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NHS Next Stage Review

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Oral and written evidence

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Oral evidence

Taken before the Health Committee

on Thursday 10 July 2008

Members present:

Mr Kevin Barron, in the Chair	Stephen Hesford
Charlotte Atkins	Dr Doug Naysmith
Mr Peter Bone	Mr Lee Scott
Jim Dowd	Dr Howard Stoate
Sandra Gidley	Dr Richard Taylor

Witnesses: **Professor Steve Field,** Chairman, Royal College of General Practitioners, **Professor Nicholas Mays,** London School of Hygiene and Tropical Medicine, and **Mr David Pruce,** Director of Policy and Communications, Royal Pharmaceutical Society of Great Britain, gave evidence.

Q1 Chairman: Good morning, gentlemen. Could I welcome you to our first evidence session of our inquiry into the NHS Next Stage Review. I wonder if I could, for the record, ask you to introduce yourselves and the position that you currently hold? Could I start with you, David.
Mr Pruce: I am David Pruce; I am Director of Policy and Communications at the Royal Pharmaceutical Society.
Professor Field: I am Steve Field; I am the Chairman of the Royal College of General Practitioners.
Professor Mays: I am Nicholas Mays, I am Professor of Health Policy in the Department of Public Health and Policy at the London School of Hygiene and Tropical Medicine.

Q2 Chairman: Welcome once again. Could you tell me briefly, in two or three sentences, what is your opinion about the NHS and the Next Stage Review? Do you accept that the NHS required another review at all?
Mr Pruce: Did we require another review? Possibly we did need another review; whether we need another reorganisation is a different matter. I think pharmacies look forward to contributing much to more to improved patient care, and we were pleased that the Darzi Review mirrored a lot of what was in the Pharmacy White Paper. Pharmacies are open for extended hours. We offer an alternative route to healthcare within 20 minutes to 99% of the population. We think that is a key advantage. The report by Lord Darzi, coupled with the Pharmacy White Paper, is our way forward to making real changes, we believe, to experiences of patients.
Professor Field: Given that there was a White Paper only very recently in 2006, our first feelings about it were, "Why are we doing another review?", but when we considered what was being proposed, we thought it was actually a timely stock-take of the Health Service as a whole. We have been pushing, as you know, for many years, for high quality patient-centred care, moving care out into primary heath care teams, who manage most illness in this country, and moving the focus to more about health promotion and prevention. We saw this as an opportunity to look at the whole health system in this country, and just doing it for primary care on its own was unreal, so we welcome the chance to look across the board and the focus on quality, particularly, we have supported very strongly.
Professor Mays: I think the main reason that the Government wanted a review was to have a different kind of perspective on the Health Service. I think the main justification for the Darzi Review is not so much, necessarily, that there needed to be a substantive new review—I am sure that the previous White Paper still has not been fully absorbed by the system—but I think it appealed to the Government to have what was ostensibly a clinician-led review. The test of Darzi is to what extent is it actually different from the kind of White Paper that one would otherwise have seen, and that is quite a big claim that is being made. It is a distinctive kind of approach. For example, the argument about whether the White Paper includes enough information about implementation is a question about whether you think that maybe previous White Papers were too directive. I think its main justification is actually in style and in who was directing it and who was engaging clinicians across the NHS in the process, not so much whether we needed, once again, to review the NHS. We review the NHS persistently.

Q3 Chairman: Steve, can I go back to you. You mentioned quality. Is poor quality the most single, the most individual challenge facing the National Health Service at the moment?
Professor Field: If you are looking at the Health Service today and over the next ten years, I think it is a question of providing high quality care, as I said earlier, moving towards prevention, putting more power, if you like, towards patients so that they can take more responsibility for their own health. Those are important because of the demographic change. What is happening is that, as patients are getting older, they are having more complex conditions, physical conditions as well as psychological conditions, and with that comes an increase in cost to the Health Service, and so the challenge is about how you manage an increasingly aged population with complex medical conditions and how you

maintain value and quality within that. It is quite a complex number of issues. From a GP's perspective, we have seen a real change in what we are doing from workload for more elderly patients who do not have single disease issues like you see from NICE guidelines, like diabetes or renal failure, we are managing an increasingly elderly population with a lot of what we call co-morbidity complex problems. It is how you manage that in a much more effective, safe, high quality system. That is where we are coming from.

