself could go. I am a chief exec. I suffer under the burden of regulation and bureaucracy every day, but there are people here and they need to be treated with respect. "Thank you for doing a good job. We have decided to do things in a different way", I think is the right way to go about it. I make no apology for saying that.

Q26 Rosie Cooper: I totally agree with that, but after you making those representations we still had the Prime Minister, No. 10 and that which comes thereafter, talking about "bureaucrats" and "bureaucracy" as though, if you made those hardworking people disappear, it is all going to work wonderfully well. It is going to collapse.

Julie Moore: My great concern is why anyone would want to choose a career in management in the Health Service at the moment when all you get is negative press. In fact, I challenged one of the journalists who talked to me afterwards to come and spend a week as a manager in the NHS because it is not an easy job. We want to attract in bright, talented people. It is a complex organisation that needs well managing. We need the right people in. We need bright, intelligent people to come in. There are a lot of alternative careers on offer and we need to make it more attractive. I find that kind of language very unhelpful.

Professor Field: I wanted to make a very strong statement in the report because I have felt, over the last year, from all sides and from the press, that managers have been under a lot of pressure. We have been losing senior managers. I wanted to make a very strong plea that we needed to value them more.

Chair: I hope you noted as well that in the report you referred to, which we published at the beginning of April, we included a recommendation along the lines of what Julie Moore has just said.

Professor Field: I think we were copying, actually.

Q27 Mr Sharma: What would be your advice to the Government about not being unfair towards the management and not to use this language?

Professor Field: There is a difference between bureaucracy, which is not just managers doing things, it is the bureaucracy, and the role of the manager in that. In the recommendation, which we put in, it talks about senior managers supporting clinical leaders and, at times, leaders themselves. That is great. It is a bit like the old arguments between consultants and GPs. You have to try to understand what the other profession has to offer and respect that. Politicians generally make statements which might be popularist and look good in the *Daily Mail* but might not be helpful, sometimes, for the delivery of the NHS.

Q28 Valerie Vaz: This is a general question. What was your view before the Health Bill? Were you having discussions with all the political parties about what needs to be done with the NHS? Did you think there was a need for reorganisation?

Professor Field: Of the NHS?

Valerie Vaz: Yes.

Professor Field: Absolutely. You can track my speeches back. At Harvard I teach business stuff and health systems and I am on record as saying that we need a health system which is more integrated around the needs of the patients. We need to integrate health and social care and we need competition in the system to free up some of the poor-quality services that are provided. We have too many hospital services in some areas. I was pleased that the Government took a lead to try and radically change the environment we have. We need an environment of innovation and change, taking best evidence in quicker. I am very happy, outside of this room, to talk to you about the role of doctors. We have been very complacent in what we do as well.

Q29 Valerie Vaz: You are more or less in favour of this top-down reorganisation.

Professor Field: I am on record as supporting the principles of the Bill and the move towards clinically-led—I have always talked about clinically-led—commissioning. The two things which I don't think were emphasised enough were the integrated nature of health care and the fact that you need to tackle the financial challenge. If we don't do that, we won't have a Health Service. I think all political parties agree with that.

Q30 Valerie Vaz: When the current Secretary of State was spending eight years looking at this, did he have discussions with you then? Did you talk to him then?

Professor Field: I first met the Secretary of State about six months before I took over leading the

College of GPs, which was five years ago. I was very well aware what he intended. Of course, the financial situation became much more focused towards the end of my term, at the start of his.

Chair: Can I move the discussion on, otherwise we are not going to get into process?

Q31 Yvonne Fovargue: Will the Future Forum be publishing a list of all the meetings held and will the minutes be published? You did mention that you wanted the public to have access to the information.

Professor Field: We didn't keep minutes of all of the many thousands of meetings we went to. We took notes in many. Lots of people sent in sheets of advice, etc. To be perfectly honest, I have not had a discussion about what we publish, what we don't, what is available and what isn't. Frankly, there was so much stuff that it was not a consultation. The Government has already had a consultation. You've done your work and, as far as we were concerned, the reports were what stood.

Q32 Rosie Cooper: There was poor consultation because it missed completely all that we have been talking about. It was not very good.

Professor Field: I am sorry, what is the question?

Rosie Cooper: The consultation itself could not have been terribly good because it missed everything that we have been saying that you are putting on the table now.

Professor Field: The Prime Minister is on record as saying that he has learnt a lesson on how the public consultations and discussions with stakeholders were carried out.

Valerie Vaz: It's called a Green Paper.

Chair: Grahame, do you want to ask a question about process?

Q33 Grahame M. Morris: It is an issue that Professor Field has just touched upon, and that is commercial competition. I know there are huge concerns, and I am sure the Forum members have been listening to them from staff, various stakeholders, patients and political parties, about the introduction of American-style commercial competition into our National Health Service. I would like to refer to one of your recommendations, which I agree with, that the Government should not seek to increase the role of the private sector as an end in itself. I wanted to seek clarification on why, perhaps, you didn't go a little further. In the Government's response, it is clear that the Secretary of State is saying there is no ban on the sub-contracting of the commissioning of management arrangements. I accept there are these statutory bodies undertaking the commissioning function, but the actual management could be sub-contracted. Isn't the position, in reality, that you have kept the privatising elements of the Bill when there was an opportunity here to run them out?

Sir Stephen Bubb: Can I respond to that? I want to respond, first of all, by saying that I am slightly disappointed at the messaging there has been over the role of competition since we produced our report. If you read the report of my panel, there is no suggestion in it that competition does not have a role to play in the Health Service. We heard concerns, but we also heard and saw evidence—studies by the LSE and Bristol—which showed that competition introduced under the last Government had driven up quality and in one case, in the LSE study, had saved lives. Competition does have a role to play.

I am very clear that that competition has to be managed properly. I am also very clear, despite what some have said, that there was no attempt to introduce American-style privatisation in the Health Service. One of the things that disappoints me about this debate is that it proceeds on the basis of, "Are you in favour of privatisation or are you not?", as opposed to thinking about how competition could be used effectively.

Competition is also not just about the role of the private sector. As the leader of ACEVO, I know that the Health Service needs more work from charities and social enterprises.

Q34 Valerie Vaz: And you will provide it?

Sir Stephen Bubb: Yes.

Q35 Grahame M. Morris: Sir Stephen, there is a weight of evidence that we have had presented in this Committee that says price competition can be extremely damaging and can fragment the service. You mentioned the Bristol study. There is another weight of evidence, too. Can we just go back to this point about commercial privatisation and so on? How do you feel the recommendations your panel has brought forward will change the Government's direction of travel? Or will it not? Is the status quo prevailing, because it is being sold to us as a sea change in terms of the direction of travel for the Bill? My suspicion is that, fundamentally, nothing has changed and that the face of the Bill does permit private health care companies to contract and to be awarded services both as commissioners and providers.

Sir Stephen Bubb: Could I, perhaps, talk a bit more about the framework that we are suggesting? I am very clear that there is a role for competition and the debate needs to move on now to how we maximise the benefits while minimising the risks. We have suggested a framework around choice, so we are clear that competition is improving choice in a Health Service that, in many cases, denies people choice. That is the driving force for what we are suggesting. We are suggesting that the Secretary of State gives the Commissioning Board a choice mandate. There are a number of principles in that choice mandate which emphasise, for example, integrated services, which emphasise the fact that 70% of the Health Service budget is spent in long-term conditions, yet we have a system that treats long-term conditions as a hospital issue and not a community and care issue. That is why we have simply got to drive more integrated services between hospitals and doctors, between health and social care. That framework is then backed up by what we are suggesting as increasing citizens' rights.

Why I think the Government got it wrong on Monitor—it was suggesting that this was about giving Monitor a duty to promote competition—I like to see this as how we improve citizens' rights to challenge

the system. For me, one of the most important parts of our report is this idea of a citizen's right to challenge.

Q36 Chair: Could you tell us a bit about how you think that would work? What would a citizen who wanted to challenge do? To whom would the challenge be addressed? What would be the consequences of a challenge being initiated?
Sir Stephen Bubb: I will. Can I say, first of all, I am very aware that more work needs to be done on this? We said in our report: how does that work in the Health Service? The idea comes from the Government's Localism Bill where there is a community right to challenge. Community organisations and citizens can challenge bad service, poor service delivery or where they have better ideas.

Q37 Valerie Vaz: How would they do it legally?
Sir Stephen Bubb: In the Localism Bill it will be a legal right. The Localism Bill sets safeguards and guidelines for that legal right. But, absolutely, a group of citizens and community organisations could say, in terms of a service, "Actually, we don't think this is delivering."

Q38 Chair: To whom is the challenged addressed? Is it to the commissioner or the provider?
Sir Stephen Bubb: These are the sort of issues we need to do more on. In terms of the Localism Bill, it is to the local authority. It is to the commissioning body. In the Health Service it would be to the consortia.

Q39 Valerie Vaz: Auntie Mabel goes along to her GP and asks for two treatments, but one is cheaper than the other. What does the GP do?
Sir Stephen Bubb: It wouldn't be to the GP. It would be to the commission.

Q40 Valerie Vaz: But Auntie Mabel is going to the GP.
Sir Stephen Bubb: The challenge is to the consortia.

Q41 Valerie Vaz: Hang on. I am talking about the patient going to the GP directly. Are you suggesting that Auntie Mabel then takes legal action against the consortia?
Sir Stephen Bubb: No. I think I need to distinguish between the complaints system for individuals—

Q42 Valerie Vaz: We are talking about choice, aren't we?
Sir Stephen Bubb:—and a legal right to challenge.

Q43 Valerie Vaz: You don't get your treatment, so how do you do that? You are saying you challenge it.
Professor Field: The individual has rights under the NHS Constitution, which was introduced under the last Government, which we have cited all the way through these documents. The individual, because I am a GP, has the right to challenge me in the consultation. She has a right to a second opinion. She has a right to a referral. She has the right to NICE approved treatment under the Constitution. The example I have been giving—Stephen might agree or disagree with this—is if you are in a rural area and you have only got one provider there and the service is not desperately good and the commissioners are still commissioning a poor service. At the moment the problem is that the patients don't know what is good or bad. Therefore, you need information. I think all parties support that. Then a group of citizens can come together to challenge the commissioning of the service they are getting. Those are the themes we have been talking about. It might be, for example, that, in Herefordshire, Hereford's hospital, in a very rural part of the country, is providing a poor service within the building of Hereford hospital. University Hospital Birmingham might provide a better service, but the commissioners are not thinking about how they challenge. That is happening already. Renal services in Hereford are provided by Julie's hospital. What we are trying to do, and I support Stephen very strongly on this, is to give citizens more rights to affect their local services, because it hasn't worked in the past.

Q44 Grahame M. Morris: Is it conceivable—you mentioned the University of Birmingham—that BUPA or a private health care company could make a challenge?
Professor Field: No, they could not. These are citizens.
Sir Stephen Bubb: It is very clear in the Localism Bill—this is where it starts—that it is a community right to challenge. It is not a right for private sector organisations.
Grahame M. Morris: My understanding is that, elsewhere in the Bill, under European competition law, they would have such a right if they felt that their commercial interests were threatened.

Q45 Chair: The right to challenge is not in the Bill. This is a proposal that has come from the NHS Future Forum. It is not in the Bill currently. The purpose of this element of the discussion is to work out precisely what that recommendation is, and indeed whether you think the Government is likely to implement it.
Sir Stephen Bubb: Yes.

Q46 Rosie Cooper: Could I ask you to add a bit on to that? I am not against all competition if it is strongly managed. My problem here is that Grahame is right. Private companies with a lot of money at their disposal could motivate, supply, do PR and encourage people to challenge funding by companies that may very well benefit from that challenge.
Sir Stephen Bubb: Perhaps they could, but I have rather more faith in community organisations to resist that blandishment from the private sector. I do not think that is a good enough reason for saying you shouldn't have a citizen and community right to challenge.

Q47 Rosie Cooper: I think you should build in the safeguards.
Sir Stephen Bubb: Absolutely. We have said in the report that this is a very high-level recommendation and it requires more work. As to the Government's response, I would have hoped the Government would have jumped at this because it is very much in line

with the Prime Minister's talk about building a bigger and stronger society. I would have hoped that they would have said, "Absolutely. We will do this." They have been slightly more limp on it but they haven't rejected it. I am hoping that, as part of the process we are now going through, we can persuade the Government to do it. I have said that we are very happy to do more work on this to persuade them on the issues around the guidelines and procedures.

Chair: For clarity, the Government's response, which you might not think is jumping at it, is this: "Following the Future Forum's recommendation, we will carry out further work on the feasibility of a citizen's 'Right to Challenge'."

Q48 Yvonne Fovargue: My concern on that is the availability of the advice and support to citizens groups to challenge. We all know that Links is extremely patchy, and HealthWatch is likely to be patchier still. Would you envisage that being a function of HealthWatch being beefed up and perhaps given more time to work with that?

Sir Stephen Bubb: I think you are completely right. I also think that the dear old third sector and community organisations are sometimes quite good, if they are given a toe in the door, at prizing that door open. I have a lot of faith that, if we get that legal right, we will start using it.

Chair: Chris and then Sarah.

Grahame M. Morris: Could I just follow up on that very point?

Q49 Chris Skidmore: No, you can't. Come on. You've had enough questions. I have been very polite. I have not interrupted anyone. I would like to ask Sir Stephen about his report, which I was very encouraged by personally. Do you not regret the fact that Monitor is losing this duty to promote competition, which would help charity organisations? I don't know if the panel has read Alan Milburn's article in *The Daily Telegraph* today, but I wanted to quote one paragraph, which says: "Now the regulator, Monitor, which was to have been charged with promoting competition, will have a duty to promote integration. Words have meaning in the NHS. Every single local decision-maker will read that change as a signal to weaken competition, not strengthen it, and to protect the public sector incumbent over the private or voluntary sector insurgent. The debacle has set back for a generation the cause of market-based NHS reform." Would you agree with that?

Sir Stephen Bubb: I read Alan Milburn's article and that was the exact bit I picked up from it. It is a point I have made to Ministers on a number of occasions. Messages in the Health Service are incredibly important. I saw in my day job, to which I hope to return very shortly, that when Andy Burnham made a speech and said that the policy is now preferred provider, what happened in the Health Service was that a whole heap of the right to requests from staff went out the window. A lot of tenders also went out of the window because the message was, "It's okay. We are not doing competition any more. It is about the Health Service. We'll do it ourselves." That message was disastrous for us in the third sector. Some of the messaging that has gone on since our reports were produced is quite dangerous because the Health Service needs competition. It needs innovation. Innovation can be delivered either through competition or by consortia thinking about new ways to provide integrated care pathways. If the message is, "It's business as usual. You don't need to think about how you use the third sector or the private sector", that is not going to be helpful for the long-term future of the Health Service. I think these are very fair points that he is making.

Q50 Chair: I think it would be interesting for the Committee to hear Julie Moore, who is a real live NHS manager. Do you agree with what Sir Stephen has just said?

Julie Moore: The past few weeks have been interesting because, on occasions, I have agreed with Sir Stephen. I have disagreed on a variety of occasions, too. Competition does have a place but we need to think a bit wider about it. Steve Field is right. Information is the key. We should have competition as well between hospitals. We should compare results and look at how we can drive up performance in that way.

My concern about competition is that health is not just a business. It is part of our national infrastructure. I have a responsibility as a major trauma centre. If there is a plane or train crash or if anything should happen, I must have every service in the hospital to support that. As Members will know, we treat the military coming back from having been wounded overseas. On occasions we have had 11 or 13 specialties working on one person. If one of those services was contracted out, that would seriously weaken my ability to do that. It is a very fine balance about getting competition in to drive up performance but making sure that the infrastructure is not weakened. On those occasions, I would like to think about competition in terms of sharing results with other big trauma centres, looking at how they are doing it better and looking at how we can drive up performance in that way. The NHS needs innovation but I have a view that the NHS can innovate itself as well. We don't always need outsiders to do that.

Professor Field: You can see, Chairman, how the Forum has had some very robust and interesting discussions over the last eight weeks. The papers have been put together, surprisingly, with a lot of care, so that the messages on competition are very clear. Competition has a place but it needs to be managed. The infrastructure in the Health Service needs protecting but the Health Service cannot stay as it is. It has to change to meet the financial and demographic challenge.

One of the joys—going back to Valerie's question earlier on—has been setting up the Forum. There has been a really good balance of views and thoughts in it. The discussions have been robust and the editing processes of the papers have been intriguing. It has been a real privilege to chair that Forum.

Q51 Dr Wollaston: Professor Field, do you think that we should allow the commissioners to be innovative and trust them to be the people who are

best placed to balance the need to protect what Julie has been talking about and the need for innovation in the wider needs of the NHS? Do you think that is the way forward?

Professor Field: It is the way forward. The tension is going to be the balance between local commissioning and central commissioning, and getting away from what we have had, unfortunately, over the last few years, which is a very top-down dictat. Putting a Darzi centre in some of our rural areas where they did not need it is not a great idea of how you manage the NHS. Designing local primary care services integrating with social care, you can see, if local commissioning works, you will get somewhere like Torbay moving forward, where the outcomes are better. It also allows innovation. Of course, 20% of mental health is provided by non-NHS providers. Turning Point even provides brilliant services for learning disabilities and mental health in Scotland, which is not meant to have competition.

Q52 Grahame M. Morris: Some have been a disaster, particularly the one in Bristol.

Professor Field: There is always going to be good and bad. But Julie's point, and the point I made earlier on, is that at the moment you don't know what good or bad is. Most citizens do not have a clue, until something horrible happens, whether it was bad. Also, most people, at the moment, do not know what is good. I have been on the receiving end of fantastic care in Julie's hospital for our family, and the most appalling care. I am absolutely determined, whatever I do—if I ever have another job—to do something about improving the quality of care in this country.

Julie Moore: Could I just add that the appalling care wasn't at my hospital?

Professor Field: No. I said it was good at your hospital. You sorted out the problems.

Sir Stephen Bubb: To respond to Julie, one of the things we said in our report is that the Health Service provides a wide spectrum of services, and competition will be more relevant in community and mental health, in providing integrated services, than competition for an A&E department. That is clearly not right. The fact that 70% of the budget is spent on long-term conditions gives you a real clue about where you need competition and where you need integration. There are some extraordinarily good charities out there which are not being commissioned. We have a situation, which is disgraceful, where the majority of people, at the end of their life, die in hospital. The majority of them do not want to. They want to die at home or in a hospice. We are not commissioning the Marie Curie's or the hospices to provide end-of-life care. This is bad for the citizen and it is bad for the Health Service because it is more expensive. That is where we can really drive change. But we can't drive change if we give messages that it is about no change.

Q53 Chair: Can I just pick up Sarah's point? Do you think that the main drive to consider alternatives, which is, in effect, the other side of the competition argument, ought to be through Monitor, as was originally drafted into the Bill, or do you think that is, in effect, a form of performance management of the commissioning process?

Sir Stephen Bubb: We have seen it as the Commissioning Board, which is why we talked about the choice mandate and why we say that that choice mandate is the framework for the system. Therefore, the system is the Commissioning Board, Monitor and the consortia. Those are the guiding principles. Monitor regulate against that mandate. I don't think it was ever about promoting competition. It was about a very strong regulator, a regulator that protects the interests of citizens and a regulator that, under our framework, will be promoting integrated arrangements, whether that is through competition or collaborative arrangements in consortia.

Q54 Andrew George: On that point, Sir Stephen, are you saying, in effect, there is no need to change the Bill? The issue for you is the interpretation, really, isn't it? It is a question of the interpretation or how the Bill could be, in your view, misinterpreted?

Sir Stephen Bubb: Partly, yes. That is right. However, I don't think that was sufficient. That is why I think an element of external challenge is so important. That is why our report suggests a legal right to challenge. That is why we have suggested this idea of a Citizen's Panel, which is part of HealthWatch England, which would have a role in assessing how far the Commissioning Board and Monitor are working. They should make an annual report and I have suggested they make that annual report to Parliament—potentially to this Committee—in order that there is a bit of a check on how the system is working. If the Commissioning Board and Monitor are not providing more integration and choice, there is a bit of a challenge there. This would be a body that is made up of non-professionals.

Professor Field: There is a specific point to add, which is that the way Monitor was described in the Bill was unhelpful. The main duty of Monitor about citizens is great. To put the first line underneath it, "Promoting competition", was extremely unhelpful. If you say you are going to do X or whatever on the top of your list, you are going to do the top of the list. There were some very unhelpful descriptions of what Monitor's role might be when it was first described. The whole ambience, the discussion and the debate became very polarised and was very unfortunate.

Sir Stephen Bubb: Yes.

Professor Field: We did take some advice. We did meet with Monitor a few times and spoke to a lot of people about this. When you look at European law and the role of the OFT, declaring that this is a sector regulator for health is very different to setting up something which looks suspiciously like a regulator for the water industry, which, as a utility industry, is different. We have been very careful as to how we have written the paper and advised. It is up to the Government if they want to take that on board. We believe that we need a sector regulator because competition needs to be there and, in some areas, they will, as part of the seven factors of the choice mandate, make a market, because you do need, in some instances, to create a competitive environment as well.

