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National Health Service Landscape Review

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12

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Committee of Public Accounts

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Committee staff

The current staff of the Committee is Philip Aylett (Clerk), Lori Verwaerde (Senior Committee Assistant), Ian Blair and Michelle Garratty (Committee Assistants) and Alex Paterson (Media Officer).

Contacts

All correspondence should be addressed to the Clerk, Committee of Public Accounts, House of Commons, 7 Millbank, London SW1P 3JA. The telephone number for general enquiries is 020 7219 5708; the Committee’s email address is pubaccom@parliament.uk.

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Summary

The Health and Social Care Bill, published on 19 January 2011, proposes a new model for the NHS focusing on patient outcomes. The proposals are intended to transform the NHS in England into a highly devolved, market-based model in which local commissioners and providers of health services are freed from central control, with an increased say for local authorities, patients and the public. The two significant structural changes proposed in the Bill are the abolition of the current structure of commissioners of health services and the regional organisations that oversee them (Primary Care Trusts and Strategic Health Authorities), and the creation of the NHS Commissioning Board and GP commissioning consortia to make commissioning more clinically led. The Government also expects all health service provider trusts to become Foundation Trusts by 2014.

The reform programme will need to be managed alongside the imperative, set in 2009, to secure challenging efficiency gains across the NHS of up to £20 billion by the end of the financial year 2014-15 and the requirement to reduce administrative costs in non front-line organisations by 33% over the same period. Within the context of an increasing health budget, these savings are to be reinvested in the NHS to offset cost increases driven mainly by increasing demand. The Department of Health (the Department) is taking steps to integrate the efficiency plans with the transition to the new NHS model, but it acknowledges that the risks to delivering all of the planned savings have increased in the light of the planned reforms. In particular, the one-off costs and disruption of reorganization at the same time as seeking £20 billion efficiency savings provides an additional challenge to the NHS.

It was clear from the evidence we took that many critical issues have yet to be resolved. Most important, for instance, the Department has not yet got a framework to deal with failure in the system, be it on the provider side or the commissioning side.

Establishing strong, effective systems of governance and clear lines of assurance and accountability supported by robust flows of information will be key to ensuring that public money is safeguarded. There is a continuing need to provide accountability to Parliament and for information and assurance to be aligned with new funding channels. There is a natural tension between this and the decentralisation of key funding and spending decisions closer to the 'front line', which needs to be reconciled in a way which satisfies Parliament that every pound of taxpayers' money can be followed and accounted for. The lines of accountability must be explicitly clear.

Ultimate accountability for the performance of GP consortia, and for the money they spend, will rest with the new NHS Commissioning Board and its Chief Executive, Sir David Nicholson (currently the NHS Chief Executive). Consortia themselves have considerable room for manoeuvre in developing their internal structures, but can only function with the Board's approval. The consortia also have a duty to consult their local communities when planning and commissioning services. They are accountable primarily to the NHS Commissioning Board for their performance.

The Government requires all hospitals to become Foundation Trusts by 2014 or cease to

exist as independent entities. They will compete with non-NHS providers. Competition law puts the focus on protecting services rather than providers. This has serious implications for the less competitive NHS hospitals, particularly those with expensive PFI contracts. It is imperative that the Department puts in place clear and transparent policies for dealing with failure of commissioners or providers to ensure patients are protected and value for money is assured.

High quality risk management will be crucial if the change programme is to be delivered to time and budget and to realise its intended benefits, especially during the transition stage.

The cost implications of the programme to deliver the reforms are clearly set out. The Department estimates the initial cost of the reforms will be a total of £1.4 billion, mainly redundancy costs, to be offset by a 33% (£1.7 billion) reduction in administrative spending by 2014-15. At this stage there is scope for these cost and savings estimates to change, for example, if GP consortia are reluctant to employ staff from existing NHS commissioning bodies.

It is unusual for the Committee of Public Accounts to examine the progress of reforms at such an early stage, but given the scale of the changes and our ongoing interest in health spending, we thought it important to gain a greater insight into the accountability and value for money issues raised by the reform proposals. We undertook our inquiry on the basis of a landscape review by the Comptroller and Auditor General¹ and we took evidence from the Department and, at a second hearing, from four expert witnesses: Professor Chris Ham of the King's Fund; Dr Clare Gerada, chair of the Royal College of General Practitioners; Dr Shane Gordon, a GP who is also chief executive of the North East Essex GP Commissioning Consortium, a 'pathfinder' GP consortium; and Jill Watts, chief executive of the private healthcare company Ramsay Health Care UK.

This report provides an overview of aspects of the reforms where Parliament requires clarification and draws out a number of risks associated with the transition to the new model that need to be managed. We intend to review the progress of the reforms at regular intervals and this report signals the sorts of issues we will want to examine in future.

1 C&AG's Report, *National Health Service Landscape Review*, HC708, 2010-11

Conclusions and recommendations

1. Our focus in respect of the health reform programme is on accountability for taxpayers' money. With the health reforms still at an early stage, there are some aspects of the accountability arrangements which have yet to be resolved. There are also a number of risks during the three-year transition period which need to be managed.

Areas for clarification

2. **Parliament, and this Committee in particular, needs certainty about who to hold accountable for health spending once the reforms are complete.** The different accountability arrangements for commissioners and providers are complex. The Department should provide detailed answers to the following questions:
 - **Who will be accountable to Parliament for protecting the interest of taxpayers in a devolved health system?** The respective roles and responsibilities of the Department's Permanent Secretary, the Chief Executive of the NHS Commissioning Board, the regulators, Monitor and the Care Quality Commission, and the Accounting Officers for Foundation Trusts require further clarification, along with the arrangements for securing assurance about the propriety and value for money of local health spending. Whilst we understand that legislation underpinning this accountability has been in place for some time, we are concerned at the capacity implications of accountability for, potentially, over 200 individual Foundation Trusts resting directly with Parliament.
 - **To what extent will health bodies having a 'duty to engage' locally with, for example, Health and Wellbeing Boards and Local HealthWatch, lead to accountability ?** These are key mechanisms for communities to influence the shape of their local NHS services and need to be robust, with clearly articulated responsibilities, for the public and patients to have confidence that there is effective scrutiny over the quality and value for money of those services.
 - **What structures will link local GP consortia and the national NHS Commissioning Board, to which they are accountable?** The Commissioning Board will not be able to directly oversee several hundred GP consortia; what regional or other structures will be used and how will their cost-effectiveness be secured? Is one regional structure being abolished simply to be replaced by another one?
 - **What information will be available to decision makers, the health regulators and the public on the cost and quality of services?** Our reports have often been critical of the lack of robust information on the performance of health services; we understand that the flow of information is to be rationalised and streamlined in the Health Information Strategy. The information must be relevant and fit for purpose so that effective accountability can be secured.

3. **There are a number of practical aspects of the proposed reforms which require clarification.** This will help us to identify and focus our future hearings on the issues which present the greatest risks to value for money. The Department should lay out in detail the answers to the following questions:

- **How will the treatment of patients with rare and expensive conditions be funded?** To what extent will such conditions be funded through allocations to ‘risk pools’ rather than routine allocations to consortia and how will disputes be resolved?
- **How will continuity of services be safeguarded when a GP consortium or Foundation Trust hospital is failing or has failed?** What roles will the NHS Commissioning Board, Monitor and the Care Quality Commission play and how will their actions be transparent to the local communities affected? Who will pick up liability for the debts of independent Foundation Trusts?
- **How will commissioners and providers contract with each other to drive value for money in the system?** There seem few incentives for GP consortia to drive better deals or for providers to offer prices below tariff. The Department has said that there will be no competition between providers on price, but there are concerns about what the Department means when it says that it wishes to see prices driven by the most efficient providers.
- **How will the NHS Commissioning Board work with GP consortia to redesign primary care services?** How will potential conflicts of interest between GPs’ roles as commissioners and as providers of primary care be managed?
- **How will the NHS Commissioning Board work with GP consortia to ensure the proper configuration of acute services so that value for money for the taxpayer and effective quality of healthcare for the patient is secured?** This is an issue of particular importance in urban centres where the NHS is presently seeking to redesign acute services.
- **How will providers secure capital funding in future?** Capital funding may be provided by the private sector, either through PFI deals or through direct borrowing by trusts. These funding arrangements can be expensive, as recent reports by this Committee demonstrate. Will the Secretary of State ultimately underwrite these borrowing arrangements, and if so, how will the Department manage the residual risk it would bear should a trust be unable to meet its commitments? Who will manage the risk that some trusts reduce their capital spending too far in order to cut costs?
- **How will legacy debts from Primary Care Trusts be handled?** The Department has indicated that GP commissioning consortia will not inherit Primary Care Trust debts, but accepts that it cannot guarantee this in all cases.
- **How will the reforms affect existing health inequalities and performance variations for some NHS services?** The NHS currently has wide variations in the services patients receive in different parts of the country – for example, there is an eight-fold variation in the extent to which GPs refer their patients to cancer

specialists. GPs' new role could help to reduce such variations, through more effective peer engagement. How will the Department and the NHS Commissioning Board monitor the effect of the reforms on service variation? What safeguards will there be against unacceptable variations in services in different parts of the country? How will the reforms drive a reduction in the present unacceptable health inequalities which exist?

Risks during the transition period

4. **The Department acknowledges that it may not be able to achieve all the savings intended under its efficiency programme.** The Department said that 40% of the savings were controlled nationally, through pay freezes, central budgets and management cost savings, and it was confident it could deliver these. A further 40% would come from efficiency gains in providers, delivered through setting the tariff. The final 20% would be due to service change such as shifting services from hospitals into the community and these would be the most difficult to achieve. The Department needs to monitor the savings and report regularly on progress against the target.
5. **The Department's estimates of transition costs rely on GP commissioners being ready to take on a certain proportion of former Primary Care Trust staff.** The Department has no control over such decisions or the resultant redundancy costs. The Department needs to regularly review the emerging costs of the transition and have contingency arrangements in place if costs exceed expectation. We will monitor the progress and costs of the reforms, beginning later in 2011.
6. **The Department told us there are at least 20 NHS hospital trusts which will struggle to obtain Foundation Trust status.** The Provider Development Authority will have the responsibility to bring them up to the required standard but this will be particularly challenging where hospitals are burdened with significant PFI or other debts. The Department should set out its contingency arrangements to ensure the supply of services in areas where trusts cannot meet the criteria to become Foundation Trusts. This should include clarifying the roles of Monitor and the Care Quality Commission in such cases. The Department will need to make arrangements for handling PFI debt in a way that allows all Foundation Trusts to operate on equal terms in the marketplace.
7. **The small size of some GP consortia risks creating inefficiencies in the system.** Currently there are pathfinder consortia with as few as 14,000 patients. Very small consortia may lack commissioning expertise and influence over providers, affecting their ability to secure the highest quality services for their patients. They may also have disproportionately high overheads. There is a risk that the funding of £35 per head for the running costs of GP consortia may allow small consortia the scope to be inefficient whilst larger consortia are overfunded for their running costs. The flat rate charge may also lead to some consortia trying to 'game' the system. We will take a close interest in the efficiency of the system in this regard and the Department should take steps to ensure that the level of administrative funding for consortia of different sizes is adequate but not generous, and does not introduce perverse incentives.

8. **Given the pace of change, there is a risk that there is insufficient time to learn the lessons emerging from the new model, for example how the NHS Commissioning Board will organise itself to oversee and support consortia of potentially widely varying sizes.** The NHS Commissioning Board will be formally established in April 2012, which will provide limited time for it to learn the lessons of the GP pathfinder consortia, for example, at what scale efficient commissioning decisions should be made for different services. We will expect to see the proposals refined where appropriate to respond to lessons arising from the pathfinders. The Department should set out in detail how and when it will appraise the pathfinder consortia and when those results will be made public.

1 Accountability and assurance in the new NHS model

1. The Health and Social Care Bill, published on 19 January 2011, proposes a new model for the NHS, focusing on patient outcomes and aiming to empower and liberate clinicians to innovate.² The proposals involve major changes to the role of the Department of Health (the Department) and many parts of the NHS.³ The two significant structural changes proposed in the Bill are the abolition of the current structure of commissioners of health services and the regional organisations that oversee them, and the creation of the NHS Commissioning Board and GP commissioning consortia to make commissioning more clinically led.⁴ The Government also expects all health service provider trusts to become Foundation Trusts by 2014 and to compete with private and third sector providers within a market-based model.⁵

2. Accountability to Parliament for health spending needs to be more clearly spelled out under the reforms.⁶ The Accounting Officer for the Department told us that she will be responsible for making certain that an overall system of control is in place for ensuring proper stewardship of public funds and that she would expect Parliament, through this Committee, to hold her to account for any control failures in the system, such as those arising from deficiencies in the policy framework or legislation. The Department proposes that the accountability relationship between the Department and the NHS Commissioning Board will be set out in a detailed framework agreement covering the Commissioning Board's purpose, governance and accountability, management and financial responsibilities. The Department recognises that there is further work to do to specify, describe and communicate the accountability arrangements⁷.

3. GP consortia will be accountable to Parliament through the Chief Executive of the NHS Commissioning Board. The Department expects that consortia Accountable Officers will be responsible for ensuring that adequate systems of control are in place within those organisations, and they should expect to be held to account for any failures in quality, safety and performance⁸.

4. Foundation Trust Accounting Officers will continue to be directly accountable to Parliament. The Department sees individual Foundation Trust Accounting Officers as accountable if financial failure should occur in their own trust, but the Department's Accounting Officer would be accountable should any such failure in Foundation Trusts result from a deficiency in the policy framework or legislation⁹. The accounts of

2 C&AG's report, para 4

3 C&AG's report, para 2.4, 2.7 and 2.11

4 C&AG's report, para 2.4

5 C&AG's report, para 2.17, 2.18

6 Qq 2-7, 20-23

7 Ev 40

8 Ev 40

9 Ev 40

Foundation Trusts will in future be consolidated within the Department of Health's accounts, which the Department believes will improve accountability to Parliament.¹⁰

5. The regulators, Monitor and the Care Quality Commission, will have dual accountability to Parliament, directly through their chief executives and also through the Department's Accounting Officer, who retains responsibility for the appointment of the chief executives of the two bodies. As Accounting Officers in their own right, either or both chief executives could be called to this Committee alongside trust chief executives. It is not yet clear to us how those relationships will work in practice, however, given the changing structures within the health service and their respective roles within it, or where ultimate accountability lies.¹¹

6. Monitor will be required to report annually to Parliament to demonstrate value for public money. The Department will monitor the Care Quality Commission's financial and operational performance, and risks at a strategic level, but the NHS Commissioning Board will be responsible for assessing and ensuring the quality of its inspection or monitoring of specific providers on a day-to-day basis. The Commission will be accountable to Parliament.¹²

7. Local planning and partnership working is a key part of the reforms. New statutory Health and Wellbeing Boards in each upper-tier local authority will bring together the NHS, public health and social care services to assess needs and plan services.¹³ However, the powers and influence which these bodies will have on GP consortia commissioning decisions is not clear. Dr Shane Gordon told us that while his consortium had a duty to engage with the local Health and Wellbeing Board, it was not accountable to it.¹⁴ The King's Fund told us that under the proposed legislation there would be no formal accountability from GP consortia to health and wellbeing boards; the formal accountability would be upwards to regional offices of the NHS Commissioning Board. The King's Fund considered that this was a logical way of making the commissioning side work, but one consequence of this would be a much weaker role for local authorities in relation to GP commissioning than was anticipated in the White Paper published in July 2010.¹⁵

8. The Department intends that greater accountability to patients will be a key part of the reforms, whereby new HealthWatch organisations will act as 'patient champions'. Local HealthWatch bodies will carry forward the functions of Local Involvement Networks (LINKs) and will continue to be funded by local authorities and accountable to them for effectiveness and value for money. In addition, Local HealthWatch will have a role in decision-making for commissioning through a seat on Health and Wellbeing Boards.¹⁶

10 Q175

11 Ev 40, Q178

12 Ev 40

13 C&AG's report para 2.32

14 Q276

15 Q277

16 Ev 40

9. Accurate, relevant and timely information flows will be an important element of the reforms, and the NHS Information Centre will have an important role in providing the information that local decision-makers, the public and health regulators need.¹⁷ The Department expects to publish its information strategy in 2011.

17 C&AG's report para 2.39

2 Managing the transition to the new model

10. The reforms proposed will in the short term mean extra costs to the NHS from staff redundancies and reorganisations, but in the long run the Department expects that they will produce a 33% per cent reduction (from £5.1 billion to £3.4 billion) in the administration costs of the Department, its arm's length bodies and the commissioning organisations.¹⁸

11. The Department currently estimates that the direct cost of the changes will be £1.4 billion, which will be incurred mainly in the financial years 2011-12 and 2012-13.¹⁹ The King's Fund has estimated that these costs may be higher, between £2 billion and £3 billion.²⁰ Over ten years, the Department's impact assessment, published alongside the Health and Social Care Bill, estimates that the direct benefits of the reforms will be £11.8 billion and direct costs £2 billion.²¹ The Department expects that its spend on consultancy and interim staff will go down at the same time as the change programme is delivered.²² The Department said it would monitor all the costs of transition and we intend to hold the Department to account for the costs on a regular basis.²³

12. The Department's estimate of redundancy costs of around £1 billion – accounting for the majority of the £1.4 billion direct costs of the changes – depends on the extent to which GP consortia choose to use existing Primary Care Trust (PCT) staff to provide commissioning support. The redundancy bill will increase if GP consortia decide to make greater use of private suppliers or other third party sources of commissioning support than the Department's modelling assumes.²⁴

13. We asked the Department whether it was confident it would achieve the planned efficiency savings of up to £20 billion, which were announced before the reform programme. The Chief Executive of the NHS told us that the first 40% of the savings would come in areas such as the pay freeze, reductions in central budgets and the delivery of management cost savings on which the Department had a “national handle” and he was “pretty confident” they could be delivered. The next 40% of the savings were essentially the delivery of efficiency gains in the provider arm, which would be delivered by setting the tariff with a 4% efficiency gain for next year. The remaining 20% of the savings were around service change, such as shifting services from hospitals to the community, and would be the most difficult to achieve.²⁵

18 C&AG's report para 3.6, Qq100, 101

19 C&AG's report para 3.8, Department of Health Coordinating document for the Impact Assessments and Equality Impact Assessments, Health and Social Care Bill 2011 (para 56)

20 Q283

21 C&AG's report para 3.9

22 Qq 110, 111

23 Qq 206, 207

24 Q199

25 Q127

14. The Department has not yet worked out how the NHS Commissioning Board will be structured in order to commission both national services and the primary care services provided by 8,500 GP practices.²⁶ The Commissioning Board would have management tiers between the national Board and the local consortia, but the Department could not yet say whether this would be a regional structure. The King's Fund considered that there would need to be four to five regional commissioning offices.²⁷ The Department has decided to keep existing accountability arrangements and central controls in place during the first year of the transition process, the financial year 2011-12.²⁸ There will be 50 clusters of Primary Care Trusts. On 1 April 2012 the GP commissioning consortia will become accountable to the Commissioning Board.²⁹

15. The Government wants all hospitals to become Foundation Trusts by 2014.³⁰ To that end the Department is working out a trajectory, with the Strategic Health Authorities, to achieve this. But around 20 of the some 120 organisations that are currently not Foundation Trusts will not achieve that status and other options need to be worked out in the coming months. These options include demerger, splitting up organisations and moving them to different places, takeover by existing Foundation Trusts, or the model proposed at Hinchingbrooke Hospital where a franchisee is expected to be appointed to run the hospital.³¹ Some trusts have substantial PFI debts. The King's Fund believed some way will need to be found to write these off.³² The regulator, Monitor, will in its new role have responsibility for ensuring that 'designated services' continue to be run, making sure that patients have access to services.³³

16. We asked the Department about its plans to provide an 'operationally independent banking function' to Foundation Trusts including making repayable loans when there is a reasonable expectation that they will be repaid. The Department told us that the purpose of this proposal was to regularise what happens at present and to put it on a more transparent basis. Providers could seek a loan from the Department or from the private sector. The details of the Department's scheme were still to be worked out.³⁴

26 Q104

27 Q249

28 C&AG's report para 3.17

29 Qq 105, 106

30 C&AG's report para 2.18

31 Qq 87, 88

32 Q90, 270

33 Q41

34 Qq183-188

3 Establishing effective GP commissioning

17. The majority of commissioning will be undertaken by GP consortia, from budgets allocated to them by the NHS Commissioning Board.³⁵ Consortia will be accountable to the Commissioning Board and will have performance indicators against which they will be held to account.³⁶ GP consortia will receive an allowance of about £35 per head of population for their running costs.³⁷ So far, the Department has announced the formation of 141 ‘pathfinder’ consortia which will be established in shadow form from April 2011.³⁸

18. The size of GP consortia is determined by the GP practices which form them. The 141 pathfinder consortia range from one to 105 practices, covering populations of between 14,000 and 672,000.³⁹ The Department said that part of the purpose of the pathfinder process was to address questions about the right size for a consortium.⁴⁰ Dr Gordon acknowledged that there was a tension between achieving economies of scale as a large consortium and remaining responsive to the needs of individual patients. However, he considered that one of the benefits of clinical leadership in consortia was the trust that develops between the leaders of the consortia and their peers in the practices.⁴¹

19. We asked the Chief Executive of the NHS how small GP consortia would deal with patients with expensive, rare conditions. He told us that the Commissioning Board would run a series of ‘risk pools’ as insurance, which consortia would pay into in order to cover the needs of such patients and that the Bill allows consortia to ask the Commissioning Board to take responsibility for some of its activities.⁴²

20. In the transition from PCTs to GP consortia the Department’s aim is for PCTs to pay off any debts over the next two years, so that by the first full year of operation in 2013, consortia do not have any legacy debt attached to them. The Department acknowledged, however, that this may not be possible in all cases.⁴³

21. There will be an intervention regime for failing GP consortia, which the Department has yet to develop.⁴⁴ This may take the form of ‘a rules-based stepped process’ beginning with a consortium being issued with performance notices and ending with the removal of its right to commission.⁴⁵

35 C&AG’s report para 2.11

36 Q237

37 Q101

38 C&AG’s report para 2.15

39 C&AG’s report para 2.15

40 Q120

41 Q236

42 Q120,125, 141

43 Qq 117-119

44 Q238

45 Q239

22. GP consortia will not commission primary care services, which will be the responsibility of the NHS Commissioning Board. Dr Gordon foresaw some difficulty in redesigning primary care services, where this was needed, from the current very fragmented service of small GP practices, using the 'large scale commercial levers' available to commissioners.⁴⁶

23. The NHS currently has wide variations in the services patients receive in different parts of the country – for example, there is an eight-fold variation in the extent to which GPs refer their patients to cancer specialists. The King's Fund told us that it had looked at many different examples of these variations which seemed to be unexplained by factors such as differences in population. The King's Fund believed that GPs' new role under the reforms could help to reduce such variations, through more effective peer engagement.⁴⁷ The Chief Executive of the NHS said that equity of treatment would be the responsibility of the NHS Commissioning Board. National quality standards would be set out in guidance for consortia.⁴⁸

46 Q267

47 Q246

48 Q154

4 Overseeing hospital services

24. The majority of hospital trusts in England are now Foundation Trusts, with much more financial and operational freedom than other NHS trusts. Foundation Trusts will face increased pressure to improve their cost-effectiveness, through wider adoption of the practice of reimbursing hospitals for treatment given to patients according to the costs incurred by the most efficient hospitals, rather than the average.⁴⁹ The Department told us that the existing regime to address any failure of Foundation Trusts, which is triggered by the Secretary of State, would be adapted in legislation so that it can be triggered by Monitor. A more comprehensive insolvency and special administrator regime would come into effect in 2013 or 2014.⁵⁰ The Department also told us that in cases where a trust “went bust” a special administrator would be appointed to ensure the continuity of services that had been designated.⁵¹

25. If a Foundation Trust fails, the services it provides which have been ‘designated’ would be preserved for the public and patients by the regulator, Monitor, stepping in to appoint a special administrator. The administration process would include addressing any Private Finance Initiative debts which the trust might be carrying.⁵² The Department said the details of the special administration regime had yet to be worked through, including the question of whether the cost of future PFI projects might be driven up because of the increased risk arising from the possibility of a trust going into administration.⁵³ Ramsay HealthCare UK’s view was that in the private sector everything would be done to prevent closure, but if it could not be avoided, this would present an opportunity for another provider to come in and run the hospital. It may therefore be possible in the future for private providers to take over the running of NHS hospitals.⁵⁴

26. Monitor’s new role will cover the regulation of providers of NHS services, including private and voluntary providers as well as NHS Foundation Trusts. It will act to ensure continuity of supply, setting prices to ensure a viable provider market, rather than the viability of individual organisations. This is distinct from its old role as the regulator of Foundation Trusts, authorising hospitals to become Foundation Trusts, ensuring compliance and intervening if necessary. The King’s Fund noted that Monitor had a range of responsibilities to interact with bodies such as the Office of Fair Trading, the Competition Commission, the Care Quality Commission and the NHS Commissioning Board. It would need to employ staff with specialist skills in regulation, finance and the law and this would mean significant transactions costs in the system. It was unknown whether these costs would be higher than those of the present system.⁵⁵

49 C&AG’s report para 2.20

50 Q33

51 Q35

52 Qq 34-37

53 Qq 84-86

54 Q257

55 Q284

5 Securing value for money in the new NHS market

27. The Department believes that the introduction of GP consortia with responsibility for commissioning health services will create incentives for clinicians to ensure commissioning decisions provide value for money and improve quality of care.⁵⁶ We heard mixed views about the benefits of GPs' engagement with commissioning. Dr Gordon said GP commissioning was the only real way to align GPs' incentives with those of hospitals. While there were currently too few GPs with the necessary skills in commissioning, there was time to address this.⁵⁷ Dr Gerada said the Royal College of General Practitioners had estimated a cost of around £300 million in GP time alone as a consequence of the reforms and that GPs' involvement in management would take them away from understanding the needs of their patients.⁵⁸

28. On the provider side, the Department told us that in the future the main mechanism for ensuring trusts provide value will be the setting of prices for services. This will be the joint responsibility of a new economic regulator - which will collect information from NHS providers, including the private sector, about their costs - and the NHS Commissioning Board.⁵⁹

29. Pricing for NHS services is generally on the basis of a fixed national price, known as the tariff. The tariff is currently set on the basis of the average costs incurred by all providers.⁶⁰ The Department said it would like to move to a pricing structure based on the most efficient provision in the market, but would not do so until it could be assured that providers could deliver within that price as a large number of providers would fail if prices were set based on the lowest cost provider in the country. The viability of the provider side had to be considered as one of the criteria for deciding where to set the tariff.⁶¹

30. Under the proposed reforms, the tariff will become a maximum price. Commissioners and providers will be able to agree a lower, local price if they can demonstrate that the quality of the service will be maintained, through setting clear quality standards and monitoring performance against them.⁶² In subsequent correspondence addressed to NHS chief executives, Sir David Nicholson and his deputy, David Flory, have indicated that this flexibility for providers to offer services to commissioners at less than the mandatory tariff price is not intended to signal a move to price competition.⁶³ The Department said it

56 C&AG's report para 2.4

57 Q225

58 Qq211-212, 233

59 Q44

60 Q67

61 Qq 73, 74, 76, 77, 82

62 Qq 50-53

63 Department of Health, 'Dear Colleague' letters from: a) Sir David Nicholson to all NHS chief executives, Equity and Excellence: Liberating the NHS – Managing the Transition (Annex B), 17 February 2011 (Gateway reference 15594) and b) David Flory, Publication of the final 2011-12 Payment by Results tariff package, 18 February 2011 (Gateway reference 15607)

expected that for most of the activity commissioned, the maximum price would be paid. The incentive to GP commissioners to negotiate a lower price would be that this would create more resource for them to spend on other things.⁶⁴ Similarly, Foundation Trust providers would have an incentive to deliver services more efficiently because this would deliver a greater surplus, enabling trusts to invest, borrow or improve services for patients.⁶⁵ However, under the Department's plans to set prices according to the most efficient providers in the market, it is hard to see how GP commissioners could get a better price by shopping around.⁶⁶

31. As well as price, the Department said there were a number of different operational pressures on Foundation Trusts which force trusts' boards of directors to take full responsibility for the proper and best use of the resources that they earn from their contracts. These pressures were: the Accounting Officer responsibility held by the chief executive of each Foundation Trust; contractual arrangements, in which commissioners would have a deep interest in value for money; patients' choices and the public's views.⁶⁷

64 Qq 63-70

65 Q58

66 Qq 78-81

67 Q48

Formal Minutes

Monday 4 April 2011

Rt Hon Margaret Hodge, in the Chair

Mr Richard Bacon

Mr Stephen Barclay

Dr. Stella Creasy

Jackie Doyle price

Matthew Hancock

Chris Heaton-Harris

Jo Johnson

Mrs Anne McGuire

Austin Mitchell

Nick Smith

Ian Swales

Draft Report (*National Health Service Landscape Review*) proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 31 read and agreed to.