Q4 Chairman: Quality is the thing that is in this report, but do you think it should have concentrated a bit more on the issue of value for money? We have got something getting near a £100 billion per annum budget now. Would that have been a better way of approaching it, do you think?
Professor Field: I think it is more complex than that. As I said, it is how do you shift care from the doctor or the health professional being the centre to the patient being the centre? How do you move healthcare so that the patient can take more responsibility? Then, how do you provide a much safer, much more high quality system? Certainly we are then talking about productivity, we are talking about reducing risk, reducing waste. It is a mixture of quality and cost-effectiveness, I think. We were never going to have the amount of money that they throw into the system in Massachusetts, but they have realised in Massachusetts, when they have moved to a health insurance system, that they are short of GPs to act as the gate keeper. So, in fact, whatever you do, it is going to be a balance between safety and cost-effectiveness.

Q5 Chairman: Nick Mays, have you got anything to add to that?
Professor Mays: Yes, I think I would agree, from the tone of your question, the document is written as if resources are not a problem, and Lord Darzi tends to point to the fact that, "Well, we have got £100 billion", but, of course, the prospects for the next few years are not quite as rosy as they were in the period when we were trying to implement the NHS Plan and other such things. I think it is interesting that the document does not really talk very much about the implications for efficiency. For example, it is very much in the style of a document that wants to make the NHS a richer environment for patients. In primary care we are going to have other parallel primary care centres alongside conventional GP practices, which, of course, is designed in order to encourage choice and also some degree of competition between conventional general practice and these new GP-led health centres, but, of course, that will come at a cost, and to do that consistently across the entire country, particularly in the less well doctored areas, I would have thought, is a fairly major undertaking. I have got no figures to hand, but Darzi does not really make any inferences about how easy that will be to do. Likewise, the measurement of quality on a routine basis across the wide range of measures of clinical effectiveness, patient experience and quality of life has not been attempted, I do not think, across a wide range of services in any other health system and, again, it will be a resource-intensive activity, quite apart from the need to develop the methods in the first place, because these methods are used in research studies at the moment, they are rarely used routinely on 100% of the patients passing through busy primary care or hospital institutions.

Q6 Chairman: Obviously there are quite a lot of aims and objectives in the report. When it gets round to implementation, of course, you are talking about eight paragraphs, which is not a lot. Do you think it is deficient in terms of how you would achieve or provide adequate information? Does it do that in terms of implementing quality, or do you think it is deficient in that area? It just seems to me there are plenty of aims and objectives, eight paragraphs on implementation, and big question marks hanging over all of it in a sense.
Professor Field: The big issue is about how you implement the ideas locally. I think one of the issues the college has had has not been really about the Primary Care Review Group, which I think we have had a lot of influence on over the last five or six months, it is really how you implement locally, because the SHA work-streams were very silo-driven. The contribution of jobbing general practitioners from the college was not that great in some of the SHA committees, and so you had anomalies, for example in the Yorkshire paper, about who was looking after children and the emphasis on childcare. My concern is not about Lord Darzi's paper nationally, it is ensuring that we have more appropriate local implementation with very good, high quality clinical input, and that is where I would put my emphasis for the next phase.
Mr Pruce: I would agree with Steve. It is all about how well it is implemented. We are particularly concerned about how variable implementation is by PCTs. For example, the Pharmacy White Paper and Lord Darzi's review talk about minor ailment services through pharmacies, yet only 24% of PCTs actually commission those already. They are seen as something that should be a national service. When we went through the SHA vision statements we saw enormous variability and a lot of variability also about who was involved. Pharmacists were involved in very few of those groups, even though we tried to get on them. Just as one example, in the Staying Healthy clinical pathway three of the SHAs identified pharmacy as a vehicle for that, and yet Lord Darzi's review suggests that vascular health checks should be done through GPs and pharmacies; so there is a disconnection between the two.
Chairman: We may want to want to pick up on one or two of those things, David. Let me move on now. Peter.

Q7 Mr Bone: I want to ask a couple of questions about health centres, or polyclinics. The first one is what evidence is there that they will be more cost-effective at delivering primary care trusts than the existing model? Perhaps Professor Mays might answer that, please.