Q55 Andrew George: Would it be right to interpret that in this way? You don't think the Bill was wrongly intentioned, but you think the interpretation of the Bill was perhaps rather unhelpful in that it gave an impression that promoting competition was rather more important than you felt the Government intended? I think that is a reasonable conclusion to draw, isn't it?

Professor Field: Yes. In the discussions I have had with the Prime Minister, along the lines we have debated, that there is an important role for competition but also an important role of integrating around the needs of the patient, he gives this most wonderful couple of descriptions about his son and the need for health and social care and focusing, in the hospital, on the individual. I don't believe the intention was as people have written in the press. I do believe there has been a lot of scaremongering over it. Part of it is communication and part of it might well have been the computer, I am afraid.

Q56 Andrew George: Can I ask two questions rolled into one? The first may be for my benefit, which is the interrelationship between the concept of a choice mandate and the right to challenge as proposed. Are they not part of the same thing? I can see that the challenge option is something of a reaction to perhaps not being given the choice, but I wanted to get clarification on that. On the debating point side, I can see tensions with that particular theme of choice mandate, the right to challenge and your recognition of the need to produce an efficient Health Service. Is there not a risk that, in offering everybody a right to challenge, you will be driving inefficiency into the NHS? You will need a lot of bureaucracy to be put in place to manage all of these challenges and choices, rather than ensuring that you have systems in place which deliver community services to people rather than individuals being able to pick and choose their pathways of care. Is there a risk that it might produce fragmentation and drive inefficiency into the system?

Professor Field: The risk would only be there if the Commissioners were not doing their job. Geoff's area was critically important in this. How do you get more meaningful patient and public engagement in the design of everything? How do you get more collaboration between all of the health professionals in the design of the services? How do you take difficult decisions together as a local community? There is the important role of HealthWatch. If you get it wrong, then it is right that citizens have rights to challenge as individuals and collectively. If the Health Service is going to move forward, it is going to have to change.

Q57 Chair: Geoff Alltimes has sat patiently waiting his turn. The theme has come up several times this morning that this ought to be about integration across the Health Service but also including health and social care. My question would be: Is there a magic bullet? Is there a key objective that we should be looking for in the Government's conclusions to your recommendations that will facilitate the faster development of proper integration of these services?

Geoff Alltimes: Thank you. Let me connect that with one or two other things that have been said before. My workstream was in relation to both patient involvement and the public accountability. In relation to patient involvement, the absolute message from a number of groups had two elements, essentially. One was lots of examples of where patients, their carers, the people around them, patient organisations and so on, were involved in care. What a fantastic difference it made to the quality of life of people and how many of them were able to be supported to stay at home longer. It was a cheaper solution as well. There were quite a lot of good examples of that and some particularly good debate at the Health Foundation event that they organised which my group was part of. That connects with the point that Sir Stephen was making in relation to the 18 million people with long-term conditions and the 70% of health spend in relation to that group. You all know that the social care spend is pretty much at the top end of that group of people.

The second concern from patients and their organisations was around the frequent failure to deliver a seamless service to individuals. That pretty much determined the way in which we approached the work of my group and how we took that forward.

In that context—the financial issues of the Health Service and the equally difficult issues for social care—where we are all looking to how we manage a reduced budget both in the year we are in and the next three years on top of that, the only way we are going to do that—I will now switch to what it is like working on the ground in my borough of Hammersmith and Fulham—is to be able to capture those efficiencies of doing it jointly with the Health Service. It is as much with the Health Service as providers as with commissioners. Locally, we need to be in a position where we are able to get the fruits of joint commissioning, but that joint commissioning needs to deliver improvements on joint service delivery. That includes GPs being the centre, the first point of Auntie Mabel coming in to see the GP but then being directed to services that need to be multi-disciplinary team services, not separate teams from health and social care.

Q58 Andrew George: The question that I was attempting to articulate was this. Would it not be better for those commissioners if those services were parcelled together rather than potentially fragmented as a result of choice, assuming that this choice is not simply taken up by the most informed and assertive in society?

Geoff Alltimes: If I can make that connection, therefore—Chairman, you were asking that question in relation to the importance of the recommendations around integration—I believe that that is the goal, the key ambition. We recommended that there should be opportunities to build on the few existing places—you mentioned Torbay but there are a number of others—where there is a strong commitment to that joint commissioning. As a local manager in services, I strongly believe we will get better responses to those individuals by local innovative ideas brought together by GPs, health providers and social care providers in

relation to that. There is a fragmentation at the moment and we need to use those mechanisms to drive greater integration of those services. I would hope to see that develop over time. In trying to respond to that point, locally I would be looking to the commissioners and providers developing a joint community health service, for example. It may well be the case that we want to see some competition between teams which provide that service because we want that service to be as efficient and high quality as possible.

If you take, again, the example in my locality, it does not have to be competition all over the system. If you have a local provider of health and social care covering the borough of Ealing, it may well be that patients with their GPs, who are on the border of the two, could see that as an alternative provider which may provide a better service to them because they know what their neighbours are saying about the quality of that service and so on. Those are the sort of measures and ways in which choice can use competition to get a different service.

Q59 Rosie Cooper: May I give you just a throwaway line and then come to the point I am trying to make. You said you wanted two lay members on the commissioning body. We shied away from that simply because it is really difficult to identify those genuine representatives of the community. I want to go straight to the coalface. I couldn't be more supportive of lay people—patients—being at the centre. They know what is happening to them. They see what is happening to their families and relatives every day. They are a resource which we do not tap except to shout at and tell them what they say is not regarded.

Let's swing right over to the other end. In your report, you talk about the fact that there will almost certainly have to be some disinvestment in hospitals. When that decision comes to be looked at and made, who, in the end, will make it? Will the clinical consortia, the clinical senate, the clinical network, the regional outpost or the National Commissioning Board? The local authorities and the Health and Wellbeing Boards, as so constructed at the minute, have only got, as I call it, a "power to spout". They can talk for England but they won't be able to get at it. How, when you look at all of that, do you give patients real power to break in and make the difference? I know you actually talked about the right to challenge, but again there is a difficulty. You have also clearly said that the Secretary of State must be responsible. No matter what layers you put in, the truth is that when people are really unhappy and they have hit the complaints system, they are all going to come back to each of us as individuals. How do you see us being able to play a real part in shaping change when you want to be also free from political influence? I know there is a hell of a lot there, but that is the core of where we are going to be.

Geoff Alltimes: In my group we spent quite a bit of time debating those issues. We did not actually recommend two lay members on consortia. We said there should be independent representation on consortia and the Government's response has been to that effect. But we were debating the same issues in relation to clinicians. How do you have the range of clinicians and other professionals with patient representatives? Our conclusion was, because of the necessity to do this jointly, that we should put a lot of emphasis on the importance of the Health and Wellbeing Board as the place where you would see those people who have responsibility for the cash: thus, executive members of the council as the commissioners—not just for social care but wider wellbeing services—and executive members of the commissioning consortia being part of that. We saw the Health and Wellbeing Board as being key to patient and community public representation.

Q60 Rosie Cooper: What about the powers?

Geoff Alltimes: I am coming to that. What is necessary is to build on Links in a much more significant way and to respond to the patient organisations and the importance of patient engagement by a whole attitude—we refer to it as the commitment to shared decision-making—across all of the commissioners and providers. I would see that as being the responsibility of the Health and Wellbeing Board, which is joint council and commissioning consortia, to promote. It would need to be bigger than HealthWatch. HealthWatch would be a part of it but it would need to be a system that incorporated the fact that we involve patients in the design of specific care pathways in relation to diabetes and cancer. You would need to bring those things together. I am going to get to your difficult question.

Q61 Rosie Cooper: Who is in charge?

Geoff Alltimes: My position is that there has to be more than one group in charge because the responsibility for commissioning, for a variety of services, rests with the council and, for others, with the commissioning consortia.

Q62 Rosie Cooper: Absolutely. For example, in the case I mentioned about disinvestment in a service and disinvestment, perhaps, in a whole hospital, all those people you have talked about will be sat round a table at a Health and Wellbeing Board. They can argue, but somebody, somewhere else, is going to make the decision. Who is that?

Professor Field: We carried on with that debate by saying it depends on the scale of the change. If you are in the City of Birmingham, where there are currently about 12 pathfinders—probably there need to be very few—but one local government organisation, one council, and you have three teaching hospitals and lots of things across there, you are not going to have one pathfinder, one consortia for the future or group—whatever they are going to be called—making that decision. It needs to be scaled up. We believe, as Geoff said, that the Health and Wellbeing Board should have a view not just on the local consortia it is working with but also on the Commissioning Board's decisions which will be at a different level of scale. That will vary depending on where you are. The Commissioning Board will have to have involvement in local decisions on disinvestment from hospitals, depending on the scale of those. Ultimately, if they go up higher, like you

have the debate on paediatric cardiac surgery at the moment, it would be at a national level. It really depends on what the service is. If, from an integrated pathway, it is about which optometrist you use, the patient makes the decision. If it goes up higher to a particular scale in a hospital, then you would make your decision on where is appropriate, but patients must have more involvement. The clinicians have to have more—

Q63 Rosie Cooper: But they have to have power.
Professor Field: Quite right. The clinicians have to have more power, too, and they have to exercise that power responsibly. In the areas where I have been involved in reconfiguration discussions, it is often the professionals who are the most difficult, not the patients.

Q64 Chair: Would it be fair to draw the conclusion that the majority of the difficult, heavy lifting decisions that Rosie Cooper is talking about would be made at the level of the PCT cluster in the future—what is to be, as we understand it, the local branches of the Commissioning Board?
Professor Field: Clusters are not legal entities and will cease in April 2013.

Q65 Chair: But will become the local branches of the Commissioning Board.
Professor Field: There is no indication we have seen, as a Forum, that that is going to happen. The National Commissioning Board will be the responsible system and it will be up to the chief executive of the National Commissioning Board how he organises his different regional outposts, or whatever they are going to be called.

Q66 Chris Skidmore: If the clusters disappear in April 2013 and we have this patchwork quilt of successful areas which develop their consortia in advance being able to pull ahead, you are going to have one huge amount of centralisation, with the NHS in certain deprived areas which need that extra money coming from the savings made by handing over money to the consortia being run from the centre. That is exactly the opposite thing that we need to happen. You will create a two-tier NHS by April 2013 if we have both of these together.
Professor Field: We have been very careful. We have worded our report to say that we believe there should be a comprehensive network of consortia. That means everybody has to be part of a consortia. We recognise that, in some areas, the consortia will not be ready in April 2013, but I think you will find the wording is about the Commissioning Board doing everything they can to make sure they become consortia and divest power to the local people. In one part, in the recommendation, we use "as quickly as possible" and, later on in the document, we use "swiftly". We believe there should be a local system, not a centralised system. As you quite rightly say, Chris, the danger is of it remaining central.

Q67 Dr Wollaston: Would you like to have seen more clarity in the Government's response about what kind of intermediate arrangements should be present between a national Commissioning Board and local consortia?
Professor Field: That is for the Commissioning Board and we are awaiting their command paper or discussion paper—whatever the technical term is.

Q68 Dr Wollaston: The Committee did not take a view.
Professor Field: No, on purpose. Also, at a meeting I had with David Nicholson, there was a series of papers they wanted to release. One of those looked at the role of the Commissioning Board. In the discussions we had, we agreed it would be better for them to wait and learn the lessons of the listening exercise for when they issued their authorisation papers for consortia and on the Commissioning Board. If this was a true listening exercise and David agreed with it, his paper would need to learn lessons. Government has a role but so does the Commissioning Board as it is developing.

Q69 Dr Wollaston: It is interesting that the King's Fund report demonstrated it was the strategic health authorities that needed to do some of the heavy lifting in service reconfigurations because local people don't ever accept the closure of their hospital, although I take your point that it is often professionals who also lead the charge on that score. However, if we are going to release funds to provide a more community-based approach, that is going to be necessary.
Professor Field: I agree.

Q70 Dr Wollaston: Does it concern you that, currently, that tier might not exist?
Professor Field: I think that is for you to ask David Nicholson. I do not believe you can run a health service from London. Therefore, there will need to be some intermediate level intelligence and decision making, not just at the consortia level. In a city like Birmingham, where you have 1.2 million people, a lot of decisions can be made across that. It does not have to be made across, say, the West Midlands, which is 5.4 million people and very diverse. You should question the chief executive on that. It is an issue about the difference between rural systems and inner cities. London is a whole different world in itself. When you look from the outside, London is quite amazing for all sorts of reasons.

Q71 Chair: Can I ask a related question? There has been some stress, rightly, in my view, on the importance of integration around the services for the 70% of people with long-term conditions. Geoff Alltimes focused the attention on the commissioners as the people who ought to be leading that process, possibly through joint commissioning or single budgets. I wonder if you feel that is possible when the local commissioning groups within the Health Service are conflicted out of discussion of primary care.
Geoff Alltimes: I don't think that, but I recognise the complexity of that. One of the points we make in relation to the Health and Wellbeing Board is that it needs to be a place which brings together the local representation of the national Commissioning Board,

too, so you have that representation around the table. In practice, I find that, in the current shadow arrangements where we are working locally with our GPs as well as the PCT cluster about developing the future service, there is recognition of the importance of improvements in the primary care service. That is something the GPs around the table, i.e. future commissioning consortia key members, are able to recognise and want to be part of. I recognise it has that double element to it, but I haven't seen it as something that prevents us from being able to develop proposals for improvements in the system overall.

Q72 Chair: Sometimes, in a local health economy, the GPs who recognise there is a problem about the delivery of primary care in a particular locality will also, potentially, be personally interested in the solution.

Geoff Alltimes: Indeed.

Professor Field: As I am on record as saying many times, one of the great benefits of the new proposals is that we can challenge the variations in delivery in primary care. One of the reasons we are very keen on getting more health professional input from pharmacy, nursing and elsewhere is that we can look at different models for providing primary care. As you know, I have started chairing this National Health Inclusion Board, looking at the care of the homeless, travellers and asylum seekers. Some of the care that is provided in this country is hopeless. Some of the homeless patients I have spoken to in the last eight weeks, and before but certainly in the last eight weeks, who I have met twice, say they can't even—and this is their quote—"get to see a bad GP, let alone a good GP." In London, we have fantastic services provided by UCL. The more I look at the care of these vulnerable groups, the more it has to be tied up between primary care, secondary care and social care, but the variations in primary care, in both Muir Gray's Atlas and in the King's Fund review on primary care, really worry me.

Sir Stephen Bubb: One of the points you made, Chair, was about conflicts. One of the big issues is what we are going to do with hospitals. I deliberately used a quote from the King's Fund in my report. If you want to develop more integrated care that is provided in the community—community-based care—for people with long-term conditions, then you need a very fundamental shift in the model of our Health Service, away from hospitals to integrated care. The point that the King's Fund makes is that we need to see a progressive shift of resources from hospitals into community care. That raises the whole issue of whether we have too many hospitals and how we go about closing them. We cannot continue to have a system where, for long-term conditions—I suggested a King's Fund meeting that I had—the system is based on leg-chopping, not dog-walking. The whole system, if you have diabetes, is based on very good care if you need your leg chopping off or you have problems with your eyesight because you are not getting proper care, but it is extraordinarily bad on providing advice and support on exercise and diet. If we could develop an integrated system which included some choice—we have also recommended in our report personal budgets—you could say to people, "Actually, part of our care is that we are going to give you the choice to join Fitness First or buy a dog", for example. We don't do that, but we know that that is a very effective way of giving people support who have long-term conditions such as diabetes. The system at the moment does not work like that because it is geared around hospitals. How are we going to change that? We raised this question without providing the answer because we recognise how very difficult it is for the system to deal with closing hospitals but, frankly, if you are going to have a different model, you need to close hospitals.

Q73 Chair: Valerie wants to come in but, before she does, we have the general manager of one of the largest hospitals in England. I wonder how she reacts to the way that conversation has gone.

Julie Moore: We have had this debate. I could close beds tomorrow because I have, at least, at any one time, between 50 and 100 patients waiting for social care packages. I haven't got an issue with that. There are very few patients who are in hospital with long-term conditions. However, I recognise that, nationally, the picture may be very different.

Q74 Chair: It is slightly different from that. It is people coming to hospital because they have long-term conditions that are not being adequately managed. It is a short-term condition in hospital but they need not have been there if there had been early intervention.

Julie Moore: That is absolutely right. Quite often it is portrayed that I have people roaming the streets looking to drag people in through A&E just so we can get the money in. That has been said. Of course we are not doing that. There has been a lack of alternatives for patients, and that is absolutely right, but I am very keen on looking at a lot of alternative methods as well. We have developed a web-based system for patients to manage their own condition. Under the current system, it is very difficult to get that recognised or paid for. We have to look at new and innovative ways of doing it. I am completely in favour of people with long-term conditions being managed at home. We would like to help with that. We would like to have computer access and the rest of it, but it is cart and horse. You can't close one before you set the other one up. That is often what we have tried to do.

As to hospitals, I pointed out to Sir Stephen that if he is ever unlucky enough to need coronary bypass grafts, he is not going to have them done in the community. He is probably still going to need a hospital. There is a place for every part of this. We have got the balance wrong at the moment. We have certainly got the balance wrong between health and social care and we all need to work together to sort it out. We often characterise it as, "A hospital is bad, sucking in people and money", but it doesn't feel like that. I would like to keep people away who are inappropriately turning up.

One of the good things with clinical commissioning is that we have been able to start having discussions with GPs about different ways of doing it. One of the worst groups of people for getting health care is men of a certain age. That is usually about working age

and older. They don't often go for their health checks, yet they will turn up at A&E when they have got into a fight and got a broken nose or something else. Could we do those health checks there? Could we find a way of involving GPs? Those kinds of discussions are the ones we want to get into with our local clinical commissioners. We have started doing that and it has been really positive because I have got a nice new hospital and it is very big, but it is absolutely full at the moment.

Q75 Grahame M. Morris: Can I ask you a supplementary on this theme? Do you believe, Julie, that it is helpful from the Bill—this hasn't been addressed in the recommendations—to have an unlimited number of non-NHS patients treated in an NHS hospital?
Julie Moore: Provided alternative provision is made, I don't see a problem with that at all. Are you talking about private patients?
Grahame M. Morris: Yes.
Julie Moore: I have a very small number of private patients in my hospital, but what irritates me is the fact that my cap of around 1% means that the profits the private sector are taking I could have ploughed back into the NHS, if I were allowed to do more of that. How we operate private patients is that we keep them completely separate. We don't cross-subsidise it any which way, but the private sector money goes back into the NHS. I am in favour of a raising of the cap for those obvious reasons.
The other thing which is not helpful is that, when the private sector treat patients and they get into trouble, they are sent to me in an ambulance. That is not helpful for me in planning the workload and all the rest of it. I think the proposals around allowing us to do that are fine, and I do not have an issue with that. We would make alternative provision for it.

Q76 Valerie Vaz: Can I just take you back to competition and, Sir Stephen, to your report at page 29. You say: "We have been reassured that the Health and Social Care Bill does not change the application of competition law." Could you say who reassured you? Did you get a look at the legal advice?
Sir Stephen Bubb: I have had various sessions on this, to be honest, and my head hurts, about whether it does apply or does not apply. Obviously, I talked to the experts in the Department and I talked to Monitor about this. We decided, in the end, that we should not spend a lot of time talking about this because there are different views about whether it does or does not apply. The core thing we wanted to say was that we were convinced with the argument that having a sector-specific regulator was a good thing. Giving them this concurrent power with the Office of Fair Trading was a good thing, we said, so we would support that.
The other point is that we did not think there was anything in the Bill that altered the position one way or t'other. In other words, you have an EU directive on competition and it either applies or it doesn't apply. The Bill does not alter that. I also heard that almost certainly Andy Burnham's preferred provider policy would have breached European competition law if there had ever been a challenge, and that would have had serious consequences for how policy operated in the Health Service. I can't be more helpful than that. I am sorry.

Q77 Valerie Vaz: The question was: did you see the legal advice? Andy Burnham is not the Secretary of State and he is not in the Government now, but did you see the legal advice? Apparently, there was some legal advice.
Sir Stephen Bubb: Yes.
Professor Field: Was it the Department's advice?
Sir Stephen Bubb: Yes.

Q78 Valerie Vaz: Did you see the legal advice?
Sir Stephen Bubb: Did I see the legal advice? No. I spoke to the official on this. I don't think I did see it.

Q79 Valerie Vaz: The official?
Sir Stephen Bubb: In the Department.

Q80 Valerie Vaz: Right. So you have not had legal advice on it, but you have been reassured that it doesn't change the application of competition law.
Sir Stephen Bubb: Yes. I am not sure I am ever reassured by getting legal advice, but the key point was that I talked to the officials in the Department who work on this and in Monitor.