Conclusions and recommendations 1 to 8 read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Thirty-third Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Monday 9 May at 4.00 pm]

Witnesses

Tuesday 25 January 2011

Page

Una O'Brien, Permanent Secretary, Department of Health, and **Sir David Nicholson KCB CBE**, Chief Executive, NHS

Ev 1

Tuesday 1 March 2011

Chris Ham, Chief Executive, The King's Fund, **Dr, Clare Gerada**, Chairman, Royal College of General Practitioners, **Jill Watts**, Chief Executive Officer, Ramsay Healthcare UK, and **Dr. Shane Gordon**, GP Commissioning Lead

Ev 24

List of printed written evidence

1 Department of Health

Ev 40:40:

List of Reports from the Committee during the current Parliament

The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2010–11

First Report	Support to incapacity benefits claimants through Pathways to Work	HC 404
Second Report	Delivering Multi-Role Tanker Aircraft Capability	HC 425
Third Report	Tackling inequalities in life expectancy in areas with the worst health and deprivation	HC 470
Fourth Report	Progress with VFM savings and lessons for cost reduction programmes	HC 440
Fifth Report	Increasing Passenger Rail Capacity	HC 471
Sixth Report	Cafcass's response to increased demand for its services	HC 439
Seventh Report	Funding the development of renewable energy technologies	HC 538
Eighth Report	Customer First Programme: Delivery of Student Finance	HC 424
Ninth Report	Financing PFI projects in the credit crisis and the Treasury's response	HC 553
Tenth Report	Managing the defence budget and estate	HC 503
Eleventh Report	Community Care Grant	HC 573
Twelfth Report	Central government's use of consultants and interims	HC 610
Thirteenth Report	Department for International Development's bilateral support to primary education	HC 594
Fourteenth Report	PFI in Housing and Hospitals	HC 631
Fifteenth Report	Educating the next generation of scientists	HC 632
Sixteenth Report	Ministry of Justice Financial Management	HC 574
Seventeenth Report	The Academies Programme	HC 552
Eighteenth Report	HM Revenue and Customs' 2009-10 Accounts	HC 502
Nineteenth Report	M25 Private Finance Contract	HC 651
Twentieth Report	Ofcom: the effectiveness of converged regulation	HC 688
Twenty-First Report	The youth justice system in England and Wales: reducing offending by young people	HC 721
Twenty-second Report	Excess Votes 2009-10	HC 801
Twenty-third Report	The Major Projects Report 2010	HC 687

Twenty-fourth Report	Delivering the Cancer Reform Strategy	HC 667
Twenty-fifth Report	Reducing errors in the benefit system	HC 668
Twenty-sixth Report	Management of NHS hospital productivity	HC 741
Twenty-seventh Report	HM Revenue and Customs: Managing civil tax investigations	HC 765
Twenty-eighth Report	Accountability for Public Money	HC 740
Twenty-ninth Report	The BBC's management of its Digital Media Initiative	HC 808
Thirtieth Report	Management of the Typhoon project	HC 860
Thirty-first Report	HM Treasury: The Asset Protection Scheme	HC 785
Thirty-second Report	Maintaining financial stability of UK banks: update on the support schemes	HC 973
Thirty-third Report	National Health Service Landscape Review	HC 764

Oral evidence

Taken before the Committee of Public Accounts on Tuesday 25 January 2011

Members present:

Margaret Hodge (Chair)

Mr Richard Bacon
Dr Stella Creasy
Jackie Doyle-Price
Joseph Johnson
Austin Mitchell

Stephen Barclay
Ian Swales
Nick Smith
James Wharton

Amyas Morse, Comptroller and Auditor General and **Mark Davies**, Director, gave evidence. **Gabrielle Cohen**, Assistant Auditor General and **Marius Gallaher**, Alternate Treasury Officer of Accounts, were in attendance.

Examination of Witnesses

Witnesses: **Una O'Brien**, Permanent Secretary, Department of Health, and **Sir David Nicholson**, Chief Executive of the NHS, gave evidence.

Q1 Chair: We have a few visitors from the Sierra Leone Parliament, so a very warm welcome to you. I hope that we will be able to share the experiences of how we hold the Executive to account.

Welcome to Una O'Brien and Sir David again. This is a very different sort of hearing in that we are trying to tease out and understand, at a very early stage in the development of proposals for reform of the NHS, how it will impact on our role and how you will deliver accountability to Parliament and ensure value for money for this enormous amount of public spending. I hope you will see this as a conversation rather than an interrogation, and that you will feel free to really contribute so that we can develop our understanding, and hopefully we can add something to the work you are doing in the evolution of the proposals.

Now I have a bit of an odd question. We were told that Karen Wheeler was to be one of the witnesses, and somewhere along the line that changed. Is she the senior responsible owner of the project?

Una O'Brien: Karen Wheeler is a senior programme director. The senior responsible owners for the project are myself, Sir David and Richard Douglas.

Q2 Chair: And will Sir David be the senior responsible owner when he takes on his new job?

Una O'Brien: There will continue to be responsibilities for implementing the change, and we haven't clarified the SRO responsibilities post-2012, but I fully expect that the accounting officers in the ALBs will have responsibility for continuing the implementation of the change.

Q3 Chair: It arises out of some discussions we have been having around accountability, and we are keen to know, at the beginning of a fantastic, huge, enormous change project, as this one is, who the senior responsible owners will be, so that we and Parliament can hold them to account.

Sir David Nicholson: The project itself is divided into three elements. There are the changes in the

Department and the arm's length bodies, where Una is the senior responsible officer now, then there are the provider side changes and the commissioning side changes. I am the senior responsible officer for the commissioning and the provision, but obviously on 1 April 2012, when I become the Chief Executive of the Commissioning Board, the senior responsible officer for the provision will be someone at the Department.

Q4 Chair: And that has yet to be settled?

Una O'Brien: That's right.

Sir David Nicholson: Yes, that has yet to be settled.

Q5 Chair: That is very helpful. We hope that you will all be in post throughout the project, so that you can properly be held to account.

Sir David Nicholson: Thank you for the vote of confidence. It's official.

Q6 Chair: The first questions are around accountability, because that is what we are about. It says in the Report somewhere that the current role of the Chief Executive of the NHS—your current role, Sir David—and the Permanent Secretary will no longer be necessary. Will those jobs go? Paragraph 2.5 states: "The new model for health envisages that the current NHS leadership functions—in which the Permanent Secretary of the NHS and the Chief Executive of the NHS both hold Accounting Officer roles—will either no longer be necessary or will"—so are these jobs going to go?

Una O'Brien: Perhaps in an attempt at brevity—and may I say it's a really good and helpful Report—some of the richer detail hasn't come through. It's very, very clear that the accounting officer responsibilities will be set out in the new world, and the diagram in this document has captured that very well. The Permanent Secretary, the role I hold, will remain the accounting officer for the entirety of the spend voted to the Department of Health by Parliament and then—I'm talking here post-2012—there will be accounting

officer responsibilities designated in each of the arm's length bodies, the chief of which is the NHS Commissioning Board, and Sir David will be the accounting officer—

Q7 Chair: Post-2012, who will be responsible for the whole of GP commissioning? You, or David, or both of you? Who will we hold to account?

Sir David Nicholson: You'll hold me, through my accounting officer process for commissioning.

Chair: So if a GP consortium overspends?

Sir David Nicholson: Yes, it's me.

Chair: It's your responsibility?

Sir David Nicholson: Yes.

Q8 Chair: And what will you be able to do?

Sir David Nicholson: Well, hopefully, I'll prevent it happening in the first place.

Q9 Chair: How?

Sir David Nicholson: Well, there is a series of elements of the reforms that enable us to do that. The first and most obvious one is that the Commissioning Board is responsible for the authorisation in the first place of each GP consortium, so that the arrangements that they have in place for internal control, the way they manage themselves, the way they make decisions, will all be part of that authorisation process. So, the first thing is that we will identify, in order to become a GP consortium, the standards required to make that happen?

Q10 Chair: Down the line.

Sir David Nicholson: And then as you go through it, we'll of course allocate the resources. We'll have a relationship with the commissioning consortium whereby each commissioning consortium as a statutory body will have an accountable officer, and the Commissioning Board are responsible for the appointment of those accountable officers.

Q11 Chair: So each GP consortium cannot appoint its own accounting officers?

Sir David Nicholson: It has to be approved by the Commissioning Board.

Chair: Every time they change?

Sir David Nicholson: Every time they change. Yes.

Q12 Chair: Go on.

Sir David Nicholson: So that's the third thing. The fourth thing is that the relationship between the Commissioning Board and the commissioning consortium will be determined around something called the Quality and Outcomes Framework, which is a series of measures and financial incentives that will go between the Commissioning Board and the consortium, one of which will be staying within the resources that you have been allocated, and they will lose money through that process if they don't.

Q13 Chair: If they overspend—and they will lose money; it's like a snowballing—what do you do?

Sir David Nicholson: And then finally we have the ability to intervene—

Chair: Which is based on what?

Sir David Nicholson: Well, we haven't designed yet the intervention system, but you could see us putting people in there, supporting them, moving the management of the consortium to another consortium which is more successful at managing, bringing in people from outside; the kind of things that you would expect an intervention regime for—

Q14 Chair: So you won't just let them fail?

Sir David Nicholson: No.

Q15 Chair: You will intervene to improve?

Sir David Nicholson: Yes, in to—

Q16 Chair: And that will be set in the legislation?

Sir David Nicholson: Yes, it is in the legislation. .

Q17 Chair: And if the whole thing overspends—we had Nick Macpherson telling us last week that the NHS budget in the past—what did he call it, Jo?

Dr Creasy: Special measures.

Chair: Had gone into special measures.

Joseph Johnson: Lost control.

Q18 Chair: So we know resources are constrained and we know we've got the Nicholson challenge. So you are coming in two-thirds of the way through the year and you look as if you're heading for an overspend.

Una O'Brien: Can I just make a comment, if I may, first of all on the connection with history, because it's so important that we do, and we definitely want to, learn from our history in what we do in setting up this programme? I haven't had the opportunity to read the transcript of your discussion last week; I've only got the reported detail of what Nick said. I'm sure that whatever he said was right, but there is more to be said about it. The essential thing, just to be clear on the facts, is that the deficit that we're referring to occurred on the provider side of the NHS in some providers and emerged before the reorganisations of the PCTs and the SHAs. They are sort of broadly around the same time, but if you look at the actual sequence of events, there's no direct causality.

The other thing that is important for the record is that the Department of Health has never broken its delegated expenditure limit, so although there was an overspend in particular providers, the deficit was tackled very swiftly. It was just shortly after that, I think, that David became the Chief Executive of the NHS and that was then dealt with. So I think the idea that somehow there was a big financial problem and it was all linked to reorganisation is perhaps not the full story, or indeed, even the accurate one.

Q19 Chair: Well, I've allowed you to say that. Now if we look to the future and we've got these NHS commissioning consortia—we'll come back to them in detail; I'm just trying to focus on the accountability—

Austin Mitchell: Can we ask what happens to the foundation hospital?

Chair: Yes, we will come to those.

Austin Mitchell: Is that likely to go bust?

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Q20 Chair: Yes, let's come to those. Let's do GP commissioning first, and then I promise you, Austin, we'll come back to the trusts. If you're heading for a dozen, 15, 20 commissioning overspending your old budget, what happens? I'm trying to get the division of accountability between the two of you.

Sir David Nicholson: Well, I'll be accountable for the totality of the commissioning spend.

Q21 Chair: And you, Una?

Una O'Brien: I have responsibility for the overall stewardship of resources voted by Parliament to the Department of Health.

Q22 Chair: Where does the buck stop?

Una O'Brien: It absolutely stops in the Department.

Q23 Chair: With you or with Sir David?

Una O'Brien: Well, as I explained, there is a scheme of delegated accounting officer responsibility. David will be the accounting officer for the commissioning spend and will be responsible for staying within that limit.

Chair: It's a bit muddled. I just don't quite get it.

Q24 Stephen Barclay: The language you used there was very interesting, because you said the buck stops with the Department, and that was the point that Sir Nicholas was making last week in terms of managing public money; the requirement to satisfy yourself. But at our hearing with Sir David last week, when the Chair challenged on variations in hospital performance in terms of foundation trusts—I've got the transcript here—"So in the new world, when they're all foundation trusts, where will the buck stop?" Sir David: "The buck stops in the foundation trust." So, I'm just a little confused. If you're saying the buck stops in the Department, and last week we were being told the buck stops in the foundation trust, could you just clarify for us how that works?

Una O'Brien: Perhaps one way in to thinking about this is perhaps to think of it as a scheme of accountability that is distributed across different parts of the system in different ways, so, of course, it is right that the money is voted from Parliament for spending on health and social care, and we have a scheme of accountability to deal with that. Currently, right the way up until April 2012, the accountability divides directly between David and myself, in so far as David is responsible for the NHS request for resources and I'm responsible for the much smaller amount that relates to social care, the arm's length bodies and the Department of Health's own spending. Separately, going back to the legislation of 2003, foundation trust chief executives are accounting officers in their own right and responsible, accounting to Parliament, and they lay their accounts before Parliament for the way in which they use their money, and also for their own statement of internal control and for the good use of public money following all the rules. So that's already in the legislation and it's been there for seven years. If it would be helpful to the Committee I could pause at that point or I could go on and set out how the scheme is going to change.

Q25 Joseph Johnson: Can I come in on Sir Nicholas's point before we move off it completely. What you're saying is a little bit at variance with what Sir Nicholas was saying, because he was very clearly, in the hearing last week, making the point that it is periods of reform that make Departments more likely to lose control of public expenditure, and what you're saying is there was no link at all in the case of the NHS, and that in the periods when the NHS did lose control of public expenditure, particularly on the provider side, that was not linked to the reorganisation and the creation of the PCTs and SHAs. Is that correct?

Una O'Brien: Well, in the sequence of events they were not directly related. Those deficits were emerging in a small number of trusts and were not related to the doing of the reorganisation, so that was really the point that I was making from that.

Q26 Joseph Johnson: Do you think the period of reorganisation that we're about to embark on increases the risk that the NHS will lose control of its public spending responsibilities?

Una O'Brien: Well, I'm sure David will want to comment on that in a moment, but in general terms, of course, if you're organising a big change programme, it's a lot of additional activity in what people are going to have to do, and knowing that risk and understanding that risk, which is our responsibility, we then take and implement a number of different actions in order to tighten the grip on the finances, which we are doing in the current year. I think David can give you a fuller account of that.

Q27 Stephen Barclay: Exactly, but that makes it even more pertinent, surely, that where there's widely fluctuating performance those variations are understood, and what we got to the bottom of last week was that the Department's view is it provides the tools to foundation hospitals; whether they use the tools or not is an issue for the board, not for the Department, and what surely flows is that if management focuses on the changes—a loss of personnel, more interims, perhaps bringing in consultants—not only will the risk increase anyway because focus is diverted, but the Department does not see its role as satisfying itself as to why there are wide variations.

Sir David Nicholson: There are two things. I don't know whether you want me to take on the risk business, because the risk is higher. If you try and reorganise, the risk becomes higher. I think we'd be kidding you to say that it wasn't, because it is heightened. That's why it's so important for us to get mitigating circumstances into place. I don't know whether you want to talk about those mitigations now or later, but we have put in place a whole set of mitigations to make sure that the risk is absolutely minimised.

Chair: I think we want to come back to transition later. We all accept that in the process of transition the risk is higher.

Sir David Nicholson: But the Department is not responsible for managing the number of nurses on a ward or anything of that nature.

Q28 Stephen Barclay: No one is suggesting they are; that's not the point that's being made.

Sir David Nicholson: We use the tools that we have with foundation trusts, which are the contractual tools, which is setting out guidance and supportive help to enable them to create information, but we do not instruct foundation trusts how many nurses they should have on a particular ward.

Q29 Chair: Let's come back to foundation trusts, because you didn't actually answer the question about whether you will need a Permanent Secretary for NHS? Is there a quick yes or no—in the new world?

Sir David Nicholson: The Chief Executive of the Commissioning Board is the accounting officer and he—who happens to be me—is outside of the Department. So the Permanent Secretary then is responsible for the whole system in terms of the accountability for the finance.

Q30 Chair: Do you want to come in on that? I want to move to the foundation trusts.

Amyas Morse: Just let me ask one thing at that level if I may, Chair. Thank you very much. It's really just to be clear. As I understand it in the logical scheme of division you've got the commissioning side of the house and the providing side, if I can put it very simply. How are you going to conduct the dialogue about what the appropriate balance of resources between those should be? Because you have a lot of demand, you've got your providing capacity and you've got demand coming up from the GP consortia. It's not a difficult question; I'm just curious to know. So at some point you're going to be having a discussion about what capacity you need and estimating that. How is that going to go on now you've got a sort of two-sided dialogue; how are you going to bring that together into a total decision about resource? I'm curious to know how you're going to do it.

Una O'Brien: I'm not sure whether your question is about planning or about request for resources.

Amyas Morse: I guess, starting with planning. You're obviously going to be having a dialogue about it, so it's not a difficult question. You'll start with planning; then, if it turns out the demand is more than the supply capacity, how will you handle that to-ing and fro-ing? You've got the supply side and the demand side and they're both running up separate chains, suppose one is asking for more than the other can provide? How is that going to be done?

Una O'Brien: In general terms, looking to the new system, the policy that the Government has set out, the intention is not to have some grand plan for the supply side of health care services. The approach is to introduce a diversity of supply and to enable the suppliers to come forward to respond to what commissioners actually want, whether that's commissioners in consortia or commissioners led nationally by a programme of national commissioning that the Commissioning Board will lead. So there isn't some sort of grand planning process that would try and calibrate those two things and then plan for provision; it's a more dynamic process to enable new

providers to become available to provide new and different forms of care.

Q31 Chair: Let's take that a step further, which is really Austin's question. What happens in that world? As I read the Report, you're weakening your controls on foundation trusts in that Monitor will no longer be able to remove members of the board, which has been one of your powers of intervention. In that world, where you're encouraging diversity of provision, what happens if a foundation trust goes bust for any reason: just no demand for its services or actually it's a right old shambles?

Austin Mitchell: Or it's crippled with a huge PFI bill?
Chair: Yes.

Una O'Brien: If I could just set out the policy as it's described in full in the Command Paper, which was published just before Christmas, first of all we're not planning for failure; that's not the point here.

Chair: It'll happen.

Una O'Brien: I just want to make that clear.

Q32 Mr Bacon: Can I just stop you there? Actually, I object to that sentence. You absolutely should be planning for failure. Part of your job is to design for a failure regime. I've sat on this Committee for 10 years and I can tell you: things will go wrong. If you don't think things will go wrong, you shouldn't be doing your job. I don't know what will go wrong; I can't tell you where it will go wrong, but that something will go wrong somewhere in this enormous, £80 billion organisation, is as near to a certainty as we will get. So you should be planning for failure. Hoping for success, but planning for failure.

Una O'Brien: Indeed. As I pick up the rest of my sentence—thank you for that—what I was going to go on to say was of course we have set out in the White Paper, in the Command Paper, indeed now, in the legislation, more detailed plans for a comprehensive failure scheme should that occur.

Q33 Chair: What is it? Because it seemed to me reading it that it's weakened, you see? We had Sir David last week telling us trusts are in their own world, which was Stephen's question. We have, as I understand the Bill, a weakening because of the removal of the capability of Monitor to remove board members. We have an intention to have a much greater diversity of provision. There will be failure. What tools will you have to intervene? We just really want to be specific?

Una O'Brien: To be specific, if I could take the three stages in terms of the high-level points, there is already a failure regime in the 2009 legislation, which was put in place just recently. That regime will be adapted in the legislation going through Parliament this year so it can be triggered by Monitor in its current role. At the moment it's for the Secretary of State to trigger that regime; there's a possibility of de-authorising foundation trusts and that's going to be removed in the legislation. Thirdly, a more comprehensive insolvency and special administrator regime will come into effect in either 2013 or 2014. Depending on progress on the development of that regime, a lot of it will be developed through

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secondary legislation so that there are opportunities for engagement and to clarify the details of how it will work. And that regime—this is a very relevant part of this—also links particularly to what we would call designated services. That can be any services that are provided—NHS services regardless of the type of provider—and the process of working out what those designated services are will be between Monitor and the Commissioning Board. David may be able to fill you in on how that will work in practice.

Chair: Well, no, let's stay on the trusts.

Q34 Austin Mitchell: The Bill merely provides that Monitor could give them instructions and Monitor are responsible, as you know, for maintaining services. What happens if a foundation trust goes bust?

Chair: Quite.

Una O'Brien: You're asking about the future; well, it would depend on the degree to which the services in that trust had been designated. That's a critical part of the design of the failure regime. So the actions that would be taken for the designated services would be absolutely for the regulator to step in on behalf of the public and patients to preserve those services for patients.

Q35 Austin Mitchell: They can go bust and they can be pushed out and Monitor will take over the services?

Una O'Brien: Monitor would appoint a special administrator whose job would be to ensure continuity of services that had been designated.

Q36 Chair: Does the Board get sacked?

Una O'Brien: Well, I wouldn't expect—sorry there is one other piece of the design that I haven't referred to, which is that the legislation is strengthening the role of the governors of foundation trusts and giving them more power in relation to the—

Q37 Austin Mitchell: But they don't all start from an equal basis. Some are lumbered with big PFI bills, which they've got to pay whatever happens. That isn't starting from the same level as the other ones, which haven't got PFI. So what happens?

Una O'Brien: In the unlikely event that we were dealing with a situation like that, there would be a process whereby the creditors and the debtors of the process would be worked through in the administration regime, and the responsibility in the end to resolve that would sit with the Department of Health.

Chair: We're still muddled.

Q38 Dr Creasy: There are two areas, in my original set of questions, which are about your concept of what you would intervene on. But paragraph 2.27 in the Report actually says that Monitor will have those powers that you're talking about removed.

Chair: Quite.

Dr Creasy: So I'm a little bit confused. Now you're setting out that Monitor will be the organisation that will intervene. It also talks about a subset of existing foundation trusts. It sounds like some are more monitored than others.

Una O'Brien: Monitor's powers as the new regulator apply to all providers of NHS services, not just to NHS foundation trusts, and that's the critical difference. At the moment it relates only to NHS FTs and in the new arrangement it is a regulator—

Q39 Dr Creasy: So will those powers apply to everything?

Chair: Monitor can take over Bupa?

Una O'Brien: It sets the competition regime, the pricing regime and also the designation regime—it would be helpful if David explained that a bit more fully—and its powers apply to providers of NHS services, regardless of their ownership, and that's the critical difference between Monitor as it currently exists and Monitor in the future.

Q40 Chair: This is really fascinating. So if Bupa ran a hospital—for some of us this is very real, looking at the east London MPs.

Austin Mitchell: Well it can, because any willing provider can run any service.

Chair: If Bupa ran a hospital and it overspent; it went bust; it was incompetent; it failed on the quality regime, you wouldn't sack the directors because there are no powers so to do, but Monitor would come in and do a takeover, really, of that service, and run it because it's an essential service or a designated service in that area.

Sir David Nicholson: I perfectly understand why this is confusing and I guess there are very few people who've—there are very clever people in the Department who spend all their time thinking about all of this.

Q41 Chair: But we should understand it.

Sir David Nicholson: No, I understand. Monitor will have two roles: it will have its old role, as old Monitor, and its new role as new Monitor. If I just take the old role—I'm sorry, you're not supposed to laugh when I say that—old Monitor has significant powers over foundation trusts; it's the regulator of foundation trusts. Its responsibility is to authorise foundation trusts, i.e. make sure that they're capable of running and then setting a compliance regime to make sure they deliver what they're supposed to deliver, and it has wide-ranging powers of intervention. That will carry on for a selection of foundation trusts after 2012 that we think are particularly challenged. So for those that we're worried about, Monitor will continue to have those powers for two years after 2012.

Austin Mitchell: Temporarily.

Sir David Nicholson: It will also, for the new foundation trusts that come forward, have the ability to keep those powers for two years after they're authorised. So old Monitor could have all of those powers right up to 2016 in terms of existing foundation trusts, and that is an important way of managing the transition and making sure that we're in the right place and we're keeping those controls in place. New Monitor is an economic regulator. It's not interested primarily in the viability of an individual organisation. What it's interested in is the continuity of supply. So just as the water regulator is interested in

ensuring that water is always available, the economic regulator, new Monitor, will be responsible for ensuring that designated services—i.e. those services that are designated in a particular organisation or where there is no alternative anywhere else for patients—continue to be run. So new Monitor's intervention powers will be around keeping supply going; making sure that patients have access to services. And they're two quite distinct roles, but because they're in the same organisation people run between the two. So that's essentially what we're trying to do. Is that clear?

Chair: Yes, it is clearer.

Q42 Dr Creasy: I have to say that I don't think the water regulation industry, having done quite a lot of work on it in another life, is a very good parallel to make, because one of the ways in which the water regulator does ensure continuity of supply is to look at the viability of suppliers and to take that into account in the decision that it makes.

Sir David Nicholson: Yes.

Q43 Dr Creasy: Something I really wanted to push you on, and something I think we have a great concern about on in this Committee, is you talked before about staying within the resources allocated and obviously that's quite a strict interpretation of what an economic regulator would do. That's not the same as value for money. Under this system, how are you going to ensure not just that they don't go bust but they're spending their money wisely, because that's what we have a concern for?

Sir David Nicholson: The main way in which you do that is by setting price. That is fundamentally the way in which the system operates.

Q44 Dr Creasy: But you just said that you wouldn't necessarily look at viability, so how are you going to—in a monopoly system, price is—

Sir David Nicholson: No, I said their prime concern. In a sense it comes back to a question that was asked earlier about how you make sure the commissioners and providers work together to make something sensible, because it's not in the interests of the Commissioning Board to have an unviable provider side, because we need to provide services and it's not in the providers' interest for the commissioners to go bust. So the main arrangement there is the setting of price, and that is a kind of joint responsibility between the economic regulator and the commissioner. So the economic regulator will collect and has powers of collecting huge amounts of information from individual NHS providers, including the private sector; huge amounts of information about the way they structure their costs, the way their costs operate and all the rest of it. It will make judgments about the price that you have to set that will give you that viable provider side. So that is the main way in which the economic regulator will do that.

Q45 Dr Creasy: That's not the same as value for money though, is it, as a metric?

Sir David Nicholson: No, but it is in terms of the leverage that the Department and the system has over

individual organisations, that is the main way that that gets played out.

Q46 Dr Creasy: How does that tally in with what Una talked about before, about not focusing on the supply side and not having a grand plan? It doesn't quite tie up.

Sir David Nicholson: Well, it's not the Department that's doing it; it's the economic regulator.

Q47 Dr Creasy: No, but do you understand the concern that we have?

Sir David Nicholson: I absolutely understand it, yes.

Q48 Dr Creasy: If you are a foundation trust trying to meet the needs in all our communities of people who have quite complex health needs, and your only metric for whether or not the services that you can provide are value for money and therefore meeting that need is price, and you don't have any connection with the supply side, you've now cut those two adrift, it's not a great guarantee that you're going to be able to deliver the services that community needs and plan for the services that community needs in the years to come within the budgets that you're setting. Price can't be the only metric you have about whether or not you're actually going to be able to deliver that, can it?

Sir David Nicholson: No.

Una O'Brien: There are a number of different operational pressures on any foundation trust that force the board of directors to take full responsibility, as is the intention of Parliament, for the proper and best use of the resources that they earn from their contracts. That exists first of all from the accounting officer responsibility; secondly the contractual arrangements, and there's quite a lot of power in those contracts to drive value for the use of the money. After all, the commissioners have a deep interest in the value for money. Obviously, the role of patients and the public and, increasingly, the choices that they make, forces pressures and opportunities on to that organisation. So I think it's really about seeing those things in the round, and also it's price, as David has said.

Q49 Dr Creasy: Our difficulty is that we have to be able to see how we hold people to account for value for money. From that model it sounds like we should be evaluating the contracts for each service. That's where you're saying the pressures will be and where you can be held to account. That would be a very, very good change in the current system, wouldn't it?

Una O'Brien: Well, what I was saying was those are the forces that are driving good use of resources within a foundation trust.

Q50 Ian Swales: A quick point on pricing. How granulated will your pricing mechanism be, because clearly somebody performing an operation in a 50-year-old cottage hospital may have a totally different cost base from somebody working in a new PFI hospital, and there are the different parts of the country; there are all kinds of factors that mean that even the same thing will have a different cost and

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therefore, potentially, a different profit regime for the provider depending on how you decide to set price. I'd be interested to know how complex you're going to make this. It's Stella's point: value for money means getting both equality and the price right, given the local circumstances, and it could vary a lot.