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Professor Mays: My reading of what is in the report is that actually what Darzi has put forward is not the original, as floated, concept of the polyclinic. If I understand it correctly, the polyclinic idea was bringing community health professionals and generalists from the community alongside hospital specialists in a single entity. What Darzi is proposing is what we call GP-led health centres, which are, if you like, extended primary care centres, both extended in terms of the range of services and professionals than you might normally expect in a typical general practice and extended in terms of extended hours. The question is more will this slightly different kind of primary care provide value for money? Darzi does not couch it in that way. The way he couches it is in terms of providing an alternative for patients to conventional general practice, albeit that GPs are now being told, or they make the contract adjustment, to extend their opening hours. This is a further addition to that accessibility and perhaps a different style, and essentially it is very much a New Labour idea of choice and competition. It is saying, "Initially, you can use these centres as a walk-in centre", so it is an extension of the walk-in centre concept where the non-registered person can just avail themselves of a convenient episodic bit of primary care, and then, "Over time, if you feel that that extended hours centre is where you want to go, you can enrol". The gist of it, again, is not so much cost-effectiveness as choice and competition, designed to generate improvements in quality and by putting pressure on the conventional general practice.

Q8 Mr Bone: You said something quite interesting there. Do I understand from that, you will not have to register?
Professor Mays: You will not have to register to use them.

Q9 Mr Bone: You will be registered with another GP?
Professor Mays: You will stay with your ordinary GP, and then the document talks about the probability, possibility, that you will then in the future, if you choose to, decide to transfer your enrolment, and I think that is something that the BMA will be quite sensitive to. It is very much the continuation, if you like, of the reinvention of the market, this time in primary care. We know it was considered at a much earlier point in the development of the post-2002 reinvention of the market that there would be some attention given to a market in primary care. The Government tended to say, "Let us deal with the hospitals for a start." This is the next phase.

Q10 Mr Bone: Can I stop you. I think the answer to my question is that there is not any evidence here that there is going to be more cost-effectiveness.
Professor Field: From the Royal College's perspective, we have tried to find some evidence and have not found any. That does not mean we are against large health centres.

Q11 Mr Bone: No, having cleared that point, that there is no evidence perhaps either way on that issue, I want to try and get my head around the concept, which Professor Mays started to talk about, of the health centres. We have walk-in centres now, and I understand that some hospitals have GPs at their accident and emergency. In my patch most of my GPs do extended hours and there is already a proposal to have a much enhanced new medical centre attached to what is, laughingly, called a hospital but it is not a hospital any more, but that was done before any idea of health centres came along and it was evolving in relation to local needs. I am not quite sure where these health centres fit into all those existing models.
Professor Field: There is a considerable body of evidence about the value of the generalist GP, family health centre, family practitioner, gate keeper role. From an evidence point of view, we know about the role of a GP, Barbara Starfield and others, and we welcome the investment, frankly, in primary care. In many of our inner city areas there has been very poor investment in infrastructure for many years. In many of our inner city areas there are insufficient numbers of GPs to manage the service. So, of course, as a college we have been plugging away, lobbying for more investment for many years. The problem with the polyclinic idea is not that large centres are not needed. If you look in constituencies adjacent to where I practise, they have been planning large centres and knocking down the big hospitals, moving to primary care for some time. This is not new. The problem seems to be that the investment, which is welcome, has been sprinkled down to PCTs and PCTs are implementing large, let us call them, polyclinics in areas where there is high-quality general practice, and they are not needed, whilst in other areas they probably need more investment. If I was to manage this system—and this is what we are saying from the college—we would say the investment is welcome but it is the implementation which is the problem, and perhaps there is still time to review that, to look at where perhaps we could invest better for patient care. The danger is that some good quality practices would be destabilised through this procedure. The danger is that some practices that need investment will not get it and will perpetuate, in some areas, the poor investment, the poor number of GPs that we have already got. It is quite a complex argument, but we do welcome the investment.
Mr Pruce: I think we also have to look at the wider impact of bringing GPs together into one place. Most of the polyclinics that are being invented have pharmacies within then, and we would certainly support that. However, most pharmacies are dependent on dispensing volume. They get maybe 80% of their income from dispensing. Our main concern is if you bring together GPs in an area, patients have to travel further, carers have to travel further and they are going to rely on the pharmacy much more. The local pharmacy is going to be their local healthcare professional. If you have most of the dispensing done in these polyclinics, that could make your local pharmacy unviable, so you end up losing