Q81 Grahame M. Morris: Isn't the key point and the truth, Sir Stephen, because you said there is no difference in terms of the application, that the whole architecture of the NHS is changing: the abolition of SHAs and PCTs and the opportunity for private providers and the independent sector to be delivering health care? Is it not the fact that the architecture has changed and then will that not result in a risk of challenges using EU competition law, rather than what is in the Bill?
Sir Stephen Bubb: That may well be the case. That was one of the reasons why we felt, in terms of Monitor's growth, it was quite important to have it established that Monitor is not an economic regulator. It is a regulator for the sector, and that provides you some protection.
Professor Field: All of the discussions we had—we spent a lot of time with Monitor, their policy advisers and the team talking through the consequences and with Department officials—were about, "If the scenario pushed this in this direction, it was more likely to give that reaction," and, "If you add things together, you are more likely to do that." We talked about the private patient cap and if that was opened that would be very much more likely. My personal view is that we need to have another look at the private patient cap. It still needs to be capped, but it does seem ridiculous that the Royal Marsden sits at about 30% because of historic figures and University Hospital Birmingham is at about 1% because you can't reinvest. The advice on that was, if you opened it, it was very likely, with European law and the OFT, that the whole thing would go down. It depends on scenarios. If you make one suggestion you get that action. If you put two, you get double. It was very conflicting. However, we felt, when we wrote the

report, that what we were suggesting would make it very unlikely that European law would be a problem with this.

Q82 Valerie Vaz: I think you were speaking to the same set of people who were involved with the Bill, anyway and you didn't take your own independent advice.
Sir Stephen Bubb: No, we did not.
Professor Field: No.

Q83 Valerie Vaz: Just to turn to competition again, do transaction costs worry you? Certainly the evidence we heard from people was that, if you opened the NHS to competition, transaction costs were huge.
Sir Stephen Bubb: It depends how you do this. There is a very old-fashioned procurement way of doing competition which often does have very high transaction costs and we have seen that across the public sector—anally retentive procurement where you have to fill in hundreds of pages of tender documents.

Q84 Valerie Vaz: I asked you whether you were concerned about transaction costs.
Sir Stephen Bubb: You have to be concerned about transaction costs, but you also have to be concerned about the benefits that competition brings. It is a trade-off, isn't it? There are costs to doing competition, and you have to do it in a much more proactive way. You can actually do competition without having the whole tendering paraphernalia. You could say, in a consortia, coming back to diabetes, "We've looked at how we want to tackle diabetes." We are saying to a whole group of people in the private sector and third sector, in other districts, "We've got £20 million to tackle diabetes. You tell us how you would best provide an integrated care package", and then you make decisions on that. That is perfectly possible.

Q85 Valerie Vaz: And the European companies, because they are also entitled to bid for it, aren't they?
Sir Stephen Bubb: In this case, you are taking it outside the competition framework—it is part of the integration framework—and you are saying, "We want your ideas about how you would deliver these services." Some of this is happening on the ground but, for goodness sake, the Health Service isn't actually encouraging it. Some of the work that Diabetes UK has been doing with private sector providers and other third sector providers is saying to commissioners, "Why don't you commission us to deliver integrated services?" Marie Curie has been doing exactly the same to commissioners in terms of end-of-life care. That is why we say that competition needs to be seen in a framework where you are encouraging integration so you can have different ways of doing it. Local authorities are getting very smart at how they encourage organisations like the third sector to get involved in delivering services which do not have to be through this paraphernalia of tendering.

Q86 Valerie Vaz: Can I just take you to page 11 of your report, paragraph 3? You mention there, "stronger safeguards to prevent providers from 'cherry-picking'." Did you have any suggestions in mind of how that could be done?
Professor Field: On both that and the legal advice question, on the legal advice I did see lawyers' opinions on questions that I asked for in particular, but they were through the Department of Health. That is just to clarify that.
On this, we had a lot of discussions about "cherry-picking." In fact, within the group there were lots of different definitions of what cherry-picking meant. We also went back to talk to the Department officials who had written the original work under Labour 10 years ago, when they were talking about competition. I can't remember the exact date. We interrogated them about the discussions. The view was, "We are not the ones providing the solutions, but we should raise it as an important issue because we have heard it a lot." We heard, as well, that part of the solution was the commissioning process, not Monitor. Actually, by writing what we did, it put the emphasis back on the Commissioning Board and that process. All the way through, which is why it is difficult listening to this debate, we were listening to people raising concerns, we were synthesising that, we were taking information and advice through where we could get it, and now it is up to the Government to respond and answer those questions in more detail.

Q87 Valerie Vaz: Can I turn to page 11 in both of your reports? Professor Field describes where we are going with the NHS as being able to have "choice, collaboration and integration." Yet Sir Stephen describes it as "choice, competition and integrated care". Is that where you split on the two? Could you just expand on that?
Sir Stephen Bubb: I think I am right and Steve got it wrong, actually. Someone else pointed that out.

Q88 Valerie Vaz: Be careful or he won't invite you again.
Professor Field: It has been very interesting talking to him because he does come from a slightly different angle, having seen it in the third sector, whereas I have been talking about integrated health care for years and, from working in America, I understand the role of competition. I have also seen it go bad.
The "collaboration" word is an important one. I spent some time with Stephen and others with the King's Fund looking at their integration work and what came out was the different levels of integration. What we forget is that we still have, in some parts of the country, GP practices which aren't integrating with their community services desperately well and working in a collaborative way all the way through to fully integrated care pathways in diabetes, where we are way behind some of the big integrated care organisations in the States, through to good models of health and social care integration in Torbay and elsewhere.
One of the key things—and the reason it is in mine—of "collaboration" is, I believe, that is about collaborating between human beings. It is

communication and working together. You can't really have integration if people are not actually collaborating. That doesn't mean you cannot have competition within a pathway.

Q89 Valerie Vaz: I was wondering if there was a difference of opinion on the two because they are both very similar sentences with just the words interchanged.
Professor Field: No, not at all.

Q90 Valerie Vaz: It is a mistake. What is the word we are looking for then?
Sir Stephen Bubb: Steve got it wrong. It was a drafting thing.
Professor Field: No. Genuinely, we are coming from a similar position where it is about people collaborating, integrating health care and having choice and competition within that. I can't see what the problem is.
Sir Stephen Bubb: The argument has sometimes been made that they are opposites—it is a point we make in our report—and you either have collaboration or competition. I think that is wrong because you can use competition to drive collaboration. In the example I was giving of the treatment for diabetes, you could have arrangements where you encourage a whole range of providers out there to come forward with packages that provide that collaboration and integrated care. Both are correct.
Professor Field: I don't see that there is a problem. In diabetes, my patients would have a choice of optometrists to go and check their retina as part of a more comprehensive package. They might see the same specialist at Julie's hospital or out in the community, hopefully, but they might choose their optometrist in Manchester because their daughter lives there and it is more convenient when they happen to be there. As long as they have similar standards, the whole key thing is about information and shared records.

Q91 Valerie Vaz: I have a couple of general questions. The first is how much this whole thing has cost the NHS from the start, from July 2010 when the Bill was going on to now. Do you know how much it all cost?
Professor Field: Our listening exercise?
Valerie Vaz: Everything—the whole thing.
Chair: Valerie's question is about how much the reorganisation has cost.

Q92 Valerie Vaz: Did you ever have discussions with the Department about this?
Professor Field: No. You would have to ask the Department of Health that.

Q93 Valerie Vaz: What about your listening exercise in terms of staff? Members of staff were giving evidence to you, weren't they, in the hospital? You heard from a variety of people.
Professor Field: As you will see, we have recorded that we met with 6,700 people and we had 250 listening events. As to the actual costs so far, I think Andrew Lansley said in the Commons it was about £6,000.

Q94 Valerie Vaz: I am not talking about expenses, travel and that. I am talking generally about the whole cost. Is there a figure? You may not be able to answer.
Professor Field: No. Forgive me, I don't know.

Q95 Valerie Vaz: Nobody knows what the figure is?
Professor Field: No. We haven't asked. I don't know.

Q96 Valerie Vaz: Presumably, in going round, you talked to PCTs, etc. Did you?
Professor Field: We had people from PCTs involved with us.

Q97 Valerie Vaz: These aren't trick questions. I am just asking for information.
Professor Field: I am just trying to narrow down the question. Is the question—

Q98 Valerie Vaz: I am just formulating it.
Professor Field: Go on. Tell me.

Q99 Valerie Vaz: When you talk to PCTs, I am concerned about what is going on, in terms of productivity, on the ground and what morale is like on the ground. What was the feeling you got from them all about everything? Could all of this have been done without a Bill?
Professor Field: You have also got to remember that, since stepping down from leading the College of GPs, I have been working both nationally and locally with lots of PCTs and consortia as they are coming up, doing a trouble shooting-type role. What we have picked up is that we have lost some senior managers in some PCTs. In others, they are working very closely with the emerging consortia. Some SHAs have lost a lot of senior staff whereas, in others, they have retained them. It is very patchy. In some areas, lots of the Health and Wellbeing Boards—I can't remember the percentage—are getting up and running and starting to work well. There is great enthusiasm among a lot of GPs and others who are getting involved, and there is a lot of worry and concern among others.
One of the feedbacks we have had in all of this is that the pause, for some areas, has been a real problem because they haven't been allowed to move forward. I was at a meeting of 1,500 clinicians, mostly GPs, yesterday at Olympia. They were very concerned about the fact that the Government's response might mean they are slowing down what they are doing, and their enthusiasm, because of having to have specialists formally on the boards—where they are going to get them from, etc.—when they were working very well. There is a group of enthusiasts who do not want to be restrained and want to go forward, there is a group which are worried about everything, and the vast majority just need some help with direction. I can't remember anyone who has disagreed with Andrew Lansley's principles of clinical leadership, patient engagement and improving patient outcomes. The Secretary of State is absolutely right on the principles.

What we have to do is help him with how you deliver it.

Q100 Valerie Vaz: You said you had left the Royal College of GPs.
Professor Field: Yes.

Q101 Valerie Vaz: Did you speak to them and did you speak to the BMA?
Professor Field: I regularly spoke to members of the College locally and nationally.

Q102 Valerie Vaz: Did you speak to them in this listening exercise?
Professor Field: Yes, of course we did.
Sir Stephen Bubb: Yes.

Q103 Valerie Vaz: And the BMA?
Professor Field: Yes.
Sir Stephen Bubb: It is hard not to talk to the BMA.
Professor Field: This is one of the most amazing things we had all the way through. We had a really constructive meeting, for example, with the unions as a group. They were really supportive and very good. A lot of their concerns were my concerns as well when you read the detail about the Secretary of State's responsibility. They were hugely enthusiastic about the Constitution because they were part of the group that wrote it.
We met the BMA formally with all of their craft chairs and had a very constructive and helpful meeting. We met with a number of the colleges. The Royal College of GPs is my college. I am still a trustee and a member of Council. I stood down at the end of my term and I spoke to Clare Gerada at least once, twice or three times every week—often every day—because we are good friends, we talk a lot and she was my deputy.

Q104 Valerie Vaz: But you have different views, don't you?
Professor Field: We have very similar views on almost everything, actually. Whatever people say in public, perhaps, what their concerns are and what my concerns are, I shared many of her concerns. I understood a little better, I think, some of the intentions sometimes, but we have met with hundreds of people.

Q105 Valerie Vaz: What you have described, really, is a state of confusion. People are quite keen to move on.
Professor Field: No, I have not.

Q106 Valerie Vaz: You have. You have said some people are going one way and other people are keen to move on.
Professor Field: No. I am telling you what we have picked up. There are enthusiastic pathfinder GPs who want to get on with it, like in Cambridge, and don't want to wait until April 2013 because they have delegated budgets already. My message to them, very clearly, is, "Get on with it" because we want to learn what the lessons are. We don't want Torbay, Hereford and others, which have integrated systems with doctors and nurses all involved, to be held back. But there are some areas which haven't yet got to the point where they understand what their configuration is going to be or who is going to lead. They will need a lot of tender loving care. The pressure to relax the April 2013 date is sound but, as Chris Skidmore said earlier on, you have to protect against it just continuing for ever and ever. I have learnt a hell of a lot in this and I have also learnt a lot of people's concerns. When we went and looked at what was written in the Bill and spoke to the Department, there were concerns which had been blown out of all proportion. Actually, when you talked to them, there was very little difference. That includes politicians as well.

Q107 Valerie Vaz: Do you see Southern Cross unfolding as a result of the Bill? Would you see that ever happening or do you think that could be saved?
Professor Field: Southern Cross?

Q108 Valerie Vaz: Yes.
Professor Field: I don't think it has anything to do with what we have been doing.

Q109 Valerie Vaz: If you get a private provider who has a monopoly on the care that they give.
Professor Field: If you look at the NHS at the moment we have a lot of trusts that are being bailed out to £10 million—

Q110 Valerie Vaz: But not someone who has 70% of the care, which is what they have, don't they?
Professor Field: We haven't looked into Southern Cross's details, but if you are looking at that there needs to be a robust failure regime and it needs to support the patients. Frankly, we have trusts across this whole country—people say 30, although I don't know what the figure is—that have been in financially dire straits for years. You need hospitals which are well run and can manage working with their local communities to be looking at taking forward and providing more care.

Q111 Valerie Vaz: That is what we identified, that there was not a failure regime. You have recommended that, have you?
Professor Field: We have not got into any great detail on a failure regime. We have said that, in relation to foundation trusts, we need to support the pipeline but, again, like commissioning, we need to be flexible. We have said that we are worried about the compliance system that Monitor has, but if that goes too quickly we cannot rely on governors of foundation trusts. Therefore, the governors need a lot of support, education, training and help before you release that. We have said things about making sure that people are protected but we have not gone into detail about the failure regime.
Chair: I think Sarah wants to come in.

Q112 Dr Wollaston: Can I return, Sir Stephen, to a point you made about encouraging competing integrated care packages? As we all know, one of the frequent complaints from patients is that already it can feel rather fragmented in the NHS at times and

nobody seems to take overall responsibility when things go wrong. If we instituted integrating care packages where the whole package was commissioned, do you see it would make it a lot less likely to happen that there could be an individual who finally takes responsibility for all parts of the system?
Sir Stephen Bubb: Yes. What could be quite exciting—forgive me for using examples of all my members—is this. Let us say you commissioned Diabetes UK to handle all your people with diabetes type 2. What could be really interesting about that is they then work with a whole range of people, high street opticians, fitness companies and other people in the voluntary sector that might not even be health organisations. They might be organisations like BTCV, which is the biggest volunteering charity in the country, which runs green gyms. It is about getting exercise. What would be exciting about that is you would then say to Diabetes UK, "Okay, these are the people we have with diabetes type 2. You take them on and you provide a patient-centred approach." I prefer the term "citizen-centred approach", because people with diabetes type 2 don't regard themselves as patients. They regard themselves as citizens like the rest of us. You could then provide support, mentoring and advice in that system. That mentor, for example—this is what Diabetes UK has been talking about—would then provide guidance to the person, with Diabetes UK, on the range of things they need, including then saying, "At this point you need to see your doctor or a nurse."
I made a point earlier about the messaging. What would worry me is if the messages going out from the Government and the Department are, "We are back to the status quo". It discourages lots of people in the system who want to do something really different; who want to be innovative; who want to use competition to drive change or who want to drive the examples that I have given. I think it would be disastrous if we do that.

Q113 Grahame M. Morris: But we don't need the Bill to do that, because those examples you have given have developed under the existing arrangements.
Sir Stephen Bubb: A lot of the professional organisations said to us that integration is very important, and it is. One of the good things about this process was this emphasis on integration that came out and how important it is. Some of the organisations saying that integration is so important are exactly the organisations who should have been doing it. You don't need legislation to do integration, so why hasn't it been happening in the last two decades? One of the reasons why I think competition can be useful is because it is a bit of a spur to change.

Q114 Chair: It is a perfectly fair question that Grahame is raising, is it not? What is there in this legislation that is going to change the problem that you identify?
Sir Stephen Bubb: That is where I think the role of competition can actually spur change. Also, going back on what I have been saying earlier about the framework, that is why I think things like a citizen's right to challenge could be really good.
Geoff Alltimes: I would add that the Health and Wellbeing Board idea is one that will encourage that sort of integration. The sort of example that Stephen gave of innovative ways of doing things differently is what will emerge from that local joint consideration.

Q115 Dr Wollaston: That is particularly apt because it is Diabetes Week. Are you concerned, because you mentioned earlier the dog walker versus the leg chopper, that we would still have the resources at the end of the day if those patients did ultimately need to have surgical intervention? Would there still be resource in Julie's hospital to fund that operation?
Sir Stephen Bubb: That's a good question.

Q116 Dr Wollaston: That's the real challenge, isn't it? Ultimately, however you keep people well, some people will become patients even if, as you rightly say, most people with diabetes don't regard themselves as ill.
Julie Moore: That is an absolutely key point because, at some point, no matter how well Stephen runs all of these services, people are going to die. They are going to get sick and die. What we could be looking at here—and I have not seen any long-term modelling—is that we can keep people out of hospital for longer and we can keep them until they get older, but at some point people are going to get an illness and die. We have to think about that and model that through.
Sir Stephen Bubb: There is no difference between me and Julie on this because one of the things I found really fascinating was a meeting I had with the Dementia Alliance, who said that one in four people in hospitals have dementia, although they are not there for dementia. They are there because we are really bad at treating dementia and people have lots of accidents. That is not a very good way of using our resources in the Health Service.
Julie Moore: It is a salutary lesson that when the NHS was established the intention was to get rid of this reservoir of ill-health and then we wouldn't need it and we wouldn't need to spend as much money on it. You get rid of that reservoir and we develop further long-term chronic diseases that we didn't survive to develop before.
Professor Field: If I could get in a mere word, which is unusual, the third sector does have a role to offer. They haven't got the whole offer, strangely. There is some emerging evidence, although it is early. Ideally, what you want is for people to live a long and healthy life and then die suddenly at the end without having all the disability which gives them poor quality of life and high cost expenditure. There is increasing evidence from some of the long-term conditions that if you act early on arthritis and put expensive TNF and other treatments in early, you can keep people from the erosive disabilities you can have. They have been looking at this more in Scandinavia. One thing we need to do is more Health Service research looking at the consequences of early aggressive treatment on long-term conditions and see what the outcome is on disability and the cost on health. That is the first point. We don't have the evidence, but some evidence is

starting to emerge. If you talk to the musculoskeletal people, that is one of their big selling points.
The second issue on cost is that, in this country, we have a very fragmented system. As you know, between primary care, secondary care, tertiary care and social care, it is hugely variable. One of the Government's proposals, which I would support very strongly, is public health going into local government so that we can join up the transport, health and education systems to try and get some more local action. I think that would be very strong. Again, on your answer—I think it was to Andrew or Valerie earlier on—about what happens to the Future Forum, one of the things I have suggested is that more work needs to be done on the area of public health. One of the real dangers is people falling down the gaps between health, social care and public health; how we join up the funding to make it more cost-effective and how we make sure public health has more of an independent voice and is not just controlled by either the local council or the Government.

Q117 Valerie Vaz: I would like to ask a follow-up question, as you mentioned that. In terms of public health, you have not actually recommended a stand-alone body, have you—or have you?
Professor Field: No. We have recommended that it should not be set up within the Department of Health. The reason behind that is that we or I am not an expert on different models, whether it is a special health authority or an executive agency. From the discussions we had, it looked more like an executive agency would do the detail, but I am honestly not an expert.

Q118 Valerie Vaz: But not an NHS organisation away from the Department?
Professor Field: I think it needs to stand clear of the Department, able to influence the Department but not controlled by it. That was a real worry for me at the start. The public health lobby, generally, was very good at getting their views across, but my belief is that it is the public's health not a public health speciality. How you work on the public's health is different and we did not have time to go into that in detail. We had eight weeks and only eight weeks.

Q119 Andrew George: I am sorry, but we are doing a lot of chopping and changing. I want to take you back to legal advice and competition law just briefly, if you don't mind. If you were reassured that the existing Bill does not open the NHS up to significant challenges in relation to competition law as you come forward with your own sketched-out proposals with regard to choice mandates, rights to challenge, etc., I wondered to what extent you were also reassured that the direction in which you are suggesting the Government ought to go would not also expose the commissioners of those services to legal challenge as well under competition law.
Professor Field: We were very clear that extra work needed to be done. We didn't have the answers.

Q120 Andrew George: Did you seek or were you given access to legal advice as you sketched out your alternative pathway proposals?
Professor Field: Valerie's question was very good. Apart from a couple of areas, we did not see the written legal opinion from a lawyer with LLB on the bottom. It was discussions with Monitor, Department staff and others as part of a listening exercise outside.
Andrew George: That is fine. Thank you.

Q121 Grahame M. Morris: It seems bizarre—this is following on from Andrew's point—that the Future Forum is independent and on this key controversial question you did not seek independent legal advice. It seems strange. I don't want you to comment on that necessarily, but I would have thought that would have been a sensible thing to do rather than just taking the advice given by the Department.
The question I would like to ask is in relation to national terms and conditions for staff. Sir Stephen, Steve and Julie mentioned some of the issues around fragmentation and the discussions and representations that you had had from the BMA and the Royal Colleges. What are the implications in the Bill and your report or what are the assurances that staff working in this service can have in terms of their nationally recognised terms of pay and conditions?
Professor Field: We didn't get into that, but we support wholeheartedly the NHS Constitution.