Sir David Nicholson: For an increasing amount of activity within the NHS there will be a fixed national price and, as you say, that is quite a blunt instrument to deal with the system as a whole and that's why it's so important we get it as right as we can.

Q51 Chair: Can I just get this clear: is it a fixed national price or is it a fixed maximum price?

Sir David Nicholson: At the moment it's a fixed—

Q52 Chair: But under the new arrangements, as I understand, it becomes a maximum? Is it a maximum?

Sir David Nicholson: It is now a maximum price.

Q53 Chair: So you could go down?

Sir David Nicholson: You could if you satisfy the test that I set out at the last Committee, which is that you've got to be able to measure what you mean by quality. So you've got to have real clarity about the quality standards you want to deliver. You need to monitor them and then you need to have patients who are sufficiently educated and informed to be able to help you do that. We have yet to come across any services that have done that, but it seems to us that to leave that open would be sensible way of taking things forward.

Q54 Ian Swales: So are you really saying that, if I want to have my hip replaced at St Thomas' across the river, it will be exactly the same price as at my local hospital in Middlesbrough, for example?

Sir David Nicholson: Yes.

Ian Swales: Really?

Chair: That's not what our Report says.

Q55 Ian Swales: That really is stunning if that's the case, because that means that you've got massive differences in local circumstances, age of assets and so on, and you're not going to give competitive power to the providers to work inside that, which was the Chair's question.

Sir David Nicholson: Can I just explain? That's the pricing system. There is another funding system for the service that operates in parallel with that, which is known as the market forces factor. So although for the commissioners there is one price, hospitals get slightly more depending on where they are in the country and what the market forces factor is. So, if you take Guys' and St Thomas', as far as the individual local PCTs are concerned, they will pay the same price there as they will at UCLH and the Homerton; any hospital that they use. But underneath all of that there's something called the market forces factor, which provides support to organisations in areas of very high expenditure or whatever.

Q56 Chair: Hang on a minute. I'm just going to stop you, because there's a lot of muddle in thinking. Paragraph 2.20—tell me if it's wrong—states:

“Foundation trusts will face increased pressure to improve their cost effectiveness through a wider adoption of the practice of reimbursing hospitals for treatment given to patients according to the costs incurred by the most efficient hospitals, rather than the average.” That spells to me diversity; there won't be a tariff, there'll be diversity of tariffs.

Ian Swales: Otherwise how will we extract value for money?

Sir David Nicholson: That's another complexity in it in the sense that at the moment the price that is set is the average price. What we do is we look at the costs across the whole country and we set at the average. In future we might think about setting the price not at the average but amongst the most efficient in order to drive efficiency elsewhere in the system.

Q57 Chair: So you don't spend the same at St Thomas' as you do at Ian Swales' local hospital? You don't spend the same for a hip replacement?

Sir David Nicholson: As far the commissioners are concerned they do, but there's a set of subsidies underneath all of that in relation to the market forces factor that offsets some of the pressure that they have. That's the existing arrangement.

Q58 Dr Creasy: What's going to drive that though? The commissioners are paying the same price anywhere. What would be the incentive to Guys' and St Thomas' to do it more efficiently and perhaps at a lower price?

Sir David Nicholson: Because it drives their surplus and their surplus enables them to either invest money, to borrow money or to improve services for patients. That's what drives it; it's the delivery of the surplus.

Q59 Chair: This is very muddled. Just say yes or no to us. Will you pay the same for a hip replacement in every hospital in the country?

Sir David Nicholson: When you say “you”, who do you mean? A commissioner?

Q60 Chair: A GP consortium.

Sir David Nicholson: Yes.

Q61 Chair: Pay the same price?

Sir David Nicholson: Yes.

Q62 Chair: So is this sentence wrong?

Una O'Brien: The sentence is correct because—

Sir David Nicholson: No. No.

Q63 Ian Swales: Sorry, this is crucial. A GP consortium will have no incentive whatsoever to go and find the most efficient provider. Is that right?

Sir David Nicholson: The national price that's set is the same across the whole country.

Mr Bacon: What's the answer to Mr Swales' question?

Sir David Nicholson: What we are saying is that is a maximum price—

Mr Bacon: What's the answer to Mr Swales' question?

Sir David Nicholson: I'm trying to answer it. If you want to get a lower price, you have to be able to

demonstrate that you can identify what the quality is—because what we can't have is that lower price providing lower quality—so you have to identify what the quality is quite clearly, you have to be able to have a mechanism for measuring it and you have to have talked to your patients about it.

Q64 Mr Bacon: When you said “you”, who were you referring to?

Sir David Nicholson: The commissioner.

Q65 Mr Bacon: Yes, well Mr Swales' question was about the GP, and that's why I kept on saying, “What's the answer to Mr Swales' question?”

Sir David Nicholson: The GP will have to do those three things.

Q66 Mr Bacon: Mr Swales' question is: what is the incentive to the GP? That's his question. In fact his question was: is there no incentive to the GP?

Sir David Nicholson: The incentive to the GP is that they create more resource to spend on other things.

Q67 Dr Creasy: You said they're paying the same price?

Mr Bacon: They're paying the same price?

Sir David Nicholson: I'm sorry, there is a national price—this is from a commissioner point of view—there is a national price that is calculated using all the evidence we have from what all the various providers do. At the moment we rank that at the average price. We could think, in the future, about making that national price lower than the average price, in order to drive efficiency, right? So that's the first thing. So you have a national price that is a maximum price, and our expectation is that in most of the activity that people do they will pay that maximum price. They have the opportunity to try and get a price lower than that, or be offered a price lower than that in the locality by an individual organisation, but in order to do that they have to show that they are getting the equivalent quality.

Q68 Ian Swales: So I'm a GP consortium and I'm buying a hip replacement. Will I see a difference in my budget if I go to hospital A or hospital B as a result of hospital B having lower costs than hospital A? Will I see a lower price in my budget or not, or will I be charged the national price?

Sir David Nicholson: If the organisation can demonstrate that they can provide equivalent quality and monitor it, then you can pay a lower price and you will get the benefit of that lower price because you will keep the difference.

Q69 Ian Swales: So I will see two tiers of prices set with reference to this national price? Is that possible?

Sir David Nicholson: It's possible that you'll get a local price offer.

Chair: I think where we're muddled is where you say there are national prices and local prices.

Q70 Nick Smith: It sounds like the buyer has to show that the supplier is providing a better cost and quality service from your explanation.

Sir David Nicholson: The commissioner has to demonstrate that to pay the lower price it is getting equivalent quality, yes. That's true.

Amyas Morse: I think that the point is—I'm trying to help here—that the national price is a ceiling price, isn't it?

Sir David Nicholson: Maximum price.

Amyas Morse: So that if you have a very popular hospital you can't say, “Oh, actually the price is going up here.” You can't charge more than a certain amount, but you could charge less if your hospital costs are low; you could offer to provide for less if you can show that you can maintain the service quality. Is that it?

Sir David Nicholson: Yes.

Q71 Joseph Johnson: But it's a maximum price based on the costs incurred by the most efficient hospitals, so it's a maximum price but it's also going to be the lowest price available nationally, so therefore how can anybody shop around for a better price when the tariff is already the lowest possible price available in the market?

Sir David Nicholson: It isn't at the moment.

Q72 Joseph Johnson: No, but you're moving to a new world where it is.

Sir David Nicholson: That's one option, but to do that—

Q73 Joseph Johnson: You're not saying it's an option. In paragraph 2.20 it's saying it is the plan.

Sir David Nicholson: Yes, but you have to take into account the impact that will then have on the provider side.

Q74 Joseph Johnson: What do you mean?

Sir David Nicholson: Well, we could set the prices at the lowest of any provider in the country. What that would mean is that huge numbers of providers would fall over because they wouldn't be able to deliver—

Q75 Joseph Johnson: But this is what paragraph 2.20 says you're going to do.

Sir David Nicholson: No, we have always used the average. We can move that average down as we become clearer about the way in which the provider side operates.

Q76 Joseph Johnson: Hold on a second, are you saying that paragraph 2.20 is incorrect, because it's saying you are going to do this, and at the moment you're saying, “We may,” subject to everything not falling over?

Sir David Nicholson: One of the criteria you will use to decide how to pitch it is the viability of the provider's side. It's not an academic exercise; you have to think about the consequences of putting it lower.

Q77 Joseph Johnson: So you're not certain you're going to move to this pricing structure based on the most efficient provision in the market?

Sir David Nicholson: I think we would like to. That's absolutely what we would like to—

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Joseph Johnson: Even though, as Mr Swales says, that would effectively create a situation where the GP commissioners have no incentive to shop around, because the price you were offering them would effectively be the lowest price in the market.

Q78 Mr Bacon: That's what I don't understand. That's why I kept on going on about it. You were busy conflating the yous and theys with commissioners and GPs. Mr Swales was focusing on the incentives to the GPs.

Sir David Nicholson: To the GPs as commissioners.

Q79 Mr Bacon: He originally asked what incentives the GPs would have to shop around. That was the question I was asking.

Q80 Ian Swales: Consortia.

Q81 Mr Bacon: What incentives would the GP consortium or consortia have to shop around? But if the price that they can get is already the most efficient—set on the basis of the most efficient in the market—it's hard to see how the GPs by shopping around are going to get a yet better price. It might be the case that some of the poorer providers will improve so that they could do it at that cost, but that's not the same thing.

Sir David Nicholson: It may not just be price, of course, that people decide to—It may be quality.

Q82 Chair: I'm going to move us on. Let me draw together this bit of the discussion. There will be a maximum price, but if quality standards are met, there could be a lower price, which will have to be quality assured, and, if there is a lower price, GPs can accept the additional thing. But in answer to Jo's very important point, you will not be lowering your maximum price to the most efficient hospitals until you are assured that providers will be able to deliver within that price. So you will not be doing what they say here—moving to the most efficient quartile—until you are assured that won't impact in a bad way on the provider's side. Is that a yes or no?

Sir David Nicholson: Yes.

Q83 Chair: Right. And even though—

Sir David Nicholson: -ish.

Joseph Johnson: Ish?

Chair: Even though, accepting what you've said to Jo, which is really important, that might impact on your ability to deliver the efficiency gains you need for the Nicholson 4% per annum. True? Yes.

Sir David Nicholson: Yes.

Chair: Okay. Thank you.

Q84 James Wharton: I've been quietly following this and it becomes increasingly clear to me that I mustn't understand it, because it seems to make sense to me and that puts me at odds with everybody else here. I'm quite interested in something we touched upon earlier, which is the idea of insolvency of trusts or administration, and the process through which a trust is going to be allowed to become insolvent and allowed to go into administration, and also linking that

in with something that we talk about a lot on this Committee, which is PFI costs and new PFI projects. I'm particularly interested because my local trust, which is North Tees and Hartlepool NHS Trust, are trying to get themselves a new hospital by PFI and I would like to understand how they're going to do that. The concern I have is, if you're going to allow trusts to go into some sort of insolvency or administration mechanism—I'd like you to explain how that's going to work, please, if you will—then when they go to bid for a PFI, is that not going to drive the costs of the PFI up? Because if you bid for a PFI now, the Secretary of State, the Department, effectively, is standing behind that PFI. So if the trust falls over or if the trust can't pay it's PFI, the private-sector lender knows that the Government is going to step in and they're going to get their money, so it de-risks it and they can lend at a lower rate. If you're saying that you're going to actually give more autonomy and more responsibility to the Trusts, including a mechanism through which they can become insolvent or go into administration or some sort of mechanism of redress if they get this wrong and they can't afford their PFI, does that not increase the risk, and therefore the cost, of future PFI projects? Sorry if that's a long question.

Una O'Brien: I think it's worth stating at the outset that all the details of the special administration regime have yet to be worked through. The high level principles are set out in the Command Paper and in the Bill, so this is precisely the development work that we're going through right at the moment, but I think the important thing that I would like to stress about the special administration regime is there will be a range of options open to the special administrator to ensure continuity of services. So that's the really important thing here; it's not about taking the services away or putting them somewhere else, but actually getting in there on behalf of patients and the public to ensure continuity of services.

Q85 James Wharton: Obviously that is extremely important but we're looking specifically at value for money. At the moment, my understanding is that if you enter into a PFI with your trust, the Secretary of State signs it off and the Department stands behind it. So if something goes wrong with that trust, you as the private PFI provider know you're going to get your money. If that changes and you've had an administration regime or an insolvency regime there's a new risk, whatever that regime is. You may have different options, but unless the only option is the Department stands behind it and pays it, then the risk is increased. If the risk increases then you want a better return on your money. What are you doing to make sure this is not going to drive up the cost of future PFI?

Una O'Brien: Well, that's exactly what we'll have to focus on now as we work our way into the details.

Q86 James Wharton: So we don't know yet?

Una O'Brien: Well, we're seven or eight months into this. This is a big and complex thing. I wouldn't want to suggest that we've got every nut and bolt sorted out. That's absolutely not the case, but I think the principles of the regime are very clearly set out.

Q87 Joseph Johnson: Just to try to give a concrete example of what James is getting at, the South London Healthcare NHS Trust is, I think, the most indebted in the country. Under the proposals, unless it achieves foundation trust status by 2014, which at the current rate at which its deficit is increasing rather than decreasing seems a stretch, it will either cease to exist as a separate body or merge with existing foundation trusts, if I understand the proposals correctly. What does “cease to exist as a separate body” under option 1 mean, and what if independent foundation trusts, with their own board of trustees, do not wish to merge with this, frankly, basket case of a merger of itself three NHS trusts? So what happens?

Sir David Nicholson: At the moment we are going through—not to personalise it to South London, although I acknowledge there is a significant issue—

Q88 Chair: You could personalise it on Queen’s hospital.

Sir David Nicholson: I thought we were going to have a debate about who was the biggest basket-case. There are over 120-odd organisations that are not foundation trusts and the moment, and currently we’re going through each of them individually with the strategic health authorities to work out the trajectory to get them to foundation trusts by 2014. Most of that number are relatively straightforward—we see a pathway to do that—but there are about 20 across the country as a whole that enter the places that you’ve just described, and over the next six months or so we have got to work out what the trajectory of each of those organisations could be. You’ve identified a couple of options there: the demerger in a sense, the splitting up of organisations and moving them to different places; the taking over of organisations by foundation trusts. You are absolutely right; we would have to put the right incentives in the system to enable that to happen. There is also the model that we’ve developed at Hinchingsbrooke, where we’ve got a franchisee coming in. So there are some options; we haven’t worked all of that detail out yet, but we’re currently working on that.

Q89 Chair: So at the moment, to take that to its conclusion—it means we have got to talk to you again at some point in the not too distant future—you haven’t quite worked out your failure regime for foundation trusts, taking on board issues like the PFI. Also, you haven’t quite worked out—it is interesting that Jo’s got it; we’ve got it in east London where we probably have two basket-case hospitals—how on earth you will ensure the continuation of local services, A&E onwards, in organisations that we don’t think will ever achieve foundation trust status.

Sir David Nicholson: I understand why you use the term basket-case, but I think it’s highly unfair to the people who work in the organisations—

Q90 Joseph Johnson: They’ve been lumbered with structurally very difficult PFI projects; that’s the fundamental problem.

Sir David Nicholson: There are structural issues there that need sorting.

Joseph Johnson: Absolutely. No, I don’t at all denigrate the work that they’re doing.

Q91 Austin Mitchell: I can’t help thinking that, when I successfully survive the next election and become the oldest MP in the House and probably the oldest MP ever and I go to the Grimsby consortium for my hip replacement operation, they will say, “Hop off to London, because economies of scale give London hospitals a huge advantage in pricing and we’ll have to pay less for it.” I don’t want you to answer that, because it’s going back over old ground, but in this section we’re dealing with the changes. Now, taking those changes overall before we come to the transitional arrangements, isn’t it true that this is really a gigantic leap in the dark that is justified because the Government promises that it will be more economical; that there’ll be big economies from scrapping strategic health authorities and the primary care trusts. The costs are clear but the economies are unproven and unlikely to materialise. Every experience we’ve have of big reorganisations tells us on this Committee that they always cost more than is prophesied and the returns, the benefits, are always less than are prophesied. Isn’t that the case with this?

Sir David Nicholson: Well—first of all I don’t—

Q92 Austin Mitchell: Or how can we stop it being the case?

Sir David Nicholson: We need to talk about the transition now. I don’t accept that it’s a leap in the dark. I think we have learnt a lot of lessons over the last few years about how to do this sort of thing, and we have learnt quite a lot of lessons around, for example, GP commissioning. We have had 20 years of experience of involving GPs in commissioning at various levels; from GP fundholding, through total purchasing, through practice-based commissioning and through now. So it is not as if we are on a blank sheet of paper here. We have really good ideas about how that might go forward, and we’ve got a set of GPs who are very keen to make that happen. On the foundation trust provider side, we have experience over the last seven or eight years about independent providers and how they function in the system. So it is not a leap in the dark in that sense. It is a big leap forward; it is a big change. I would not underestimate the size and scale of that change, but I do not think it is a leap in the dark in the way that you describe it.

Q93 Austin Mitchell: But you cannot guarantee either, can you, that the costs won’t be higher or the benefits smaller?

Sir David Nicholson: Well I think the risks are obvious and no doubt we are going to discuss these as part of the transition.

Q94 Chair: Can I just get one assurance from you? Will you be monitoring the costs of transition to the new—

Sir David Nicholson: Yes, absolutely.

Una O’Brien: Absolutely.

Q95 Chair: So we can hold you to account for the costs of transition on a regular basis?

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Sir David Nicholson: Yes.

Una O'Brien: Yes.

Q96 Stephen Barclay: I just wanted to look forward to the Nicholson challenge and the cost savings that you have set out, I think of £15 billion to £20 billion. The starting point for me was therefore to look at the last value for money programme that you ran, which was the Comprehensive Spending Review programme set out in 2007 for the period 2008–09 to 2010–11. How much was that to save and what percentage has been delivered?

Sir David Nicholson: Well, if you look at a top level in terms of the resources that were made available to us and the way that they were used and the outputs that we delivered for it, without going through the whole of our last Committee, we delivered virtually everything that the Government asked us to do, whether that be waiting time reductions or improvements in healthcare-acquired infections; all of those things, we delivered them. And at the end of the day we delivered them with a £1.5 billion surplus on the resources that were made available, which was the biggest surplus the NHS has ever made.

Q97 Chair: Stephen, let's stick to the future, because—

Stephen Barclay: No, no, Sir David has answered—

Sir David Nicholson: As part of that, every year for the first two years of the spending review we expected all NHS trusts and foundation trusts to deliver a 3% efficiency gain and they delivered it. In the last year, we asked them to deliver a 3.5% efficiency gain and they are well on target to deliver that for this year.

Q98 Stephen Barclay: With respect, you have answered a totally different question to the one I posed. I was referring to a different hearing that this Committee had, where we looked at the breakdown by Department that is set out in the National Audit Office Report HC 291 on page 17. It showed that at the interim stage the Department of Health had delivered 20% of its target. We are now in 2011. First, it was just an opportunity for you to bring us up to date as to what extent we have moved on from 20%, so my question was what is the percentage that you have delivered and what was the total figure? Because if we are looking forward to trying to make a saving of £15 billion to £20 billion, is it not relevant to look at how many billion the last saving was for and how much of that has been delivered?

Sir David Nicholson: I have not got the document you talk about to hand and I have not got the graph that you show. I am sure it exists.

Stephen Barclay: Sir David—

Sir David Nicholson: Yes, but what we did not do in the way that we run the NHS is we did not set out a set of requirements on the NHS in the way that you have just described it. The way we did it was to say to each individual foundation trust and organisation, "You have to deliver a 3% improvement in your efficiency."

Q99 Stephen Barclay: Again, with respect, you are answering a different question. What I am saying is

that at the interim stage of your last value for money programme, your department had delivered only 20% of its target. Now, you are now setting the Nicholson challenge; you are setting a new target. Surely you have an idea how you did on the last one without having to refer to the document. You must have a ballpark idea what percentage you delivered.

Chair: You have set that out. I really want to push us to the purpose of today's hearing, which is to look at the arrangements in the reforms, which is where I thought you were taking the question.

Stephen Barclay: It is where I am going.

Chair: Will they deliver the 4%, which I think is a—

Joseph Johnson: This is directly material to that, because if you are only achieving 20%—let us say for sake of argument it has gone up to 30% six months later—that implies that if you are aspiring to achieve 20%, you would have to aim for £60 billion of savings in order to achieve your 20%.

Stephen Barclay: And that is two-thirds of the NHS budget.

Joseph Johnson: It is.

Q100 Stephen Barclay: But actually Jo, it was even worse than that, because 20% was the reported savings, but the NAO Report found that only 38% of what Departments had booked was actually green—was valid. So actually, there is a degree of that 20% not being real savings. But I did want to come on to the future. Pulse magazine reported that PCTs' management salary costs increased by 25% in the two years between 2007 and 2009 and they needed a number of Freedom of Information requests in order to establish that. When the Department of Health was challenged on that, apparently it said, "It is for PCTs to determine their management costs and to ensure they are securing value for money." Therefore, what safeguards are there in terms of the management costs of GPs' consortia, and how is the Department going to satisfy itself that we are not going to see a similar inflation in terms of their admin costs?

Sir David Nicholson: It is one of the big changes in looking forward to looking back. In the past, you are absolutely right, we have made it a policy of the Department that it is up to individual organisations to decide what management arrangements they require in order to deliver the services for their patients. Going forward, and in a different financial climate, we have said that is not acceptable in the future. What we have identified for the total running of the system—by this I mean the Department, arm's length bodies, the strategic health authority; the whole of the commissioning function—that there will be a running cost limit. The current cost of that is £5.1 billion and we are going to get it down over the period to £3.7 billion.

Q101 Stephen Barclay: Does that include consultants and interim spend?

Sir David Nicholson: Yes, it does. It includes all of that. So what we are doing at the moment is identifying how you allocate that to the different—sorry, it is £3.4 billion. Slightly less ambitious, £3.4 billion. We are currently going through a process of identifying which bits of the system will get the

running cost allowance they require. So for example, we have announced that we are looking at about £35 per head of population to run the GP consortia. That will be performance-managed rigorously from the centre and we expect both to deliver a totality across the commissioning system and each individual organisation to deliver to their target.

Q102 Chair: This is very interesting. That is a very helpful answer. It's interesting; it is very central control, so it is slightly different from the decentralisation. Let me ask you a few more questions. Are you going to have a regional structure?

Sir David Nicholson: The Commissioning Board is one organisation.

Q103 Chair: But will it have regional arms?

Sir David Nicholson: Well it will have management tiers in it.

Q104 Chair: So will it have regional arms?

Sir David Nicholson: Well there will be management tiers. You could call them regions or not, but there will not be me here and all of the consortia there; there will be something in the middle.

Ian Swales: Location. That means location. The question was: will the Commissioning Board have a regional structure?

Sir David Nicholson: Well we have not worked all of this out yet, but if you think about the responsibilities of the Commissioning Board, on the one hand it is going to commission itself big, important national services, so the kinds of services that only need to be commissioned once, and there may be only one or two or three sites in the country. But it is also going to commission directly primary care; it is going to commission the 8,500 GP practices. So it will need both a national and a much more local representation in order to deliver that.

Q105 Chair: So you will have a commissioning body and you will have regional arms. You will have to.

Sir David Nicholson: Well at the moment, we have set out we are going to have 50 clusters.

Q106 Chair: 50 clusters to the commissioning body?

Sir David Nicholson: Yes. Those clusters, which are currently clusters of GPs, will be accountable to the Commissioning Board on 1 April 2012, so you will have, in a sense, 50 of those in the environment we are going into.

Q107 Chair: I am sorry to pursue, but maybe we will get this clear. In your answer to Stephen, you said there is going to be really rigorous monitoring to ensure that we keep down management costs.

Sir David Nicholson: Yes.

Chair: Great. There is a little bit of, "Is this local; is this national?" but great. But on the other hand, you will then need a machinery of governance to ensure that accountability. All I am trying to get out of you is: is that machinery of governance going to be a regional or a local thing? Are you going to have 150 of these at local authority level or are you going to

have a regional structure? You, Sir David, as boss of this new commissioning whatever it is.

Sir David Nicholson: We have to work all this out. We are only just working out how much money is available.

Q108 Chair: If I can then take it to its next point, it is not going to be that different from the SHAs, is it?

Sir David Nicholson: Well the SHAs do provider-side stuff, they do work force and they do commissioning; they do the whole system.

Q109 Chair: They may do slightly different things but it will be the same structure.

Sir David Nicholson: That is a big difference. That is a significant difference. We have not worked out yet how we are going to organise the Commissioning Board. Do not forget we have got until 1 April 2012. What I am doing at the moment is trying to put transitional elements in place in order to manage the arrangements as we take it forward.

Q110 Stephen Barclay: Can I just then tie in with that, because you said, "We haven't quite worked it out," and when there is big organisational change, often that is when consultancy spend or interim spend goes up. We know from the Cabinet Office they want to have a tighter grip on that. We had a hearing on consultancy spend and, interestingly, the Department of Health is one of the two biggest spenders within Whitehall on consultancy; that is after your consultancy spend went down by 45% from 2006. So what are you foreseeing budget-wise in terms of your consultancy spend and your interim spend over the next two years? Are you seeing that going up at the same time as you are delivering the Nicholson challenge?

Sir David Nicholson: It will go down.

Q111 Stephen Barclay: It will be going down, will it? Even while you are delivering this major change programme?

Sir David Nicholson: Yes.

Q112 Stephen Barclay: Given that the Cabinet Office have said that they want monthly data from Departments on consultancy spend, can I assume that you will be publishing monthly what is spent on consultants, interims and professional services, both in terms of the Department centrally and any of these other agencies set up as part of the reforms?

Una O'Brien: All of this will be made more transparent by the Cabinet Office. Just for the record, because I do think it is important, I know you have observed the scale of DH spending on consultancy in the past, but in the first six months of this financial year, our consultancy spend was £12 million. The full year cost for 2009–10—last year—was £155 million. So I think that just gives you a sense of the dramatic reduction in consultancy spend. We are absolutely, across Government, committed to bringing this down and indeed it is going to be a very important opportunity for civil servants to build their skills and to really make the most of what we have learnt from working with consultants in the past.

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Q113 Mr Bacon: Of that £155 million down to £12 million, how much is NPfIT?

Una O'Brien: I could not give you the breakdown, but I am happy—

Q129 Mr Bacon: Could you send us a note?

Una O'Brien: I am happy to do that, yes.

Mr Bacon: It is probably mostly NPfIT, isn't it? It is really aside from—

Una O'Brien: Yes.

Q114 Austin Mitchell: On these clusters, we are now clustered in a big Humberside cluster, which will inevitably be dominated by Hull. Now you know from your experience of Trent that devout prayer in Grimsby is always, "From Hull, Hell and Halifax, good Lord deliver us." You are delivering us on to Hull. Now, I am not concentrating on that point, but it does mean surely that, if the cream of the officers of the present PCTs in that cluster are creamed off to run the overall cluster in Hull, the ability of the doctor consortia, which I assume will be on the old local authority level of North East Lincolnshire, to pick the best for the management of their consortia will be deeply damaged because the best people are going to go to Hull.

Sir David Nicholson: Not necessarily.

Austin Mitchell: But probably.

Sir David Nicholson: And in fact the only guarantee the cluster people have is that there is a job until the end of March 2013. There is no guarantee after that that they have a job. So quite a lot of people will want to work in the GP consortia and we would encourage them to do that, because I think that is exactly the right place—

Q115 Ian Swales: And are they getting redundancy payments on the way through? That is a legend that is starting to emerge.

Sir David Nicholson: A lot of this depends on minimising the redundancy cost to the NHS as whole, and, in a sense, what we are trying to do here by a system of assigning people to consortia is to reduce the redundancy cost, which I think is an issue for us.

Q116 Austin Mitchell: Let's move on to another point, because North East Lincolnshire is a primary care trust plus; in other words, it involves the local authority and brings them together. Now, I see there is a new clause in the Bill—or a clause that I did not realise was there until I saw the Bill—that provides that care trusts plus—there are only six of them in the country I think—because they involve the local authority on the care side and bring it into a close working relationship with the NHS, will be continued and the desire is that that situation should not be disturbed. Now, how is that going to be maintained when at the same time we are going to be part of a cluster of other primary care trusts based in Hull? In other words, shouldn't there be a distinct regime for North East Lincolnshire Care Trust Plus?