the local pharmacy as you have lost the local post office, the local parade of shops, and the knock-on effects for the local economy is quite significant, let alone the fact that patients and carers will have lost immediate access to healthcare advice and support that they increasingly begin to rely on. There is good in the ideas. How it is implemented is going to be quite significant, and, although Lord Darzi seems to have pulled back from the idea of the super polyclinic, we do not see that PCTs are pulling back from that and there seems to be pressure on PCTs to have at least one of these in each area.
Professor Field: Could I add to that? I do think it is a local implementation issue and solution, but I have been impressed by Lord Darzi in how he has listened to what we have been putting forward. As you know, we were working on what we called the "road map" two years ago and published it before this review was announced, and the federated model of practices, working together with large and small practices, is the way forward, and we have been pleased that during the consultation period, the development of the primary care part of the strategy, that has become much more prominent; but in order for that vision to happen (and we would welcome that because then you could target the investment to where patients need it) you actually need to say to PCTs, "Have you consulted with what is really needed? Do you really need to put in that walk-in centre or that large GP health clinic", or whatever they are called this week, "in that particular area?" I think there is time. Why is it being rushed? Why do we have to have implementation and procurement by December? Why can we not say, "Let us have another good look. Why do we not invest in some of the high-quality general practices we have already got in the areas where we need it? If you look at rural areas, why are we not using that money to invest in already built large centres to extend the services? Why are we not using that money to invest in community hospitals in those areas? I think this is a very wide issue that affects both rural and inner city practice.

Q12 Sandra Gidley: I want to pick up on the investment, because it seems to me, and correct me if I am wrong, that there is money available for brand spanking new GP-led health centres. If local GPs, to quote an example, want to use a community hospital to strengthen the use of a community hospital and work in some sort of federated fashion to provide services through them, maybe involving other local health practitioners as well, the money does not seem to be being allowed to be used for that, and I think Darzi himself has confirmed this. Does this not mean that this is all just a front, if you like, to bring in a greater element of the private sector or do you not see it that way?
Professor Field: You might see it that way.

Q13 Sandra Gidley: I was asking how you saw it.
Professor Field: I know you were. I think one of the dangers is fragmentation. The money, as far as we understand, is only for three years, I think. The problem is, on the one hand, in some of our inner city areas we found it very difficult to attract GPs to work. In some of our inner city areas, frankly, there has been a lack of investment in premises. So we support what Lord Darzi wants to do about investment. In other areas there has been quite a lot of investment, there are good community hospitals: why say there has to be one in each PCT? Why not say this money needs to be invested based on need? The argument is not with Lord Darzi, it is the local implementation of the policy we have concerns about.

Q14 Dr Stoate: I would just like to put on the record that, in addition to being a practising GP, I am also a Fellow of the Royal College of GPs, and I therefore know where the bodies are buried! I would like to ask you, Steve, whether you think that Darzi's proposals undermine the traditional gate keeper role of the GP?
Professor Field: The answer is, I do not think they do, the policies as a whole. I have been part of the advisory board since it was set up in November, and questions were raised then about the role of the GP, the role of the pharmacist, the role of nursing, and that is a big issue as well, and as we looked at the evidence, the evidence supported the role of the gate keeper, which is a cost-effective system, which increases the incidence of true disease presenting to specialists. All the evidence is about hospital outcomes being better if you have high numbers of high quality GPs. So, by the end of the review period, Lord Darzi and ourselves were at one over that. I think the question the Chairman mentioned about competition in the private sector is such that we also know that some quality of care is not good in some areas and, frankly, it is PCT's responsibility to do something about that. As a college we are involved in setting standards for practices and individuals, and we can highlight what is good practice, but patients, unfortunately, do not have the information to make choices. So, we do not think this is an attack on the role of the GP, it is actually the system, and how do you move influence and power to the patients so that they can make those two choices? I think that is the underlying theme. Put the money in, create a bit of competition so that patients can choose to go to the good practitioners. The worry is that that might undermine some of the good ones, but I do not think it is an attack on principles.