Q122 Grahame M. Morris: What are the implications in the Constitution for pay and conditions, that they would be upheld?
Professor Field: If you look at the staff responsibilities, duties and pledges—I was part of the team writing this—it says: "Staff have extensive legal rights embodied in general employment discrimination law." It talks through the environment and the pledges. When we met with them, that question did not come up in the discussion with the unions. It was a very good discussion about the NHS and where it is going. There were some very good challenges, just like you have on privatisation and where that is happening, and certainly it helped us in the discussion about what sort of safeguards we might suggest. You are absolutely right about the legal issue. We did not see it was our role in eight weeks to do all the extensive stuff. It was to make suggestions to the Government, for them to respond and then, quite rightly, in the political way, for you to be able to challenge them in Committee.

Q123 Grahame M. Morris: The prospect of legal challenge seems such a key issue, both for the GP commissioning groups and for the providers in secondary care. It would seem blindingly obvious that, if I was in your position, I wouldn't take the Department's advice. I would seek some independent advice as to whether this would apply.
Professor Field: You can say that, yes.
Grahame M. Morris: I just have. It is just an observation.

Q124 Chair: I think you have got the answer to the question, Grahame, and you have made a comment about it from your point of view.

There are two questions I would like to ask in conclusion. One is because Julie Moore chaired the group on education and training but we have not covered that at all this morning. Are there any comments you would like to make about the way the Government has responded to the recommendations of your group on education and training?

Julie Moore: No. Education is at a different stage. The actual consultation had just finished so I had the benefit of that. People were extremely helpful in wanting to meet rapidly and I met a whole variety of people: the BMA, all the colleges—everybody—and patients. People generally agreed with the overall direction we were going in. It was the route and the speed of the route that was the issue and the fact that three timetables needed to coalesce and they did not. That is what the recommendations do. More than any other, there is a lot more work to do on this. I noted three times that Mr. Lansley said in the House much further work needed to be done. He is absolutely right because it is at a different stage. Actually, I think it is in quite a good place at the moment.

Q125 Chair: Thank you for that. The second point of the concluding question picks up something that Sarah was asking about, whether we are confident the money is not going to run out. That is a theme the Committee has developed pretty much since it was established at the beginning of the Parliament. It is what we term "the Nicholson challenge". The only way the money does not run out is if we deliver a 4% efficiency gain four years running. That links very neatly with Alan Milburn's article this morning. I would be interested in your reaction to his concern expressed in that article that where we are now means we have reduced our chances of meeting the Nicholson challenge. He writes that the "U-turn" as he describes it, slows the pace of reform and dramatically reduces its impact. He makes a number of points, but perhaps the key one is: "GPs' ability to drive more services out of hospital and into the community has been severely compromised." I wonder if you agree with Mr Milburn.

Professor Field: In his article he talks about competition, and I think competition is important but, from the words you have just used, I believe he is wrong. The biggest problem we have at the moment is people really understanding the scale of the financial problems we have. When we go out to groups of GPs and consortia, some really have got it but many haven't. The pause, in a way, has delayed people tackling the implementation. Shedding high- quality managers from some of the SHAs and PCTs will have a negative effect on that, but I don't think it is the competition which would deliver what he suggests it will. As we put in our last recommendation, with the financial challenge and managing a transition, we want a Health Service which is safe, first, and provides the highest-quality care within the resources available, but if we don't tackle the system, the efficiencies and the costs, we will absolutely lose it. If you look in the West Midlands, where I live and work most of the time, at the funding of drugs and you drill down on to the variations in what individual practices prescribe and then scale it up, many tens of millions of pounds can be saved in local areas just on drugs. I believe the answer is a much more integrated health and social care system where you try to keep people out of hospital, but when they are in hospital, give them sufficient time to get better. Sometimes lengths of stay are too short to get them right when they want to come out and, many times, we can't get them out because of the differences in how social care and general practice is managed. We need to address, quickly, the variations in care in general practice as well as we need to work differently. His whole article, for me, is wrong. This is a time for politicians to get out of the NHS and give us some space to get on and run the Service. I would like to see the Bill passed through as quickly as possible and amended to make it work. The plea is, as a GP, that I want to get on and help my patients.

Chair: Sarah—a GP.

Q126 Dr Wollaston: To return to a point you just made about prescribing costs in the NHS, as you know, there has long been a scandal where dispensing practices will, effectively, raise their own practice profits by over-prescribing branded products, and PCTs have been unable to control that for years. How do you see the new commissioning groups being able to tackle this very important variation? It has been a scandal for years.

Professor Field: Thank you, Sarah. I chair the Medicines Management Board for the West Midlands, and I understand this very well. It is mostly pharmacists, actually. It is interesting. What you are saying about dispensing doctors is hugely variable.

Dr Wollaston: Yes. I should have clarified that.

Professor Field: Some are the most efficient and the best you can find. We know, looking just at our region, some of the diabetes drugs are not approved by NICE directly. In some areas dispensing doctors use a lot and in other, inner-city areas they are using the same drugs because of access for pharmaceutical representatives. I know the detail well. I don't think we should only challenge dispensing doctors.

Q127 Dr Wollaston: No. You are quite right.

Professor Field: Let's talk about prescribing generally. One of my worries in transition is that we will lose the medicines management advice because they are employees of PCTs and we are losing high-quality medicine management pharmacists, who are going off and working in industry because they want to be able to pay their mortgage next year. I have all sorts of issues about transition, and I was very careful how I answered Stephen. The answer to your question is not just about the prescribing of GPs. It is about the referral patterns and the quality of general practice. I refer to the King's Fund report. I believe that commissioning groups led by GPs with multi-professional input are more likely to tackle bad practice than PCTs were.

Q128 Dr Wollaston: You don't think there will be collusion between practitioners?
Professor Field: We have to be very careful, which is why we have said something in the report, but, also, we need information available. In the West Midlands everyone does have access to individual prescribing data, but in some areas we have been held up from sharing it with GPs and with the public. Why shouldn't the public have all the information available?
In PCT land, to go back to compare, Tower Hamlets were fantastic at doing all of this and sorting this type of issue out, but PCTs failed across the country in many areas to tackle this issue. I think clinical leadership, transparency of information and patient input, but challenged by Health and Wellbeing Boards locally as well, is the way. We must not have collusion or GPs earning vast amounts of money because of their conflicts of interest making that happen.

Q129 Dr Wollaston: Do you think the fact that the Government has accepted your recommendations on the make-up of the commissioning groups will be very positive and helpful in that regard?
Professor Field: We hope so. We look forward to the legislation coming forward.
Dr Wollaston: Thank you.
Chair: Andrew George, a small one. You promised.

Q130 Andrew George: That is right. It is a big question but it comes back to your concluding remark a moment ago with regard to the taking of politicians out of the micro-management of the Health Service. I think that is something we probably all endorse. In your report there is this conundrum between the NHS being free from day to day political interference and yet, on the other hand, you recognise there is a need to ensure that the Secretary of State clearly is and remains responsible for the delivery of a comprehensive Health Service. I wondered whether you still see that there is a tension which needs further definition to ensure the risk of political interference has gone.
Professor Field: It is a very good question, Andrew, because it is one of the big issues that has come out all the way through. It goes back to Valerie's point about the law as well. The assurance we had was that the Bill does not remove the Secretary of State's responsibility. However, I was very keen to put in a recommendation to make sure that was clear to everybody, even though, being independent, we had heard advice.
What we must not have is a Secretary of State getting involved in, I think it was, patients in Bedford Hospital, or wherever, as they did years ago, and ringing up a chief executive of a trust and telling them to do something. You have got to get rid of that nonsense. Ultimately, the Health Service needs to be accountable to the people, both politically and nationally, and that is the conundrum. We all support very strongly the Commissioning Board being separate so that it can get on and manage the NHS. I am a taxpayer. The NHS is mine because I am paying for it. I want to make sure that there is political input into high-level decisions on the funding as well as the responsibility, ultimately, for the Health Service as a whole.
Chair: That is a dilemma which is as old as the Health Service. It is unlikely to be resolved before we adjourn this morning. Thank you very much for coming. It has been an interesting session.

Tuesday 5 July 2011

Members present:

Mr Stephen Dorrell (Chair)

Rosie Cooper	Chris Skidmore
Yvonne Fovargue	David Tredinnick
Andrew George	Valerie Vaz
Grahame M. Morris	Dr Sarah Wollaston
Mr Virendra Sharma	

Examination of Witnesses

Witnesses: **Rt Hon Andrew Lansley CBE MP**, Secretary of State for Health, **Sir David Nicholson KCB CBE**, Chief Executive, National Health Service, and **Richard Douglas CB**, Director General, Policy, Strategy and Finance, Department of Health, gave evidence.

Q131 Chair: Gentlemen, thank you very much for joining us this morning. As we have a lot of ground we would like to cover, I have been asked by the Committee to appeal to you for brief and focused responses to our questions as we go on this morning in the interests of preserving all our lunch commitments.
Mr Lansley: I would hate to interfere with lunch commitments.
Chair: We would be grateful if that was a shared objective on all sides.
Mr Lansley: We don't have lunch commitments, do we, gentlemen?
Sir David Nicholson: No.
Richard Douglas: No.

Q132 Chair: The Committee does have lunch commitments and would like to be able to meet them. Thank you for coming. We would like to move on to cover a lot of ground on the changing proposals in the Health and Social Care Bill, the result of the listening exercise and so forth. However, we would like to start this morning by looking at the background against which those proposals are being worked out, in particular what the Committee tends to refer to as "the Nicholson challenge" and the requirement to deliver unprecedented efficiency gains if we are going to continue to meet demand for health care out of more constrained resources during the lifetime of this Parliament. The Committee would be interested to hear, to begin with, how you feel that process is developing. How confident are you that the proposals for service change, implicit in that commitment, are being prepared and are going to be delivered in a timescale that ensures we can achieve the objective of efficiency gain on the scale required?
Mr Lansley: Thank you very much. Can I say, for the record, that I am accompanied by Sir David Nicholson, Chief Executive of the NHS and Chief Executive-designate of the NHS Commissioning Board, and Richard Douglas, who is the Director General of Policy, Strategy and Finance at the Department of Health? Happily, we meet on the 63rd birthday of the National Health Service—5 July.
Last week, David Flory, who is the Deputy Chief Executive of the NHS, in his fourth quarter report on the performance of the NHS completing the 2010–11 financial year, set out a strong financial performance. On a range of 21 measures of performance—for reasons of brevity, I will not detail them—by which the NHS has customarily been measured, if memory serves me right, something like 14 or 15 have seen an improvement, several have been maintained and only one has deteriorated. In that case, there were two young people below the age of 16 who were admitted to adult in-patient psychiatric beds, contrary to the standard that we try to maintain. That was a very strong performance.
During the course of that financial year and now moving into 2011–12, especially in 2011–12, as you know and as we have discussed previously, we are looking for significant savings—what you describe as the Nicholson challenge. I will not go into the history of all that, as you know it well. This is the first year of doing that. While we will report on a quarterly basis on the financial performance of the NHS in achieving this, the things which contribute to that quality, innovation, prevention and productivity challenge are all making good progress. First, it is because we are clearly—as David and his colleagues across the Service have set out to do—maintaining or improving performance while undertaking transition. Secondly, we are taking steps—David or Richard might like to say a bit more about this—to cut the costs of administration and to focus resources on the front line. If anything, we are making faster progress on that than we had originally expected, including significant progress in 2010–11. We are benefiting—and the staff of the NHS are themselves substantially contributing to this—through the pay freeze; we are seeing improving productivity within the NHS already; we are seeing, through the tariff processes, a constraint upon growth of costs in the NHS; and we are seeing the commencement of a substantial redesign of services through the work already beginning to take place through clinical commissioning groups locally working with PCTs and local authorities. All of those are contributing to this.

Q133 Chair: That is the key, isn't it? In order to deliver productivity gains sustained in the medium term, yes, you can reduce costs through wage restraint and reducing unnecessary bureaucracy, but the key is service redesign in order to deliver care that is more up to date and meets higher standards of both quality and efficiency following redesign.

Mr Lansley: Yes. We were always clear in QIPP that this year would be a year where the greater part of the financial contributions to the efficiency savings would be generated through control of central costs, central budgets, the tariff changes, which are substantial, and the commencement of the redesign of services. However, that redesign of services in itself is more important as one proceeds through the subsequent years of the QIPP process than it is in the first year. What is encouraging is the extent to which the clinical commissioning groups, even though they have not, in most cases, taken any formal responsibilities—some have delegated responsibilities during the course of this year, but the majority have not—are, none the less, engaging directly in that process of redesign. If I might, I would ask David to add a bit about how that QIPP challenge is being responded to.

Sir David Nicholson: The point you make is absolutely right. If you look at the QIPP challenge across the whole of the four years, about 40% comes from the central things we discussed, about 40% comes from the tariff changes and about 20% from service redesign. The real danger for us, and the risk we face if we don't do that redesign, is that you end up making the savings through operational efficiency, and that is where you get into problems with quality. That is absolutely the case. We need to focus our attention on that. We always knew—I think I have said it here before—we had front-loaded the savings profile in the first year around the first two rather than the service redesign. There are two big elements to it. One is the service redesign which results in a flattening and then reduction of non-elective activity—it is service redesign around long-term conditions and all of that—and then there is the bit around the concentration and specialisation of sites. Those two things are relevant.

There is a lot of work going on around the country in planning both those things. I do not think we are going to see many results soon in relation to that. You will see the results of the service redesign coming on-stream towards the end of this year and beginning of next year, but our response is not uniform nationally. For example, there are parts of the country where they are making greater progress in relation to managing non-elective activity—the east of England is one, south central is another—and places where they are having real difficulty with that—and London would probably be identified as being in that category. Similarly, in terms of the centralisation and concentration of services in areas, you will know that we are currently at consultation on paediatric cardiac surgery as a very important part of that process. There are a number of consultations either beginning or about to begin around the country on service redesign of that nature. During this year you will see more of that as people plan and organise themselves to make the changes in years two and three.

Q134 Chair: I have one final follow-up and then I will ask Sarah to come in. Is it correct to identify 20% as attributable to service redesign and 40% parked as being the result of tariff change? Surely tariff change is merely a mechanism for forcing service redesign, isn't it?

Sir David Nicholson: It is, but the focus of the 40% on tariff redesign is predominantly around those things that we have known for a long time—better care, better value—

Chair: The fact that we have moved on—

Sir David Nicholson:—about operational efficiency. You have to deliver operational efficiency. It is not only about service redesign. The other argument that people make is, "You can't do it unless you service redesign." You can make a lot of savings just by improving productivity.

Mr Lansley: In effect, that is the process. There is now quite a substantial process of tariff development with which we are trying to make much faster progress. A lot of that is about best practice. Much of what David is describing in this 40% is driving out unnecessary variation and moving the service progressively towards achieving best practice. The tariff is intended to drive that, but the tariff development itself is going to be pretty important. Of course, in the response to the Future Forum, one of the issues we have been very clear about is the desirability of ensuring that we extend the tariff into new areas—that we make sure the tariff extends into the community services as well as hospital services—because that fosters redesign. Otherwise the tariff structure in itself would be an impediment. The same will be true in mental health services. As we shift the tariff towards a focus on paying for outcomes rather than paying for processes and activities, that, too, will help in the design. That all forms part of the productive care element of QIPP but, as we do it, it not only drives that productivity but also opens the door to a more constructive service redesign.

Q135 Dr Wollaston: For the record, Sir David, as to the challenge that has been set out as being "the Nicholson challenge", could you clarify for the Committee when you first set that out and informed the NHS that that would need to happen?

Sir David Nicholson: Thank you for giving me that. I appreciate it. It was in May 2009 when we did an analysis of the forward look for the NHS—what we thought was going to happen and what we thought of the financial circumstances the country found itself in—and we thought we needed to do it early. It did not come on until 18 months later because we needed to do the planning and engagement to get people to understand the nature of that. It was May 2009.

Dr Wollaston: Thank you very much for clarifying that date.

Q136 Chris Skidmore: Sir David, in 2009, when you had the original QIPP challenge, it was to be achieved over three rather than four years, I believe.

Sir David Nicholson: Yes.

Q137 Chris Skidmore: My concern is this. Now we have seen the delay in the Health and Social Care Bill, to what extent, in the terms you were talking about—the service redesign being part of the QIPP challenge later on in the Parliament—will this delay affect achieving the financial savings that need to be made?

Sir David Nicholson: I do not think so. All the way through we have tried to keep momentum, particularly

in relation to the two aspects of the change which are especially important, on clinical redesign. We have been talking to the pathfinder clinical commissioning groups—at least I have got it right this time—

Q138 Chris Skidmore: They were the consortia.
Sir David Nicholson: Please don't say it. The clinical commissioning groups have been working hard on all of this. There is lots of activity and we don't believe that has been slowed down by it.
The other issue is the foundation trust pipeline. In order to get people through the hoop of becoming clinically and financially viable organisations, you have to tackle a load of things, and we certainly have not rolled back on the foundation trust pipeline. We have kept the momentum going and we do not believe that the delay in the Bill will materially affect it.

Q139 Grahame M. Morris: I would like to ask the Secretary of State about competition policy, particularly, since the Bill was first published on 19 January, we have had this pause—this listening exercise—and the Future Forum report which indicated that competition should not be an end in itself. On the day when we are celebrating the 63rd birthday of the NHS, there are real concerns and issues with the modified Bill around, "Are the emperor's clothes full of holes?" Staff and service users are very concerned about clarity.
Can I remind the Secretary of State that in his statement to the House of Commons on 14 June—this is the statement on the Future Forum report—he said the principles and rules for co-operation and competition would be placed on a statutory footing? At the moment, the Government have not tabled any amendments to do this. The Secretary of State went on to say: "We will keep the existing competition rules introduced by the last Government"—that is, the March 2010 rules, which included "preferred provider". Is this a contradiction in relation to the recommendations on Any Qualified Provider and would the Secretary of State like to take this opportunity to set the record straight and give some clarity as to the Government's intention?
Mr Lansley: I believe what I said before was entirely accurate. The premise of your question was that the principles and rules of the Co-operation and Competition Panel included the NHS as preferred provider, and they do not. As far as I am concerned—as indeed was said by the then Government at the point at which they established the Panel and set out those principles and rules—they were reflective of the situation in competition law and, in effect, simply translated into operational terms within the NHS the potential application of competition law in the NHS in any case.
What we are doing, through the legislation—and we have in fact put amendments forward to the Bill—is ensuring that those things are on a statutory footing in the sense that Monitor, as a sector-specific regulator, will be responsible for their application but will do so in an evolutionary way by maintaining the distinct identity of the Co-operation and Competition Panel and maintaining their rules in the form in which they had previously applied. As I said before—to this Committee and elsewhere—the legislation does not, of itself, change the extent or application of competition law to the NHS.

Q140 Grahame M. Morris: Can I remind the Secretary of State that we had David Bennett, the Chief Executive of Monitor, giving evidence to the Bill Committee? In that evidence he said it is an unknown. He indicated that the exposure of the new structures to challenges using EU competition law was for the courts to determine, but he did not know whether that was going to be the case. Can I also ask, in relation to this point about competition: we are differentiating between good and bad competition but, from the regulator's point of view, how easy is it to make this distinction between good and bad competition?
Mr Lansley: I have two points. First, I entirely agree with David Bennett. The point I was making was that the Health and Social Care Bill as such does not change the extent or application of competition law in relation to the NHS. Of course, if you are trying to establish with certainty the boundary of that application of competition law, he is absolutely right. It is a matter essentially of debate and will be something that would, other things being equal, only be determined over time as cases were brought before the courts. In fact, the view which the Future Forum set out, having considered it during these last few months, was that the NHS would benefit significantly from the involvement of a sector-specific regulator in the health sector in applying such competition rules inside the NHS.
On your second point—good and bad competition—the whole point of the response to the Future Forum and the changes we have made, and indeed the legislation itself, is to use competition as a means to an end. To that extent, it is an issue for commissioners to say, "Where do we believe competition helps us to secure the quality that we are looking for?" In other circumstances, there may not be a competitive environment. Looking at the ends of a spectrum, if, for example, you are looking for accident and emergency services you are very unlikely to be doing anything other than commissioning directly from a single provider. At the other end, you might be, as we have been for some years, looking at access to planned care for elective operations and you may well be doing so in an environment of patient choice. To that extent, competition will apply. From our point of view, it is very clear that we are looking to create a structure which is focused on competition on quality because of the extension of tariff. In response to the Future Forum we made it very clear that we are going to pursue the extension of tariff-based competition, but then commissioners will be looking, through the extension of patient choice, to see where competition best applies to deliver that quality.

Q141 Mr Sharma: Are you satisfied that the Secretary of State will in future not only be accountable to Parliament and the public for the NHS, but will have sufficient powers to correct problems when action is needed?
Mr Lansley: Yes.