Sir David Nicholson: Yes, there should be and there will be. The point about the cluster is we are trying to do two things. We are trying to concentrate our people in one place to ensure that we do not go through a process over the next two years where individual

primary care trusts fall over because people go off and work in consortia and all the rest of it—so to concentrate them in that—and also to provide a very clear line of sight and accountability. That does not mean you have to disrupt some really good services and relationships on the ground to make that happen.

Q117 Jackie Doyle-Price: I just want to explore the transfer from the primary care trusts to the new consortia, because the final sentence of paragraph 2.15 of the Report says: "The Department is seeking to clarify other issues, including, for example, the handling of legacy debts and liabilities from primary care trusts." I ask that question because my primary care trust is South West Essex.

Sir David Nicholson: We want to give the GP consortia the best possible chance of success, and part of that is to get them into a place where in their first year of operation of a budget, which is 2013, they do not have a legacy debt attached to it. That is our ambition. We are not saying that we will write everything off, because we cannot; we have not got the resources to do that and it would not be the right thing to do. So what we are saying is, in your part of the world, you have got two years now, working with the GPs—because it is in their interest as well as that of the PCT—to get rid of that legacy debt. That is what we are focusing our attention on.

Q118 Jackie Doyle-Price: So what about ongoing liabilities? For example, the PCT's commissioning of Brentwood community hospital has been a very expensive PFI with a lot of sunk costs in it. What would be the implications for the transfer of that liability?

Sir David Nicholson: Yes, sorry—

Jackie Doyle-Price: Because there is a fixed cost in the PCT's annual expenditure.

Sir David Nicholson: Does the PCT run it? I do not know that particular hospital, I'm sorry.

Q119 Jackie Doyle-Price: Right. This particular community hospital was commissioned directly by the PCT and there is sitting in there an annual fixed cost. It was very poorly executed and the management of the PCT will readily acknowledge that. Now, obviously, that fixed cost is going to have to be absorbed somewhere. Is that going to be transferred to the GPs? Because it is a very under-utilised hospital—when I went round there I was switching lights on—and it would be very unfair, again, setting up the GP consortia, to have this sunk debt that is setting it up to fail.

Sir David Nicholson: We have got two years to try to sort all these issues out. We want the GP consortia to start off with a blank sheet of paper, if you can possibly do that. So we will be seeing how we can make that a reality. It may not be that we can do it in every single case, but certainly that is our ambition.

Q120 Ian Swales: I was on the same paragraph, 2.15. When we had a private session a few months ago, Sir David, one of the issues that came up was what sort of size GP consortia should be. I remember the figure, because it was about the same size as my local PCT,

strangely enough, which was a minimum of, say, 100,000 to 150,000 patients. I note from paragraph 2.15 that the Pathfinder practices run from 14,000 to 672,000, which is a massive difference. The reason we had the discussion about the size of GPs was because of the internal insurance in terms of what might happen with a given population in terms of rare diseases and so on. What happens to the consortium with 14,000 people if it has the misfortune to have half a dozen expensive rare conditions occurring? How will it deal with it?

Sir David Nicholson: The Government policy was very, very clear, which is that was entirely a matter for general practitioners to come together in consortia of whatever size they thought was the right thing to do, and I perfectly understand why that is the case in terms of getting the innovation and the commitment to it happening. But there is no doubt that in this world you have got this very different set of arrangements. Of course, what the Commissioning Board will run is a series of risk pools in the system, because I do not think any of the consortia, even the biggest, will be able to deal with every particular arrangement. So what you will have to do in those circumstances is identify a mechanism for setting up risk pools at various levels with individual consortia all paying into a pooling system in order to ensure that when those do come along we are capable of doing it.

Una O'Brien: It is perhaps just worth adding that part of the purpose of the Pathfinder process is to learn and address some of these questions about size.

Q121 Chair: The 14,000 one might not work?

Una O'Brien: Well, that is what we are going to find out. What is really good is that people are coming together early on so that we have an opportunity to learn those lessons early.

Q122 Chair: But Ian raises an interesting point. If they do not work, will you legislate to ensure that the practice has a minimum number of patients?

Sir David Nicholson: First of all, we will not authorise them, because they will not get through the process if they do not work.

Q123 Chair: But in effect, you will take a view on the minimum number of patients?

Sir David Nicholson: No, not necessarily, because if you take the 14,000 one as an example, it may be when you look at it that it is a perfectly reasonable population size to deal with 70% or 80% of what they do. In those circumstances, they always have the opportunity for the 30% that it is not appropriate that they do to be taken on by either a risk pool arrangement or directly by the Commissioning Board itself.

Q124 Chair: But just to pursue the 14,000 very quickly, if it has a lot of elderly patients—somebody over 75—they are a small proportion—

Dr Creasy: Bournemouth. East Bournemouth.

Austin Mitchell: Sorry—

Chair: Oh yes, Austin and then me. They will cost much more, so how will you ensure that, in that

example that Ian gave, they will look after that elderly patient?

Sir David Nicholson: Well that is the point I am trying to make. For a population size of 14,000, there is quite a lot of activity that operates on a population size of 14,000.

Q125 Ian Swales: Sorry, can I just come back on something you said, Sir David? I suppose as a child of the sixties, the rock-'n'-roll nature of all this should appeal to me really, but you actually just said that you felt the Commissioning Board could come in and take 20% or 30% of the work of a GP consortium. Is that what you said?

Sir David Nicholson: The legislation allows for consortia to ask the Commissioning Board to take responsibility for some of its activities.

Q126 Ian Swales: So they would become local commissioners for certain activities?

Sir David Nicholson: Well the Commissioning Board then would make a judgment about whether they would give that to another consortium to do or whether they would set up their own arrangements to make it happen, but yes, that is what would happen. That is, in a sense, the safeguard in the system.

Ian Swales: Okay.

Q127 Nick Smith: Sir David, when Austin challenged you about these plans being a great leap forward, you said no—

Austin Mitchell: Great leap in the dark.

Nick Smith: Sorry, leap in the dark. You said no, you thought they were a great leap forward, and I was reminded of other people's earlier remarks about Maoist political processes. But tell me something. I want to come on to QIPP and the expected savings of £20 billion—a big number. We need to know more about the processes that you are going to engage on QIPP programme. We want to look at the impact of it and how you are going to measure the success of this massive saving that you expect. Have you got confidence that you can make these £20 billion savings?

Sir David Nicholson: Well we have never done it before—we have never done anything of this scale before—so it is new territory for us. We expect levels of efficiency gain that we have never seen, against a background of an NHS that has grown at 4.5% every year since 1948. So it is a big change—a step change—in the way that we deliver services and the way in which we take money out of the system. Having said that, we are in the position whereby the money that we generate we actually keep. It is not as if we are giving this money up to somewhere else, so there is a shift in the way that the money is allocated in the system. That is a good thing as far as I am concerned. So we have to do something we have never done before. We identified this sum 18 months ago, we spent a long time talking to the service—talking to clinicians and organisations in the system—to get people to understand what we are trying to do and to start to think about how they might do it. Unusually in the NHS, there is a consensus about the requirement to do it, which is not always there in the

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circumstances. Also, when we have set out our overarching strategy for dealing with it, all the various commentators—the King’s Fund and all of these people—have said we have broadly got the right figure and we have broadly got the right areas by which we can make the changes happen.

We have been through all of that, and we are now in the place of working with individual organisations as to how they are going to do it. We have set out the operating framework that they will work in, and all the organisations—you will no doubt see them in your locality—are now working through the practical implications of making the kinds of savings that we need to do. All that activity is going on and we expect by the end of March, beginning of April, to have a plan for every individual organisation in the country that sets out how they are going to do the first year and some ideas about how they are going to do year two, year three and year four. All of that is in train and people are working on that at the moment, so we will have that in position by the end of this financial year for next financial year. You can read in the newspapers about action that has now started to be taken in order to deliver those savings in future years. Now, if you look at the totality of the savings, about 40% of those—sorry, am I going on too long?

Nick Smith: No, no, I want you to—

Sir David Nicholson: You’re bored?

Nick Smith: We’re leaving that space there for you to fill.

Sir David Nicholson: 40% of those savings come from a variety of the pay freeze that we have over the next couple of years, the significant reductions in the amount of money we hold nationally—the central budgets—and the delivery of the management cost savings, which we are driving nationally through the work I talked about earlier around the running cost envelope. For 40% of them, we have a national handle on them and we are pretty confident we can deliver those. The next 40% of the savings are essentially the delivery of efficiency gains in the provider arm. The way we deliver that is we set the tariff and we have set the tariff with a 4% efficiency gain for next year. We have done that and we have created a whole set of help and support for people to enable them to deliver it, whether that be the Long Term Condition Programme or whether it be the work we are doing nationally on the Productive Ward. So there is a whole series of help to people to make it happen. Then 20% of the savings are around service change. It was the kind of thing that I talked about last week around shifting services from hospitals to community. That is the level. In degrees of confidence in terms of our record in this, I think the first 40% we are confident about; we can deliver it. The second 40% we are medium confident about and then the final 20% I think is going to be the most difficult to do. So that is the overall approach.

Q128 Chair: We did have this discussion last time and we are going over old ground. What we are trying to focus on here is where the new arrangements are going to—

Nick Smith: Can I come in on that point?

Chair: Okay, if you promise me it is on that point.

Nick Smith: I can see how you can anticipate savings by cutting staff costs and pay freezes; I can see where the 40% is coming from. I am less confident that you can save 40% on tariffs and 20% on service changes. How are you going to measure the impact of those changes?

Chair: Nick, I am going to stop you, because we really covered that ground last time. We have got another half hour and we have a heck of a lot of ground to cover, honestly, on these new arrangements. I am not being mean, but the whole of Productivity was around those issues. So if people can just focus, there is a huge agenda here of change that we have really got to try to get our brains around.

Q129 Dr Creasy: I have two questions. The first relates just in following up on what Ian was asking you there. Do you envisage a situation where patients could be turned away from their GP under these new arrangements because they are in that 30% of need that they cannot meet? So that the consortium will say, “Look, I’m sorry, we cannot deal with you,” at which point you have to intervene and you have to find another doctor somewhere else who will deal with them. What happens to the person who is the difficult 30%?

Sir David Nicholson: If you are talking about the individual and their relationship with their GP, they go to their GP—

Dr Creasy: I am really sorry; I cannot hear what you are saying.

Sir David Nicholson: The individual patient who goes to their GP with a rare condition will be referred to wherever and whatever service the GP thinks appropriate; that is unaffected by what I have just said. The issue is who holds the contract for that patient; who allocates the resource to that patient. In normal circumstances that will be the consortium. In an environment where the consortium has put that into a risk pool, it will be the risk pool that pays for it. If it has gone to the Commissioning Board, it will be the Commissioning Board that pays for it then.

Q130 Dr Creasy: So who manages your care?

Sir David Nicholson: Your doctor.

Q131 Dr Creasy: So your doctor says, “I think you need x treatment but we do not have the budget for it, so somebody else”—

Sir David Nicholson: No, that is not how it works. I am talking about the individual doctor and the consortium. The consortium is a statutory body with statutory responsibilities. It is not an extension of the GP. It is a statutory body. The GP as a deliverer of service—someone who does that—is quite separate from the consortium.

Q132 Chair: But the consortium hasn’t got the money for this expensive patient.

Sir David Nicholson: It is no different from the position that we have now.

Q133 Chair: So what happens to the patient?

Sir David Nicholson: Well, by and large the patient gets treated, don’t they? At the moment.

Chair: No.

Q134 Dr Creasy: By and large?

Sir David Nicholson: Sorry, the patient gets treated.

Q135 Chair: By—go on.

Sir David Nicholson: By a provider.

Q136 Dr Creasy: But who makes the decisions? What you are talking about is the allocation of resource for a particular condition. If it is somebody with a long-term condition, it might be a very expensive patient. Who makes the decisions about the allocation of resource in that situation? Who is the risk pool?

Sir David Nicholson: The risk pool would be a group of consortia. At the moment you do not have a position for most cases whereby if a GP refers you to hospital, someone else gives them permission in order to make the treatment. There are a small number of cases where that does happen and that is done by a clinical panel. That will be no different from the arrangements we have at the moment.

Q137 Dr Creasy: But now 30% of people could be covered by that risk panel.

Sir David Nicholson: Well, I use the example 30% just to illustrate that.

Q138 Chair: Sir David, can I get this clear? There is a consortium. The consortium gets a budget and they can spend that budget. Along comes a patient who is hugely expensive. The consortium decides they cannot afford it. They go to another bit of your organisation that controls this risk pool money. Is that right?

Sir David Nicholson: Carry on. I understand what you are saying.

Q139 Chair: This is why I was asking about regional structure. Within your structure you have got consortia with their budgets; above that, you have got a bit of your organisation with extra money, which is a risk pool. So if consortium A has a very expensive patient, they can go to the risk pool and get extra resources. If that fails, they can come to you at head office and say, "Hang on, we have this huge issue here. We want extra dosh from you."

Sir David Nicholson: No, the risk pool is what it says it is. It spreads risk across the system.

Q140 Chair: But it is money.

Sir David Nicholson: It is not a permission pool; it is in order to help various organisations manage it—

Q141 Chair: I understand that. It is a pot of money.

Ian Swales: It's an insurance company.

Sir David Nicholson: Yes. It is an insurance; it is not giving you permission, so—

Q142 Dr Creasy: Aren't you then creating a situation whereby it is an incentive to the GP commissioners to refer things to the risk pool because it takes the risk out of their budget?

Sir David Nicholson: Well, there will be a conversation between the consortia and the

Commissioning Board about what they ask the Commissioning Board to take on. That is absolutely true.

Chair: It is no different from a PCT.

Q143 Dr Creasy: So if you have a patient with a debilitating and expensive condition, who is going to make the decision about paying for their treatment and who will hold that responsibility?

Sir David Nicholson: It is no different from what it is now.

Q144 Dr Creasy: So this GP commissioning body says, "No, we cannot afford it, we'll go to the risk pool." The risk pool says, "Sorry, you should be paying for it." Who makes the decision? Where's the appeal?

Sir David Nicholson: The GP.

Q145 Chair: You might have got the answer there. What was the answer?

Sir David Nicholson: I don't understand.

Una O'Brien: I think the most important thing to manage is if consortia are small—

Q146 Chair: We want the specific answer.

Sir David Nicholson: Okay, let me—there are two—

Q147 Dr Creasy: We ask in a completely selfish fashion, because my fear is all these people are going to come to our surgeries and say, "Help me."

Sir David Nicholson: Okay, there are two issues. If you have a risk pool, what you do is you set out in advance the kind of conditions that you want to have in the risk pool and how much money you will have in order to support that risk. A patient will come to a GP, they will have the condition, the GP will refer them to whatever services they have got and the risk pool will resource and pay for it. That is it.

Q148 Dr Creasy: So they will always pay for it, no matter what?

Sir David Nicholson: That's the arrangement. That is for the pre-arranged stuff.

Q149 Dr Creasy: But will they always pay for it no matter what, whether there are any complications in the treatment, whether they develop any other—

Sir David Nicholson: Well that's what happens now.

Q150 Dr Creasy: Can you see our concern that there's a real risk there that patients who develop debilitating conditions that are quite complicated—

Sir David Nicholson: No.

Dr Creasy:—or develop complications become very expensive?

Sir David Nicholson: No. The risk pool would have to pay. They would have to pay it out of the resources that were made available.

Q151 Chair: Can I just ask a supplementary on that one? We are hearing stories in the press that in some areas of the country, under the present system, you may be limited to one cataract op, not the two you need. In the new system, focusing entirely on that,

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who would pick up the tab to ensure that there is not a postcode lottery on cataracts and that wherever you live you can get your two cataract ops if you need them?

Sir David Nicholson: Yes. That is the role of the Commissioning Board.

Q152 Chair: So quite a lot of this money—the £80 billion—will be held back to pick up expensive patients and to ensure equity of treatment across the country?

Sir David Nicholson: Well, for the expensive patients, only when asked to by the individual consortia.

Q153 Chair: And equity of treatment?

Sir David Nicholson: But the Commissioning Board will have a budget of about £20 billion itself.

Q154 Chair: Okay, and equity of treatment?

Sir David Nicholson: That is the responsibility of the Commissioning Board. The new system sets out, through national quality standards, the high quality services for patients, and those quality standards will be set out in commissioning guidance for each of the consortia. So it will be very clear what the national standards are in that place.

Q155 Dr Creasy: I have a patient who has come to my surgery who says, “The commissioning consortium has said they will not pay for my treatment because the risk pool should and the risk pool say the consortium should.” Who adjudicates if there is a disagreement on that model?

Sir David Nicholson: At the moment, if there are particular conditions—I am sure there must be some, but I cannot think of any—there is a mechanism locally where clinicians oversee exceptional referrals, and that is the way it would be done.

Q156 Dr Creasy: So the doctors would make the decision?

Sir David Nicholson: Yes, the doctors would absolutely make the—

Q157 Dr Creasy: Which doctors? The GP consortia?

Sir David Nicholson: The GPs.

Q158 Dr Creasy: So the GP consortium says, “We think the risk pool should pay,” and they trump the risk pool saying, “No, we should not pay”?

Sir David Nicholson: But in a sense this is a debate for the bureaucracy to have after the event.

Q159 Dr Creasy: But do you understand from our perspective as people trying to judge value for money that it is a very worrying situation, because you have created an incentive in which GP commissioning bodies will want to put as much as possible on to the risk pool and the risk pool may not want to take that? So we cannot judge where that money is going and if it is being spent well if there is an incentive to try to push cost on to someone else.

Sir David Nicholson: Okay, but that is a pre-organised thing; it is not something that is going to happen. So at the beginning of a period the

commissioning consortium will have to set out what kind of conditions it does not think it is equipped to deal with.

Q160 Dr Creasy: But who will adjudicate on that decision as to what they should and should not take? Could that lead to delays, because at the moment in the system you are talking about, there are delays in treatment to people if there is a disagreement about who should pay and whether or not a treatment can be authorised, aren't there?

Sir David Nicholson: In very exceptional circumstances.

Q161 Dr Creasy: But it does happen.

Sir David Nicholson: But not for complex, life-threatening conditions. That is not what it is.

Q162 Dr Creasy: What about long-term debilitating conditions if somebody wants a different type of treatment? That is an expensive process as well, isn't it? Who will adjudicate, Sir David? That is going to be the critical question for all of us, because we will be the ones writing to them.

Sir David Nicholson: I think the doctor will. The doctor will decide—

Q163 Dr Creasy: You think the doctor will?

Sir David Nicholson: No, the doctor will decide what is the best—

Q164 Chair: The doctor will, but the doctor does not have the money.

Dr Creasy: Yes.

Sir David Nicholson: Yes, but in a sense, that is not the problem of the individual GP as a provider.

Q165 Chair: It is; it is the commissioning—

Sir David Nicholson: It is not; it is the Commissioning Board. It is absolutely the consortium's problem, not the individual's.

Q166 Ian Swales: What about the rogue GP consortium that does not even pay into the risk pool in the first place; decides not to: “Oh, we can carry whatever, because we are quite large”—or we get our sums wrong—“so we are not going to pay into the risk pool”? Will you have any sanction over them or will you force people to cover certain—

Chair: No, he will de-licence them.

Sir David Nicholson: But also, the Commissioning Board allocates the resource, so the Commissioning Board decides who gets what.

Chair: Okay, we have been around this one.

Sir David Nicholson: This is not a change in the arrangements around people getting their care; this is not trying to put an obstacle in front of—

Q167 Dr Creasy: No, the issues is about budgeting where the money goes and who is held accountable for how it is spent, because right now, we challenge the PCT. If you take away the PCT and you are now leaving those decisions to the GP commissioners or the risk pool, at some point people are going to fall

through the cracks unless there is an adjudication mechanism.

Sir David Nicholson: Well you will hold the consortium to account in the way that you hold the PCT to account.

Q168 Dr Creasy: And the consortium says it should be the risk pool; the risk pool says it should be the consortium. Who will make an intervention in that process? Where is the accountability for that decision?

Sir David Nicholson: Well the accountability is the consortium's accountability to their population.

Chair: There is a lot evolving, so I think you should take this one away and if you can write to us with clarity on it, that would be really, really helpful. We are not trying to catch you out, but to ensure that there are proper accountabilities, particularly in a situation where we have reducing real budgets, where this could occur. But I am really pleased to hear you can have your double cataracts wherever you are because somebody is going to pick up the tab.

Q169 Mr Bacon: Two questions, one immediately following on from something that Stella just said, which was that in the old world we have held the PCT to account. It reminds me of what you said earlier about the fact that hospital trust chief executives are accounting officers and are held accountable to Parliament. Indeed, we have had hospital chief executives sitting here as accounting officers. In the Report, in the table on page 23, it describes who is accountable within the organisation and there is a list there, including the Permanent Secretary and the NHS Commissioning Board; you two represented here. Underneath that, it says, "Accountable officer", and then underneath those two are two further accounting officers; the Trusts and the arm's length bodies. What is the difference between an accounting officer and an accountable officer?

Una O'Brien: Perhaps I can give you my interpretation of it.

Mr Bacon: It might be a question for the NAO.

Una O'Brien: Of course and I am sure that Mark may wish—

Mr Bacon: Because I know what an accounting officer is.

Una O'Brien: I certainly know how I operationalise it, but Mark, if you want to—

Mark Davies: Well, yes. An accountable officer would be somebody appointed within the health hierarchy and accountable through that hierarchy to David or Una. An accounting officer is somebody who will be appointed and would be accountable to Parliament.

Q170 Mr Bacon: What I am really asking is if a GP consortium decides to go haywire and runs off to the Netherlands Antilles with the money—we have seen public money going off to Caribbean tax havens since I have been on this Committee, so it is not such a stupid question—will the chief executive or managing partner of the GP consortium be coming before us to explain his actions, assuming he has not been arrested and in jail, or will you be?

Sir David Nicholson: It will be me.

Mr Bacon: It will be you, okay.

Q171 Chair: And will you on hospitals?

Una O'Brien: The accounting officers—which is a different role from the accountable officer of the consortia—are directly accountable to Parliament where there are NHS foundation trusts.

Q172 Chair: So we are expected to see however many foundation trusts we end up with?

Una O'Brien: Yes. On the specifics of what goes on inside that operational unit of a foundation trust, that is what the legislation currently says.

Chair: It is a bloody nightmare.

Una O'Brien: Yes.

Q173 Ian Swales: Can I just clarify this, because I think one of the issues we have had as a Committee is this question of arm's length bodies and the extent to which the National Audit Office can intervene in what they are doing. When it says "accountable to Parliament", it has not been evident to me that that direct link between an arm's length body and Parliament, particularly as expressed by this Committee, is actually happening. So can you just, perhaps by way of an example, pick an arm's length body and say how you see them being accountable in the future?

Una O'Brien: Well the first thing I would like to say is that, in relation to Departments and their arm's length bodies, across the board we are tightening up the governance of that relationship. In any case, it is something that I would want to do inside the Department and am taking this opportunity to do that, as we bring new arm's length bodies into place and we implement our arm's length body review. The important thing to say is that there is a line of accountability to Parliament, because where there are accounting officers, just as in the future you may wish to speak to David, you can call them directly. In terms of a full and fair account to Parliament, to simply do it through the Permanent Secretary as the sole accounting officer does not give you the full picture that you need. So where appropriate and where the responsibility for spending is held very clearly within an arm's length body, I think it is right that their chief executive should be designated as an accounting officer and that you are able to call them.

Chair: You may think it is right; it is just ruddy impractical that this Committee is going to have to hold to account I don't know how many foundation trusts that we will end up with. As Richard said very much earlier on, there will be things going wrong—there has to be another system; there has to be. If you are evolving it, I am saying to you at this point and I will say it in the House next week, it is not acceptable to have in that system Parliament having to hold to account 200 to 300 hospital trusts. It is absolutely bonkers; it will not work and it therefore, I think, undermines proper financial accountability to Parliament. It is a reform too far.

Q174 Ian Swales: Because you have removed the Department of Health—sorry, you haven't removed the Department of Health. Just to finish my question,

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can you pick an arm's length body? I think we understand the foundation trusts. Pick an arm's length body where you think this new arrangement will apply, just to make sure we understand what sort of bodies we are talking about. Because we are not talking about private providers here, are we?

Una O'Brien: No, no.

Ian Swales: So what are we talking about?

Una O'Brien: The arm's length bodies of the Department of Health will be the NHS Commissioning Board, the Care Quality Commission and Monitor. The Health Protection Agency is actually coming into the Department of Health, so that will no longer be an arm's length body. Those are the sorts of bodies that I am talking about; that is what encapsulates an arm's length body.

Q175 Chair: You haven't got a job, Una, at the end of this.

Una O'Brien: I certainly have, because the Department—

Chair: We have, holding them all to account, but you don't.

Una O'Brien: If I may, I think there is a very, very important point that I would like to make about the way in which the accounting system is changing, because this is really significant in relation to your point about foundation trusts. Currently, the foundation trusts' accounts are laid before Parliament separately.

Chair: I understand that.

Una O'Brien: Okay. Under the alignment arrangement and the changes that are being brought in from 2011–12, in order to bring a full account to Parliament of the total amount voted for Health and the total amount that is spent, the accounts of foundation trusts will be consolidated within the Department of Health's accounts. We are in the process now of implementing that change and I think that will improve accountability to Parliament, because it will give you a fuller picture. But the accountability also lies in the system for which the Department is responsible, and that is another really critical element of it; it is not simply—

Q176 Chair: I do not understand what that means.

Amyas Morse: It is important and it is—

Q177 Chair: What does it mean?

Amyas Morse: This came up in our accountability hearing and I have been pondering it and it is quite clear in management of public money. We can call the accounting officers from individual Trusts if we need to; that is true. But what we can also do, and probably do rather more rigorously than we have done, is to examine whether the system of accountability—If Una is the chief accounting officer, the people in arm's length bodies are still accountable to her, actually, and therefore she is still accountable for having a system of control and management that holds them to account properly. If it does not work or it is inadequate or it is seen not to work in practice, we can very reasonably ask you to come and explain whether that system works properly or not. I think there is something to

be done in that area. I am not saying it would be easy, but I think that is part of the solution.

Q178 Ian Swales: Let me give you an example of the confusion. You just gave the Care Quality Commission as an example of a group that would be an arm's length body and would be accountable to Parliament, yet on the top of page 24, it says, "A new body, Health Watch England, will be kept independent from Government by being established as a committee of the Care Quality Commission."—will be kept independent from Government. That seems to cut across the idea of whom they are accountable to. If the Care Quality Commission is accountable to Government, how can one of its committees by design be independent from Government? It just does not seem to hang together.

Una O'Brien: Foundation trusts exist within a regulated system. They are independent, autonomous public sector organisations that exist under the umbrella of the regulator—currently Monitor—and will be in a different regulatory regime after the legislation is passed. So I think that there is a different relationship between the Department of Health and its immediate arm's length bodies on the one hand and the Department and foundation trusts on another; it is not a parallel relationship. So I am not in a line management relationship to foundation trusts at all and that is set down very clearly in the 2003 legislation. That is the legislation and those are the powers that I have and I do not have.

Mark Davies: Can I just make one point to clarify this? In a sense, on the foundation trust side, you have the accounting officer within the Trust itself, but you also do have those two regulators in the form of Monitor and the Care Quality Commission, which both have very specific duties past, present and future. They have accounting officers who could be called alongside the relevant chief executives of the Trusts themselves.

Chair: But I like to know where the buck stops, and at the moment I cannot work out whether the buck stops with the foundation trust, the Department, Monitor or the Care Quality Commission and if somebody could make that clearer to me, I would be much happier about proper accountability to Parliament. I just do not know where the buck stops.

Amyas Morse: I think we do need more clarity over this, although—and this did come up last week—it is fairly clear in Managing Public Money that your duties as an accounting officer do not stop because you have appointed somebody as delegated accounting officer, and that part of your job as an accounting officer is to make sure that those other accounting officers do their job.

Q179 Mr Bacon: Presumably part of your statement of internal control is that you have the mechanisms to do that. Is that correct?

Una O'Brien: In relation to the arm's length bodies, I see the board minutes, I receive the statements of internal control—

Mr Bacon: I was talking about the Trusts, actually.

Una O'Brien: Yes. Well when it comes to foundation trusts, it is different in the legislation, because the

accounting officer responsibility goes with the role of chief executive and that is set down in the legislation. So it is not something that I can give and take away or that Monitor can give and take away currently; that is just the way the legislation is set up, in order to fulfil the intention of Parliament that foundation trusts should have those freedoms. That is the situation that we have at the moment and that is the intention of current Government policy as well.

Q180 Mr Bacon: Can I come on to another issue relating to central and local? That is something Sir David mentioned earlier about the savings and where you are going to get them from. One of the headings was a lot less money kept at the centre. How much less money do you anticipate will be kept at the centre?