Q15 Dr Stoate: Good. I am pleased to see that the college's view on this is rather more measured than the BMA's view. I am very pleased with the constructive way you are looking at this. What I want to talk about is your federated health centres. You have already talked about that. I know that the college is currently consulting about your model. What I would like to ask is how the federated health centre model differs from what Darzi is proposing?
Professor Field: You have got to define what Lord Darzi is proposing, and he is proposing federated models of general practice; so he does not differ at all now. He talks about practices and pharmacies working together, and I would own this as well

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personally, having been part of the advisory board. The integration horizontally with social care, with nursing, is absolutely key for the future. Integration with specialist services is key. The only way you can really do that is by the general practices working together. Where the college has moved the agenda on is to say that, first of all, gone are the days where single-handed GPs should work on their own in splendid isolation. They should work by sharing clinical outcomes, by sharing guidelines, critical events, audit together. We have moved it on by saying that could be done much more effectively with terms of reference and terms of agreement and, in fact, then moving on perhaps to a far more integrated company or organisation across practices. What we are trying to do is say there are things that need to change, and the federation will allow individual small practices to survive but be able to use resources more effectively in the bigger centres. It will be able to share expertise. I was really heartened this week. I went to Croydon and met with the 14 practices in Croydon that have set up as a federation of single-handers and large practices. They have got leads for chronic obstructive pulmonary disease, for heart failure, for diabetes. They are sharing, not just expertise, but guidelines, and their next phase is to try and encourage the specialists, and some of them are not keen on coming out into primary care and there is still this difficulty with secondary care wanting to lose market share. They are encouraging specialists to work in much more of an integrated manner. So I have seen where we can go and I think the future is really, really bright.

Q16 Dr Taylor: For the record, may I declare that I have known Steve for rather a long time, because he was my houseman at some stage rather a long time ago. I want to come back to the GP-led centres, the 150, and the money available. I think I am right in saying there is £250 million available for these 150 GP-led health centres and 100 new GP practices. Is that right, and is that going to be anything like enough, or is that what is constraining things? I have tried to push to have three smaller GP health centres in my area, and there is not possibly enough to have three of these small ones as opposed to just one large one, so is it not money that is dictating that there has to be just one for each area?

Professor Field: I think the initial investment, the way I think it has happened is that the money has been allocated and, therefore, they have worked out how many centres could be afforded. As I have said all along, the college's position is we welcome that investment but it needs to be used appropriately. There is not enough money in order to change all practices and bring them all up to the standard that we would want. One of the ideas about the federated model is that we could start to look across geographical locations about how you use that money more appropriately. So in Wyre Forest you will have specific needs and you will have a specific small district hospital which might also need some investment in one way. We are saying one size does not fit all, but the role of the gate keeper is important.

Q17 Chairman: You said on several occasions, Steve, the issue about the PCT should see whether it is needed there or it should invest in need. How do you measure need?

Professor Field: Gosh, that is a very good question. I think there are a number of parameters that we as a college would look at and are highlighted, actually, in some of the papers. To start with, the number of general practitioners in a locality seems to have an effect on quality, from the literature. So you can look at those under-doctored areas—that would be one thing—you could also look at the infrastructure needs, but, of course, what really should happen is we should have a constructive dialogue with patients, the public and the local doctors and other healthcare professionals about what is needed in their particular area. There are some gross statistics which would be useful. Unfortunately general practitioners historically have gravitated, even before the Health Service began, to areas which might not be as challenging. There are some others, like myself, who go the other way, but how do you encourage GPs and pharmacists to work together with other healthcare professionals in very deprived areas and, conversely, in very rural areas, and need might be very different in those two different extremes?

Q18 Chairman: I am quite interested in this, because the Government put the first tranche into spearhead areas where there is disease about. My own constituency is above the national average in most areas of ill-heath, yet I have GPs complaining about the building of a primary care centre in the next constituency to mine. The pattern and spread of GPs has been around in the same way as it is now since, we assume, the last 60 years, and yet the disease burden in constituencies like mine is far higher even than in some neighbouring constituencies. I am not convinced that anybody is measuring the proper need, and that is the need of the patients as opposed to the need of the practice on the ground in my constituency, which I have some disagreements with, I have to say.