Q142 Mr Sharma: You are satisfied.
Mr Lansley: I am satisfied that the Bill will achieve exactly that. We have tabled amendments to the Bill that the Secretary of State will not only have a duty to promote a comprehensive health service, but a duty to secure the provision of that. The Secretary of State will also have continuing duties to report to Parliament, through an annual report, on the performance of NHS bodies, will have power to oversee and assess all of the national NHS bodies and will be clearly accountable for the performance of the NHS to Parliament.

Q143 Dr Wollaston: How are you going to balance the need to retain responsibility without interfering in the day-to-day decision making? It strikes me that you have all the responsibility but without powers. Are you satisfied that you will be able to get that balance right?
Mr Lansley: You are absolutely right. It is very important to get that balance right. We have always set out and continue to maintain the principle that, on behalf of taxpayers and Parliament, the job of the Secretary of State is to be clear about the mandate for the NHS. What people were concerned about the Future Forum quite properly reported and we have responded to. People want to know that that process of setting a mandate does not distance the Secretary of State from a duty to provide a comprehensive health care service and that it does not separate the Secretary of State from accountability to Parliament for how well the service has performed. They also want to know that, if there are significant failures in the system, the Secretary of State has, if necessary, the power to intervene.
The Secretary of State's relationship with the NHS should be one that is essentially determined through the mandate, which is set annually but is a multi-year mandate, and the purpose of which is to be clear to the service about what, on behalf of taxpayers and the public, Parliament and the Secretary of State are setting out for them to achieve, but then leaves the NHS free to determine how they can best achieve those results.

Q144 Valerie Vaz: What does that mandate look like? Presumably you are going to say that to Sir David Nicholson, or whoever is going to be in charge of the NHS Commissioning Board—whatever it is called. What is that phrase? Are you going to say to them, "Here is a mandate"?
Mr Lansley: The mandate will be a document that sets out for the NHS Commissioning Board, and through them to clinical commissioning groups, the relationship between the resources they receive, the nature of the comprehensive service they are expected to provide and how the Secretary of State is looking to them to secure the continuous improvement in outcomes reflected in the NHS Outcomes Framework.

Q145 Valerie Vaz: It is going to be a big document, is it?
Mr Lansley: It will be a document.
Sir David Nicholson: It is worth saying that in the Bill it is a document that is consulted on. In terms of the Bill, it sets out a timetable for public consultation on what is in it.

Q146 Valerie Vaz: There is a slight change, and I am looking at your response to the Future Forum. You said at paragraph 2.10, page 12—this is a kind of Jeremy Paxman-Michael Howard scenario, isn't it?—"Ministers are responsible, not for direct operational management, but for overseeing and holding to account the national bodies." There is a change, isn't there? It is a different NHS.
Mr Lansley: Do you mean a change from now?

Q147 Valerie Vaz: From now.
Mr Lansley: Yes, it is a change, in that—

Q148 Valerie Vaz: There is a different reorganisation.
Mr Lansley: We have always been clear—and this remains true—that we are looking for the NHS to enjoy greater autonomy in how it delivers the results it is intended to achieve. We have always been clear that we think it right for there not to be day-to-day political interference in the NHS. We think there should be a clear strategic framework for the NHS and a mandate for the improvement in outcomes that we are looking for, but we do not think that day-to-day political interference in the NHS is helpful.

Q149 Valerie Vaz: That is the royal "we," isn't it? It is a "we". It is not the Prime Minister's "we" because he was saying before the election that this is no top-down reorganisation. This is a huge change from before. You are giving all your powers to the NHS Commissioning Board. Isn't that correct? That is what you are basically saying here.
Mr Lansley: I don't think I am saying that because clearly the Secretary of State—

Q150 Valerie Vaz: I read it as that.
Mr Lansley:—continues to maintain considerable powers. Indeed, the strategic oversight and accountability through the mandate and other duties and powers are maintained. There is a transfer of day-to-day responsibility at the moment—which technically is vested, in the legislation, in the Secretary of State—into the NHS Commissioning Board. Of course, that is true.

Q151 Chair: It is more in the nature, is it not, of a self-denying ordinance on the part of the Secretary of State? He has the power to do it but is choosing, in the context of the mandate, not to use it because the NHS would be better run if it is run without day-to-day political interference. Is that a fair characterisation?
Mr Lansley: It would be contrary to the structure of the legislation in future for the Secretary of State to say, "I have the power to do it," and, in effect, take back powers from the NHS Commissioning Board. Except in the event of a significant failure on the part of the NHS Commissioning Board, the legislative structure would be that the Secretary of State would set the mandate and the NHS Commissioning Board

would then have the power to commission and to provide those services.

Q152 Chris Skidmore: If there ever needs to be any future reorganisation, can the NHS Commissioning Board as a statutory body achieve that without going to the Secretary of State, or would there need to be further legislation?

Mr Lansley: One never knows with these things, but I am hopeful that the structure of the legislation should be enduring. We are trying to deal with as many issues as possible. That is one of the reasons I thought the role of the NHS Future Forum was very helpful. It enabled us to address many of the questions—some of which had clearly arisen over recent months, since the publication of the White Paper and the Bill itself—so that they are dealt with in the legislation rather than left to be dealt with again in future legislation. It is much better to deal with the legislation properly now and get it right. Part of that is I do not think there would be an expectation that the NHS Commissioning Board would have to seek further legislation.

The legislation is clear about the structures. It is very clear, and continues to be clear, about the twin pillars, as it were, in terms of commissioning. We are talking about a National Health Service, nationally funded, to which people have rights of access under the NHS constitution. The NHS Commissioning Board discharges that responsibility in setting a national framework for resource allocation and national standards and undertakes national commissioning in terms of primary medical services and other family health services, plus national and regional specialised commissioning. Thus there is a big structure for the NHS Commissioning Board. The other pillar is locally-led, clinically-led commissioning. Between these two, we are creating space for flexible structures not requiring legislative prescription.

What the Future Forum did, of course, was to say, "We want to know, in between the national and the local, how these work together." What is being done practically, in terms of clustering primary care trusts and strategic health authorities, is giving people clarity about the evolution of organisation in the NHS to support clinical commissioning groups. The Future Forum's recommendations, which we have endorsed fully, about the development of clinical senates and clinical networks—and the development of those, hosted by the NHS Commissioning Board—is giving people a very clear shape, both administratively and clinically, of how we mesh national standards with local clinical leadership.

Q153 Andrew George: I wonder if I could bring you back to the broad brush rather than the specifics. What has changed as a result of the pause? In reality, has anything changed?

Mr Lansley: There are quite a lot of things that have changed. We have been clear, in the way that I just described, about the specific duties and accountabilities of the Secretary of State. We have further entrenched our determination that bodies across the NHS should respond to the NHS Constitution. We have extended further the requirements in terms of transparency, both of the clinical commissioning groups in future and indeed of foundation trusts. We have set out a framework for multi-professional involvement in commissioning, both at a local level and through the NHS Commissioning Board. We have set out a more flexible framework for transition while retaining the determination that we should do so, as the Forum said, making as much pace and progress as we can.

We have been clear about additional powers for Health and Wellbeing Boards in relation to commissioning, so that the Joint Strategic Needs Assessment and the strategies derived from that drive commissioning plans more explicitly than was the case. I have set out, in response to the Future Forum, my expectation that Public Health England will be established as an executive agency, balancing independent expert and scientific advice with the integration of policy and operational response to health threats. We have set out very clearly in the legislation how competition should be a means to an end, not an end in itself.

Q154 Andrew George: Was it ever an end in itself?

Mr Lansley: It was not intended to be, in our view, but there has been this change in the structure of legal duties. You will know very well that when you set up any form of regulation under statute, it is very important how you express the duties of such a body and the ranking of those duties. The ranking of those duties is very clear about the importance of Monitor as a sector-specific regulator focusing on what is in the best interests of patients and seeking to secure the integration of services around the needs of patients. We have done some very specific additional things in the legislation: changes which ensure that Monitor, as a sector-specific regulator, could not fall into the trap of the past of seeking to advantage one set of providers by reference to their ownership compared to others, supporting integration and ensuring safeguards against cherry-picking, including the extension of tariff. We have also said we are intending to be very clear about the transparency and robustness of a failure regime while ensuring that patients continue to have access to the services they require but not doing so, as we had previously intended, by an ex ante designation of services. So a few changes, then.

Q155 Andrew George: Yes, a few changes, but most of them, as you were describing yourselves, are matters seeking clarification, wanting to re-emphasise points and, also, reassuring. The narrative has been that you felt you had been misunderstood and you wanted to clarify issues. The changes you have described represent changes of emphasis, wanting to bolster issues and to reassure the public, and there are some welcome changes with regard to accountability and transparency which can certainly be seen as progress. However, as far as the broad direction of Government policy in this area is concerned, PCTs are still being abolished rather than simply remoulded, competition is still as relevant to these reforms as was previously the case and choice is as much emphasised as before—it is no less emphasised than it was before—and, while you have changed the

responsibility for driving competition from Monitor to the NHS Commissioning Board, those broad themes are still there, are they not?

Mr Lansley: I would not characterise it quite like that. I entirely understand the point you are making but legislation, by its nature, is precisely about ensuring one captures the intentions, sets out the safeguards and is clear about the accountabilities. I agree it was not recommended to us by the NHS Future Forum that we should depart from the fundamental principles of the Bill. In fact, they said there was widespread support for the principles of the Bill. I would not necessarily describe the principles in the way that you did. In the principles they were describing, it was not choice for patients but giving patients a real share in decision making and greater influence. That is as much about information as it is about choice. They were very clear about support for an outcomes focus, and there is a great deal we are doing on that. They were very clear about support for clinical leadership and devolved leadership. There was support for democratic accountability. Those are the principles of the Bill and they did not disagree with them. Indeed, I am not even sure that, politically speaking, political parties disagreed with them. Even the shadow Health Secretary is on the record as agreeing with the principles.

The point is to make sure, where people had concerns, that we addressed those concerns in the legislation. Through the Future Forum we had a very thorough means by which we assessed those concerns. You are right to say that some of them were misplaced concerns. That does not mean it is not important to try to respond to them and, in some cases—and this is certainly true where, for example, the duties of the Secretary of State are concerned—make changes to the legislation that demonstrate, I hope without fear of ambiguity, that the structure we are putting in place does not reflect those concerns that the Secretary of State no longer had this duty in relation to a comprehensive health service.

That is a good example. It is about language and changes in the legislation. Some are indeed to try and continue to reflect the principles more accurately. Others are genuine changes in the sense that we were going to pursue it in a particular way—for example, in relation to the failure regime—and we are not going to pursue designation in that way in future. So we are changing and there is a process of redrafting the legislation to make that happen.

Q156 Andrew George: Earlier, you said—and I think you used the expression—you were addressing the ranking of competition versus integration, addressing the inequalities and also patient choice. In what way have those four themes been re-ranked—which has gone up and which has fallen?

***Mr Lansley:*:** From memory—and I do not have the drafts of the amendments in front of me for this purpose—essentially, in the original structure, the legislation said that Monitor would have what is, in effect, a primary duty to pursue the best interests of patients and the public through the promotion of competition where appropriate, and regulation where necessary. If I recall the structure of the ranking of duties, it is to focus, first, on pursuing the best interests of patients and the public through the integration of services and the duty to improve quality. Subsequently, there is a range of further responsibilities and duties to which Monitor should have regard.

I come back to the point—which I have known over many years, and I am sure many Members will be very well aware of—that, where you establish under statute a body with a set of duties, it is important to be clear about what the relative ranking of those duties are. To that extent, people raised a concern with us that, other things being equal, they felt the structure of the legislation might have encouraged Monitor to step in in circumstances where commissioners had created an integrated structural provision in order to try and break it up and expose it to competition. Indeed, in the legislation there was a potential that Monitor could use competition powers in order, for example, to require NHS bodies to give competitors access to their facilities. What we are doing, through amendments to the legislation, is to make it absolutely clear that integration around the needs of patients trumps other issues, including the application of competition rules.

Q157 Andrew George: That is a change. Integration has now trumped competition whereas, in the previous legislation as drafted, competition was either at a similar rank or was trumping integration. Is that a fair characterisation?

Mr Lansley: It is a characterisation. I am sure one can quibble, so I will not quibble. Essentially, there was a risk. There was a risk that we had—

Q158 Andrew George: What I mean is it was a big defeat, wasn't it?

Mr Lansley: No. There was a risk that we had commissioners who we knew—and we were positively encouraging commissioners—would look to the integration of services around the needs of patients, which is why we were pursuing things like networks and clinical redesign. At the same time, we had a sector-specific regulator, the application of whose competition powers might impact adversely on that. People were concerned about that. We recognised that concern and I think we have made it absolutely clear that if one is acting in the best interests of patients, integrating services around the needs of patients and continuing to give patients access to information and choice—and, where appropriate, choice of Any Qualified Provider—then the way in which Monitor applies its sector-specific competition rules should not get in the way of that happening.

Q159 Andrew George: I want to try and square this one. I do not want to focus on Monitor as a whole. I want to look at the impact of the Bill. I am trying to get my head around whether there has been a fundamental alteration in the ranking of competition overall, in other words, in the net effect of the legislation itself. Has the ranking of competition in relation to, for example, integration in addressing inequalities retained its previous status or has it now

been trumped by other issues and competition is less significant—overall?

Mr Lansley: The amendments that we are proposing to the Bill quite clearly change the relative structure of duties for Monitor so as to make it absolutely clear—

Andrew George: I do not just mean Monitor, because the NHS Commissioning Board now has a more significant role.

Q160 Chair: It has a new duty, hasn't it, to promote integration?

Mr Lansley: Yes, it does have a new duty. Indeed, across NHS bodies, the Bill will make it clear that there is a set of duties about promoting integration, as there is a set of duties—and always was—to promote the continuous improvement of quality. Specifically, of course, since the NHS Commissioning Board did not have a duty to promote competition as such—and the powers in relation to competition with Monitor—what has been important is that the amendments properly reflect, as they do, like other key parts of the NHS structure, the fact that there is an inherent duty to promote the best interests of patients and to do so, in the first instance, by securing the integration of services around the needs of patients.

Q161 David Tredinnick: May I move from competition to choice? The Government response to the Future Forum report says: "Nearly everyone who contributed to the listening exercise felt patients should be given more choice and control over their care."

Last week, there was another report about worries about the use of combinations of allopathic drugs, in this case in elderly people. One of the reasons, I would suggest to you, that more people turn to what we used to call complementary medicines, perhaps herbal medicine, acupuncture—some of it now NICE approved—or homoeopathic medicine, is that they are worried about side-effects, or just the effects, of drugs. Under the new arrangements, if a patient goes to his doctor and says, "Doctor, I would like to be treated by a doctor who is qualified in homoeopathy"—a doctor who is regulated under the Faculty of Homoeopathy Act 1950 is properly trained and is a doctor—how would a patient's request be handled?

Mr Lansley: I am not sure there is a change in the new system as compared to the current system, in that patients have a right to seek out a general practitioner of their choice. In so far as there is a distinction between general practitioners, as long as one is, to that extent, accessible to them, I am not sure there is any constraint upon them treating that as one of their criteria. David, I don't know if I have missed something on that.

Sir David Nicholson: No.

Q162 David Tredinnick: Broadly, there would be no objection if a patient goes along with a specific request and says, "My choice is to be treated by a physician with particular training." That would be possible. We do not have homoeopathic doctors right across the country, so one of the issues you might want to address is further training of those doctors—a further increase in the provision of that particular service. I also think we are going to have to see a greater interest by the Department in herbal medicine, acupuncture and ayurvedic medicine because there is going to be an increased demand if patients are genuinely given more choice over their treatments.

Mr Lansley: Would it be helpful, David, to say a word about the process by which we are looking to develop choice for patients?

Sir David Nicholson: Yes. We have had extensive discussions with patients' organisations about these kinds of issues—in a sense, about where next to go with choice. We will not go from no choice to choice of everything. We will have to introduce it over time, get evidence, knowledge and understanding, and work it all the way through. The patients' organisations have come up with a set of things that they think—and these are the national patient voices and organisations—would be suitable for choice for patients in terms of the next stage. These relate to things like wheelchair services for children, some services around long-term conditions, aids to daily living, talking therapies and those kinds of things. People are thinking they are the next phase of choice. We would like to think then about what nationally we would say about that range of choice but also how we would stimulate the provision of that choice using Any Qualified Provider. That kind of approach, of talking to patient groups, drawing up lists, testing them in consultation, putting them into a national framework, inviting Any Qualified Provider and designing tariffs, seems to be a way of rolling this out over time rather than going from one place to another.

David Tredinnick: Thank you very much.

Q163 Chris Skidmore: One of the best bits about the Bill for me was the element of Any Qualified Provider, which could offer constituents certain services that they simply cannot get with the sort of silo mentality that exists at the moment. There was a document that came out just before the pause, aimed at providers, explaining what "Any Qualified Provider" would mean. That document talked at the end about establishing—I think we have just said—a national framework, specifically around registration, so that if providers came up to commissioning groups they would not have to endlessly register in different local areas. In terms of your response to the Future Forum, you have mentioned that "commissioners will decide...to which services choice of 'Any Qualified Provider' would apply and, where it applies, commissioners would determine pathways, referral thresholds and relevant local quality standards." That sounds slightly more fragmented than having a national framework. I was wondering if you might you be able to explain, for those who want to join Any Qualified Provider, whether they will have to go through each individual local commissioning group. Surely that would create a situation where you are going to have a variation in services.

Sir David Nicholson: We are due to publish something—I am not quite sure whether it is in the summer or the autumn—on all of this to explain it in the way that you have described. You are absolutely right. What we want is a system whereby people can register to be an Any Qualified Provider but that

would be applicable across the range of the NHS, not only in local circumstances. We need to consult on what mechanism that is because we want something that gives us reassurance but is not a huge bureaucratic process that stops people wanting to do it. A precondition for Any Qualified Provider is, of course, a tariff. That, in a sense, is why you need a national framework because you will need a national tariff to do that. Those sorts of things I have described will be the next phase of drawing together a national tariff. If you are an organisation who looks at that range of things and says, "Yes, I think I can provide them at the quality standards I provide," we will set out a national process for them to identify what they have to do in order to get on to the list of qualified providers. Then they can start providing them. That is the mechanism for doing it.

Q164 Valerie Vaz: Secretary of State, I think you are being slightly disingenuous, with the greatest respect. I do not mean to be rude, but I need to pull you up on some of your remarks. Before the Health Select Committee, when the White Paper was out, we had 6,000 responses from professionals who were concerned about what was happening with the Bill. Professor Steve Field was on record as saying that he supported the Bill beforehand, as you have said. He has said to us in evidence that he did not take his own separate legal advice on competition; he was reassured by the Department of Health. Therefore, we need to question his independence. Also, you can't have it both ways. You cannot have an evolutionary approach and then also have legislation. If it was an evolutionary approach, you would not need legislation. Many professionals have said that you could carry out some of this in a pilot exercise and you would not engage the NHS in this massive reorganisation with great cost to people's morale and their jobs—and we have not even touched on how much this is all costing. However, I want to move on to the National Commissioning Board now, if I could, Sir David. I am thoroughly confused. Yes, okay, you can patronise me later. But I am not sure—
Sir David Nicholson: I—
Valerie Vaz: Not you—
Mr Lansley: Apparently, I am doing the patronising. I had not thought that I had said anything.

Q165 Valerie Vaz: He always makes faces at me.
I am thoroughly confused because I have a number of questions about your role and where you see your role and the Secretary of State's. As I understand it, he is going to be sitting in a big armchair and getting the National Commissioning Board to do all the work and have all the power. I notice from this little diagram in "Designing the NHS Commissioning Board" that there does not seem to be an accountability link between patients and the public and the Department of Health, the Treasury and Parliament. There is between you and the Secretary of State, but nothing between the public and the Secretary of State. Also, what are the local commissioning groups now? How do they fit in with the senate and what is the "14 to 17 health systems"? Could you expand on all that?
Sir David Nicholson: There are quite a lot of questions in all of this and I do not want to go on for ever.

Q166 Valerie Vaz: Yes, but I am flagging up the headings.
Sir David Nicholson: Okay. First of all, you have a document there which I sort of recognise. We plan to publish, later on this week, an introductory document about designing the NHS Commissioning Board. I understand that there is a copy on some website of an early draft, so my assumption is that you have a leaked copy of that document.
Chair: I think it is on the Department's website right now.

Q167 Valerie Vaz: And you are going to be in charge of the NHS. Oh, dear.
Sir David Nicholson: It's an outrage.

Q168 Valerie Vaz: And it wasn't you.
Sir David Nicholson: I have only been away for 10 minutes and they've done that.

Q169 Valerie Vaz: And it wasn't you.
Sir David Nicholson: Given that I have not signed it off, and indeed I have a discussion this afternoon with a whole set of general practitioners about it, it is extraordinary. Nevertheless, the final document on all this has not been published yet. They may have put an early draft on the Department of Health website, and good luck to them for doing that. However, the importance of that is to try and set out to people who work in the Service in particular, and the clinical commissioning groups, what the totality of the system will look like. People have been dealing with little bits of the system independently, so all the debate is around Monitor, but the real issue is the relationship between Monitor, the commissioners and the Government and the rest of it. It is trying to explain how all of that works together. That is the first thing in relation to all of that.
What was your next question about?