Sir David Nicholson: I am just thinking about this coming year. I think we are going to keep about £100 million at the centre. At its peak, that has been several billion in the past.

Q181 Mr Bacon: Okay. So when you say several: two, three, four, five?

Sir David Nicholson: I couldn't tell you. Certainly more than four or five.

Q182 Mr Bacon: But it is now down to £100 million?

Sir David Nicholson: It is now down to £100 million for next year.

Q183 Mr Bacon: That brings me straight on to my next question, because it says in the Report, Ms O'Brien, that you are going to become a banker, in paragraph 2.20. Doubtless you are getting very excited now, because of the prospect of all these bonuses that will be coming your way. It says, "The Department"—that is you—"will provide an 'operationally independent banking function' to foundation trusts, including making repayable loans to Foundation Trusts when there is a reasonable expectation that they will be repaid." It is good to know that you are going to make loans that you expect to be repaid rather than ones that you think will not be. How much money do you think you are going to be putting aside for this function?

Una O'Brien: I think it is just too early to say. We have a lot of details to work out. The purpose is to regularise a system that happens anyway at the moment and to put it on a more transparent basis to make the principles absolutely clear. It is a strengthening of the current system, and the transparency is to be welcomed. We have had a very constructive and challenging conversation today. This is month seven and month eight. We have done a lot to close down the policy uncertainty in so far as we have the White Paper, the Command Paper and the legislation. The next stage for us is to work through these operational uncertainties, of which there are many and they are interconnected. I think that it is good to have your challenge at this point, when we are turning our minds to those things, and we will be more than happy, David and I, to come back at any

point on some of these sub-issues that in themselves merit an in-depth conversation.

Q184 Mr Bacon: This is a rather important sub-issue, because if it turns out under the new world that foundation trusts cannot actually make a go of it unless they are in deep hock to you as the Department, Sir David's number could go back up from £100 million to several billion, potentially quite easily. So it is really quite central; I certainly would not think of it as peripheral. I am not saying you said it was peripheral. This is loans to foundation trusts, isn't it—acute hospitals, basically—not loans to consortia?

Una O'Brien: That is right. But they do not have to come to us for a loan; they can go anywhere they like.

Q185 Mr Bacon: They could go to a bank.

Una O'Brien: Exactly.

Q186 Mr Bacon: Yes, and banks would also make loans on the reasonable expectation that they would be repaid. Would you be offering market rates or better than market rates?

Una O'Brien: As I say, no details on that have yet been worked through.

Q187 Nick Smith: Do any other health systems in the world have their own internal bank like this?

Una O'Brien: I couldn't say.

Q188 Mr Bacon: Would these loans all be inside one financial year, or would they potentially be borrowing from the Department to enable them to tide themselves over and balance within a financial year, but the loan continued to outstand over the financial year into the next year?

Una O'Brien: As I say, all those details will have to be worked through and they will become clearer as we start to develop how the regime will work.

Q189 Mr Bacon: At the moment they have to balance, don't they?

Una O'Brien: What has to balance and what has to be met is the Department's expenditure limit, and that is the fundamental discipline that we work within and that this would be contained within.

Mr Bacon: Okay, thank you.

Q190 Nick Smith: Can I just come back to the question? Are there any other health services across the world that have this internal banking suggestion that you put forward?

Chair: Write to us about that.

Una O'Brien: I just do not have that information at my fingertips, but of course I will write to you.

Chair: It will be quite interesting.

Q191 Stephen Barclay: Three specific questions from me; I am conscious of time. In the new landscape obviously the reforms rely on the role of the GPs. Just picking up on one of the earlier points about unforeseen events, can I just clarify whether the final salary pensions of GPs are within the scope of Lord Hutton's review and, given how powerful the GP trade body is, as we saw from their previous contracts,

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is there any risk attached with changes to GP pensions?

Sir David Nicholson: I couldn't answer that question; I will have to send you a note on that.

Q192 Stephen Barclay: Thank you. Out-of-hours GPs has obviously been a hot topic and a big constituency interest of mine; it was my constituent Mr Gray who was unlawfully killed by the German out-of-hours GP Dr Ubani, who is still able to practice in Germany although he is banned in the UK. So there is an imbalance firstly between someone being able to work here because they are qualified in Germany but being banned here and not being banned in Germany. The GMC do not have unfettered control in setting language and competency tests for European qualified doctors when they come to the UK. It may be something you want to send me a note on, but I would be very keen to establish by what time UK legislation is going to allow the GMC to set the language and competency tests in the new health landscape in order that they can ensure that those coming to this country are correctly qualified and can speak the language.

Sir David Nicholson: We will send a note on that, yes.

Q193 Stephen Barclay: The third thing is around confidentiality agreements for clinical staff who have left their posts for non-clinical reasons or for whistle-blowers. This really ties into Amyas's point around your ability as the accounting officer to meet Sir Nicholas Macpherson's test, which, as he set out, is in order that you can satisfy yourselves that the financial systems in place in organisations are correct. Could you clarify in the new landscape whether those sorts of confidentiality agreements are going to be allowed to continue?

Una O'Brien: It is not something I have any reason to think is changing, but I will certainly verify that.

Q194 Stephen Barclay: I am very keen for it to change; that is my point. Do you have sight—

Una O'Brien: Could you rephrase your question?

Q195 Stephen Barclay: Yes, okay. At the moment there is concern that whistle-blowers or clinical staff who—

Una O'Brien: That their confidentiality is protected?

Stephen Barclay: Well, the Trust that is potentially at fault—or there are serious issues within the hospital that the Trust management may want to cover up—are signing confidentiality agreements with those clinical staff that in essence cover up what has gone on.

Mr Bacon: Some years ago the NAO did a report on the management of the suspension of clinical staff in situations where their clinical competence is not in doubt. The most famous case that comes to mind is that of Dr Raj Mattu, which ran for several years. He was a cardiologist who pointed out that the hospital management's proposal for changing the number of specialist units—so that instead of having one per patient, you would have, shall we say, four sets of machines for five patients on the basis that that would probably be all right most of the time—was actually causing deaths. He was suspended, but there have been lots of other cases—the NAO did quite a

substantial report on this many years ago now—where clinical staff were suspended by a Trust where their clinical competence was not in doubt and then public money was used to pay them salaries for sometimes 18 months, two years or even longer, while the NHS managers—in this case a foundation trust—and the employee—the competent clinician—were in a long-running dispute that got settled more or less satisfactorily from somebody's point of view and was then subject to a confidentiality clause, including quite often a big pay-off.

Chair: I think you are going to have to write to us on this one.

Stephen Barclay: It is just that it is even more important during a major change that clinical staff and whistle-blowers are able to speak out. This has been flagged in the past and these confidentiality agreements are still continuing. So if it needs to be in a note, so be it, but as the accounting officer, surely you should be driving the change by saying, "Let's get transparency on this so we can see exactly what's going on."

Q196 Chair: We have to draw this to a close, but can I just ask you finally on transition, because we have not covered that enough? Transition is obviously a huge area. Currently your estimate of the cost is—

Sir David Nicholson: £1.7 billion.

Q197 Chair: And your redundancy costs are?

Sir David Nicholson: Just slightly less than that.

Q198 Chair: Right, and in those redundancy costs, people are constantly raising with me whether you have put into that the whole load of people who are going to go at 50 and therefore you will have to roll up their pension costs into that?

Una O'Brien: The redundancy estimate in that £1.7 billion is based on a detailed set of assumptions. We do not know all the individual cases yet, so it is very difficult to be precise about the costs, and I would emphasise that, because we do have more work to do in the coming months to get the precision of cost that we want and we need. But in the impact assessment, we have included assumptions about average salary and length of service—

Chair: That might have changed.

Una O'Brien: And we put it high in order to make sure that we are not underestimating the costs. So we have actually got underlying assumptions that are set out in the impact assessment.

Mark Davies: Just to clarify that, actually the redundancy costs currently are around £1 billion; the estimate is £1 billion, plus or minus.

Q199 Chair: Okay. Now, this is a massive change and therefore clearly preventing those costs—the £1.7 billion—escalating is going to be a huge challenge. Going back to the very beginning: are you satisfied now—you two, as the owners of this project as you have announced yourselves to be—that you have got mechanisms in place to contain those costs so that they do not spiral?

Sir David Nicholson: We think they are a good estimate of what will happen. However, the unknown

for us and what will drive that cost up is if the GP consortia choose not to use existing NHS arrangements for commissioning support. That is the big unknown as they go through the process of identifying what commissioning support they need and how they are going to spend the £35 a head. The more they decide to use non-NHS but go out to the private sector, the bigger that redundancy bill will be for us. So on one level we are saying to the NHS people, "You had better organise yourselves and get yourselves into a place where you are very sellable to GPs, so the things you are doing are responding to what their needs are"; that is one way we will reduce it. On the other hand, we have to make it clear there is only one pot of money, so if GPs go and use lots and lots of people from outside the NHS, there is only one pot of money and that will be the Commissioning Board budget.

Q200 Chair: But actually, you have just talked about commissioning; the same thing could happen on the provider side, because if you suddenly get new providers popping up all over the place and existing providers going out of business, somebody will have to pick up those redundancy costs.

Una O'Brien: The estimates that are made in the impact assessment relate to the management changes in the arm's length bodies, the SHAs, the PCTs and the Department of Health itself.

Q201 Chair: They do not relate to the providers?

Una O'Brien: They are very specific to those management cost reductions.

Q202 Chair: That is interesting, because that means that an extra cost of transition could arise out of the change in the landscape of providers.

Una O'Brien: These are things in the future about how the new system will work in practice. So there will be change in the new system and it is designed to drive change; to drive innovation; and to drive greater transparency. It would not be possible for us two to three years out to have any sense of, or even to be able to understand, what that dynamism in the new system might introduce in terms of costs and benefits.

Q203 Chair: Okay. The 2% that you have taken out of PCTs to meet non-recurring costs, which I assume are the costs of transition, is money that has gone out of paying for direct patient care in one way or another.

Sir David Nicholson: This is the money that we have identified—

Q204 Chair: But it has gone out of direct patient care?

Sir David Nicholson: Well it is not just the cost of redundancy, of course; 2% of the budget is significantly greater than the total cost that will be described there.

Q205 Chair: But it has gone out of direct patient care?

Sir David Nicholson: No, but quite a lot of it is going in double running; it is actually going in investing upfront in the community in order to make the savings

in hospitals. So it has not all gone out of direct patient care by any stretch of the imagination. The other thing I would say is that the savings we are going to make on the management side, on which we are putting this money into redundancy costs at the moment, come back within two years, which I think is a remarkable payback.

Q206 Chair: Yes. I am very sceptical. Have you got the proper databases and information for us to test that over time?

Una O'Brien: Just to pick up on your earlier point, we absolutely are going to be monitoring all the costs. These are assumptions in the impact assessment and we have set out all these assumptions; we now have to build the real cost. But the point about the reduction is that it relates to the total amount that is spent in 2010–11 on management costs and what will the total amount be when we get to 2014–15. That is how the difference is calculated. It is on that basis that we are able to express a figure, because we know that we have to bring the budget down.

Amyas Morse: Just one little point to be careful of, I guess—I am sure you will have this in mind, David, in particular—you mentioned £35 per head for administration. Of course, quite honestly, if you have a large, well-organised consortium they will have much more economy of scale in how they administer and other GPs may struggle. I guess you will do some modelling to make sure this does not turn out to be a Christmas present; in other words that we are really in control of those costs. Because if you actually totted it up, most of the population of England must be patients somewhere, so it is about £1.75 billion in total if you add it up. That is quite a large chunk of money on a pretty broad-brush assumption about cost. Hopefully by the time you are implementing you will have something a little bit more targeted than that in place.

Sir David Nicholson: Well we announced the £35 a head in order to give people a planning assumption on which to take it forward; that was the basis of what we did, because if you do not do it, people are stuck with: "How many?" But I should say it is the running costs of the totality of that system, which is the largest integrated healthcare system in the world and has running costs and administrative costs significantly lower than almost any other system you would like to identify.

Amyas Morse: I was not trying to challenge; I was just saying that over time what would be very helpful would be to see how we go from a ballpark number, which I understand you need now, to something that is not driving behaviours you do not want to see.

Sir David Nicholson: Yes.

Q207 Chair: Richard has a final question. Before we come to that, I just want to say that I am really grateful, because I hope that in today's proceedings we have raised some issues that you will go away and think about. Arising out of it—we will discuss this with the NAO—we will probably ask you to come back pretty regularly over the coming period of transition, I am afraid, to account to us so that we can

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keep you thinking about accountability to Parliament for both money and value for money.

Una O'Brien: We would be happy to do that and what really matters is that we can have that sort of relationship.

Q208 Mr Bacon: I would welcome that too and, Sir David, you did say there were some clever people in the Department you hoped; I would just like to remind you—you probably do not need reminding—that out there are a lot of general practitioners who are both very clever and very adept and agile. There is somebody nodding behind you, which is always a dangerous sign in this Committee. So just be aware of that, I would say, in light of what the C&AG has just said, because the medical community in this country quite often wins over vis-à-vis the Department of Health, and we want to make sure that we do get value for money.

I had a question. Very quickly, there has been a lot of concern that I have heard expressed very recently about the position of cancer networks and how they are going to work. Can you just say something about how cancer networks will be protected in the new world?

Sir David Nicholson: We are obviously protecting them next year. They are currently funded out of what

is described as “the bundle”, which is a bundle of money that is made available to the service to do these sorts of things. After 2012, then it is a matter for the Commissioning Board to decide whether it wants to take those forward.

Q209 Mr Bacon: Can you just remind us who is the boss of the Commissioning Board?

Sir David Nicholson: I have been appointed the chief executive of the Commissioning Board—

Mr Bacon: It will be you, yes. I thought I was asking the right person.

Sir David Nicholson: I am absolutely fine to say on the record that cancer networks are a fantastic thing that have created huge opportunities for improving outcomes across the system. I cannot imagine a period where we would not have vibrant cancer networks operating in the system.

Chair: But you are holding less money at the centre.

Sir David Nicholson: How they are paid for obviously is a whole series of other issues, but I think they are a vital part of improving outcomes for patients.

Mr Bacon: Thank you.

Chair: Thank you very much indeed.

Tuesday 1 March 2011

Members present:

Margaret Hodge (Chair)

Richard Bacon
Stephen Barclay
Matthew Hancock
Chris Heaton-Harris
Joseph Johnson

Austin Mitchell
Nick Smith
Ian Swales
James Wharton

Mark Davies, Director, NAO, gave evidence. **Amyas Morse**, Comptroller and Auditor General, **Gabrielle Cohen**, Assistant Auditor General, NAO and **Marius Gallaher**, Alternate Treasury Officer of Accounts, were in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

National Health Service Landscape Review (HC 708)

Examination of Witnesses

Witnesses: **Chris Ham**, Chief Executive, the King's Fund, **Dr Clare Gerada**, Chairman, Royal College of General Practitioners, **Jill Watts**, Chief Executive Officer, Ramsay Healthcare UK, and **Dr Shane Gordon**, GP Commissioning Lead, gave evidence.

Q210 Chair: I welcome you all and apologise for the little delay in bringing you all together this morning: we had a number of things to go through. We have had a hearing—I hope you have been able to look at the transcript—on the issues that we think arise for us in terms of value for money and accountability in the NHS reforms. What we want to use this morning for—and for heaven's sake, say whatever you like—primarily is to tease out further, with a range of rather good experts, the issues that we got out of talking to David Nicholson and Una O'Brien on 25 January. So that is the framework for this morning. I want to start you on one of our prime concerns—perhaps Jill Watts could start us off on this—which is that there is a concern that the financial challenges facing the NHS with the Nicholson challenge of taking £15 billion to £20 billion out of the system, together with a very radical reform agenda, are very risky. That is the question we are asking: do the two meet well, or are we biting off more than we can chew by trying to do fundamental reform together with huge cost reductions? What from your perspective is your view on the risks with this reform agenda?

Jill Watts: I suppose any major reform is going to carry risks. I do not think you can have change without carrying some risks, so you probably have to look at the longer term benefit of actually going through that change process and what the landscape is going to look like then: is that going to be a better landscape to improve the overall system and fundamentally make ourselves a better environment to deliver higher quality care. We are very supportive of the overall direction of the reforms, because we believe by putting greater competition and greater choice into the marketplace, that you will—

Chair: We will come back to the issue of competition.

Jill Watts: So yes there will be risk, but any change will carry risk, so you have to look at what is the benefit of that risk.

Q211 Chair: And your view of the benefit would be what?

Jill Watts: I think that the benefit will be improved patient care, I think it will be a more efficient system. I think there will be significant challenges over the transition period: you cannot possibly implement this type of radical change without risk and without disruption to the system, but the alternative is to just continue along as it is, and I do not think that is sustainable.

Chair: Clare, do you want to come in on that?

Dr Gerada: Yes, of course, and this is from the Royal College of General Practitioners: We are seriously concerned about doing both at the same time. We have expressed our concerns about the pace of change, the extent of change, and, though of course the NHS needs reforming—it always does—we are concerned that disrupting the architecture of the NHS at a time of having to make £20 billion cuts is very dangerous. We feel there may have been other ways of doing that which have been well voiced: merging PCTs, capping management budgets and putting GPs on the majority of the board.

We are also concerned about the opportunity costs for this: we have made a rough calculation that it would be between 3% and 5% of GPs that will be actively involved; that is leading the process, everybody will be involved at some level. We have calculated—back of the envelope, I am afraid, because there isn't any calculation out—it will cost about £300 million in terms of GP time. That is just the GP time; we are not talking about management costs, and that is a significant amount of money.

Q212 Chair: Do you mean this is time? That is the first time I have heard that figure.

Dr Gerada: Time, yes.

Chair: So it is 3%, £300 million to £500 million?

Dr Gerada: It is £300 million if you calculate, back of the envelope I am afraid, but you calculate GP time,

removing the GP from their consulting room, having to backfill that across the consortia when they are all up and running, assuming three full-time equivalents for running the board, depending on how many boards there are. But that is a conservative estimate.

Q213 Matthew Hancock: Does that take into account the fact that those GPs will be taking on management responsibilities that others would therefore not have to do? So have you done a holistic view rather than just looking at one part of it?

Dr Gerada: No, that is the actual time, but look at the roles of the GP: number one, GPs are more expensive than managers, let's be absolutely clear here. Cost for cost, hour for hour they are more expensive. In terms of management, you are still going to need management time, you are still going to need administrative time, you are still going to need expertise within the consortia to do the things that GPs can't do. With the best will in the world, there are exceptional cases, of course, of GP managers, but GPs are trained to be clinicians, to look after patients.

Q214 Joseph Johnson: So just to be clear, your £300 million is a net number, is it, or a gross number, for the cost of GPs?

Dr Gerada: That is the cost estimated out of the number of GPs removed from their consulting room to serve the consortia.

Chair: Just to get it clear, there may be administrative savings, but there is a GP cost?

Dr Gerada: There is a real GP cost, but we are also concerned; the fact is that you have asked about doing it all at the same time. Now, clearly we have to present solutions. We do feel that we welcome the direction of travel with respect to having clinicians involved in the planning of the health service—of course that makes sense. We say clinicians because the fact is it should not just be GPs who are involved in the design of health services. We also feel that there are opportunity costs with respect to the provider reform—that is in fact improving what we should be doing on the ground—and GPs and others should be getting involved in improving services on the ground.

Q215 Mr Bacon: Let me stop you for a second. You said you have a concern that it should not just be GPs who are involved in designing health services. Can you say who has said that it should be only GPs involved in designing health services? Because we have had Sir David Nicholson here several times and I have not heard him say that.

Dr Gerada: I have read David Nicholson's transcript and you are absolutely right, but the Bill quite clearly says GPs will make up the board of the consortia. Now, of course the sensible GPs will then use clinicians to help design the services for their patients. What we are actually saying is that should then be translated into the Bill around having other clinicians involved.

Chair: So you are talking about other clinicians?

Dr Gerada: Yes.

Q216 Chair: Shane Gordon is at the other end of the spectrum: what's your riposte to what Dr Gerada has just said.

Dr Gordon: I think it depends what the key point of the reforms is.

Chair: And could I ask you to speak up, because the acoustics in this room are outrageously awful?

Dr Gordon: It depends what the key point of the reforms is. If the key driver of the reforms is to help the NHS to deliver the 20% productivity challenge that it has got over the next 5 years—

Chair: The driver of the reforms is to help the NHS deliver, that is your view?

Dr Gordon: That has to be the main focus of the NHS, to drive up quality whilst dealing with the 20% productivity gap. That requires significant innovation in the way services are delivered to make them more productive. The key agent for change is the clinicians on the ground changing the way they deliver services, changing the way they behave, and in order to do that you need local clinical leadership to persuade the majority of clinicians to move from where they are to a different way of working. That is why I think the change to GP leadership of the local health community is important. I agree completely with Clare, that if you are going to redesign services, you want the involvement of experts in those services to do that, but I think that is different from the stewardship of the local health system, which is a generalist activity, not a specialist activity.

Q217 Chair: So you think there isn't a risk in combining the two; you think the two are inextricably linked?

Dr Gordon: Absolutely, I think they are inextricably linked.

Q218 Chair: Now, Chris Ham is the expert outside this: what is your view?

Chris Ham: At the King's Fund, we have said from the very beginning, when the White Paper was published, we think there are some real risks in doing the two at the same time. We agree with the Health Select Committee that talked about the £20 billion target as being an enormous challenge, and a challenge that no other health care system in the world has ever met in the past, and to do that at the same time as such a fundamental, top down restructuring of the health service seems to us to be a very big ask of talented managers of a hospital or at a primary care level, especially when you are cutting back management costs, taking out 45% of management costs in Strategic Health Authorities and Primary Care Trusts. The reorganisation, we know from previous experience, is going to be a distraction. It will take the time and attention of managers and clinical leaders away from the core business—which ought to be about improving patient care and achieving financial control—because understandably they are going to be preoccupied with reorganising the structure, rearranging the deckchairs, if you want to put it like that. We fully accept and support the need to improve the health service, we are not arguing against reform, but our bottom line is that evolution would have been better than revolution in enabling the health service

to rise to that financial challenge and to address the outstanding concerns about care and quality.

Q219 Chair: You would have preferred really what Clare Gerada talked about: capping admin costs, putting GPs onto PCTs, that sort of an approach?

Chris Ham: Our view is that what the Government wants to achieve around more patient centred care—higher quality, better outcomes—we absolutely support. Equally, Andrew Lansley has often mentioned places like Cumbria and Cambridgeshire, which already are working in the way that the White Paper and the Bill intend the health service as a whole to work in future, which leads us to the view that if we can make it work in our current system in a number of places like Cumbria and Cambridgeshire, then it ought to be possible to extend what is happening there elsewhere without the distraction of a top down restructuring.

Q220 Chair: Let me just move it on to thinking about GPs. Anybody want to ask anything else on risk?

Stephen Barclay: Dr Gerada, you talked about a £20 billion cut; I thought any money saved was being reinvested in the Health Service.

Dr Gerada: Sorry, £20 billion?

Stephen Barclay: You used the phrase a “£20 billion cut”, but I thought any money identified as part of the Nicholson challenge will be reinvested in the Health Service.

Dr Gerada: Right, then I misunderstood; I thought that we needed to make £20 billion savings across the board.

Stephen Barclay: To reinvest in the Health Service.

Dr Gerada: If we are reinvesting £20 billion saving in the Health Service that’s fantastic.

Stephen Barclay: That is not a cut, is it?

Dr Gerada: I’m sorry, I’m not an economist here.

Stephen Barclay: We are not talking about as an economist, I am just saying, if you identify saving in one part of your budget and put it into another part of your budget, that is not a cut in terms of the overall budget on health spending. I thought that was fairly obvious.

Chair: I think we all know that.

Q221 Stephen Barclay: May I come to Mr Ham’s point? I think you present it almost as an either/or: either clinicians focus purely on clinical issues, or they are distracted on to the reorganisation, and that impacts patient care. But what Sir David Nicholson was saying was regarding the current cost of £5.1 billion on management, which has exploded in recent years in terms of the management costs. *Pulse* magazine reported that PCTs’ management salary costs increased by 25% in the two years between 2007 and 2009. He is saying that the aim of this is to get that £5.1 billion down to £3.7 billion, which will be the cap. So surely that is freeing money up for clinical need?

Chris Ham: Absolutely, we fully support that, but equally, there will be a cost. The number is disputed, as you will know, on the cost of the transition: redundancy costs, and the other associated

disturbances as we move from one system to the other. An issue I hope we can explore later is what will be the transaction costs of the new system when it is up and running, particularly the complexity around regulation with Monitor, CQC, Competition Commission, OFT and all the comings and goings at that level.

Q222 Stephen Barclay: In understanding that, why did salary costs go up 25% in two years?

Chris Ham: Because the previous Government—and I am sure this will also be the case with the current Government—wanted to make sure that commissioners could negotiate on equal terms with very strong hospitals and healthcare providers to make sure that the market, as it was in those days, was fit for purpose. Commissioning is a really hard thing to do well, and I expect in future GP commissioning consortia will have budgets to enable them to buy in the expertise, the management support they will need too. Whether they will be sufficient, as a consequence of these changes, we will have to see.

Q223 Matthew Hancock: Can I come in on a similar point, which is to do with this description that we heard from two witnesses about making savings, and efficiency savings being somehow either/or when the reforms are also on the table, because Sir David Nicholson was very clear in his evidence to us. He said that improving GP commissioning will align the incentives of GPs to deliver more efficiently, and he said that making every hospital a foundation trust will align the incentives of hospitals to deliver more efficiently. I am not an expert in healthcare but I think that, if you add in primary care delivered by GPs and secondary care delivered through hospitals, that covers quite a large part of the budget. If the reforms will allow GPs and hospitals both to become more efficient, doesn’t that mean that they will help to free up the savings rather than get in the way of delivering the savings?

Chris Ham: Absolutely, and my point is no different from that: it is around the pace of change. Pursuing the reforms in the way that we are at the moment, over a two or three year period, expecting commissioning consortia that do not yet exist—except in very nascent form—to take on 80% of the budget, and to do that successfully from April 2013 across the country is a big ask. It is also something that no other healthcare system in the world has ever aspired to or ever achieved, to place that much financial responsibility in the hands of general practitioner consortia.

Q224 Matthew Hancock: Dr Gordon, you say that absolutely you need to do the two together. You are one of the GPs who is delivering on this already, so do you agree with David Nicholson that putting GPs in the driving seat in this way will increase their efficiency and align GP incentives with the incentives of hospitals?

Dr Gordon: I think it is the only way to truly align incentives, and I guess in response to Chris’s point about “Can you do it in the current system”, yes Cumbria and Cambridge are managing to do it in the current system, but there are 148 other PCTs which

are failing to do it in the current system. The question is: can you continue to do the same thing and expect a different outcome?

Q225 Chair: Out of the 27,000 GPs, you are clearly up there and enthusiastic for the system, but is it your view that we will end up with the same thing, that some GP consortia will be capable, and will be able to eke out savings, but there aren't enough GPs with a sufficient knowledge or ability to get the right expertise to get consistency of approach across the country in the same way as there aren't with PCTs at present?

Dr Gordon: I think there are a number of factors with that: one is, the pool of GPs who have the skills currently is too small, but there is some time to develop them before April 2013 and there are, from the pathfinder programme, clearly a large number of GPs willing to commit themselves to doing that, and being generally capable people, I am fairly confident they will do well at that. There needs to be a programme to ensure the supply of GPs with those skills.

Chair: But you have got to do that within two or three years.

Dr Gordon: You have, but the question raised earlier, about all of the commissioning being done by GPs, is not the right assumption. It is a question of using the right expertise in the right place with clinical leadership to bring the body of clinicians along with the change management programme that needs to deliver the productivity benefits.

Q226 Nick Smith: So do you think there will be new higher commissioning costs for your consortium?

Dr Gordon: No, I expect the overall cost will be within the cost envelope which is proposed within the reforms, and will accommodate the 33% reduction in management overhead, including the costs of the GPs.

Q227 Chair: But I looked at your blog, interestingly enough, because you run a very lively blog, in which you said "Another interesting week begins. So many things to get to grips with as a proto-consortium lead." I love that phrase. "This week I'm juggling commissioning our organisational development diagnostic, our in-house apprenticeship programme, getting to grips with the QIPP workstreams and our 200 page system QIPP plan, reading 200-page board papers, the 367 page Health Bill, negotiating the transitional governance structures with the PCT and starting to think about scary things like safeguarding." Do you have time to treat your patients?

Dr Gordon: Yes, I still see patients every single week.

Chair: Every single day or every single week?

Dr Gordon: Every single week. I do that on two days a week.