Professor Field: I would agree with that. In my own practice area, if you can survive crossing the busy road in two halves of the area, life expectancy is ten years longer in one part than the other, and so you can look at that. The workforce distribution is a health inequality issue, the make-up of the local population, the deprivation, is another issue, and these are the sorts of things that public health departments look at. Again, the investment is welcome, it needs to be targeted at need, and in some areas they want more investment.

Q19 Chairman: Do you think the Royal College ought to have some sort of matrix that says: this is the disease burden in communities and we need more GPs in these areas, because, looking round at

research in America, the more primary healthcare practices you have on ground the more likely the population will be healthier?

Professor Field: We do, and we have published a series of documents supporting that assertion, but it is the role of the local PCTs to make sure that they have appropriate numbers and appropriate buildings for providing primary care. It is their job. Our job is to highlight what the standards of care should be and highlight these anomalies. What we have been trying to do all along is provide solutions for SHAs, for the Government, for PCTs. What we are not doing, unless my message has not come across, is we are not opposing anything, we are saying investment needs to be targeted. Clearly, in inner city Birmingham that investment is very different to rural Herefordshire. There is a lot of deprivation in rural Herefordshire but how you handle that from a healthcare provision point of view is very different to where I work in Borsal Heath.

Chairman: I know, I am just sharing my frustrations with my own constituency and one or two practices, and only one or two out of many, that seem to be obstructed. What I believe they should do is to try and lessen the work loads of general practitioners in my constituency who are carrying patient groups with very high disease burdens.

Dr Naysmith: Can I just point out that a very distinguished Fellow of the Royal College of Practitioners, Julian Tudor Hart, pointed all this out many years ago. In fact, he gave evidence to the committee about it.

Chairman: He did.

Q20 Dr Naysmith: That was all laid out 50 years ago.

Professor Field: Absolutely. The inverse care law. If you go back in health policy, one of the problems we had was the Health Practices Committee, which limited the number of doctors. When that went it actually took the lid off the flow of doctors as to where they could go. Before that you had to make a case for where the GPs were. In fact, it is much more of an open market now. As a college we have made many statements about addressing inequalities by making sure there are enough doctors, addressing inequalities by making sure there is enough infrastructure. Where we are also with Lord Darzi, when you talk about how you need to change, in some areas, unfortunately, where there might not be the will to change, you do have to use different tactics, and we do accept that in some areas you might need to put in a health centre, even though your local practices do not agree that it is needed, if the health data shows that from deprivation, health outcomes you need more doctors there. I think we are brave enough to say that there are issues and you cannot just effect change always by consensus, but the way it has gone is difficult.

Mr Pruce: I think it is much more than just using general practice better, it is using all the tools we have, it is all the health professionals, and also getting information from them about the local needs. Most PCTs have undertaken a pharmaceutical needs assessment, trying to get at what are the needs of patients for medicines in a particular area. We know that there are health inequalities in the use of statins, for example, but very few PCTs actually take much note of these and take action as a result of it. So it is not just doing the needs assessment, it is actually using those to redirect services and commission better.

Q21 Mr Scott: David, you have just been talking about the very issue of the review's greater emphasis on health maintenance rather than illness management. How do you see pharmacists fitting into the new regime?

Mr Pruce: Pharmacists already do a lot around helping people stay healthy. A lot of pharmacies will get involved in helping people stop smoking, we are beginning to see obesity management clinics, and so on, and one of the things that Lord Darzi has proposed is that vascular health checks could be done through pharmacies. That is really building on one of pharmacy's key strengths: that we are accessible. We are not seen particularly as a "health" centre, we do not have the same baggage as going to see your doctor, people wander into pharmacies, including those that are well and those that are really hard to get, the young to middle aged men who do not go and see their GPs, yet smoke. I was in that situation, and I smoked for 15 years, but I bought a heck of a lot of cough medicines. So there are lots of opportunities to get to people like me. I have stopped now, I must say. We can also, though, help to free up general practice. We estimate that there are something like 51 million GP appointments for minor ailments, for conditions that could be treated through a pharmacy, that do not have any other complicating factors. That is something like 18% of all GP's consultations. If even a proportion of those were shifted from general practice to pharmacy, think of the amount of consultations that would be saved so that general practitioners could concentrate on perhaps more complex patients, patients who really need their attention and who cannot self-treat.

Q22 Mr Scott: But, surely, you are not suggesting that there should be fewer GPs and more pharmacists?