Q170 Valerie Vaz: It is the local commissioning groups and then you also have senates. Are we talking about the same people, additional people or is there another layer? Also, what are these 14 to 17? You are on record as saying 14 to 17 health systems.
Sir David Nicholson: By "local commissioning groups", I assume you mean the clinical commissioning groups.
Valerie Vaz: Yes.
Sir David Nicholson: The clinical commissioning groups are obviously responsible for a population base in the area for commissioning those services. We have set out now what the broad shape of the governance arrangements are for the governing body of those and we have identified that it certainly needs to have a registered nurse and someone with experience and expertise in specialist services as part of that as well as at least two lay members. We have set out all of that, but that is not the only issue in relation to the way those individual clinical commissioning groups

interact with clinicians and patients and all the rest of it.

The first thing that came up in the discussion was the importance of clinical networks. As you know, some people thought that, by setting up clinical commissioning groups, we were abolishing clinical networks because somehow they wouldn't work, but they are a very important part of the way we do business in the NHS. The cancer networks, the coronary heart disease networks and so on cover big geographies—they don't just cover small areas but big geographies—that set out how the different bits of the system for a particular specialty work together. They will continue.

Q171 Valerie Vaz: Will that be locally or nationally?

Sir David Nicholson: The networks will be hosted by the Commissioning Board. That means someone needs to make sure they happen. Clinical networks do not just happen. You need to organise them. You need to get people together. You need to put an infrastructure in place to enable people to work together. At the moment, they are often done by strategic health authorities. Some of them are done by PCTs. Some are done by individual trusts, depending on the local arrangements. We think that is great. All we need to do is make sure they happen. The commissioning boards will have a responsibility to make sure they do happen. That is at an individual specialty level.

There is the issue, though, about the total pattern of service in an area. What does the whole service look like from primary to secondary to tertiary? There was a concern that clinicians engaged in those various activities did not have a say or an input into the way that the commissioning groups were going to operate or the way that the strategies were being developed, so this idea of a senate came out. Senates are operating in the east midlands—London has a clinical senate as well—where a whole range of clinicians get together across a whole pattern of service to think about how it all fits together.

Q172 Valerie Vaz: This is the SHA, basically.

Sir David Nicholson: The two that I have described do relate to an SHA area. The question is: how many of these senates should you have? We have to do quite a lot of work with the Royal Colleges and clinicians on the ground to work all this out, but where they seem to work really well is when they connect primary, secondary and tertiary care together. What you are looking at then is total patient flows and how the flows work. If you look across the country as a whole—and we have done a huge amount of analysis to see where patients actually flow—what you can see is there are between 15 and 20 total health economies in the country where they have the complete picture of all those services around them. All I was saying on the record there—I was asked the question about how many senates there would be—was if you applied that rule to the senate you would have that sort of number. Some people were worried that we would have 300 senates, that in every locality you would have a small senate. That was not the reason at all. We were looking at bigger footprints. That is where the 15 to 20 comes from.

Q173 Valerie Vaz: Where does the money flow then? You have the budget, so you can tell.

Sir David Nicholson: That is nothing to do with it. The money does not flow through them.

Q174 Valerie Vaz: No, but I am asking that.

Sir David Nicholson: Okay. The Government set out the mandate and then they set out the amount of resource attached to that mandate. The NHS Commissioning Board gets that and then allocates it. The vast majority of that will go to the clinical commissioning groups. Some of that will go to specialised commissioning and some to the local representatives of the NHS Commissioning Board who will be commissioning primary medical services. That is where the money goes.

Q175 Valerie Vaz: Are the people on the senate slightly different from the people who are on the local clinical commissioning boards?

Sir David Nicholson: Yes. There will be a whole range of clinicians who are—

Q176 Valerie Vaz: There is a whole new set of people.

Sir David Nicholson: Yes, there is a new set of people. This is not a statutory body. This is a group of people getting together. As I say, we have experience of how this works. They are really helpful because individual Health and Wellbeing Boards can ask questions and ask them for advice when they are dealing with issues in their locality, the clinical commissioning groups can ask them for advice, help and support in dealing with particular issues and the Commissioning Board itself can ask them for help and advice. Indeed, what we have said is we will ask them for help and advice in identifying how we are going to authorise clinical commissioning groups. It is a mechanism by which you can get more clinical involvement and engagement in the important decisions that we need to make.

Q177 Valerie Vaz: Turning to your Board, who is on your Board at the minute?

Sir David Nicholson: It does not exist.

Q178 Valerie Vaz: It does not exist. It is just you at the minute.

Sir David Nicholson: Not even me. I do exist, obviously.

Valerie Vaz: For now.

Sir David Nicholson: Thank you for that. I will now pull a funny face at you.

The plan is that we will set up a special health authority as soon as we possibly can in order to start the work of the NHS Commissioning Board, because there is quite a lot of preparatory work we need to do, not least to identify some more people to work for it. One of the things we have is a whole load of people who don't know where their employment arrangements are going to be. We are going to set that up as soon as we can. Before we can do that, we will

have to appoint a chair and a non-executive director. That will probably be advertised after the summer break—presumably September time. There will be a national advertisement for a chair of the NHS Commissioning Board and a non-executive director. That appointment is finally an appointment for the Secretary of State, and I guess they will come here to talk to you as part of that.

Q179 Valerie Vaz: What is the current state of the people who are working in the PCTs and the SHAs? Are you aware of what is going on at ground level? Are these people likely to be part of the senate?
Sir David Nicholson: The senate will be a clinically-based organisation. It will be clinicians who currently—

Q180 Valerie Vaz: What about the local commissioning groups? Will they have PCT people?
Sir David Nicholson: What is happening at the moment is we have clustered the PCTs together. Are you Walsall?
Valerie Vaz: Yes.
Sir David Nicholson: There is a Black Country cluster and they, essentially, have three jobs to do. The first is to make sure we deliver over the next two years while all the changes are going on, focusing on day-to-day delivery to make sure we continue to deliver the QIPP challenge and all the rest of it. The second one is to develop the clinical commissioning groups within their locality, so they have a job to help them do that. As part of that, we would like them to assign staff currently working in the PCT to individual clinical commissioning groups to get them up and running and working and moving. I know in your part of the world they have done quite a lot of that. The third bit is to develop commissioning support—the kind of support the clinical commissioning groups will need to do their job. That will be to start to develop informatics, logistics and issues around contracting, all those sorts of things, so that the clinical commissioning groups can operate from 1 April 2013. Those are the three things we have asked them to do. As part of that, some of those people will go to the clinical commissioning groups, some will go and work in commissioning support and some will work in the Commissioning Board for oversight when the clinical commissioning groups are up and running.
Valerie Vaz: Thank you.

Q181 Chair: I should apologise. I misled you. This document is not on the Department's website. It is on the *Health Service Journal* website. I apologise for that.
Sir David Nicholson: There is a difference.
Chair: There is a difference.
Sir David Nicholson: I will not be seeking revenge and retribution when I get back.
Chair: No revenge necessary.

Q182 Rosie Cooper: If I could come back to the clinical senates, do you believe that doctors will be doing this in their own time or will this be part of their paid employment? I say that because in my area we are setting up an integrated care organisation and the GPs who are independent contractors and see themselves as small businessmen resent the fact that perhaps consultants and others may attend in their duty time whereas the GPs do not. Therefore, we currently have a stand-off where GPs are not going to attend these senates unless they are paid. If this is going to be broad-based and you are going to need the engagement of doctors, do you intend to pay them to attend?
Sir David Nicholson: We have not worked out the detail of all this at all. It is something we will need to talk to the Royal Colleges and the trades unions about and all the rest of it. This kind of work—and it will not be just doctors, by the way—is part of being a doctor or a clinician, to be engaged in the planning and organisation of the services that you provide. It seems to me it is a critical part of their job.

Q183 Rosie Cooper: I would agree with you, but if you are a small businessman and it is costing you money to go, you are not going to engage as well as if you were paid or you had your costs covered in order for you to attend. It is a basic flaw if that is not addressed early.
Sir David Nicholson: We will obviously have to address that then.

Q184 Rosie Cooper: I have absolutely no idea where we are generally, but we have talked in very great detail—at the macro-level—and the Secretary of State before referred to "no day-to-day political interference". I wonder whether he could explain to us how political representation on behalf of constituents will take place in this new world.
Mr Lansley: If, for example, you mean that a constituent comes to you who has a difficulty with access to services, let us say, or some services have not met their needs, the first thing is, as a Member of Parliament, you will have exactly the same right in future to raise the interests of your constituent with the relevant body. It may be a clinical commissioning group who have responsibility for that patient or it may be that, in this particular instance, it will be a foundation trust or a health care provider you should raise the issue with. I am not sure I see any reason why that should be any different from the current situation.
If you were to raise an individual case with me, as Secretary of State, I would not expect—and my predecessors did not expect—to tell an individual primary care trust how they should behave in relation to a particular patient. However, Secretaries of State in the past and in the future have an expectation, if they are asked by Members of Parliament, to be able themselves to ask the relevant NHS body, whoever that may be, to respond, perhaps through the Secretary of State or directly, to an MP.

Q185 Rosie Cooper: But in this case, those people will be making those decisions. For example, there will undoubtedly be hospital closures and rationing. Everybody acknowledges that.
Mr Lansley: I am sorry, which hospitals are you expecting to close?

Q186 Rosie Cooper: No doubt, you will be very seriously telling us very soon.
Mr Lansley: I don't know of any.

Q187 Rosie Cooper: Let's see. I will put my Mystic Meg hat on and say that that will be a result of these processes.
Mr Lansley: You assert this with great confidence as though everybody knows this. I don't know it.

Q188 Rosie Cooper: My PCT has a number of operations which it will only agree to being done, if at all, under certain criteria, for example, varicose vein operations. I have a constituent whose GP, clinician and NHS consultant say she needs the operation. The remaining vestiges of the PCT say it does not meet their criteria and she is not eligible to have that done. In the brave new world—and we substitute clinical commissioning groups for the PCT—when the patient does not get any better response, what avenues are open, beyond just readdressing the clinical commissioning group, to the taxpayers to pursue their legitimate and supported clinical requests? I will say it on record: this is a question which will exercise, I would suggest, coalition MPs as the constituents whose services are reduced or are removed are seeking answers as we march towards the general election.
Mr Lansley: Don't you think your question rather well illustrates the benefits of the changes that we are seeking to bring forward? At a local level, from your point of view, in relation to your constituent, you are experiencing in practical terms a divide between what is felt to be appropriate from a clinical perspective and what is being applied as a policy from a managerial perspective. What we are setting out to do in clinical commissioning groups is to make absolutely clear that that is not an appropriate divide and that there should be—

Q189 Rosie Cooper: Secretary of State—
Mr Lansley:—clinical leadership around the interests of patients.
Rosie Cooper: —you are not listening to the second part of my question. I said when that the PCT is substituted by a clinical commissioning group and they make that decision which my constituent disagrees with, what were the avenues open then? That was the real question. I was illustrating it with what is happening today.
Mr Lansley: I will come to the second question, but the first point is that your constituent is unhappy because he or she thinks that their doctor, nurse and consultant believe something is in his or her best interests and that is being frustrated by the primary care trust. If, in future, you have clinical leadership in the clinical commissioning groups, while there may be disagreement at an individual level between clinicians about what is the appropriate treatment, at least the policy of the clinical commissioning group will have been established by those self-same clinicians. There will be clinical leadership that drives decisions about resources. We cannot take away the overall issue that resources have to be managed most effectively for the best interests of patients.
You will know that, across the country, there are certainly clinicians who will make judgments about where they regard certain treatments as being of very poor effectiveness or value for money. They may well engage in that kind of prioritisation. What they will not do, however, is be required to deny patients treatment that they think is effective and is value for money.
In a sense, I come back to the answer to your first point. If, at the end of the day, the clinical commissioning group takes the decision that your constituent does not agree with, and your constituent comes to you, there will be exactly, in that sense, the same kind of relationship between the clinical commissioning group and Parliament. There is room for complaint and there is room for representation in exactly the same way as the current primary care trust.

Q190 Grahame M. Morris: Can I ask a supplementary on that? In that case, Secretary of State, why did you withdraw the proposal for designation where a commissioner could designate a particular service, irrespective of whether there was provider failure, and it would continue to be protected? What was the rationale for that?
Mr Lansley: We did not think it would be helpful, not least to the NHS, to be distracted into a theoretical discussion about whether services should be designated or otherwise. If it becomes a practical question, it should be addressed as a practical question.
Rosie Cooper: I think the taxpayers will make their own decisions on that.

Q191 Dr Wollaston: There is an issue about service reconfiguration, and you touched on the reconfiguration of the paediatric cardiology services where we know that—not only financially, but also, more importantly, for clinical reasons—you need to concentrate services. Therefore, some hospitals or services would have to close and, of course, there has never been a time in the NHS when there has not been some rationing, as far as I can remember in my involvement with it.
Something that was touched on by one of the King's Fund reports was that service reconfiguration needed to happen at a regional level because it is very difficult for local politicians, let alone local councillors, to agree to decisions that close local units, even where it is perhaps clinically or financially necessary. Are you satisfied that that service reconfiguration will be able to take place under the new arrangements and we will not see Health and Wellbeing Boards and local decision making getting in the way of necessary service reconfigurations? Is that a clear question?
Mr Lansley: Yes, I think it is. It is a clear question to which I would say, first, if we are all, in all parts of the service, clear about the four tests that we apply, it is pretty important that we constantly look at the question of, "How does this respond to patients' needs, expectations and patient choice? Would a reconfiguration unacceptably restrict that choice or not respond to patients' wishes?" Secondly, we have to look at the public view. There is a legitimate democratic accountability, which is expressed through

the Health and Well-being Boards, which needs to be part of the decision-making process. Thirdly, there is a need for the commissioners, the clinical commissioning groups or the NHS Commissioning Board, depending on the nature of the service one is talking about, to be clear that this is something the commissioners themselves see as desirable if a change is required. Fourthly, there has to be clarity about clinical evidence and clinical safety.

The starting point, before you get into the "Who takes what decision under what circumstances?", is for everybody in the process to be clear about the rationale against those four tests for any specific reconfiguration. Compared to the current situation, we are likely, under the changed structures of decision making in the NHS, to see reconfigurations dealt with better than in the past. Why? At the moment it is very often done by primary care trusts and strategic health authorities whom the public, in any given location, think are not accountable directly to them. That will change to circumstances where, in the great majority of cases, reconfiguration of services is proposed and led by the two sets of people whom the public would expect to be directly involved: the clinicians—the doctors and nurses in whom they put their trust and whom they expect to have the clearest view about what services they do need in their area—and the people whom they elect, their local council, who together, through the health and wellbeing strategy, should be clear about the implications of any service reconfiguration on the overall structure of services in that area. Thus, from the public's point of view, to the extent those two sides are directly involved, we are more likely to have a proactive agreement about whether service reconfiguration should happen.

Q192 Dr Wollaston: Except that, even in an area, say, in London, where it is accepted that there is perhaps over-provision of acute hospital services relative to other parts of the country, if you try to close a hospital or a service, there is likely to be a very vociferous local campaign to keep it open.

Mr Lansley: Of course, absolutely.

Q193 Dr Wollaston: Even where you have involvement, if that local involvement says, "No, we don't want our local service to close," how will that be pushed?

Mr Lansley: I say this on the back of years of experience of these things, as indeed David and Richard will have. Very often it is precisely in circumstances where you have the public as patients that you will have a local authority, GPs and even hospital and other clinicians all objecting to what is being proposed. Is it any wonder that there is considerable public antipathy to some of these reconfiguration proposals?

If you then move to a place where, from the public's point of view, people they know and trust, particularly their general practitioners, have been in a position of helping to make these decisions in the first place and the clinicians and the local authority are proactively looking at what is in the best interests of their area—and sometimes there are difficult, challenging decisions to be made about the structure of service configuration—a shift of services into the community is clearly going to happen, it is going to lead to changes in service structures and provision inside the acute sector. People will have to go through these issues. However, if they can see that it is happening as something that is clinically-led, locally-led, they are more likely to accept it. We have seen it happen even since the election. We have seen circumstances where reconfiguration proposals—which before the election were very much objected to because they were effectively being dictated by what was regarded as a less accountable bureaucratic process—have become clearly owned, not least by the GPs as commissioners coming together owning the decision. From the public's point of view, that makes a big difference.

Q194 Dr Wollaston: In circumstances where that was not the case, where local people still felt very strongly that they did not want their particular local service to close, if the commissioners still took a decision that it was in the wider interests for that to happen, that could still take place.

Mr Lansley: There will be—and we are clear in the legislation that there will continue to be—a mechanism by which, through the local authority, that can be referred to the Secretary of State. There is still the same scope for that kind of referral leading to the Independent Reconfiguration Panel's scrutiny. There is still an independent process, if necessary.

Q195 Rosie Cooper: Secretary of State, are you really saying that you see a group of independent contractors, acting as a local commissioning group, as the democratic accountability of this system? Health and Wellbeing Boards and councillors with no power other than to speak and try to influence do not add up to one jot of democratic accountability.

Mr Lansley: I don't think I did say that at all. In this context, they are not independent contractors. They will be members of a statutory body. They are not independent in—

Q196 Rosie Cooper: But you are asking people to trust them based on—

Mr Lansley: Democratic accountability does not come through the clinical commissioning groups. It comes through the role of the Health and Wellbeing Board as an executive function of the local authority.

Q197 Rosie Cooper: Forgive me, Secretary of State, but it is like sitting in a parallel universe. Health and Wellbeing Boards do not have any power and currently—

Mr Lansley: They will do under the legislation.

Q198 Rosie Cooper: Health and Well-being Boards do not have a veto on what is commissioned and the commissioning groups, as they are now called, do not have to listen to them. It is not mandatory that they listen to them. How can that be direct accountability?

Mr Lansley: There was always intended to be a strong relationship between the Health and Wellbeing Boards and the clinical commissioning groups fashioned through the Joint Strategic Needs Assessment and the strategy, and we intend to strengthen that further

through amendments to the legislation. Richard, I don't know if you want to talk us through that a little bit.

Richard Douglas: We will be setting out in the statutory guidance how commissioning groups have to take into account the views of Health and Wellbeing Boards and there will be the option for Health and Wellbeing Boards to make referrals back to the NHS commissioning boards. There will not be an overall right of veto—you are absolutely right—but there will be the opportunity to make referrals to other organisations.

Q199 Rosie Cooper: People will be sitting there completely stunned at the fact that we are giving over the Health Service to groups of commissioners. Let me take this document, "Designing the NHS Commissioning Board," which is not on the Department's website but on the NHS website: "I envisage a significant role for clinical commissioning groups themselves in overseeing primary medical care contracts and improving the quality of primary care, supported by the Board." Everybody is looking in at themselves. There is, surely to goodness, a huge amount of conflict here.

Sir David Nicholson: The point you particularly raise is a really important one because we know from experience that the best way of driving up the quality of care in the primary sector is the activity of your peers. That is what makes the difference. It is a response, in a sense, but the real levers are going to be held by the Board, which they are, because the Board has the statutory responsibility to commission primary care. The issue is: how can we bring the Board and the local GPs together to get the best of both worlds, to get the transparency of accountability so that it is clear who is commissioning for what but, on the other hand, get the power of peer review to drive up the quality of primary care, which is what we want to do?

Q200 Rosie Cooper: Absolutely. I understand that, and you can use peer group pressure to deal with outliers. As to having doctors look at other doctors in their area, you are not saying that is not going to be open to abuse of some sort.

Sir David Nicholson: That is why it needs to be transparent and why the accountability remains with the Commissioning Board. We want doctors to look at each other. We want general practitioners to benchmark themselves against each other to see how they are making improvements. That is exactly what we want.

Mr Lansley: I have been very encouraged by the discussions I have had with lots of GP groups across the country who have seen it as one of their principal objectives to deal with poor performance in primary care and in general practices. To be frank, they have often felt that primary care trusts have not been able to do that because it is almost a case that the only way the primary care trusts can do it is by taking what are rather extreme measures in relation to their contract. This kind of clinical governance at a local level is absolutely essential.

Q201 Grahame M. Morris: We are dealing with commissioning which seems quite abstract, looking at some of the concepts, but giving a practical example brings it to life. I would like to raise an issue that the Secretary of State referred to in his opening remarks, at least very briefly, in relation to mental health services. The Department's own figures show that the investment in statutory mental health services in the north-east is less than in other regions and we are aware that GPs are concerned they do not have the right skills to treat mental illness, let alone to commission services. There are all sorts of issues building up in the north-east that are impacting on the ability to deliver the service because we rely quite heavily on the third sector. In particular, I should mention the Northern Rock Foundation, as £3 million from the Northern Rock Foundation has been lost. The likelihood is, when the bank is re-privatised, that everything invested in the region will be lost, and most of that goes into mental health and emotional wellbeing services. £800,000 is being lost when the North East Mental Health Development Unit closes this October and I am sure you are aware of the pressures that the Public Health Observatories are under. Ours in the North East specialises in mental health issues and develops the profiles.