Q228 Matthew Hancock: So would you say it is similar to lots of other careers, where everybody goes in, say, as an engineer into an engineering firm, but some become managers and some carry on engineering.

Dr Gordon: Absolutely.

Matthew Hancock: So that's perfectly reasonable.

Q229 Chair: It is an interesting issue, and there may be a difference in the Committee on this. Should GPs only be seeing patients twice a week, once a week?

Dr Gerada: I think you were saying once a week.

Dr Gordon: No, I see patients every week.

Chair: Every week; what, once a week? One out of your five days a week?

Dr Gordon: Yes, I spend one day a week seeing people.

Chair: So you spend 20% of your time seeing patients. Is that the right thing for a GP to be doing? I think maybe there is a difference.

Joseph Johnson: He is the GP lead.

Q230 Mr Bacon: The question really is, should clinicians be managers, and there is presumably one school of thought that says you spend a lot of money training somebody to be a clinician, why would you have them as a manager? A few years ago, this Committee visited Boston, and we went to the Harvard Business School. One of the five presentations we had was from a doctor, a trained general practitioner, who was doing a doctorate in business administration and his likely future job would be running a large general hospital. In the NHS, we do have some chief executives of big acute trusts who are GPs. Now, if we have 27,000 GPs and we have 150 or 200, large acute hospitals—I would be interested in all of your views on this—but it doesn't seem to me extraordinary that a very small proportion of those 27,000 GPs, with that training, would end up in senior management. I think that having people with a clinical background running large acute hospitals, say, or running large commissioning bodies, say, instinctively, intuitively is probably a good thing, not a bad thing. All the conversations I have had with the GPs in my constituency over many years, always boiled down to a frustration with the PCT and the people in it, and crudely—and it is crude, and of course there are some good people in PCTs—we had six primary care trusts in Norfolk, with a lot of people, not all of them of the right level of skill, frankly, a lot of them very highly paid. Of course there has been a lot of slimming down. I would love to hear Dr Gerada and Dr Gordon on this but is it wrong in principle that we should be seeing clinicians moving into management, or is it right?

Dr Gerada: I will answer that, but can I just pick up first this issue about efficiency savings and being a GP? I am a GP: I see patients. I do not make efficiency savings when I see my patient, and I think that is, to me, the crux of it. What the reforms do, if we as GPs are going to be starting to think of our patient and making an efficiency saving when we see that patient, then I think these reforms are very dangerous.

Q231 Mr Bacon: Could you possibly answer my question, which was not about efficiency savings.

Dr Gerada: I will answer about management, but I just wanted to make that point. The other point about seeing patients, we are absolutely, but the whole point about putting clinicians in charge of commissioning is that they bring their clinical skills and their knowledge of their patients and their patients' needs, and of their

population, which means that if you have done two or three years of general practice and then move out and become a manager, you go native. You clearly bring your intelligence and medical training, but you are leaving behind the things that make you.

Q232 Chris Heaton-Harris: So what is the point being chair of the Royal College of GPs, then? Are you going native? Are you becoming a kind of union rep? Are you shooting from the hip rather wildly?

Dr Gerada: I bring to the Royal College of GPs an active, clinical workload; I've been a GP—

Chris Heaton-Harris: Don't other GPs do that in other roles, then?

Dr Gerada: I understood from Mr Bacon that these doctors went to management school.

Mr Bacon: It was one particular doctor.

Dr Gerada: That is the model in America, but if you are bringing your GP skills to management, and you are not doing the GP bit that is bringing the skills, then *de facto*, why not bring in a senior manager?

Q233 Mr Bacon: So what you're really saying is that there is benefit, but the benefit would be greater, much greater, and the risk of going native would be lessened.

Dr Gerada: I think you should stop deriding managers, professional managers.

Mr Bacon: Hang on, I was not deriding anybody. I was asking a generic question, I was not trying to ask an adversarial question, particularly. I am trying to understand the extent to which there is benefit in having people with a deep clinical background helping manage NHS organisations, and it seems to me intuitively that there is a benefit. There may be a cost as well, and you have just identified the cost of potentially £300 million of management time—that is the gross cost, without the net savings on the other side—but I am really trying to get to this much broader point about the benefit of having clinicians involved in managing, and it sounds to me like there will be a benefit. You are saying that the benefit will be much less if they disappear from their frontline role, in a similar way that head teachers who stop teaching stop being such good teachers. Now, that seems to me an argument, probably, for having those clinicians still maintaining some clinical contact, but really I am trying to get to the overall point about the scale of benefit in having clinicians manage, I wasn't saying anything negative about managers generally.

Chair: Can I just say to the Committee, I'm going to allow our witnesses to give a response to this issue.

Dr Gerada: General practice is extraordinary, in that the higher up you go the more you still do the day job. It is one of the only specialties in medicine, one of the only senior professional groups where you can continue to do the day job. So Dr Gordon does the day job, I do the day job—I do the day job actually two and a half days a week—and it means that you stay grounded. It means that when you read the manual, as many people read the manual, and think you can translate that to the patient that I saw the other day where I had to sit on the commode in order to meet their needs because there isn't anywhere to sit, you keep grounded. You keep grounded with your

population and you keep grounded with your patients. So yes, of course GPs are highly intelligent people who can manage anything, with enough training. But it takes them away from the reason you have asked them to do it, which is they understand the needs of their patients and their population.

Q234 Chair: Okay. Now I'm going to ask Shane Gordon to answer that, and then Chris Ham, and then I'm moving on to the next issue.

Matthew Hancock: And Jill Watts, also.

Chair: Okay, let's go to Shane Gordon first, Chris Ham and then Jill.

Dr Gordon: The question was "Is it right to have people with an intimate knowledge of the core business leading the business?" The answer is yes.

Chris Ham: I have studied a lot of the US organisations that you are referring to, and I would also say yes, there are real advantages in having people with that clinical knowledge, GPs and others, involved in commissioning and provision of healthcare. But when you go to the best of those organisations in the States, wherever you see a clinical leader, that person works hand in hand with a very experienced manager, and it is that partnership which is fundamental to their success. The challenge in GP commissioning is partly around training more people like Shane to be in the vanguard and to lead GP commissioning consortia. Even more so, I would suggest, is what some people would call "followership": GPs are not great followers of GP leaders. We need to invest in helping them to be good supporters of the people who would be heading up the commissioning consortia, and I think that is under-recognised. The third thing is this: I think GP commissioning—as long as it is broadly inclusive of nurses and hospital specialists—will be beneficial when it settles down, but there are some things that GP commissioners are unlikely to do well. The complex service reconfigurations of hospitals in London, for example, are a very, very big challenge and I do not think there is any evidence from previous examples of primary care-led commissioning that GPs have the appetite or the expertise to undertake them. They'll need a lot of support from the commissioning board and, I suspect, the regional offices of the commissioning board, in dealing with those kinds of issues, because they are very, very difficult.

Jill Watts: As a nurse and a midwife who has moved over into management and has done an MBA in health administration, I think it is extremely beneficial to understand the world in which you're working when you are managing it.

Q235 Mr Bacon: Do you still deliver babies?

Jill Watts: No, because I use that expertise in different ways, and certainly that close understanding of how organisations work, and as a provider of healthcare I think it has been invaluable.

Matthew Hancock: Does the fact that you don't still deliver babies make you any worse as a manager?

Jill Watts: No. I think I have that past experience, so I understand that, but it's about individual preference: people choosing to develop their careers where they want to go.

Q236 Austin Mitchell: One of the problems is the scale of the units of GP commissioning, because it seems to me that those bodies that already exist are larger units that amalgamated several primary care trusts. Now, you could argue for it on economy grounds, and it might well be more economical to have a larger area, but you cannot argue for it on the grounds of expressing the patient's wishes and allowing patients to be effectively represented by doctors in the area, nor in terms of developing close contacts as we have in Grimsby—because we have a care trust plus—between the primary care and the local authority. So this is going to be a real tension. What is your area, Dr Gordon? Is it a big amalgamation of areas, and is there going to be a trend to bigger and bigger commissioning units which are going to be out of touch with the patients?

Dr Gordon: I completely agree with your tension. Our area is 320,000 patients, which is the size of our existing primary care trust, but within that structure we have localities which are very much made up of and in touch with their local GP practices. One of the benefits of clinical leadership in consortia is the trust relationship between the leaders of the consortia and their peers in the practices. It isn't a hierarchical relationship, it's a flat relationship. It is very different from the hierarchical relationship between existing management structures and GP practices.

Q237 Chair: Can I move us on to two other issues on commissioning that I think we need to talk about. We spent quite a lot of time in the first evidence session talking about accountability. I had not realised that your area, Dr Gordon, is basically the same size as a PCT, which I think is perfectly sensible, and I hope my lot do the same, but if you get much more fragmented consortia out of your 27,000 GPs, how do you think the accountability can work properly, particularly from our point of view, where we have an interest in ensuring value for money for the pound spent. Question two: there was stuff in the papers yesterday about the way in which the commissioning body, Nicholson's body, is going to validate a consortium, and then take away that validation if things go wrong without any right of appeal. Do you think that is the right approach? Validation's probably the wrong word: commission. The commissioner will commission consortium and decommission.

Chris Ham: I think it is the authorisation process? I think that's what you're referring to; the commissioning board will have responsibility...

Chair: But the two issues of accountability; do the first and then the second.

Chris Ham: I think to begin with there will have to be some sort of authorisation process run by David Nicholson and the commissioning board to assess whether commissioning consortia are ready to take on the responsibilities that are being offered to them. I think we would all accept the need for that: if you're handing over £80 billion of public money eventually, then they need to have the right governance arrangements in place, having accountable officers, having financial and other expertise to enable them to do their job effectively. I think commissioning consortia would welcome that, as well as those

concerned with accountability for public resources, and that is something that is being developed as we sit here. We don't yet know what that process will be. The second bit is really around how then, when they're up and running, when they've been authorised, they are held to account by the commissioning board, and my understanding is that there will something called a "commissioning outcomes framework", which the commissioning board will determine, setting out the criteria indicators that will be used—not targets—for assessing the performance of the commissioning consortia, and there will be some rewards built into that, so I would expect, now we know who the chief executive of the commissioning board is going to be, that there will be a reasonably robust authorisation process in the first stage, and an accountability process in that second stage.

Q238 Chair: You think that's okay?

Chris Ham: I think it will be okay. There are lots of complex issues. For example, the commissioning board will have to create some kind of financial contingency to deal with financial failure by commissioning consortia. Some commissioning consortia will be fantastic—better than the best of the PCTs—some will be okay, some will almost certainly fail. Now, if that is not the case then commissioning consortia will defy the bell curve of performance which all organisations in every sector are affected by. So you will need to plan for failure, plan for that contingency and take some money out to allow for how that can be dealt with.

Chair: That was another issue that we raised with both David Nicholson and Una O'Brien, and Una O'Brien did say she "wasn't planning for failure".

Mr Bacon: Eventually, about three minutes later—because I cut her off at that point—she did make a very rapid recovery. Within two or three minutes she was using the phrase "the design of the failure regime", so one hopes they are thinking about this. What's your view about what the Department has done, so far, in the design of the failure regime? Because you are quite right: the bell curve will show there will be failure; the real question is, net-net-net, will we be better off than we are now or worse off? We've had PCTs fail and go into debt. What's your view?

Chris Ham: My view is you need to design a regime that anticipates and prevents failure happening, rather than a regime which is designed to sort out failure when it's happened.

Mr Bacon: If it does get that far, you need a rescue regime, don't you?

Chris Ham: You need a rescue regime, which is partly having access to a pool of money, if it is financial failure, to bail out a commissioning consortium that gets into difficulty, and secondly having a regime for, if it is persistent failure, successful commissioning consortia or others coming in to take over the management of those organisations.

Q239 Chair: Before I bring in Chris, do any of you want to add anything on the accountability and failure regime issues?

Dr Gordon: The failure regime will not be an all-or-nothing regime. We are told that it will be a rules-based stepped process which will start with performance notices, essentially, followed by active intervention, followed by suspension of the right to commission, followed by the loss of the right to commission, and you would have to fail at every single step before you lose that right to commission. I think that makes for a very structured and sensible opportunity to pick your game up.

Stephen Barclay: How long would that process take?

Dr Gordon: I don't think it has been specified yet.

Chair: What happens to the patient if it actually does fail?

Dr Gordon: Well, there's a question about which point in that regime is actually failure, because there are plenty of PCTs that are in that sort of regime already.

Q240 Chris Heaton-Harris: I have a question, probably more for Dr Gordon, about low volume commissioning. Nearby to me in my constituency is the headquarters of the Motor Neurone Disease Association. Obviously very few GPs in their time will come across a patient with Motor Neurone Disease. How does this capability to provide for and commission for that particular sort of patient fit in to this new life?

Dr Gordon: The capability does not exist at the moment in the current system to do that adequately. I would hope that what we will all do together is ask ourselves "Are we capable of doing that sort of work?", come quickly to the conclusion "Not within consortia", and look for solutions like professional networks, advice from national bodies or lead commissioning arrangements that start to bring the right concentration of expertise to bear on the question, which we can then all use in our commissioning process. That happens already through organisations such as NICE, but also through the colleges, national service frameworks, etc.

Q241 Chair: I want to ask one final thing, then move to the providers side of it. At the moment, the GP is your advocate—this is really looking at patient focus—and there will be a change of role. It will alter now: the GP becomes both the advocate and the purse holder. So the GP will have to ration in a way that maybe in the past he or she has not had to do. Maybe it is a question to you, Dr Gordon, and maybe to you Dr Gerada: how are you going to do that? We hear these stories about hip replacements becoming unavailable in bits of the country because of rationing, or IVF treatment, or whatever it is, or an expensive bit of cancer treatment not being funded. How are you going to decide? How are you going to fulfil your role as the advocate on behalf of the individual patient with your new role as the distributor of what will always be limited resources?

Dr Gordon: The General Medical Council already in its guidance, "Good Medical Practice", requires every doctor to have regard to the efficient use of resources, which is that population health perspective. As a profession, we have underplayed our role in stewarding the health of the entire population that's

on our list, the 1,500 to 2,000 patients that we all look after as GPs. We have failed to square that with the advocacy for the individual patient in front of us.

Q242 Chair: But the obese woman may still want a new hip. You are going to have to make those decisions.

Dr Gordon: We do make those decisions already, and the beautiful and brilliant NHS

Atlas of Variation, which was published at the end of last year, shows how vastly different the thresholds are in different areas for making those decisions. In no sense are we making rational rationing decisions across the piece at the moment.

Dr Gerada: I think that is the most important part of these reforms, and one that really vexes us at the College, and the one for which we haven't got the perfect answer. I disagree with Dr Gordon: we are well aware as GPs of our role with the public purse, and I think every decision we make we're well aware of that. I think patients don't quite realise how aware we are of that. We prescribe, for example, 90% of our medicines generically. That saves a staggering amount of money for the public purse. If the patient wants a non-generic, we steer them away from it. So it is not patient choice: it is based on evidence and value for money. Only one in 20 consultations end in a referral: only 14% of the population are actually ever seen by a specialist, and those are concentrated in about five very serious clinical conditions. So we are well aware of that. But anything that undermines those decisions that we make so that the public think that we are making decisions on their health based on us benefiting in some way, or our consortia benefiting in some way—and remember, we are going to be kept to account for financial balance—that is where the problem will start.

Now, in addition to that, with the abolition of practice boundaries—so at the moment we'll make a clinical decision and we may well say to the patient "This isn't in your best interest" and there's lots of cases we do that—if a patient is now free to move to different GPs, different consortia, shop around until they find a consortium that will offer them a treatment, that also complicates matters. So it is a very, very, very important issue.

Q243 Chris Heaton-Harris: They could move to Scotland.

Dr Gerada: They could move to Scotland, absolutely, or to Wales, or to Northern Ireland. In actual fact, GPs have for years been aware of this. It is important that we maintain that. With respect to the college, we believe that good commissioning is about being a good GP, and that is our strap line. It is about understanding how we use resources. It is understanding how we use resources in the consulting room, how we do peer review, how we involve patients in those decisions, and how we involve the public, and that's where it starts for us, right in the consulting room. So these ethical tensions are not going to go away, they're going to get worse.

Q244 Stephen Barclay: Are you saying that GPs, in breach of the GMC's "Good Medical Practice"

guidance, would put their own financial interests before their duty to their patients? Is your concern that GPs will do that?

Dr Gerada: I don't know, because I don't know what the Bill will say. We've already heard about the failure regime, we've already heard about efficiency savings. This is different language for GPs. GPs at the moment don't, as I said before, talk about failure rate within their own practice, and they don't talk about efficiency savings.

Q245 Stephen Barclay: No, but you were making a very specific point. You were saying that you were concerned, in contradiction with Dr Gordon, who I think pointed out some of the variations already in the system, and we saw that at our previous hearing: certain hospitals have more than three times the number of staff per bed; one hospital had less than 20% emergency admissions, whereas another was over 60%, so there are already significant variations. I thought you were making a very specific point: you were saying that there was a potential conflict where, because of the incentives within the GP consortia, GPs may get a financial benefit which starts to influence their decisions, which contradicts their duties as doctors and is quite an indictment to say of the people you represent.

Dr Gerada: I think if you backtrack to what I said, I said "Anything that interferes with the public perception that that's what we're doing." At the moment we do it anyway, we use our resources efficiently with a patient in front of us, but also, as I said, making sure that we use resources effectively and efficiently. Anything that interferes with respect to the public getting the inference that we're doing things not in their best interests, but in order to reach financial balance, or—as we've heard earlier—for efficiency savings, I think is the conflict. We haven't sorted it out: we're just aware of it and we've just highlighted it as a big risk.

Q246 Mr Bacon: This Committee published a report this morning that pointed out, among other things, that there is an eightfold variation in the extent to which GPs refer their patients to cancer specialists, much of which cannot be explained by variations that you might expect like socioeconomic factors and the rate at which different people smoke in different parts of the country. Would you expect, in the shift to GP consortia, that this eightfold variation that we have at the moment would go up or would go down?

Dr Gerada: I don't know. What I do know is that I have examined the variation in referral to outpatients, and I have also examined the variation in use of accident and emergency services, and once you start looking at these variabilities—clearly general practice has to improve, everything has to improve, and I'm not saying it can all explained by factors other than the GP themselves—there are issues. For example, one of the biggest variabilities about your use of A&E is how close you live to A&E, so therefore in urban areas, you tend to have a much denser population, as are how poor your area is and the proportion of overseas people, in particular eastern Europeans, who may make different use of healthcare services. So

there are explanations. I don't know what might explain an eightfold change: it might be access to diagnostics, it might be skills of the GP, it might be prevalence of cancer in that particular area. Whether it is going to change with consortia, I don't know—I really don't—and that's again one of the issues that we need to be watching for. What I would say, and where the college would come from, where we're moving to next, is that we must concentrate on providing improvement: we must concentrate on improving my profession to make sure that we diagnose cancer better, we refer better. Whether this is going to be achieved by 4% to 5% of my profession dealing with commissioning rather than improving the provider side, I don't know.

Chris Ham: We will be publishing at the King's Fund a major report in three weeks' time on the quality of general practice, looking at many, many different examples of these variations which seem to be unexplained—as far as we can tell—by factors such as differences in population. There is a case to answer around the current variability around what's done within general practice, even though general practice as a whole provides a very good service to the population. I think the potential within the reforms is for the GP commissioning consortia to look at these variations, where they are unwarranted variations, much more successfully than primary care trusts have been doing, through having knowledgeable GPs leaders who can use that data and ask tough questions of their peers. But, it relates to your work in the sense that at the moment the responsibility for managing the GP contract will be put with the commissioning board at a national level, not with the commissioning consortia at a local level. We know where there has been progress under the current system in the best of our PCTs, it's been where they've had very good medical directors coming from a general practice background who know the local practices very well, who have got credibility to go in there and ask them tough questions about why those variations exist. So we hope the commissioning board will work with and through the commissioning consortia, who ought to have that local knowledge, to really make this work better in future.

Chair: That's interesting; it's strong/weak, isn't it, so that's quite a strong centralisation within a decentralisation, and it assumes a capacity in a commissioning body to be able to do that. I thought one of the interesting things in David Nicholson's evidence is that there is a danger that the commissioning body ends up like the current strategic health authorities. So you end up having a big centre; you have the strong commissioning body with him at the helm, and then London Health—whatever it's called, people who drive me completely potty—still there, determining what GPs do.

Q247 Matthew Hancock: You have described how the changes could improve the distribution, and potentially take away some of these unexplained distributions in service from a top down perspective. But doesn't the removal of the boundaries, which Dr Gerada talked about, also allow the patients themselves to reduce some of these unexplained

differences, because if your next-door county, say, has a better performance, then you can go to a GP in that county and therefore actually drive the improvement and drive a more equal playing field that way, from the bottom up as well as from top down.

Chris Ham: In concept yes; in practice, I think there's a philosophical issue here as to whether you believe in bottom up patient choice, as opposed to—it's not top down, more peer pressure within the professional group.

Matthew Hancock: It's in the provider, rather than from the customers.

Chris Ham: That's right, and I think all the evidence that I'm aware of suggests that if you're trying to improve quality of healthcare provision it's using that peer pressure within the professional group of GPs, in this case, that's likely to have a bigger impact in reducing unacceptable variability in the quality of care than patient choice, although patient choice will also be important.

Q248 Chair: Your peer pressure, or your commissioning body, will involve a regional infrastructure?

Chris Ham: I was referring to it around how I hope and believe the best of the commissioning consortia will behave; people like Clare and Shane leading these arrangements at a local level, knowing the practices, having the credibility among the GP community, looking at the evidence about variation.

Chair: But David Nicholson will require quite a tough structure if he is to be an effective commissioner.

Chris Ham: What he will require is the support, the will and the ability to work with the commissioning consortia, because at the moment it's David and the commissioning board that have the locus around managing the GP contract at a national level: that is not a commissioning consortia responsibility.

Q249 Mr Bacon: No, but David Nicholson was very anxious to avoid saying that he is going to develop a regional structure for the commissioning board. He went to a lot of trouble not to say that; I think it was quite interesting, not to say funny, watching him not say it. But is your expectation that the commissioning board, which is going to be a £20 billion body, is going to have some sort of regional representation so that there are interlocutors on the ground locally who know the local GP consortia?

Chris Ham: Absolutely. I have been a student of the health service throughout my career. There has never been a time in the history of the NHS in England when there has not been—call it sub-national, call it regional—some kind of regional presence, simply because of the span of control from a national body; we don't know how many commissioning consortia there will be. I would expect 250 to 300, looking at what's emerging around the country. You cannot manage that relationship from one national commissioning board to 250 commissioning consortia. You will have to have four or five sub-national, regional offices of the commissioning board.

Q250 Mr Bacon: Dr Gordon, I think you wanted to come in on this question of GP leaders asking tough questions of their colleagues

Dr Gordon: Yes, the question was: can you shift from an eightfold variation to a much narrower range of variation? The answer is absolutely yes: it's what my consortium has spent its time doing over the last four years through practice-based commissioning. I and my colleagues, my fellow GP leaders who spend many fewer hours a week doing what I do, have visited every practice in our consortium every year to have the difficult conversations, and I've got personal experience of working with GP practices to pose the tough questions about "Why are you sending that woman who's had hip pain for two weeks only to a surgeon? Why are you doing that?" And we've managed to change their performance: they have changed their thresholds as a result of peer discussion.

Mr Bacon: Do you think the fact that you're a clinician having that conversation helps, rather than being a manager? I mean "just" a manager.

Dr Gordon: You couldn't do it as a manager; I have to do it as a clinician.

Q251 Austin Mitchell: I want to talk about area inequalities, because, as Dr Gerada has suggested, this is partly a question of perception as to whether GP consortia are serving their own interests in the economy, or prescribing drugs, or serving the interests of the patient. Now, there are parts of the country, the underprivileged areas of the country, which tend not to have pushy patients, because they haven't got a large, middle-class congregation making a noise, and secondly which tend not to have the best doctors, the best qualified, the most pushy doctors, the ones most likely to maintain peer pressure on the consortium. Those areas are surely going to be disadvantaged in this new arrangement.

Dr Gerada: It is also, as the Treasury Committee found last week, that the areas of highest deprivation have the lowest figure per head of population of GPs, so you further entrench it. You also get areas where you don't get investment in general practice. But there's absolutely nothing wrong in what Dr Gordon is saying. What we're saying is that as far as professionally led improvement is concerned, the Royal College has been doing that for 60 years through practice certificates and through various tools that it has got, such as the quality practice award and we have just launched practice accreditation. There is absolutely nothing wrong with doing that, and that is, I think, where I said we should be concentrating on provider improvement on the improvement of general practice services, and improvement of the transitions, because patients have problems, and they go between one bit of the health service and another, so GPs should be talking to our consultant colleagues and to our nurses, we should be talking across social and health care, in order to improve systems. But that's happening anyway within the current systems and it should be accelerated.

Q252 Chair: I am going to move us on to the provider world, and start with Jill on this one, because this is where your interest is. Do you agree with David

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Bennett that the healthcare market should be more like the utility market?

Jill Watts: I think there's certainly some broad similarities there, but yes, I believe that by putting competition into any marketplace—anywhere where there's a major monopoly, there's not the same incentive to improve, as in a competitive marketplace.

Q253 Chair: So you think it's like selling gas and electricity.

Jill Watts: No, healthcare is a much more complex system, but there are some basic fundamental principles in having a more pluralistic marketplace; having the patient being able to choose where they go I think will drive quality of patient care.

Chair: It is not the patient, it is the GP who chooses.

Jill Watts: No, I think patient actually does influence choice.

Q254 Chair: Well, we'll see. But go back, what's the difference? David Bennett was quite clear; in his first interview in *The Times* he compares his role to the regulators who opened up the gas, electricity and telecoms market. I am really interested in what you see, as a provider in the healthcare market, as the similarities and the differences. Because I think it was a shot in the dark, but you're in the business of healthcare provision, so what do you see as the similarities and the differences?

Jill Watts: Well, I think for any private provider—I come from a company that does nothing but provide acute care hospital services, it has done it for 47 years, and that's what we do—as a private company, to stay in business, then you have to develop very efficient models.

Q255 Chair: What is the difference between this and the utility market? I'm not trying to catch you out; I'm trying to understand where you're coming from and how that relates to Monitor's potential attitudes.

Jill Watts: I am not an expert in those areas, but I would assume the difference of opening up would be the level of satisfaction and quality. You cannot be a private provider and survive if you don't provide a quality service.

Q256 Chair: Can I just ask you two other questions—James wants to come in. We're getting very mixed messages as a Committee on this one: should there be a maximum price, or should there be a national tariff?

Jill Watts: I think at this stage there should be a national tariff, because we don't have a level playing field.

Chair: So how do you compete?

Jill Watts: On quality.

Chair: And who would judge that?

Jill Watts: Patients: we need to have better information available within the system so that there is that ability, and it's about getting information on clinical outcomes on a range of different areas, so that commissioners, so that patients have that available to make choice.

Q257 Chair: Is there anything in the healthcare market that you wouldn't enter into, your company wouldn't want to participate in?

Jill Watts: No, we're an Australian company.

Chair: Everything? You'd do A&E, would you?

Jill Watts: We do A&E, we do emergency, we run whole public sector; we run whole trusts in Australia, and that's been a model that's been successful.

Chair: And you'd want to do that here, you wouldn't want to cherry pick off bits of it?

Jill Watts: No, we do everything from emergency services, neurosurgery; there isn't a service that we don't do in Australia. We run the whole public service, and that is certainly an area that we're very interested in, yes.

Q258 Chair: We talked about failure regimes for the GP consortia. What do you think the failure regimes should be if one of your units fails?

Jill Watts: Well, if one of my units fails it doesn't survive.

Chair: What happens to the patient?

Jill Watts: What happens to the patient? We don't have a history of failure, because we have expertise.

Chair: In the same bell curve, let us assume there is some.

Jill Watts: I think that we probably have a different bell curve. But yes, we have organisations that perform better than others. We probably have far less bureaucracy, a lot more stringent benchmarking.

Chair: It's quality, we're competing on quality. Something fails, and it's public money. The difference is this isn't people choosing to buy, it's public money, and therefore there has got to be a regime for failure, and I am just interested in your view as to what the regime for failure would be for—God forbid—one of your company's units, a general hospital in Barking and Dagenham, you might take over Queen's, nobody else wants to run it.

Jill Watts: It probably would be not dissimilar, we would do everything that we could. If something's failing, then we would go in, we would look at the management of that to see what are those issues, we would do everything in our power.

Chair: But you fail.

Jill Watts: Then we would close it.

Chair: Then what happens to patients?

Jill Watts: For those patients, depending on what the marketplace is, there would be opportunities for other people to come in and take over that facility, and that is what does happen: something is failing, and then someone will come in and either take that over, or, whether there is no need; you have to understand why somewhere has failed, it may be there no demand for a service in an area, and so that service shouldn't be there in the first place. If there is a demand and we can't deliver that effectively, then there is an opportunity for someone else who can.