Mr Pruce: Not at all, no. We work very closely with general practitioners, but if you are going to shift care from secondary care to primary care, you also need to free up capacity within general practice, and what we suggest is that, where those patients could present either at a pharmacy or at the general practice for exactly the same condition, perhaps they should be encouraged to use the community pharmacy so that it does not take up valuable general practitioner time and we can then have a role in reducing the burden on general practice.

Professor Mays: Just an observation. When you start talking about vascular health checks, I think there is a question for the committee about whether that would be a really top priority for the use of resources. Cardio-vascular disease is in steady decline. The main focus, I had thought, was improving the quality of treatment through stroke centres, and so on, and making sure that everyone

got to a stroke centre. I wonder whether it really is the top priority for a universal screening system, irrespective of whether it is provided by GPs and pharmacists. I would not have said that the evidence is very strongly in favour of that. I have nothing against it, obviously, as someone over the age of 40 who may well need vascular checks, but given that it is something that is, I would say, a mainstream general practitioner responsibility through the current GP contract, it is being used as a symbol of the new wellness-focused Health Service, I am not so sure it is the most efficient symbol of a wellness-focused health system.

Q23 Mr Scott: Professor Field, do you accept that the 51.4 million GP consultations could be handled by pharmacists?

Professor Field: What you have got to look at in primary care is how you use the primary healthcare team. It is not just pharmacists and GPs. I think we need a radical review of nurse training as well, the role of the nurse in primary care, and actually the school nurse in prevention, which has been a recurring theme in the Darzi review, not GPs, actually in that instance. There is no doubt that the pharmacist's role can be expanded, because we know that the footfall in pharmacies is high and they can take on more of a preventative role and they have made a fantastic impact in general practice in medicines management in surgeries. We need to keep an eye on a couple of issues. One would be the evidence-base. On the one hand, pharmacies sell a lot of cough mixture. The evidence-base is zero on the effectiveness of cough mixtures for most of the public and, therefore, are you going to be actually increasing the national healthcare bill by giving out and prescribing things and getting people to buy things which do not work. That is my view on cough mixtures; just to get it off my chest! I would agree with everything else you said. General practitioners are highly skilled diagnosticians. We train for a long time, not long enough actually, and that is another issue in the Darzi review, and acquire high level skills. It is an important issue. What we need to do is concentrate the GP's time on managing all those complex issues. Consultations in general practice are too short generally now for the complexity of the individuals coming in, and I do think working more closely with pharmacists and nurses is important. There are other issues about pharmacy, about confidentiality in the shops, about being able to do the consultation in an appropriate way, which I understand pharmacies are trying to address. There are also issues about the training of pharmacists. We should not pretend that pharmacists are cheap, less trained doctors from a diagnostic management point of view. They have different skills and there may be something about their continuing professional development in order to be able to identify more serious disease: because one of the criticisms of GPs has been why do we not pick up cancer earlier? Why do we not do this, this and this? Actually, it is extremely difficult in primary care when you are seeing undifferentiated, what is called, minor illness, and that cough could well be an early sign of lung cancer. So I think pharmacists and GPs need to work for more closely together and, yes, the time of GPs does need to be freed up to manage any increase in the complex problems of ageing. I think we are not speaking in a different way on that, but it has to be based on evidence and guidance and pathways for the patient that we can work together on.

Q24 Sandra Gidley: I should declare my interest too as a Fellow of the Royal Pharmaceutical Society. A quick question for Professor Field. You mentioned the evidence-base, and I think you are quite right and that there is a limited evidence-base sometimes in the advantage of pharmacists, but would it not also be fair to say that there is a limited evidence-base to some of the things that GPs and doctors do? We have already heard from Professor Mays that people could be treated in completely different ways in different parts of the country. So it is a slightly unfair comment, is it not?

Professor Field: No, I think it is fair, because I would agree with you about doctors as well. What the college is trying to do is say we should be based on an evidence-base which should not just look at randomised control trials of drugs, it should look at social care and the effect on the person as a whole, and that is one issue you might want to talk about with NICE, the way they look at social care in the context of patients. So, yes, I would agree. Also, I think we need to be brave nationally to say why are we putting so much money into things which have no evidence-base. Homeopathy, for example, some of the alternative therapies, actually, cost money and the evidence-base is zero, so let us look what the evidence-base really means. Yes, hands up, we agree.