My question is: how will these new arrangements ensure that, in this case, the voluntary sector receives the necessary financial support to remain viable and will have the capacity to support increasing amounts of vulnerable people? Clearly, mental illness is a function of the economic recession and pressures arising out of that.

Richard Douglas: I can let David go into some of the detail of this, but if you are looking at how this new system would work, the very simple way we are trying to present it is that the Commissioning Board's role will be to turn the £80 billion—or whatever it is we end up allocating to them—into the best possible outcomes for patients. They will do that within the framework of the mandate and the outcomes that we set, but the job of the Commissioning Board is to turn that money into improved outcomes. I don't know if David wants to say anything particularly about the mental health area.

Sir David Nicholson: We believe that this is best commissioned locally, with local understanding, local knowledge and all the rest of it. One of the criticisms we have had in the past around commissioning mental health services is that it has not been professionalised, that every PCT has one person who does mental health and they do not have the expertise—the knowledge—to do it. That is the reason why we are looking at commissioning support. In the north-east I know that the clusters involved there are working out, "How can we concentrate all of our expertise in mental health services to support the individual clinical commissioners to take that action?" That is well established and will improve the quality of clinical commissioning of mental health services.

On the other side, of course, you have what everybody in the country should have access to, which is good-quality mental health services. How do you do that? The NHS Commissioning Board is commissioning NICE to set out a whole series of standards, including

for mental health, which will be applicable to each of the local commissioning groups. We will set out a series of standards and some measures that we expect everyone to deliver. That is how we will do it, both at a national level and at a local level.

Q202 Grahame M. Morris: Essentially, in relation to mental health services, we will be relying on the clinical commissioning groups at local level to recognise the value of this service and commission it.
Sir David Nicholson: Yes, but one of the things about previous reorganisations which is different from this one is that, when a PCT was set up on 1 April, whenever it was, it automatically took on all of its responsibilities on day one. It was assumed that it could do everything. The difference with the clinical commissioning groups is we are not saying that. They have to go through an authorisation process over the next two years to get them to a place where they can. We would have to be absolutely assured that they have access to the clinical advice, the knowledge, understanding and techniques in order to authorise them to commission mental health services.

Q203 Grahame M. Morris: I understand that, but my immediate concern, as someone who is involved in this area and has had contact with some of the people who are delivering the services, is that there will be a hiatus until the commissioning groups are ready. In the meantime, we are losing this very valuable and well-established service. Some of it, incidentally, is funded by the charitable sector and some through local government—area-based grants and so on—which have also gone.
Sir David Nicholson: I absolutely accept this issue about planning blight and all the worries that you have around the move from one system to another. In a sense, it is the job of the PCT clusters to ensure that does not happen. That is their job.
Mr Lansley: I might add that in the report of the Deputy Chief Executive last week, one of the performance measures is a series of proxies for the quality of child and adolescent mental health services. Overall performance in meeting those proxy measures—that is age-appropriate services, learning disability services, 24-hour mental health cover and early intervention support services—improved to the point where 104 primary care trusts over England were fully meeting access to all those four services. That is improved performance. Thus, what David is describing is that there is a focus in the service on maintaining and improving performance at the same time as we are building capacity.
It is often true to say—David said it a moment ago—that many of those who work in mental health services say that their existing commissioners do not sufficiently understand the service they are commissioning. They would often say they are not sure that general practitioners understand the service they are commissioning, but that is not a reason to say that clinical commissioning groups should not take over responsibility in relation to this because, broadly, one in four patients who go into their GP surgery present with a mental health problem. Many GP practices actively want, through their commissioning processes, to create a more integrated service locally. I couldn't tell you how often GP groups have told me they want, for example, to have community psychiatric nursing based in their own local surgeries on the basis, alongside services, of being able to understand and integrate the service better around the needs of their patients. The business of shifting from where GPs very often are referring into a mental health partnership trust, but not really having any handle on what happens thereafter, to a situation where, through the commissioning process, they do understand the nature of the service they are commissioning and are more fully engaged with it from the primary care angle is a significant positive benefit.

Q204 Yvonne Fovargue: I am concerned about the volume of the clinical commissioning groups—the actual numbers. There are 328. In Wigan alone, which has a population of 300,000, I have five pathfinders. Do you expect that number to reduce and how many are going to be authorised and go through the process by 2013?
Mr Lansley: I understood we had 220 pathfinders who have come forward at the moment. That represents something like 87% of the population. That is an average population of about 200,000 patients. The purpose of the pathfinder process, and the purpose of the learning network that we have established between them, is for them to understand how they can best combine the obvious benefits of locality commissioning with the obvious pressures for scale. What we are doing, rather than trying to determine some size or number of patients that meets all these circumstances, is to say that they should respond to their own local circumstances in terms of the overall shape of the groups that they bring together but, through the commissioning support organisations that are being developed with them, we should enable them to access economies and benefits of scale in terms of the commissioning activity they undertake.

Q205 Yvonne Fovargue: The other concern I have is that in my locality a lot of them cross boundaries because they are not based on logic. They are based on who they work with as friends. Therefore, there is a lot of local authority boundary crossing and the patients are dispersed.
Mr Lansley: Of the 220 who have come forward as pathfinders, 16 cross unitary and upper-tier local authority boundaries.

Q206 Yvonne Fovargue: It's a pity they are in Wigan.
Sir David Nicholson: Because you don't get on with people—you are not mates—is not a criterion for allowing people to cross those boundaries.

Q207 Yvonne Fovargue: My local consortia are not based on any sort of patient links in terms of being next to each other. They are actually based on who they are working with at the moment, which you can see in one way is sensible, but it is not doing much for the patients. One person has one doctor who works over there, and another has another doctor who is

working over there and is commissioning totally differently. Do you expect that to be a significant problem?

Sir David Nicholson: We want to try and get all of those 16 practices that cross upper-tier boundaries to look at it again and think about what the relative benefits of crossing that boundary are as against the integration with local authority services, although I have to say that, just because people are coterminous, does not mean that their services are integrated. Then the Commissioning Board at some stage will take a view about what it will and will not allow. All I was saying was that a criterion will not be, "I want those people in my consortia because they are my mates." That will not be part of the criteria.

Mr Lansley: In truth, on most of 16 where they do cross these boundaries, they have done so on the basis of their approach being in relation to the catchment of a particular major provider—a provider trust.

Sir David Nicholson: Yes. The ones at Sandwell and the Black Country are an example of that sort of thing, where they relate to catchment areas of hospitals rather than local authorities. That is the predominant reason people do it.

Q208 Yvonne Fovargue: Where that does not happen, they will have to look at it again.

Sir David Nicholson: Yes.

Q209 Andrew George: I want to briefly turn back to the issue of Monitor and competition, which was mentioned earlier. Amendment 149 does what the Government said it would do, which is to remove the duty to "promote competition", and "requires Monitor to exercise its functions"—and I am reading from the briefing notes prepared by your Department, page 17, paragraph 67—"with a view to preventing anti-competitive behaviour which acts against the interests of people who use NHS services." Could you explain what the difference is between "promoting competition" and "preventing anti-competitive behaviour"?

Mr Lansley: Richard, you might want to add a little to this. From my point of view, it is the difference between seeking to impose any particular structure of competition, which would be effectively ex ante—trying to decide in advance what a competitive structure would look like—and what is effectively an ex post approach, which is to say commissioners and providers should behave in ways that they think are in the best interests of patients, and perhaps in their own best interests as an organisation. But it is only if one can actually see that they are engaging in abuse which impacts negatively on patients in practice that you act upon it. It is the difference between the theoretical and the practical.

An example of the nature of such abuse is as follows. Quite often, in the NHS you have joint appointments, or consultants and clinical staff who have a contract with one person here and another provider there. If one of those providers were to say "We are going to try and exercise a power over you through our contracts to stop you doing your work for this other provider because they compete with us," that is an abuse. It is an abuse of dominance.

Q210 Andrew George: Does the OFT not monitor that?

Mr Lansley: Your point is absolutely fair. If we are dealing with those kinds of abuses—abuse of a dominant position, price fixing, cartelisation, things of that kind—where they would damage patients' interests, the same would be true in the application of the OFT's rules and they would be perfectly capable of stepping in. Of course, the structure of the legislation is that Monitor, as the sector-specific regulator, should exercise the same powers and would hopefully do so in a way that is more aware of the overall nature of the provision of services in the NHS and can interpret them more effectively.

Richard Douglas: I have nothing I would add to that.

Q211 Andrew George: In paragraph 5.9 of your response to the Future Forum, you say: "Therefore, we will outlaw any policy to increase or maintain the market share of any particular sector of provider." That is, in effect, saying that the share of the NHS will go down. Is that right?

Mr Lansley: No. It means we do not think it is right for the Government to pursue a policy that says the private sector should enjoy a bigger market share in the NHS. Equally, we do not think it was right that the Government should have exercised a policy that said the NHS is preferred provider and the NHS can let patients down before they are able to go somewhere else. We should operate on the basis of consistent equal application of the rules regardless of the ownership of providers.

Andrew George: That is very helpful.

Q212 Valerie Vaz: That would be open to a challenge under state aid, so you could do that anyway. You are not doing anything different or new. That is what the law is.

Mr Lansley: I do not think that is strictly true.

Q213 Valerie Vaz: It is—state aid.

Richard Douglas: We have set objectives in the past around the growth of private sector elements in the NHS and when we set the ISTC programme there was—

Mr Lansley: When you say "we," you mean a previous Government.

Richard Douglas: I am sorry. The Department of Health—

Mr Lansley: A previous Secretary of State in Lady Thatcher's time set out specific objectives for the increase in the extent of private sector provision in the NHS and we are not proposing to do that.

Q214 Andrew George: That is very helpful. It does help to calm some people's interpretation of that word "maintain" in relation to the NHS. Given the fact that both the Future Forum and the Government's response to it said that "Competition will not be an end in itself", on the one hand, and "We wish to reassure people with regard to integration" on the other—so integration is going to be promoted—I wondered, in relation to the amendment that I have drawn attention to, why there is an emphasis on preventing anti-competitive behaviour but not an emphasis on

preventing anti-collaborative behaviour. If you are really going to give integration the same weight as competition, there should be a role in Monitor to prevent anti-collaborative behaviour where that is clearly in the patient's interests as well, surely.

Mr Lansley: You referred to amendment 149, which places a duty on Monitor to exercise its functions with a view to enabling services to be provided in an integrated way where this would improve quality or efficiency or reduce inequalities for patients, and that is what it does. In a sense, it positively does that which we are not intending to do where competition is concerned. It positively requires Monitor to seek to promote that kind of integration of services for the benefit of patients. I think, legally, you do not need any parallel duty for Monitor to seek to act against anti-collaborative action because that is implied in the positive duty. If you take the positive duty to promote competition away, in a sense you have to create alongside it the new structure of the duty, which is to act against abuses of competition. Otherwise, you would have left Monitor in a vacuum where it does not promote competition but, equally, it does not protect patients' interests by acting against abuses of competition.

Q215 Andrew George: No, but you know that, in order to maintain safe tertiary services where you have ITUs and the kind of anaesthetic and emergency cover that is required for those types of services, you need a range of specialties which could easily be eroded by the loss of, if you like, elective services. You were talking earlier about competition in the area of certain elective procedures, but if you do not have a critical mass of specialties on a site, then you cannot justify the retention of—

Mr Lansley: These are the practical issues but, in truth, is that not fundamentally the role of the commissioners, to seek to commission services? There may be a specific issue about the extent to which the commissioners need, for example, emergency services. You might need emergency surgery to support it and, if you need emergency surgery behind it, it may be dependent on the extent to which you have elective surgery taking place in the same location. If the issue arises, I do not think it is fundamentally addressed through Monitor's role. It is addressed through the relationship between commissioners and providers.

Q216 David Tredinnick: I would like to ask a couple of questions about clinical senates and then one about NICE guidelines. In your response to the NHS Forum, clinical senates are one of the key mechanisms to strengthen multi-professional involvement in commissioning. Who will decide the make-up of clinical senates and ensure these include appropriate representation from allied health professionals and others?

Sir David Nicholson: The senates will be hosted by the NHS Commissioning Board. We have not yet worked through how people will be nominated, what sort of process they will go through and what the make-up would be, but the whole point of it is that it has the confidence of the clinical community. It is very important that, however we design it, we design it with that in mind.

Q217 David Tredinnick: I agree with you. I think this is a critical issue in terms of patient choice and involvement. What checks and balances will be in place to ensure that all statutorily regulated health professionals, such as osteopaths and chiropractors—both regulated by their own Acts of Parliament—have the opportunity to input, through clinical senates or other means, in the design of relevant patient pathways, such as those for musculoskeletal services, for example? How are you going to bring them in? Will they have a voice? They are statutory bodies. There are other bodies, too, out there regulated through their own mechanisms. There are aromatherapists with different bodies—there are two bodies there, there are the non-doctor homoeopaths who have their own quite robust regulatory regimes and so on. There is a whole list of therapists. If we are going to get that choice, may I suggest, respectfully, that you need—as I am sure you are, Secretary of State—this thought through in a wider context.

Mr Lansley: It is important not to see the clinical senates in isolation. They are part of a process by which the NHS Commissioning Board and the clinical commissioning groups work together in order to see the broader shape of services in an area and to provide advice. Remember, they are not executive bodies. To that extent, we can be flexible about how they bring advice together. For different circumstances they might bring different people together. They don't design the individual pathways of care. Clinical networks will be responsible for the design of pathways of care, and clinical commissioning groups will look at how those are to be delivered in their area. They will draw on advice from clinical networks. They may draw on advice from clinical senates. They will clearly draw on the advice of the National Institute for Health and Clinical Excellence, which will prepare those kinds of commissioning guidelines. There is a range of expert and clinical advice. In each of those forums, whether it be the clinical networks or when NICE are producing their commissioning guidelines, or indeed even when the clinical senate is there, I would expect a relevant range of health professionals and patient involvement directly in each of those discussions.

Q218 David Tredinnick: That is great. As a supplementary to that, I have in Hinckley, in my constituency, the International Federation of Professional Aromatherapists. They have been working at George Eliot A&E hospital across the Leicestershire-Warwickshire boundary—you know it well—to develop support for neonatal and postnatal services. The aromatherapists are reducing the number of patients that the obstetricians need to see because they are taking out the stressed patients and doing the aftercare, thus making it much more effective for obstetricians to operate. It is fully supported by the management of the hospital. There is a mass of data showing how effective aromatherapy has been in reducing the burden on these hard-pressed doctors and

providing a more effective service. I am concerned that this kind of good example of practice is available to the senates and is something that you can roll out and make available throughout the Health Service. Certainly there should be notification of it.

Mr Lansley: You make an interesting point, because it illustrates what I would see as a distinction between clinical senates and clinical networks. In relation to clinical networks, we would expect the establishment of maternity networks which bring providers and commissioners together to discuss the nature of the services provided to expectant mothers. I think it would be entirely appropriate for maternity networks to ensure that they discuss, agree and be clear amongst themselves, when the commissioning groups are commissioning maternity services, as to the nature of the service that should be provided, taking account of advice and feedback on the whole range of services and therapies. That is the place. The clinical senate for this purpose is not really a relevant consideration.

Q219 David Tredinnick: Thank you very much. That is extremely helpful, and I am speaking on behalf of my constituents in the sense that Hinckley has become an aromatherapy centre, with Shirley Price Aromatherapy, and all the other different disciplines there, and nurses have been trained in this practice. It has been used in the Leicester Royal Infirmary and in Leicestershire for a long time.

My last question is about the effectiveness of NICE guidelines. The NICE guidelines on lower back pain have been extremely helpful. The guidance released in May 2009—your guidance CG88—recommended that a course of manual therapies, to include osteopathy, chiropractic or acupuncture, is considered for patients with lower back pain. A study by the British Osteopathic Association a year after the guidance was issued by NICE showed that osteopathy was being funded in only 18% of PCTs. That is only a 3% increase from when the NICE guidelines were issued. These guidelines, as I have said, have been extremely helpful, but there is a roll-out problem in that not all primary care trusts are taking note of these guidelines. I know that primary care trusts are being wound down, but I wonder if you could perhaps share some thoughts, based on my remarks, about the implementation of NICE guidelines.

Mr Lansley: We attach considerable importance to the way in which NICE does its job of establishing commissioning guidelines. It does so in an evidence-based way, taking account of a wide range of clinical, professional and patient input. From our point of view, they do this not only to secure advice to the service about what is clinically effective but what is also the most cost-effective route to treatment. From that point of view, our wish is always for primary care trusts—and, in future, clinical commissioning groups—to take commissioning guidelines produced by NICE, and endorsed by the NHS Commissioning Board, very seriously. However, at the end of the day, there is a role for local clinical leadership in deciding how they structure the design of services locally and how they deliver those priorities. We are constantly, I think, going to be in an engagement between the NHS Commissioning Board and clinical commissioning groups about ensuring that they deliver a comprehensive service and that they do so to the best possible effect and using an evidence base to enable them to do so.

David Tredinnick: Thank you. Finally, if you want to achieve a wider range of therapies out there for patients, I think it is very important that NICE look more closely at other therapies and come up with guidelines. They should continue with the good work.

Q220 Dr Wollaston: Can I come in on the back of that? I don't think you can have it both ways, David. If we are going to use an evidence base, there are many complementary therapies for which there is no evidence base whatsoever. Therefore, you might find pressure groups of patients wanting to have access to therapies for which there is no evidence base.

David Tredinnick: I would say there is evidence—

Valerie Vaz: Speaking as a doctor.

David Tredinnick: We had better not accept that as evidence.

Chair: Shall we focus on gathering evidence from our witnesses rather than having a private debate within the Committee?

David Tredinnick: I think, Chairman, it is justified now I have been challenged. I would say there is evidence for all therapies but it is just that it has not been properly recorded. That is something we have to address. Thank you, Sarah.

Q221 Chair: Secretary of State, can I bring you back to one of the things you said at the beginning of this session? You said, following the Future Forum report, that the main focus of the work had been clarifying what was going to happen between the Commissioning Board at the centre and the commissioning groups in the locality and how the middle ground, effectively, was going to be developed. While this session has been going on, I have been noting down the list of functions which are being attributed, in the legislation as it is evolving, to the Commission Board. I have what seem to me to be five key functions for the Commissioning Board—and there are, no doubt, many others: authorisation of the commissioning groups; the direct commissioning of primary care; the direct commissioning of specialist services; commissioning support to the commissioning groups; and oversight of the commissioning groups. Those are the medium-term responsibilities of the Commissioning Board. When Sir David appeared at an earlier evidence session, he emphasised that, although the intention was to delegate responsibility in the medium term to the new world, if we were going to achieve the Nicholson challenge in the short term, it was going to require greater centralisation in order to drive necessary changes. I wonder if you see both that short-term perspective and that medium-term list of functions attributable to the Commissioning Board, whether this legislation really constitutes a localisation or whether there is, as some have been observing, considerable potential for the centralisation of power in the Health Service against the background of those developments.

Mr Lansley: Let me say one thing and then perhaps David would like to add to it. I am not sure that your list is complete.

Q222 Chair: I am not suggesting that it is complete.
Mr Lansley: No, but I mean even in terms of the principal functions of the Commissioning Board. One has to bear in mind that the Commissioning Board has a specific responsibility in relation to the allocation of resources in the NHS. It has a specific key responsibility in relation to financial control. I think, when one looks, for example, at the QIPP challenge, there will be the Commissioning Board itself in the context of securing financial control, and performance will have a continuing role in driving forward those kinds of issues.
It is also fair to say that any summary of the role of the Commissioning Board would be incomplete if it did not make very clear that the Commissioning Board will have a statutory responsibility continuously to improve outcomes in the National Health Service, agreed through the mandate, and the duty continuously to improve quality under the legislation. That is as to the structure.
You make a fair point. It is in the nature of people to try and treat what are balances as if they were necessarily conflicts. In the National Health Service we have a balance. We have a balance between a national service with national resources, national standards, and, indeed, some elements of commissioning which are clearly led nationally. In order to deliver the best possible and most responsive services to patients, we want to shift as many decisions as possible close to patients—even, in some cases, directly into their hands, but especially into the hands of the doctors, nurses and other health professionals who are responsible for delivering their care and working through clinical leadership. The drive to promote clinical leadership is absolutely instrumental.
In between those two pillars is that whole area of people who have tried endlessly to set up structures and tiers of management that somehow correspond to what they regard as natural sizes of health economies. As David quite rightly says, you could arrive at maybe 15 to 20 broad health economies, and that probably corresponds to the times of the regional health authorities.
Sir David Nicholson: Fourteen.
Mr Lansley: Fourteen, yes.