Q259 James Wharton: I've listened with interest to the broad discussion that we heard about a lot of the changes that are coming in, and I think something that we just touched on and then moved on quite quickly is the issue of patient choice. I can't help but feel there is a great opportunity, but also some risk specifically

tied to patient choice, whereby it can be a real driver for change and for improvement and for delivering a better service, but there is also that danger which Dr Gerada mentioned. For example, with generic drugs, the patient wants a specific drug, what's to stop them just going somewhere else? Austin mentioned specifically those who are not necessarily pushy and middle class: how are we going to stop patients from falling through the gaps who, for whatever reason, no matter how much information and guidance we give them, are not capable of using choice to deliver a better service for themselves?

Dr Gerada: I think this is a very important point. Choice happens, let us be clear about this, when you are having a cold, elective procedure—that is when there is most choice, because then you've got the time to sit and discuss it. Most of the activity in the health service isn't around that. It's around the sort of patients that I see, that Shane sees every single day of the week: it's the patients with co-morbidity, with multiple problems, and, to be honest, it is very difficult to exercise choice there, because you want a joined up service, you want clinicians and care workers that have been working together for years, that put the services together, that don't run the risk of becoming bankrupt, as some private providers have gone in on cost and have had to walk away from the table. One says "What happens to the patients?" Well, I think that's a serious risk when you have lots of providers. What the college wants, though it sounds like a cliché, is enough excellent providers and not a multitude of any willing providers, because if you—God forbid—fell down at Westminster Bridge and broke your leg, you would want to be sure that that place across the river has all the services to meet your needs, delivers them with good outcomes and you leave safely without an MRSA infection. So we would actually go for enough excellent providers, and not multiple, any willing providers.

Dr Gordon: There's another real tension here: as a commissioner sometimes I find it very difficult to engage providers in changing their behaviour, because there is no threat of competition. There's nobody else to turn to in a health economy to provide that little bit of grit in the oyster. Equally, though, there's a question about whether in our health system we have too little supply of healthcare from hospitals, for example, or too much. I read the WHO's analysis of the proportion of care provided in hospitals in the UK, of specialist care, at 60% of specialist care, and in Europe of 30%, and I wonder, have we not got enough providers in the UK market? I don't know the answer to that, but it's a real tension.

Q260 Chair: I hate doing this, but I do get completely obsessed by my own constituency situation. When you theoretically say competition will extend choice, that sounds really attractive; obviously it will drive up quality. I think all of us can half buy into that. When I then look at my own constituency, we have got an appalling hospital, which had a report in the public interest a couple of weeks back, which is extremely rare—which actually I didn't even get a copy of, so it was only by chance that I came across it—and the hospital is an outright mess, and has been

and is bankrupt; it is basically bankrupt and has been for years and years, and in a market it wouldn't survive. Yet, for my poorest people, with the worst health outcomes, if you close that hospital they may have to use three or four buses—they don't have cars—to get to a local hospital and for their regular appointments, they won't do it. So there is a tension there between the competition driving out poor performers, and the needs of a really high-risk local population with bad health rates—take any measure and it looks poor: on mortality, on obesity, on all those sorts of things, anything that you take—then actually having worse access to local health care. And this is not for the big things, where obviously we want big, specialist hospitals: this is for the day-to-day stuff that keeps people alive and healthy.

Chris Ham: That's where you need a good failure regime for the provider side, isn't it? You need to have an arrangement: Hinchbrook is one current topical example, in the East of England, where the strategic health authority invited both public and private providers, and a private provider has been shortlisted to take over the management—not the ownership, but the management—of that hospital. The other option is to link up hospitals such as the one you described, with successful NHS foundation trusts so we can bring their expertise in.

Q261 Chair: But you'd be mad, Chris, to do that. Again, this is theoretical: this hospital has got a debt of £116 million, £117 million. Nobody's going to write that off in the current climate, and you'd be bonkers to take over that hospital with that debt.

Chris Ham: But equally, you need to maintain the public's access to a valued local service.

Chair: Quite.

Chris Ham: So you are literally between the rock and a hard place, and I suspect the harder place is around closing the hospital, as opposed to finding a resolution for that.

Dr Gerada: Or invest in primary care, because at the moment we have precious little investment in primary care, and we know that countries that have a big investment in GPs have better health outcomes

Q262 Chair: Don't start me on that one, because trying to attract GPs to my area is equally bloody awful.

Dr Gordon: I happen to live and work in the SHA which has done the first successful tender of a hospital, and it was a very interesting process to observe: there were only two bidders at the end of that process. But it comes down to the nub of commissioning and this whole argument: do you have completely open competition which drives, potentially, some failure and disadvantaging of certain communities, or do you use competition as one of the tools in the commissioning arsenal, which you apply to specific points in your healthcare provision market where you are not getting good quality? I think it's that end of the spectrum where we need the legislative support and the support from Monitor to do our jobs well. An unregulated provision market, I think is not going to be successful in the stewardship of resources.

Q263 Chair: My cynicism, having lived with this, is that there is nothing in the reforms I see that gives any incentive to any successful foundation trust or any private provider to take over my local hospital, so that the only other answer is to write off the debt, and nobody will write that off.

Chris Ham: We have a report coming out later this week looking at the experience in south London, where there are a number of general hospitals that were merged because of that history of financial problems and clinical problems too, and one of the conclusions of that is you put in a new management team, and they can do a lot of good work to produce greater efficiency and drive productivity, but there's only so much they can do when you've got the legacy of PFI debt and other long term financial problems. Looking at the lessons from that elsewhere in your kind of circumstance, somebody has to grasp that nettle and say "We're going to do something both about long-term PFI debt and about underlying financial problems to create the right kind of incentives for successful foundation trusts to want to come in and to take over that responsibility," otherwise it's not going to happen.

Q264 Stephen Barclay: We have discussed the local variations in provision—Austin touched on this—and one of the features of the health inequalities report was the fact that poor areas have fewer GPs, so it's paradoxical, and I assume that's because GPs are very well paid and like to live in nicer areas. To what extent do the reforms increase the likelihood that a GP consortium will put GPs into deprived areas?

Dr Gerada: The only way that the reforms can effect this—and this is where I started and was quite optimistic at the beginning—if consortia wish to invest in primary care, there is nothing stopping them investing in primary care. It will be a very brave consortia to do that, though, because it's actually counter-intuitive to allow GPs more time to see patients—at the moment we get about eight minutes—and to actually allow GPs to have 20 minutes to do it, to actually invest in bringing more GPs, more nurses, more healthcare assistants into general practice, so that the issues that are going on with Mrs Hodge's hospital can be addressed in general practice. But I suspect what will happen—and what is already happening—is redesigning of services is moving, for example, musculoskeletal services out, is yet again redesigning diabetic care pathways. So it won't be around that. But the reforms can be used to do that. The problems isn't so much GPs get paid too much, it's also around housing prices in London, there's all sorts of factors that stop doctors coming into areas that have high social inequalities.

Chair: Cheaper to live in Barking than in Camden.

Q265 Matthew Hancock: On exactly that point, do you think, as an expert and GP, that the evidence shows that longer face to face time with GPs would provide better value for money?

Dr Gerada: Yes.

Matthew Hancock: Does the evidence show that?

Dr Gerada: The evidence is that if you increase consultation time from five to 10 minutes—when I

first started as a GP it was five minutes—it clearly shows improvement.

Q266 Matthew Hancock: So if you're running a consortium and you're given more freedom to improve value for money, would you do that?

Dr Gerada: I absolutely would do that.

Matthew Hancock: So why don't you think the reforms will lead to that, since that is what they will do?

Dr Gerada: I hope that they will. ; that's why I said I started off by being very optimistic. If the reforms lead to that then I think that's a very good way of using resources.

Q267 Matthew Hancock: What if the reforms lead to the freedom to do that—they are permissive rather than prescriptive?

Dr Gerada: The reforms do lead to the freedom to do that, because the reforms can—I'm assuming, because of changes on the ground—be used to deliver higher quality general practice care, with more GPs, more services being delivered within general practice, more complex management of complex patients, more diabetic patients being moved into general practice, falls clinics, for example, being moved into general practice—it can be used, and I think if consortia are brave and invest in primary care delivery, I think we'll see a much better health service.

Matthew Hancock: And better value for money?

Dr Gerada: And better value for money.

Dr Gordon: There's a difficulty in the way the competition side of the reforms is being proposed, which may militate against our ability to improve the investment and restructuring of primary care to be fit for purpose for the 21st century, principally because it's in very fragmented form at the moment, and therefore not well placed to respond to the commercial levers that are being provided to us as commissioners, which are very large scale and require very high levels of effort from bidders, for example, to be successful. The track record of GPs as tiny little providers in that process is not uniformly good, and therefore it becomes difficult; we can't just take a chunk of money and give it to GPs to do more stuff. We've got local enhanced services, for example, which is a tiny fraction of spend, to do that with. But when we come to, say, building a new general practice, that won't be within our gift just to make it happen: it'll have to go through firstly the commissioning board, and then secondly through a large contestability process to run that, and the history of those tendered GP practices is mixed, to say the best.

Q268 Joseph Johnson: Can I come in please on Professor Ham's point about the need for a failure regime? We are creating conditions where trusts that aren't going to make it to foundation trust status by 2014 are going to be presented with some quite difficult decisions. They are either going to be disbanded, or they are going to be—as you say—encouraged to merge with a foundation trust. So it's not like a normal bell curve, where you will have occasional failures every now and then. We will, within the next two or three years, be confronted with

a situation where a proportion of the 20 or so NHS hospital trusts that are presently struggling to obtain foundation trust status will be faced with those very difficult choices. Are you satisfied by the level of clarity that we have over what's going to happen to that proportion of trusts that don't make it to foundation trust status?

Chris Ham: I'm glad you raised that, because I think our discussion this morning has reflected the general discussion out there: a strong interest and preoccupation with how the commissioning side will work, and much less attention to the provider side, and our view at the King's Fund all along has been that the proposals on the provider side are at least as ambitious and much more challenging, in many respects, for the reason your question points to. We think there are between 20 and 30 NHS trusts at the moment that will never become foundation trusts under the current regime, because of a combination of financial problems and clinical problems, and it's not at all clear how they will be dealt with over the next three years—because it's three years now, isn't it, 2014, not two years as originally proposed—to enable them to have some kind of future, because they can't continue as NHS trusts.

Q269 Joseph Johnson: With the example you mentioned, the South London Healthcare Trust—my constituency falls within its area of responsibility, so I follow it very closely—it is not at all obvious what is going to happen to it. It faces some absolutely appalling choices.

Chris Ham: I think, for the Government, these are much, much more intractable issues than even the ones we've been talking about around GP commissioning in future, because you are going to have to find some way of dealing with PFI legacy debt. You are going to have to find a way of dealing with long term underlying financial problems beyond PFI debt, and then find a way of encouraging the successful foundation trusts to consider merger—or a takeover, as it would be—of these failing organisations, or indeed to open up the market to allow more Circles and Sercos to come in to play their part in that process.

Q270 Chair: Is that doable? I think Jo and I have similar situations; is that doable?

Joseph Johnson: Not without writing off the debts.

Chris Ham: I think you have to find some way of writing off the debt.

Chair: They have refused to do that to date, even under the more generous Labour Government.

Chris Ham: In which case we're not going to get to 2014 successfully with all organisations being in foundation trusts, or managed by private sector companies that want to come in and take them over.

Mr Bacon: An equivalent to the bad bank idea for hospitals, do you think?

Q271 Matthew Hancock: Are those difficulties made worse or better by the reforms? Because the difficulties of PFI debt and badly financial managed trusts or groups of trusts is the problem, that is a

legacy. The question is the impact of the reforms on that position.

Chris Ham: To the extent that you're deconstructing the commissioning side and putting it back together again, and the commissioning side has a part to play, it makes it even more challenging, but the fundamentals remain exactly the same.

Q272 Mr Bacon: PFI debt we understand: we've looked a lot at PFI. That's one specific issue. That aside, these 20 or so trusts that you think will not make it to foundation trust status: in a nutshell, where does the fundamental problem lie that stops them making it to foundation trust status? Is it the wrong kind of patients? The wrong of clinicians? The wrong kind of managers? Where does the fundamental problem lie that stops them getting better?

Chris Ham: It is a combination of financial problems beyond PFI on the one hand, and clinical quality problems on the other. There's a high concentration of these trusts in London, as it happens, because in London at the moment my recollection is there are 8 foundation trusts out of a potential 30 foundation trusts—a much lower proportion than across the country as a whole—and there are deep historical reasons around London having, many people would argue, excess acute hospital capacity, including highly specialised hospital capacity, certainly compared with the rest of the country. Clare and Shane will have views on this, but our interpretation would be standards of general practice which are variable—some very good, some very poor—but generally not as high as you would see in the rest of the country, which in turn reinforces the dependence on hospital care, because people default to the hospital because of the problems of general practice, and successive commissions over many, many years, have come up with proposals for sorting that out, most recently Ara Darzi and the Healthcare for London Review, which was making some real, real progress with demonstrable improvements in the quality of stroke care and other services until about six months ago, when the Health Secretary said “We're bringing an end to Healthcare for London because it's an example of the top-down restructuring of healthcare that is the past not the future.”

Q273 Chair: Has the Kings Fund done a calculation for these trusts—which Jo and I obviously share—of how much is involved: money? Because I think the basic problem is a financial problem.

Chris Ham: We have not. I believe that NHS London has done that for the trusts in London that fall into that category.

Chair: But you haven't done it for the 20.

Chris Ham: No.

Chair: You and the Department of Health know very well which these 20 are.

Chris Ham: The Department has set up this new provider development agency—I don't know if it came up in your hearing with Una and David—dealing with this group of 20 to 30 NHS trusts and managing the transition between now and 2014. That will be the body that will have all this information at its fingertips.

Q274 Nick Smith: One of our worst afternoons here was listening to a PAC report on pathfinders in areas of multiple deprivation about six months ago where it seemed that there was slowness at introducing the Department of Health's strategy on helping out in those areas. Do you think the new regime will help at all to address some of the issues that came up in that report, going back to poor GP provision, and addressing real needs of areas with multiple health and economic deprivation?

Chris Ham: Can I clarify: pathfinders in the NHS lexicon today means GP commissioning consortia. I think you were referring to the other kind of pathfinder, which was what the previous Government set up around tackling health inequalities?

Nick Smith: Yes. On, the health inequalities agenda, I am interested in seeing whether or not this new regime will make some difference.

Chris Ham: I think Clare knows more about this than I do but I think whether the reforms will help or hinder there depends rather less on the GP commissioning and how that goes forward and more on the Government's proposal on public health, and you will know that public health is migrating away from the NHS: local authorities will employ public health staff, will have that broader responsibility in future. There was an interesting paper in the *Lancet* last week commenting on this and raising some questions about whether that's the right way to go. I think the issue for us is, while there are real benefits in directors of public health focusing on health inequalities alongside housing, leisure, transport and the broader agenda local authorities can bring to bear, we must not create this artificial divide between what the public health staff are doing and what primary care teams are doing in the NHS, because those primary care teams you might say are the foot soldiers in the fight around prevention and tackling health inequalities. They know their patient populations, they are really well placed working with public health to make more progress in future, and if you move public health to local government you risk creating a bigger division between primary care and public health.

Q275 Chair: I was going to ask that question: how do you GPs see the accountability to your local health and wellbeing board?

Dr Gordon: Those two things are separate: the health and wellbeing board is responsible for the co-ordination, or encouraging the co-ordination of strategy across the area. Public health will have very specific roles that Chris has just alluded to. There's a real need to retain some public health input into GP consortia to allow us to focus our commissioning in the areas that deliver the best benefit on equality and the inequalities agenda. I think that's absolutely vital.

Q276 Chair: How will you be accountable to the health and wellbeing boards? How will that work?

Dr Gordon: We will have membership on the health and wellbeing boards.

Chair: That is a different question: that is how will you control. How will you be accountable to them?

Dr Gordon: Well, the accountability as proposed is not accountability; it is a duty to engage with them.

So we will have membership on there which will give us an input and an intelligence function which will put us in touch with the local population.

Chair: But you don't see yourselves as accountable to them?

Dr Gordon: The legislation as it currently is does not propose accountability to health and wellbeing boards. It proposes a duty for us to engage with them.

Mark Davies: I think this particular issue was around having to share commissioning plans and proposals with health and wellbeing boards. It was this interaction with the wellbeing board.

Dr Gordon: Certainly, the development of joint strategy for the area of the joint strategic needs assessment, the joint strategy for health and wellbeing, will involve the consortia, and public health, and the local government planning together how we commission services.

Q277 Chair: But there's no accountability locally, really?

Dr Gordon: That is my understanding of the legislation.

Chair: Do you agree with that, Chris, and are you happy with that?

Chris Ham: There is no formal accountability from GP consortia to health and wellbeing boards; the formal accountability is upwards to these sub-national offices of the NHS commissioning board itself.

Chair: And what is your view of that?

Chris Ham: It is a logical way of making the commissioning side work, as it is all part of the NHS. The consequence following on from that is a much weaker role for local authorities in relation to GP commissioning and the NHS commissioning as a whole than many people had expected when the White Paper first came out.

Q278 Chair: Have you got a view, Dr Gordon?

Dr Gordon: I guess it's a question of how many masters you are trying to serve, which is the problem we create having dual accountability. I think we as consortia are going to be looking very much to the support of the health and wellbeing boards in making sure our strategies are coordinated, and therefore you will get that buy-in to the larger local community and stakeholders.

Q279 Chair: We all agree in theory about having the patient at the heart, but one way of ensuring some sort of patient voice is through the elected representatives locally. You can argue the pros and cons of that. Another is the role of patients within the consortia, and it just seems to me that that is weak. Any of us who have used the health service at all know that even the most articulate and tough middle class person needs an advocate at present, and I am not sure the new system will give you anything better.

Matthew Hancock: Actually, it is also accountability from patients. Given that there will be overlapping geographical GP groups there's accountability down to patients. But this is really getting into quite a level of policy, isn't it?

Dr Gordon: There are two strands which will ensure that. One is the authorisation process, which will look

at whether we have patient representation within consortia, and there will still be the oversight and scrutiny role of local Government.

Dr Gerada: As long as we never lose sight of the fact that most of the people that use the health service are sick, mentally ill, deprived. The likes of us around this room will find our way through, whatever the organisational systems are, and it is important. You asked about health inequalities and whether these reforms will make them better or worse. I don't know. What I do know is there have been enormous changes addressing health inequality: the quality and outcome framework for the GP contract has addressed health inequalities; the public health indicators around equality and outcome framework—like cervical smear rates, immunisation rates—are dramatically improved. We have had fantastic medical directors who have been sweeping through, dealing with very poor performers and getting rid of them, to use an awful term. So we have had some really great changes. Whether this will change it or not, I don't know. I hope that it will improve things, but unless we start to address the fundamentals, which is numbers of GPs in deprived areas, the time taken to see the patients, the complexity of services, the variability of services that we have because of bad stuck in bad, then we won't move anywhere.

Q280 Stephen Barclay: Can I just clarify that: did you read the NAO reports?

Dr Gerada: Yes I did. I only read the bit in relation to health, I hasten to add.

Stephen Barclay: What the report showed was health inequalities had increased.

Dr Gerada: They did say that, but there were also some areas where they had improved, such as the QOF.

Q281 Stephen Barclay: I'm not disputing that. One would hope that if you more than doubled the health budget to £110 billion, there would be some improvements. I think most people around this table would accept that premise. The point, and what was so disappointing about the report, was that, notwithstanding the political will—and I don't for a minute dispute that there was a political will to address health inequalities—health inequalities actually went up.

Dr Gordon: But the money went into hospitals, not into primary care, which is the principle by which you address inequality.

Q282 Stephen Barclay: That is why I was asking earlier about the number of GPs in the most deprived areas.

Dr Gordon: That will depend on how we are able to commission that, and whether we are able to commission it at all, giving that the contracting of general practitioners lies with the commissioning board.

Q283 Chair: There are two final areas I think we need to cover. One is the transition costs, and the other is the transaction costs, so if we go to the transition costs first, to get from the old scheme to the new.

Are you all confident that the money set aside will be sufficient to enable you to do that? It is £1.4 billion—anyone got a view?

Chris Ham: David Nicholson has managed this part of it very well in difficult circumstances, because I think we're getting to a better place around the transition arrangements: the PCT clusters, giving security to experienced leaders and setting aside some money from the budget, top slicing to pay for those transition costs. Whether that money will be sufficient, again, frankly, none of us knows. We are very much in the same position that Kieran Walshe from the University of Manchester articulated six months ago, that in rough terms—it's a very wide range—we think the transition costs will be in the range of £2 billion to £3 billion. Now, the Department's estimate is lower than that. I think it will come out in the wash, and maybe what's been done recent will reduce the overall cost. But there are the concerns about how long the payback will be on that, and it relates to your second point: will the new system ultimately be that much cheaper to run with the regulatory arrangements being set up and the cost of running those

Q284 Chair: Go on, on the second point.

Chris Ham: On the second point—this is all of us looking into the crystal ball and the crystal ball inevitably is pretty cloudy on these occasions—but our reading is that if you look at what is set out in the Bill, it, first and foremost, is about creating the architecture around economic regulation of the market, the powers of the new Monitor being very different, much more powerful than the old Monitor ever was. That economic regulator is expected to deal with OFT and the Competition Commission on economic regulation, with the Care Quality Commission on quality regulation, and, by the way, with the NHS commissioning board to agree on tariffs and price setting in the new system. The new Monitor is going to have to employ lots of very talented people with skills in regulation, finance, the law and so on to be able to discharge the many responsibilities that have been set out in the Bill. Our view is that will mean significant transaction costs in the system.

Chair: More than at present?

Chris Ham: I would not say more than the present: we simply do not know.

Q285 Mr Bacon: I want to go back to public health for a second. As Professor Ham alluded to, it's been moved across, of course, to local authorities. Dr Gerada, from what you've been saying about GP practices, it was to me slightly surprising when I heard it was being moved across to local councils. My instinct would have been that's perhaps a job that GPs would do rather well. Do you think that more public health responsibility is something that GPs would be well equipped to take on—leaving aside for the moment that some areas in the inner city don't have enough GPs, which is obviously something else that would need to be addressed, because that's also where the greatest health inequalities are? Do you think that, in general, GPs would be well equipped to take on greater public health responsibilities?

Dr Gerada: Yes, absolutely.

Q286 Mr Bacon: So if it turns out in say three or four years' time, that local councils haven't done such a good job of public health with these health and wellbeing boards—or even if they don't spend more money, because so far as I can see it's not ring-fenced, from local discussions I've seen it's not necessarily going to end up being spent on this. Could you just say what you think GPs, had they been given the task, would do?

Dr Gerada: Yes of course, and at the college we have established a centre for commissioning to help support our members in getting skilled up, and one of the work streams is around public health and working with the Faculty of Public Health, trying to skill up GPs in their public health role. We have already created, a few years ago, a GP with special interest framework in public health, and we want to take that forward. Bear in mind also that GPs only have three years' training, so we're now going to have to put into all of this commissioning and public health, but we at the college firmly believe that public health and the ability to take a population view, the ability to do needs assessment, should be integral to the role of the GP, and in future we'll be there, and we're hoping to set that up.

Q287 Chair: Maybe NAO can help, but the evidence is that where we've had GP commissioning, to date, when we looked at the health inequalities, the actual expenditure on public health, and therefore investment to reduce inequalities—smoking cessation, statins, all that sort of stuff—was less. Am I right in this? As I remember, as I recall the health inequalities paper, it looked as if those areas where there's been some GP commissioning, from past evolution, there was even less expenditure on those interventions that we know work, that would reduce those inequalities.

Dr Gerada: Well, that shows, then, the failure of GPs.

Chair: So why should we have confidence in the future?

Dr Gerada: I do have confidence in the future—no, I have confidence in the provider side. Where there's been greatest innovation and greatest shift in services is where GPs have got together and actually looked at what needs to be required from a service—not necessarily about smoking cessation services or giving somebody a statin—but about setting up substance misuse services, services for the homeless, services around sex and domestic violence. Those are the issues that are public health issues, although they may not come under the banner of public health.

Q288 Chair: But to be honest, the simple things that a GP could be doing now without additional powers would be stopping people smoking and making sure they don't die of respiratory diseases and strokes and things like that, and what was so extraordinary in the health inequalities was these three interventions could, between them, reduce health inequalities—correct me if I'm wrong on this—by 15% or 20%, and they're just not happening.

Dr Gordon: There's two different points there: I think you've made an assumption that where there was GPs involved in commissioning, they had control over those issues, which I don't think is correct.

Chair: I think they did.

Dr Gordon: I don't think it's correct, certainly not in my experience. We are in practice-based commissioning, marginalised to work on elective conditions, by and large. That's a gross generalisation, but I don't think that's a correct assumption. I think we do need public health input. I think it is a discipline that does the big picture stuff very well; we as general practitioners often need some help with that. I think it's the synergy of the two again. As Chris was saying about the input of expert managers, the input of expert public health specialists has been vital to our local success in improving exactly the sort of inequalities you are talking about: for instance, through the NHS health checks programme, which we have led with the help of public health.

Q289 Stephen Barclay: Two quick questions on accountability, just really benefiting from the expertise of the four of you. I raised previously my concerns around European qualified doctors working in the United Kingdom who do not meet adequate English language ability, and the Department has said it has got no ability to put a test on that, and in its note to our previous hearing they say “the responsibility lies with the employers of doctors to ensure that they have adequate skills”. I don't know whether the royal college has done any work and has got any legal advice, particularly on the interpretation of the 1983 Act, but I would be interested, if you have, whether you could share that with us, but also your thoughts on that as an issue.

Dr Gerada: It is a very important issue, and the royal college has just recently, under my predecessor, published a document looking at out of hours, and one of the most important areas was the ability to speak the language that's required. As far as I understand it—I have had discussion with the GMC around this—we are going to try and take this forward, and when these doctors come and want to be put on the GMC register, there will be an understanding and a self-declaration that they can declare that they can speak the language adequately to meet the needs of our population. Now, you may say that's not enough, but it's a start, and then it'll be down to the responsible officer locally.

Q290 Stephen Barclay: What I'm driving at is that the GMC told me it has legal advice which supports the view that the 1983 Act could be amended, but the Department of Health don't want to share that, which is why they won't share it with me. I don't know, but that is what it tells me. It is more than three years since my constituent was killed by a German out-of-hours doctor. We are talking about making changes in the future, but it's still the case now that someone who's qualified in Europe can come here, and incidentally, if they're banned here they're not banned in their own country, which strikes me as odd. We are particularly interested in whether the royal college has any legal advice on this issue that you can share with the Committee?

Dr Gerada: We have not got any legal advice. As I say, we have a report that came out under my predecessor which we are now going to turn into a

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good practice guidance: that is about all we can do. It is my understanding, though, that the GMC's advice about being able to shift the Act is what you've heard: there is some movement on that.

Q291 Stephen Barclay: Because the French interpret European law in a way that does allow them to apply French language tests. So the same European law, one would assume, could be interpreted in a constructive way here.

Dr Gerada: I'm not a lawyer, and as I said we haven't sought legal advice, but it would seem reasonable that a patient in this country would be consulted by a doctor who could speak their language, and, on the basis that the law should make sense, that would seem reasonable.

Stephen Barclay: Would you mind sharing with the Committee a note, just on what the royal college position is on this specific issue?

Dr Gerada: Yes, of course, absolutely.

Q292 Stephen Barclay: Another issue which I have been trying to get some figures on is the use of special

severance payments by foundation trusts. This is particularly the sacking of clinical staff for non-clinical reasons, often with a gagging clause, a confidentiality clause, attached. What are your thoughts on the extent to which there is an issue there within foundation trusts, and particularly also around GP consortia and whether GP consortia would be able to use special severance payments moving forward.

Dr Gerada: I would not have a view on that I'm afraid.

Chris Ham: No, I've got no awareness of that issue.

Chair: Okay, thanks very much indeed, and just to be clear, we'd like that note as soon as possible, but I'm not sure it's absolutely 100%. It isn't relevant, really, to this evidence session, so we'll be treating it outside of the evidence session.

I thank you all much indeed for giving your time and being so clear in your evidence.

Written evidence from Department of Health

HEALTH LANDSCAPE REVIEW

At the Public Accounts hearing on 25 January, the Committee asked for six notes covering consultancy spend, the accountability of GP consortia, the NHS banking function, GP pension arrangements, language and competency tests, and confidentiality clauses in whistleblowing cases. Our responses to these are attached at Annex A.

During the hearing, you asked about the arrangements for accountability and Accounting Officers, in particular about NHS Foundation Trusts. We have prepared a note to set out the arrangements, attached at Annex B.

We trust this information meets your requests.

February 2011

Supplementary written evidence from the Department of Health

You asked for further clarification of accountability arrangements in the reformed NHS and about resourcing of change management in the light of budget reductions and other resource pressures on the Department. You have copied your letter to Sir David Nicholson, and this letter is a joint response.

On a general note, accountability arrangements in increasingly devolved public service delivery systems are of relevance for other central Government departments. As you know, Sir Gus O'Donnell has asked Sir Bob Kerslake at the Department for Communities and Local Government to lead a cross Government review to examine accountability arrangements in the light of the Government's localism agenda and we are involved in that work. The outcomes of that work may of course have implications for the Department, therefore what I say below represents our current view.

On your accountability points in turn.

The roles and accountabilities of the Department, the Commissioning Board, GP consortia, providers and regulators

Having consulted widely, we have set out the roles of the component organisations of the reformed NHS in "Equality and Excellence: Liberating the NHS", "Liberating the NHS: Legislative framework and next steps", and in the Bill which is currently before Parliament. The NAO has also done so in its report *National Health Service Landscape review* on which we worked closely with the study team.

These documents provided the basis for our evidence to the Committee on the planned organisational roles, subject to the passage of the legislation, at the Committee's meeting on 25 January. These documents, and the PAC hearing, also covered many aspects of accountability arrangements in the new system. We recognise that

there is further work to do on the specification, description and communication of the post legislation accountability arrangements. We will also need to take account of work across government on similar issues arising from the “localism” agenda. We intend to work closely with the NAO on these matters, and look forward to doing so as the basis for further appearances before your Committee.

In the reformed system, which subject to Parliamentary approval we expect to implement from April 2012, the Treasury will appoint the Department’s Permanent Secretary (currently me) as the Department’s sole Accounting Officer. As such, I will be responsible for making certain that an overall system of control is in place for ensuring proper stewardship of public funds. I will be accountable for that overall system of control and I would expect Parliament (through the PAC) to hold me to account for any control failures in the overall system, for example failures resulting from deficiencies in the policy framework or legislation. Accounting Officers in individual NHS organisations (Accountable Officers in the case of GP consortia) will be responsible for ensuring that adequate systems of control are in place within those organisations, and should expect to be held to account for any failures in quality, safety and performance attributable to failures in the systems of control within their individual organisations.

The respective accountability roles of you as the Permanent Secretary of the Department and the Chief Executive of the NHS Commissioning Board

The Health & Social Care Bill currently before Parliament specifically provides that the Commissioning Board’s Chief Executive will be the Accounting Officer, which effectively creates direct accountability to Parliament. Sir David Nicholson is the NHS Commissioning Board Chief Executive designate; he therefore will be the Accounting Officer for the NHS CB itself as a Non-Departmental Public Body and for Commissioning Consortia overall.

The respective accountabilities and working relationship between the DH and NHSCB Accounting Officers will be clearly set out in a detailed framework agreement covering: the NHSCB’s purpose, governance and accountability and management and financial responsibilities. Work is currently underway on this framework agreement.

By way of example of the respective accountabilities here, the Secretary of State and the Department will be responsible for setting the outcomes to be achieved through the NHS Outcomes framework, and the NHS Commissioning Board will have overall responsibility, and be accountable, for delivering those outcomes.

When and in what circumstances we should expect to hold you to account for the performance and actions of NHS funded providers, in particular Foundation trusts, rather than the immediate trust management

Foundation trust Chief Executives are currently, and in the reformed system will continue to be, Accounting Officers for their organisations, as set out in Schedule 7 to the National Health Service Act 2006. They are effectively directly accountable to Parliament. It is already a core principle of the legislation that Foundation Trusts are autonomous organisations and therefore unlike other parts of the NHS they do not operate as a collective sector. This is fundamentally different to the regime that operates for NHS trusts, whose Accountable Officers are currently appointed by the NHS Chief Executive and where, from April 2012, for as long as NHS Trusts exist, such appointments will be made by me as Permanent Secretary of the Department of Health. The Government’s intention is that, over time, NHS Trusts should all become NHS Foundation Trusts.

The Health & Social Care Bill will provide the legislative framework for a regulated healthcare sector, with independent and individually accountable Foundation Trusts, which will provide good quality care, value for money and efficiency.

Foundation trust Accounting Officers will continue to be accountable for issues of probity, regularity, the management of resources against financial duties, the stewardship of assets and day-to-day operations within their own trusts. For example, individual Foundation Trust Accounting Officers will be accountable should financial failure occur in their own Trusts, but I would be accountable were there to be any financial failure in Foundation trusts resulting from a deficiency in the policy framework or legislation.

The accountability of the regulators, Monitor and the Care Quality Commission, for health services

As now, in the reformed system, I will continue to appoint the Chief Executives of Monitor and the Care Quality Commission as Accounting Officers for their respective organisations, with responsibility for issues of probity, regularity, the management of resources against financial duties, the stewardship of assets and day-to-day operations. The Chief Executives will therefore have dual accountability to Parliament, directly as their organisations’ Accounting Officers and through me as the DH Accounting Officer. The working relationships between DH and Monitor and DH and the Care Quality Commission are and will continue to be clearly set out in detailed framework documents.

Monitor will remain a Non Departmental Public Body. It will be required to account to the Department for its use of resources and publish annual accounts. It will be required to report annually to Parliament to demonstrate value for public money and therefore be publicly accountable through Parliamentary scrutiny, including through investigations by select committees.

The Secretary of State will have a power to direct Monitor, and other arms length bodies covered by the Bill, where there has been a significant failure to perform one or more functions. The power may not be used in relation to individual cases and it is intended that it would only be used in exceptional circumstances.

The Care Quality Commission will also remain a Non Departmental Public Body and will be accountable to the Secretary of State for discharging its functions, duties and powers efficiently and effectively. The Department will monitor the Commission's financial and operational performance and risks at a general and strategic level, but the Commission's Board will be responsible for assessing and ensuring the quality of its inspection or monitoring of specific providers on a day to day basis. The Commission's annual accounts and annual report will be laid before Parliament and it too will therefore be publicly accountable through Parliamentary scrutiny, including from Select Committees.

How the proposed new local accountability arrangements will work—in particular, how Health and Well Being Boards in local authorities and local Health watch will hold to account their local GP commissioning consortia and Foundation trusts

Local authorities will have an enhanced role to increase local democratic engagement. Whilst the NHS Commissioning Board will hold consortia to account for financial performance and outcomes, there will be a stronger role for local authorities in helping to shape commissioning priorities and in promoting a joint approach in targeting effort and resources towards improving the health and wellbeing of local communities. Subject to Parliament, the Bill will require the establishment of a health and wellbeing board in every upper tier local authority. Health and wellbeing boards will bring together elected councillors and patient and public representatives with the key NHS, public health and social care leaders in each local authority area to work in partnership. Already nearly 90% of local authorities in England have put themselves forward to be health and wellbeing board early implementers.

There will also be a heightened sense of accountability to the patient. Increased choice over where treatment takes place, and by whom, will enable a greater routine say for patients. If they have deeper concerns, the new HealthWatch organisations will act as a patient champion locally. Local HealthWatch will carry forward the functions of Local Involvement networks (LiNks). As such Local HealthWatch will continue to be funded and accountable to local authorities for being effective and value for money. As LiNks do now, they will be able to enter hospitals and view services and issue reports or make recommendations about services and receive a response within 20 days. Through their additional functions to provide information to help people access and choose services and to signpost or provide NHS complaints advocacy services, Local HealthWatch organisations will become a single point of contact for people if they want to find out more or help to shape health and social care services. In addition, Local HealthWatch will have a role in decision making for commissioning through a seat on health and well-being boards. By being able to raise issues with a new national consumer champion, HealthWatch England, there will be a route for people's views and experiences of care to be raised and acted on nationally.

With regard to your question about resourcing change management in the context of budget reductions, and with a view to securing value for money, we have tried, wherever possible, to resource the transition internally. We looked carefully at the programme resources available in the Department and chose programme managers who were best suited to the transition process. Where there were gaps in availability, we looked outside the Department for supplementary resource to help fill those gaps. These resources came from other Government Departments or the NHS.

A recent Gateway review of the overall Transition Programme flagged a need to simplify and accelerate internal processes for recruiting and acquiring necessary external skills. As a result of this we have implemented a fast-track process for decisions on urgent resource needs for the programme.

I hope that this is helpful as a description of accountabilities as they stand in policy and the Bill at this stage. As I said earlier, we are involved in Sir Bob Kerslake's cross Government work on accountabilities and localism and I will write to bring you up to date with developments when I have further information.

29 March 2011

Annex A

Health Landscape Review

NOTES REQUESTED DURING THE PAC HEARING TUESDAY 25 JANUARY

Q112 Stephen Barclay: Given that the Cabinet Office have said that they want monthly data from Departments on consultancy spend, can I assume that you will be publishing monthly what is spent on consultants, interims and professional services, both in terms of the Department centrally and any of these other agencies set up as part of the reforms?

Una O'Brien: All of this will be made more transparent by the Cabinet Office. Just for the record, because I do think it is important, I know you have observed the scale of DH spending on consultancy in the past, but in the first six months of this financial year, our consultancy spend was £12 million. The full year cost for 2009–10—last year—was £155 million. So I think that just gives you a sense of the dramatic reduction in

consultancy spend. We are absolutely, across Government, committed to bringing this down and indeed it is going to be a very important opportunity for civil servants to build their skills and to really make the most of what we have learnt from working with consultants in the past.

Q113 Mr Bacon: Of that £155 million down to £12 million, how much is NPfIT?

Una O'Brien: I could not give you the breakdown, but I am happy—

Mr Bacon: Could you send us a note?

Una O'Brien: I am happy to do that, yes.

Answer:

The significant reduction in consultancy spend is a result of:

- The implementation of the Efficiency Reform Group (ERG) efficiency controls through a more robust approvals process, together with Ministerial scrutiny of requests for consultancy expenditure across DH, CFH and ALBs has led to a much lower level of demand and more cases being turned aside or refined. This has meant that in some cases more cost efficient alternatives have been found (for example, use of DH civil servant staff through work re-prioritisation, or use of specialist contractors where not feasible to use civil servants). There has been a significant reduction in the number of new purchase orders raised (and relative expenditure against these) with the top six consultancy firms in 2010–11.
- Reductions in consultancy expenditure for specific programme areas, for example planned reductions in Pandemic Flu of circa £5 million—this was a planned reduction and related to Ernst and Young activities in 2009/10 to support the development of pandemic flu preparedness capability. This support was completed, as planned, by the end of March 2010.
- Alignment of the definitions of consultancy procurement activity, in line with OGC definitions, resulting in a reduction in the number of procurement activities previously recorded as consultancy. This has taken place through improvements in business processes and understanding and therefore is very difficult to quantify. This will also have resulted in an increase in specialist contractor expenditure. There is no simple way of quantifying the movement of expenditure towards specialist contractors as a result of improved definitions and coding, as opposed to an increase in expenditure as a result of a change in approach to delivering the work (see first bullet above).

The National Programme for IT (NPfIT) element of the total consultancy figures was £6.3 million in 2009–10, compared to £1.6 million at Month 6 2010–11. Please note that £1.6 million expenditure had occurred at the mid-point of the year only, and the 2010–11 figure has increased to £3.4 million at Month 9. This suggests a downward trend in expenditure in this area. It is worth noting that the consultancy element in relation to NPfIT relates to legal consultancy advice required to the contracts for NPfIT, rather than the NPfIT delivery itself.

Q167 Dr Creasy: No, the issue is about budgeting where the money goes and who is held accountable for how it is spent, because right now, we challenge the PCT. If you take away the PCT and you are now leaving those decisions to the GP commissioners or the risk pool, at some point people are going to fall through the cracks unless there is an adjudication mechanism.

Sir David Nicholson: Well you will hold the consortium to account in the way that you hold the PCT to account.

Q168 Dr Creasy: And the consortium says it should be the risk pool; the risk pool says it should be the consortium. Who will make an intervention in that process? Where is the accountability for that decision?

Sir David Nicholson: Well the accountability is the consortium's accountability to their population.

Chair: There is a lot evolving, so I think you should take this one away and if you can write to us with clarity on it, that would be really, really helpful. We are not trying to catch you out, but to ensure that there are proper accountabilities, particularly in a situation where we have reducing real budgets, where this could occur. But I am really pleased to hear you can have your double cataracts wherever you are because somebody is going to pick up the tab.

Answer:

GP consortia will be accountable to the NHS Commissioning Board for managing public funds and for the outcomes they achieve. In turn, each consortium will hold its constituent practices to account against these objectives. All consortia will need to appoint an Accountable Officer. The NHS Commissioning Board will have the power to intervene in consortia, but only where there is evidence that consortia are failing or are likely to fail to fulfill their functions. We propose that consortia should have the freedom to make commissioning decisions that they judge will achieve the best outcomes within the financial resources available to them. At the same time, the economic regulator and NHS Commissioning Board will develop and maintain a framework that ensures transparency, fairness and patient choice.

Consortia will be supported by the NHS Commissioning Board, who will be responsible for the allocation and accounting for NHS resources. This stewardship role will include calculating practice level budgets and allocating these budgets directly to consortia. It will also have responsibility for the financial stability of commissioners and for accounting to the Secretary of State for NHS commissioning expenditure, underpinned by robust financial management measures at consortium level. There is no “one size fits all” rule regarding the size of consortia and the key criterion for deciding on a consortium’s viability will be that the NHS Commissioning Board is satisfied that prospective consortia have appropriate arrangements in place for discharging their functions.

Regarding the potential conflict between GPs’ duties to their patients and their duties as commissioners, the first duty of doctors will always be to their patients. The GMC’s Good Medical Practice Guidance, which describes what is expected of all doctors registered with the GMC, says:

“You must give priority to the investigation and treatment of patients on the basis of clinical need’ and ‘You must act in your patients’ best interests when making referrals and when providing or arranging treatment or care.”

Q190 Nick Smith: Can I just come back to the question? Are there any other health services across the world that have this internal banking suggestion that you put forward?

Chair: Write to us about that.

Una O’Brien: I just do not have that information at my fingertips, but of course I will write to you.

Answer:

The proposed NHS banking function will provide loans to NHS trusts who require cash. We would expect the NHS banking function to provide the type of loans currently administered by DH for NHS Trusts and NHS Foundation Trusts. In both instances, these are primarily for capital investment and are not an indication that the trust is in any financial difficulty. Quite the contrary. Trust loan applications need to demonstrate the long term requirement for the capital investment in response to patient need for services and the affordability of the loan. DH also provides to Foundation Trusts who may have a shortfall in cash for operational reasons, again these trust will need to be able to demonstrate that a loan is affordable and will be repaid.

The proposed banking function is an evolution of these current arrangements and a necessary part of the reforms. The taxpayer will continue to have a large investment in Foundation Trusts and there will be a need to provide loan financing for Foundation Trusts in the future. It is important to ensure that there is a balance between managing this investment in the best interests of the taxpayer, but also ensuring that new loans are subject appropriate scrutiny and only made where repayment can be expected to the agreed schedule. Powers proposed in the bill reinforce these principles and require a transparency of operation consistent with the banking function’s relationship to an liberated Foundation Trust sector.

We are not aware of any other health systems who provide support to hospitals through such a banking function. As we understand it there are varying degrees of national and local/regional administration and financing of publicly financed healthcare. However, as with all health systems, the NHS has evolved over an extended period and our proposals for such a banking function and a natural and necessary development.

Q191 Stephen Barclay: Three specific questions from me; I am conscious of time. In the new landscape obviously the reforms rely on the role of the GPs. Just picking up on one of the earlier points about unforeseen events, can I just clarify whether the final salary pensions of GPs are within the scope of Lord Hutton’s review and, given how powerful the GP trade body is, as we saw from their previous contracts, is there any risk attached with changes to GP pensions?

Sir David Nicholson: I couldn’t answer that question; I will have to send you a note on that.

Answer:

The current pension arrangements for GPs were negotiated with trade unions, including the BMA, in 2008. Unlike other members of the NHS Pension Scheme whose pensions are based on their Final Salaries, GPs have their pensions based on a Career Average basis. This is otherwise known as career average revalued earnings scheme (CARE). Arrangements for GPs’ pensions are within the scope of the review by Lord Hutton, to ensure that they are fair to both employers and taxpayers.

Q192 Stephen Barclay: Thank you. Out-of-hours GPs has obviously been a hot topic and a big constituency interest of mine; it was my constituent Mr Gray who was unlawfully killed by the German out-of-hours GP Dr Ubani, who is still able to practice in Germany although he is banned in the UK. So there is an imbalance firstly between someone being able to work here because they are qualified in Germany but being banned here and not being banned in Germany. The GMC do not have unfettered control in setting language and competency tests for European qualified doctors when they come to the UK. It may be something you want to send me a note on, but I would be very keen to establish by what time UK legislation is going to allow the GMC to set the language and competency tests in the new health landscape in order that they can ensure that those coming to this country are correctly qualified and can speak the language.

Sir David Nicholson: We will send a note on that, yes.

Answer:

The Medical Act 1983 currently makes no provision for the GMC to be able to require EEA doctors seeking registration to sit language or competence tests. However, it is not simply the case that domestic legislation could be amended to enable the GMC to undertake checks on the competence and language knowledge of EEA migrant doctors. Whilst this would remove one impediment, any arrangements for language testing of EEA doctors would still need to be proportionate in order for it to be consistent with Directive 2005/36/EC to enable the United Kingdom to meet its treaty obligations.

Under the automatic recognition procedures provided for by Directive 2005/36/EC, the GMC is required to check that doctors from the EEA applying for inclusion on its Register hold a recognised qualification, listed in the Directive that has been issued by an EEA competent authority. This qualification attests to fact that the individual has met common European minimum standards of training. The Directive specifically provides for certain additional checks to be undertaken, such as identity checks and character references, but there is no provision for competent authorities to apply additional checks on language and competence at the point of registration.

Our assessment therefore is that the Medical Act 1983 cannot be amended to enable the GMC to undertake systematic blanket testing of the language skills of all migrant workers from the EEA, or to impose additional tests of competence before registering them because of the requirements of the Directive. Registration depends on whether or not the migrant has the appropriate qualification to practice their profession. It does not mean that a professional has demonstrated that he or she is fit to do a particular job in a particular place.

The responsibility lies with the employers of doctors to ensure that they have adequate skills for a specific post to which they recruit.

The European Commission has begun its review of the implementation of the Directive, which is due for completion 2011 with any new proposals to be put forward in 2012. The review will involve all 27 Member States. The UK Departments involved in the operation of the Directive agreed to hold a mini review in 2009–10. The Department of Business, Innovation and Skills (the lead Dept for the Directive) sent out a questionnaire to all UK regulators and analysed the replies, which included those from the health regulators which produced a report on the first two years of operation of the Directive.

The completed report was copied to the regulators and the European Commission who had specifically requested a copy of the report, which helped inform the Commission of the content of their review. The issue of language testing was raised in the report.

The Commission's review began with experience reports being completed by the competent authorities throughout Europe with responsibilities under the Directive for the regulation of doctors, nurses, midwives and pharmacists. The regulators came together in a network to discuss the issues and, in the case of nurses, the European Commission appointed the NMC as the lead regulator for nurses. However, there is no guarantee that the review will lead to any changes to the Directive and it is worth noting that only the European Commission can propose amendments to EU law in this area.

Any amendments to the Directive would be likely to take several years to be fully implemented and therefore we believe that the priority should be to concentrate on strengthening language checks under current scope of the law. The Government therefore believes that this is the most appropriate way of delivering the Coalition Agreement commitment to seek to stop foreign healthcare professionals working in the NHS unless they have passed robust language and competence tests. In particular, we plan to explore how the NHS Commissioning Board, could oversee a more effective system for undertaking checks on language knowledge of primary care. At the same time we continue to explore actively with the GMC whether there is the scope for a GMC scheme that would be consistent with the Directive and which would enable a proportionate approach to testing, where there was a concern, whether individual doctors had the right language skills for the role they intend to take up.

Q193 Stephen Barclay: The third thing is around confidentiality agreements for clinical staff who have left their posts for non-clinical reasons or for whistle-blowers. This really ties into Amyas's point around your ability as the accounting officer to meet Sir Nicholas Macpherson's test, which, as he set out, is in order that you can satisfy yourselves that the financial systems in place in organisations are correct. Could you clarify in the new landscape whether those sorts of confidentiality agreements are going to be allowed to continue?

Una O'Brien: It is not something I have any reason to think is changing, but I will certainly verify that.

Q194 Stephen Barclay: I am very keen for it to change; that is my point. Do you have sight—

Una O'Brien: Could you rephrase your question?

Q195 Stephen Barclay: Yes, okay. At the moment there is concern that whistle-blowers or clinical staff who—

Una O'Brien: That their confidentiality is protected?

Stephen Barclay: Well, the Trust that is potentially at fault—or there are serious issues within the hospital that the Trust management may want to cover up—are signing confidentiality agreements with those clinical staff that in essence cover up what has gone on.

Mr Bacon: Some years ago the NAO did a report on the management of the suspension of clinical staff in situations where their clinical competence is not in doubt. The most famous case that comes to mind is that of Dr Raj Mattu, which ran for several years. He was a cardiologist who pointed out that the hospital management's proposal for changing the number of specialist units—so that instead of having one per patient, you would have, shall we say, four sets of machines for five patients on the basis that that would probably be all right most of the time—was actually causing deaths. He was suspended, but there have been lots of other cases—the NAO did quite a substantial report on this many years ago now—where clinical staff were suspended by a Trust where their clinical competence was not in doubt and then public money was used to pay them salaries for sometimes 18 months, two years or even longer, while the NHS managers—in this case a foundation trust—and the employee—the competent clinician—were in a long-running dispute that got settled more or less satisfactorily from somebody's point of view and was then subject to a confidentiality clause, including quite often a big pay-off.

Chair: I think you are going to have to write to us on this one.

Answer:

The Public Interest Disclosure Act 1999 (PIDA) applies to workers and is designed to protect them from detriment in the workplace as a result of making a protected disclosure. If a worker was suspended solely as a result of making a protected disclosure, then this could be considered detrimental to the employee under PIDA and the employee could challenge this action.

In relation to “gagging clauses”, the Department's stance has not altered since 2005. Contracts of employment are a matter between the employing organisation and its employee. It is likely that most contracts will include some form of confidentiality clause as employees will have access to sensitive patient and commercial information that should not be released. However, the Public Interest Disclosure Act 1998 provides that any clause or term in contract, or other agreement between a worker and their employer, is void insofar as it purports to preclude the worker from making a protected disclosure.

The Department made clear, in a Health Service Circular on the Public Interest Disclosure Act (HSC 1999/198), that local policies should prohibit confidentiality gagging clauses in contracts of employment and compromise agreements which seek to prevent the disclosure of information in the public interest.

On 9 June 2010, the Secretary of State announced a full public inquiry into the role of commissioning, supervising and regulatory bodies in the monitoring of Mid-Staffordshire Foundation Trust. As part of this, he also stated his intentions to undertake further work on whistleblowing and to improve procedures for those who wished to raise concerns. These include:

- Issuing unequivocal guidance to NHS organisations that all their contracts of employment should cover staff whistleblowing rights—This has been published on the NHS Employers website on 13 September 2010.
- Seeking through negotiations with NHS trade unions to amend terms and conditions of service to include a contractual right to raise concerns—These were agreed through the Staff Council and published on the NHS Employers website on 13 September 2010.
- Issuing guidance to the NHS on supporting and taking action on concerns raised by staff—This has been completed and as stated earlier published on 25 June 2010.
- Reinforcing the NHS constitution to make clear the rights and responsibilities of NHS staff and their employers in respect of whistleblowing—A full public consultation ran from 12 October 2010—11 January 2011 to gauge public opinion on the possibility of adding:
 - an expectation that staff should raise concerns at the earliest opportunity;
 - organisations should pledge to support staff when raising concerns; and
 - the Constitution should have greater clarity around the ability of staff to raise concerns.
- Exploring with NHS staff further measures to provide a safe and independent authority to whom they can turn when their own organisation is not listening—This option is currently being explored by the Department.

Annex B

ACCOUNTABILITY AND ACCOUNTING OFFICER ARRANGEMENTS OF ORGANISATIONS IN THE NEW SYSTEM

ACCOUNTING OFFICER APPOINTMENTS

The Treasury appoints the permanent head of each central government department to be its Accounting Officer. The Treasury may also appoint Additional Accounting Officers with responsibility for certain Requests for Resources. Where there are several Accounting Officers in a department, the permanent head is the Principal Accounting Officer.

In turn, Accounting Officers normally appoint the permanent heads of departmental executive agencies, as Agency Accounting Officers for their agencies, of all its NDPBs and of most other significant arm's length bodies, as Accounting Officers for these bodies.

GENERAL ACCOUNTING OFFICER RESPONSIBILITIES

Formally the Accounting Officer is someone who may be called to account in Parliament for the stewardship of the resources within the organisation's control.

Accounting Officers' responsibilities are set out in Managing Public Money and are broadly:

- signing their organisations' accounts, annual report and statement on internal controls;
- taking personal responsibility for ensuring regularity and propriety, selection and appraisal of projects, value for money, management of opportunity and risk, learning from experience and accounting accurately for the organisations' financial position and transactions; and
- ensuring that there is a high standard of financial management, including a sound system of internal control, that financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity; that financial considerations are fully taken into account in decisions on policy proposal; and that risk is considered in relation to assessing value for money.

DEPARTMENT OF HEALTH RELATED APPOINTMENT ARRANGEMENTS

<i>Accounting/ Accountable Officer</i>	<i>Appointed by</i>		<i>Responsibilities</i>	
	<i>Now</i>	<i>Future</i>	<i>Now</i>	<i>Future</i>
Permanent Secretary (Principal Accounting Officer)	HMT	HMT	Signs DH Resource Account, statement on internal control and annual report	As now, but Resource Account includes FTs.
NHS CE (Accounting Officer)	HMT	n/a	Signs NHS Summarised Accounts and statements on internal control	n/a
NHSCB CE (Accounting Officer)	n/a	Perm Sec	n/a	Signs NHSCB and GP Consortia consolidated accounts, statement on internal control and annual report
Monitor CE (Accounting Officer)	Perm Sec	Perm Sec	Signs Monitor and FT consolidated accounts, statement on internal control and annual report	Signs Monitor accounts, statement on internal control and annual report
CQC CE (Accounting Officer)	Perm Sec	Perm Sec	Signs CQC accounts, statement on internal control and annual report	Signs CQC accounts, statement on internal control and annual report

<i>Accounting/ Accountable Officer</i>	<i>Appointed by</i>		<i>Responsibilities</i>	
	<i>Now</i>	<i>Future</i>	<i>Now</i>	<i>Future</i>
FT CE (Accounting Officer)	Primary legislation— Monitor sends appointment letter	Primary legislation—Perm Sec sends appointment letter	Signs FT accounts, statement on internal control and annual report	Signs FT accounts, statement on internal control and annual report
GP Consortium (Accountable Officer)	n/a	NHSCB CE	n/a	Signs GP Consortium accounts, statement on internal control and annual report

FOUNDATION TRUSTS

Accountability

It is already a core principle of the legislation that established FTs (Health and Social Care (Community Health and Standards) Act 2003) that they are autonomous. Foundation trust Accounting Officers (and not the DH Principal Accounting Officer) are already individually accountable for issues of probity, regularity, the management of resources against financial duties, and the stewardship of assets. They must sign the FT's accounts, statement of internal control and annual report.

As autonomous providers of healthcare FTs do not therefore operate as a collective sector and this is already fundamentally different to the regime that has operated with NHS Trusts.

The approach is already that a reformed provider system, offering independent and individually accountable FTs, will provide sufficient assurance, value for money and efficiency through regulation and commissioning. With the development of a more diverse provider landscape, users (via choice and any willing provider mechanisms) and commissioners will have more options amongst providers, and thus the competitive pressures on providers to deliver quality and value will act as a strong incentive.

Accounts

From 2011–12, FTs will move within the Department's accounting boundary under the cross-Government "clear line of sight" initiative (following the Constitutional Reform and Governance Act 2010) and will be fully consolidated into the Department's resource account. Therefore, FT accounts will, in future, need to be produced to the same standards and timescales as those of the Department and other organisations in the Department's "group".

The Department is therefore proposing powers to ensure that FTs' accounts are produced in a form and to a timescale that will allow them to be consolidated into the Departments Resource accounts.

In addition, the Department is proposing powers that will allow it to collect other information necessary to fulfil its reporting requirements for example to Parliament and the Treasury and to ensure effective delivery of Departmental business.