Q223 Chair: Everyone has seen it move from 14 to 15 as the minimum.
Mr Lansley: Then the NHS was shifted closer to the Government planning regions, but not quite, and as to primary care trusts there were 303 and everybody said, "They are too small." Then there were 152 and people said, "They are still not the right size." When you look at cancer services, it has to be a million-plus patients. When you look at serious neurological conditions, you might be looking at 3 million or 4 million patients in order to deliver the best services. What we are trying to do is to say, "As best we can, we want form to follow function." In the legislation, there is an essential characteristic called clinical commissioning groups that are locally led and there is a clear relationship with local authorities. It is not something we are going to make absolutely immutable, but there is a clear relationship with local authorities. That is an important set of considerations. There is also the issue of local authorities, for these purposes, that only have a 90,000 population and local authorities that have a population of over a million. By its nature, locality commissioning will, in some cases, be disaggregated below the level of local authorities but, ideally, not to a great extent. However, in the territory between the national responsibility of the Board and the clinical commissioning groups there is space for the flexible design of clinical networks to enable the clinical commissioning support to be delivered. That is on the clinical side.
There is also a range of other support functions which the Commissioning Board will work on not only itself but with a wider structure of providers—be they from the voluntary or independent sector, from social enterprises or from the Board itself—in order to try and capture economies of scale in the commissioning support function. We will combine, wherever possible, greater economy and efficiency in how we deliver commissioning activities with a constant focus on clinical leadership at a local level.

Q224 Chris Skidmore: Is there not a danger of what you might call "mission creep"? When the White Paper came out, it talked of handing the budgets to the GPs and to localised commissioners, yet the document that has appeared on the *Health Service Journal*'s website says quite clearly on page 3 that "the purpose of the Board will be to use the commissioning budget of around £80 billion a year to secure the best possible health outcomes for patients". On page 11, the document talks about the authorisation process not being "a one-off assessment, but rather as part of a broader developmental relationship between clinical commissioning groups and the Board." This particular document seems to be a power grab towards making a more centralised Commissioning Board, in particular, on page 3, saying:: "An alternative description for the NHS Commissioning Board, based on this rationale,"—the rationale of localised boards being named in a geographic focus—"could be NHS England." My concern is as to whether we are going down a route of creating a rather large super-quango here. Obviously, someone shares my concerns because someone has put, in the draft notes, "Is this too far". I obviously do not know what the finalised document will be, but someone in the Department shares my concerns that the Commissioning Board might take too much power—
Rosie Cooper: It used to be called the NHS.
Chris Skidmore:—-when the very rationale of what we need these reports to deliver is greater low-priced services and the budgets going to the GPs.
Mr Lansley: The legislation is absolutely clear. With the exception of those specific commissioning activities that are reserved to the NHS Commissioning Board, the leadership, in terms of commissioning, is clinical and local. That is a big change from what is effectively much more of a top-down structure. We

are strengthening both elements of what the public have a right to expect in the NHS. We are strengthening the transparent national leadership in terms of standards and services, and we are strengthening local clinical leadership. Of course, it does involve the formal abolition of strategic health authorities and primary care trusts. The reason for that is very straightforward. Neither of those organisations, in the way in which they have been structured in the past, has met the public's expectation that, in a National Health Service, they have national criteria, standards and resources, but they also have what they regard as generally locally-led access to services.

There is a balance. If we are debating the balance, that is a proper debate to have. We are trying to make sure that we strengthen commissioning at a national level, strengthen standards at a national level and strengthen the support we give to commissioning activities across the NHS. Equally, we have to make absolutely certain that, through the authorisation process, once we have competent, capable and clinical commissioning groups, they have a statutory basis on which they are making the decisions. It is not the Commissioning Board telling them how to make their decisions. They are taking responsibility and they will then lead the commissioning at a local level.

Q225 Chair: We have moved from assumed independence to earned autonomy for those local commissioning groups.

Mr Lansley: We are in a position where, yes, we are very clear that the clinical commissioning groups must show that they have the capability to do this. When you look at the past, as David quite rightly said, it was assumed that primary care trusts could do all this. When they were all established, and for years thereafter, it was evident that many were not capable of doing these things but they were given the responsibility anyway. From the public's point of view, this is one of those really good safeguards. We are going to be clear that people assume responsibility when they have the capabilities to discharge it effectively.

Q226 Rosie Cooper: When will the figures be available on how the NHS is doing for the first quarter, meeting the 4% savings that we know as the Nicholson challenge in its first year? When will this first quarter be reported on?

Sir David Nicholson: We normally report the first quarter about the end of August.

Q227 Rosie Cooper: We will get them then.

Sir David Nicholson: Yes. Quarter one will be produced.

Q228 Rosie Cooper: Have you any idea how it is doing?

Sir David Nicholson: We have been through the planning process and we have done a review of every region's plans now. In terms of what people are saying, and what is in their plans and what they have started to do, we think we have a plan for 2011–12 which will deliver both the financial and the service requirements that we have. We know we have plans that we think are robust and can deliver. There is monthly information that comes out during the period—bits of information which reflect that—and we are confident that we will be able to deliver the totality of the service offer and the financial position for 2011–12.

If I say anything about the Board, I will be accused of something, but I would say that it is a real dilemma when we start to write the paper on the Board. If you start to write the paper about the Board you hold yourself open to being obsessed with the national arrangements, but somebody has to do it. We had to set out what we thought the overall approach of the Board would be. The important thing about the document, and the thing about the Board, is that it is based and focused around outcomes for patients and on clinical and patient interests. It is a very important part of the way the Board is going to be established and the way it is working.

Underpinning it is the fact that it is a body which is there to help and support clinical commissioners in doing their job. In broad terms, if you think about the number of people who are working on the kind of work it does now—which is about 8,000—and then you think about the 3,500 that the Board will probably have, that is massive. Even if you wanted to manage everything, you simply could not because you do not have the capacity to do it, but we genuinely believe that clinical commissioning will make a massive impact on patients and on outcomes. It is my ambition, as the designate Chief Executive, to get all of these clinical commissioners up and running as fast as we possibly can and fulfilling the totality of their responsibilities. That is the way we will improve outcomes and that is absolutely at the heart of what we are trying to do.

Chair: Thank you.

Q229 Valerie Vaz: I want to turn to what we feel is a fairly major issue, which was perhaps neglected earlier on in the White Paper. That is the issue of public health. You are now going to form it as an executive agency. Could you describe how that is going to be set up and also how they feed into local authorities? Do you envisage directors of public health talking directly to the Chief Executive of a local authority? What is their role going to be?

Mr Lansley: There is quite a lot to say about that. When you say "not in the White Paper," it was in the White Paper but, of course, the "Equity and excellence: Liberating the NHS" White Paper did make reference to the strategic intention. Obviously, in the legislation we are creating a legislative structure through Health and Wellbeing Boards where local authorities lead on health improvement in their area. The public health strategy is set out in the "Healthy lives, healthy people" White Paper that was published in November. It has, to that extent, a strategy and a White Paper that is particular to the public health objectives.

As to Public Health England, we have set out our decision that it should be an executive agency. People were very clear about what they wanted. They understood the objective of being able to bring in a more integrated public health service on a national

basis. I could give you examples of how that can work. For example, if you really want to have an immunisation programme for HPV that is integrated together with the decisions of the cancer screening committees and the management of cancer registries, you can do that in Public Health England. At the moment, they are all sitting in different bodies. Quite clearly, we can have a much more integrated structure of public health. Public Health England will be engaged in health protection, health promotion and the provision of health services in the public health sphere—population-based health services. It will do so in support of local authorities who themselves, as directors of public health, will lead a public health responsibility, again, for health protection in their area. They will essentially be working as part of a single integrated structure with Public Health England, but also in their local authority driving health promotion and the delivery of some population-based health services through the public health budget that, from 1 April 2013, is intended to be transferred to local authorities. We will ask local authorities, in doing so, particularly as part of the public health strategy, to focus on impacting positively on the wider and social determinants of health, which are likely to give us the biggest overall health gain in the longer term. There will be issues like reduction of poverty, access to economic opportunities, educational opportunities, quality of environment, housing and transport that impact directly, in the long term, on the overall health of the population.

Directors of public health are therefore critical appointments that are integral to the delivery of a response to health threats, like a pandemic—influenza or something of that kind—and form part of, in effect, a chain of control and command right through the public health service. The appointment of a director of public health will be, in part, through the powers of the Secretary of State and Public Health England. They will also, however, be, in effect, the chief medical officer for their local authority. They will be directly employed within that local authority for that purpose. They will be joint appointments between the local authority and the Secretary of State through Public Health England. They will need to meet, in the characteristics of that appointment, the objectives of both.

Inside the local authority, it is a matter for local authorities precisely how they structure themselves. We expect that directors of public health, by the nature of their responsibilities, seniority and indeed—if you look at Health and Wellbeing Boards—the scale and shape of their responsibilities, to be local authority officers. They are likely to be chief officers reporting directly to a chief executive.

Q230 Valerie Vaz: They will always be part of the NHS, although it is an executive agency.

Mr Lansley: They will continue to be part of the NHS as well because of the character of the joint appointment. They will be, in effect, accountable through the local authority—but, none the less, accountable—for the management and delivery of public health functions and the public health budget, which is part of the NHS budget.

Sir David Nicholson: They will also give public health advice to the clinical commissioning groups.

Q231 Valerie Vaz: Turning to the Public Health Observatories, I am looking at the report and it is not clear whether they are going to be abolished. You say they are going to be subsumed into Public Health England. Will they still exist after that?

Richard Douglas: They will become part of Public Health England. The functions will still exist, but it will be one of the elements brought together in Public Health England.

Q232 Chair: Can I come back to the directors of public health? You say it is assumed they will be chief officers responsible to the chief executive of the local authority. There are reports around the country of directors of public health being recruited in positions where they report to the director of social services. That, surely, is not compatible with the Government's policy.

Mr Lansley: To say we have a policy for this is probably overstating it. We are setting out to make clear, with local authorities and the public health profession, the nature of the task that we are asking them to do. There have already been joint appointments, between the NHS and local authorities, of directors of public health. That is customary in any case. Of course, as directors of public health do not have that status within local authorities, to some extent that is continuing at the moment. We are expecting, through the establishment of health and wellbeing boards and the transfer of the public health budget, an enhanced status for directors of public health in future.

Q233 Chair: It clearly would not be consistent with the principle of enhanced status for a director of public health who used to be a chief officer of the NHS, responsible for 80% of the health and social care system, to be a junior officer reporting to the director of social services responsible for 20% of the health and social care system in a local health and social care economy.

Mr Lansley: Let me put it like this. Health and Wellbeing Boards may well, in due course, become the most significant executive committee of a local authority and there will be an expectation that there might well be number of chief officers who relate to that—a director of children's services, a director of adult social services and a director of public health. It is a matter for local authorities themselves precisely how they structure their reporting responsibilities within the local authority to the chief executive, but my expectation is that a director of public health would rank, in a sense, alongside directors of adult social services or children's services as a budget holder with executive responsibility.

Chair: It is likely to be a subject to which the Committee would wish to return.

Q234 Dr Wollaston: It is very important for public trust that public health doctors are independent of

political bias. If Public Health England is an executive agency of the Department of Health, how free will it be to challenge Government policy? For example, if directors of public health felt that the new Responsibility Deal was not the best approach to addressing obesity or, for example, alcohol problems, how free would they be to challenge that policy?
Mr Lansley: Individual directors of public health would be entirely free to do that because they are not responsible to the Secretary of State in that sense. Within Public Health England, there will be independent sources of expert advice and scientific advice. To that extent, the parallel is the Medicines and Healthcare products Regulatory Agency, who are an executive agency of the Department of Health. I do not think anybody would imagine that the MHRA was not entirely capable of acting independently, including being able to express, as an agency, their own views about some of these issues.

Q235 Dr Wollaston: So Public Health England would not be able to do that.
Mr Lansley: I have to say my objective is that we bring public health and the responsibilities of the Department, in terms of policy and action on public health, closer together so that we shape policy together. Not that the Department has a public health policy and Public Health England has a view about it, but that we work together in order to make this happen.

Q236 Dr Wollaston: There has been concern—I think it is fair to say—about the influence, for example, of the drinks industry and the fast-food industry in shaping the new Responsibility Deal, and indeed several stakeholders have pulled out of negotiations because of their concerns, particularly on the issue of alcohol policy. It is important to establish that if, say, Public Health England took the view—I am not saying they would, but if they did—that that was inappropriate, would they be in a position to reshape Government policy in that area?
Mr Lansley: No. The policy of the Government would be the policy of the Government. The intention is for a shared public health policy. The job of the Responsibility Deal is very simple. It is to bring people together in a collaborative fashion to secure greater progress on a range of public health challenges than would be possible without it. There are 223 partners to the Responsibility Deal, including a range of public health and other health organisations. For example, the Faculty of Public Health are participants in the Responsibility Deal. They are there not because they agree with the food and drink industry about everything, but by being there, by constructive participation and challenge in a collaborative process, we can deliver more improvement more quickly.
A classic example where the drinks industry is concerned is the pace at which we are going to arrive at increased unit labelling through what has been a process. Up to now, we have, from memory, figures of something like 30% alcohol unit labelling with the industry. We have now set a target to achieve 80% unit labelling. With the food industry, if we went down a legislative route to eliminate artificial trans-fats, it would take another three or four years. We are intending, by a collaborative route, to do it by the end of 2011. We intend to achieve more effective out-of-home calorie labelling. We have pledges from the drinks industry in relation to things like the reduction of alcohol promotions at the front of store by a retailer like Asda.
I do not think many of these things would have happened if it weren't for the Responsibility Deal. It is unambiguously making progress. From my point of view, it is a curious ideological fixation which says, "We shouldn't even be talking to the drinks industry." The drinks industry is not shaping public health policy. We are talking to them about the things that they are directly responsible for—things like alcohol marketing, unit labelling and the enforcement of legislation in relation to underage drink sales. We are not talking to them about alcohol pricing, because that would be contrary to competition law, and we are not surrendering any control over public health policy to any commercial organisations through that process.
Chair: I am now getting bids for closing questions.

Q237 Valerie Vaz: I have one. Do you have a final figure for the costs of the pause, the listening and reflecting exercise, and was it worth it?
Mr Lansley: Do we have a current figure?
Richard Douglas: The cost of the listening exercise itself—the actual cost of running it—will run to tens of thousands of pounds—I would say £100,000 tops. We did it very cheaply. We will have the cost in terms of its impact—changes resulting from it—when we produce the impact assessment for the Bill, which will be as it enters the House of Lords. We will have the final cost of it then. I would not anticipate, at this stage, that the changes have a particularly significant impact on costs. What we have done is effectively extend the life of strategic health authorities by a year. David is reshaping and shrinking the strategic health authorities during that time, so I would not think that the cost is significant. There will be some offset in savings, probably in redundancy, with some slowing down of the pace around strategic health authorities. We will have a reduced redundancy cost.

Q238 Valerie Vaz: You do not know the final figure—any figure?
Richard Douglas: I know the final figure but I—

Q239 Valerie Vaz: Any figure?
Richard Douglas: I wouldn't want to quote a figure at the moment.

Q240 Valerie Vaz: The Secretary of State has.
Richard Douglas: I would not want to quote a figure for the costs—
Mr Lansley: Did I quote a figure?

Q241 Valerie Vaz: Yes, you have, in the House.
Richard Douglas: Not for the changes.

Q242 Valerie Vaz: £36,000 I think you said. I was just asking—
Richard Douglas: For the listening exercise, it was up to about £40,000 at that point. As I say, it might

get up to £100,000 by the time we have been through everything, but it wouldn't be any more than that.

Q243 Valerie Vaz: You consider there will be an impact on costs once all these changes have come in.
Richard Douglas: There will be offsetting costs and benefits inevitably—yes.

Q244 Valerie Vaz: Was it worth it, Secretary of State?
Mr Lansley: Yes.

Q245 Valerie Vaz: So you were wrong.
Mr Lansley: Did I say it wouldn't be?
Chair: You are not required to say yes to that.

Q246 Rosie Cooper: I have three very quick factual questions. As to the news this week of GPs selling their buildings and making substantial profits, what plans do you have in this new world to make this process and those profits completely transparent, as surely there is nothing to hide?
Sir David Nicholson: I do not know what the issue is, to be frank.

Q247 Rosie Cooper: In essence, GPs or groups of practices buying buildings—
Mr Lansley: They are reimbursed through the cost rent scheme and, at the end of the day, they might end up with an asset which they can sell. That has always been true.

Q248 Rosie Cooper: What are you going to do to make that truth transparent because the public want to know about it?
Mr Lansley: In what sense is it not if it has always been true?

Q249 Rosie Cooper: Are GPs' accounts published? No, they are not.
Mr Lansley: No.

Q250 Rosie Cooper: It is something you might think about.
Mr Lansley: Are you proposing they should be?

Q251 Rosie Cooper: What is there to hide?
Mr Lansley: I thought they were independent contractors. That position does not change.

Q252 Rosie Cooper: Absolutely, and if they are making huge profits, there is a public interest. In the public interest, are you prepared to do anything about—I am not asking you to change it—making it transparent?
Mr Lansley: The rules are transparent because they are part of the General Medical Services contract. They are entirely transparent. The financial circumstances of the individual GP practice are not transparent because that is their own private business.

Q253 Rosie Cooper: Absolutely, so when they make profits in this little game—
Mr Lansley: It is not a game. It is providing health care services for their local population.

Q254 Rosie Cooper: No doubt we will come back to that one in greater detail. Could I ask how the chairs and other board members are going to be appointed to commissioning groups?
Mr Lansley: By the commissioning groups themselves. They can seek external commissioning support in that process too.

Q255 Rosie Cooper: Will the Appointments Commission be compulsorily engaged in this?
Sir David Nicholson: The Appointments Commission is going to be abolished.

Q256 Rosie Cooper: That's right, so it is. Who will supervise this?
Sir David Nicholson: We have to work all this out, but clearly clinical commissioning groups will need help and support to enable them to fulfil their obligations around the Nolan principles and all the rest of it. We will have to find a mechanism to enable them to do that. We have not worked that through yet, but we will have to do that.

Q257 Rosie Cooper: You will possibly recreate the Appointments Commission, do you think? A final question. What assistance and training are you putting in place or going to give to commissioning group members who, on making what may be an unpopular decision, may well find themselves or their surgeries picketed or subjected to lobbying, the likes of which politicians would be used to but would come as a great shock to GPs and their families?
Sir David Nicholson: I do not think any of the GPs that I have spoken to involved in the pathfinders are under any illusions as to the difficulties that they are taking on. Fair do's to them that increasing numbers are prepared to take it on, because they know there is a really important set of decisions to be made over the next few years about the NHS and its direction, living within the financial circumstances that we find ourselves in. Large numbers of them are volunteering to do it. We are helping and supporting them, through the pathfinder network, to identify what development and training they need and we are providing them with all of that. If they have problems around really difficult and important decisions that they need to make locally, we will provide them with whatever support they need. It is very important we do that as a board.

Q258 Rosie Cooper: Absolutely, because the degree of vocalism and increasing distance between them and their patients that will come with that will come as a great shock to those GPs who make a difficult decision in the face of huge opposition locally.
Sir David Nicholson: I do not think that is necessarily the case. Of course, part of being a doctor is being responsible for resources. That is part of your role. It is absolutely written into the GMC arrangements whereby you have to take account of those people who are deprived care by the care that you give to an individual. It is absolutely part of what doctors are about at the moment.

Rosie Cooper: I think there will be some shocks there, but there you go.

Q259 David Tredinnick: On the back of Sarah's question about fizzy drinks, at the Food and Health Forum meeting the other day there was a professor of nutrition who was suggesting that so-called zero sugar drinks actually stimulate the appetite because of the sugar substitutes. I think this should be looked at more carefully in the context of the worries about obesity. I make that suggestion to you.
Chair: It is in the record.

Q260 Chris Skidmore: Can I ask a final question about the future of the NHS Future Forum? You stated on the record that you are keen for it to continue. We had Steve Field here the other week, and he said he was very keen to engage and take part in any future processes but had not had any direct conversation about what that future might hold and what sort of role the NHS Future Forum would play. Are you in a position to clarify how the Future Forum might, in future, help the NHS with any decisions that need to be made?
Mr Lansley: Yes. First, we found it an extremely valuable means by which we could engage with people to try and understand the nature of specific concerns, but also to help with the design of responses to issues. From that point of view, it can be a continuing feature of how we do our business. As for specifics, we have already made it clear in discussion with the Future Forum that we would welcome it if they were able to take forward the work on education and training, which they have already begun, and develop those issues further.
Secondly, we are keen—and I think they may well be willing—to work on the NHS contribution to public health so we are very clear about how the two structures of a public health service and local clinical commissioning groups work together on the public health side. Thirdly, in the course of their listening exercise, the Future Forum derived a great deal of positive engagement on patient and public involvement. There is a further area of work that we want to develop, which is about how patients can access higher-quality information and use it to help them to participate more in their own care and to make decisions about their care. We may well find that is an area they are able to help us with because it was very much about creating that broader engagement to make that happen.
Chair: Thank you very much. We have more or less protected our lunches. Thank you for your evidence. We will see you again in the autumn.

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