Q25 Sandra Gidley: Okay, that is a fair point. You talked a bit about co-operation. It seems to me that it is very patchy throughout the country, and, particularly if we are to make the best of GPs and pharmacists, there needs to be closer working. Professor Field and David Pruce, how do you see this happening in practice? I do not see any signs of it happening locally or nationally.

Professor Field: I think I can give you lots of evidence that it is happening at a local level. In Croydon earlier this week the person who came to say hello first was a pharmacist who was a partner in one of the GP surgeries who was part of that federation. In other areas they are looking at federating with pharmacies. In our own surgery we have a pharmacist working in the surgery helping us with medicines management. So there are lots of models, but I think at the moment it is a very diffuse sprinkling of pharmacies which have come out of shops, have they not, chemist shops, and the pharmacist's role is developing. Perhaps when we are planning local services, federations are a good example of how we can do that. We should be looking at how pharmacists work more closely locally with the GPs, about where they are located. We have tried to get a pharmacy actually right next-door to our surgery, because patients get mugged going to the pharmacy in daylight where we work.

We have a bodyguard working in the surgery. They get mugged, but we have not been able to secure investment from the PCT to build a larger centre adjacent to us to bring all the services in one. This is not just about professionals working together, it is about health service managers looking at how we co-ordinate services, it is about getting pharmacies more involved in practice guidelines and how things are taken forward with the patient at the centre. There is lots of room for improvement, but we need to build on what is good.
Mr Pruce: Unlike Steve, I do not think it is about co-location. We are in danger with co-location of falling into the same trap as we are with polyclinics, thinking everything needs to be in the same place. The relationships between GPs and pharmacists are good in lots of areas. In lots of areas they do not even know each other; so there are things that need to be overcome. One of the interesting things I heard from the recent King's Fund Report looking at polyclinics was that you can bring lots of different professionals together in one place, but that does not mean they are going to work together, and the effort needs to be put into how we get GPs and pharmacists, in particular, to work together. NHS Employers are setting up a working group to look at just this point. We have had success in facilitating meetings where perhaps GPs and pharmacists come together for education, for audit, for joint working on projects, and often it is getting that understanding of each other's roles, each other's gripes, the things that are acting as barriers that seem to work. I did one piece of work with some colleagues in Bromley and the pharmacists were to report back to their local GPs around prescriptions that had very little instructions on, and patients did not understand it. For some of those pharmacists it was the first time they had gone to their GPs with something that was clinical and was solving a joint problem. The relationships that were built up out of that have lasted for a long time and, in fact, one of the pharmacists ended up being employed by one of the GP practices part-time. It needs facilitating, it needs effort to go into it and it is a key role for PCTs to facilitate in that.

Q26 Sandra Gidley: Are PCTs doing any of this?
Mr Pruce: It is very patchy. Some are, but I would say the majority are not.
Chairman: I am conscious of the time. We are about a third of the way through the questions and about two-thirds over time at this stage; so maybe we can be a bit crisper on questions and answers.

Q27 Dr Naysmith: Can we turn to equality of outcomes, and we can probably be quite crisp on this because you touched on it in the early questions with the Chairman at the start of this session. One of our advisers was reminding us at the start of this session that way back in Barbara Castle's time there were documents that focused on outcomes, and more recently, when Frank Dobson was a minister in the early days of this Government, there were documents discussing outcomes, and the vision that we are talking about for primary care says, "Making services personal and responsive to all, promoting healthier lives and striving to improve the quality of care provided". Recently we have been concentrating on other things other than outcomes, on targets and so on. Does the review contain the right proposals for achieving this vision? Professor Mays, you have not had much chance to speak for a bit.
Professor Mays: Are we talking specifically about primary care or more widely?

Q28 Dr Naysmith: More widely?
Professor Mays: I think there are some good ideas in there. As your adviser says, this has been around for a long time. One specific thing I would comment on: the review tends to assume that you need to pay more for quality. They talk in relation to amending the hospital payment system, the *Payment by Results* system, that you might augment the national tariff for high quality. Of course, a lot of the evidence suggests that high quality costs less because you do not get repeat operations, you do not get readmissions, you do not get the cost of treating infection, and so on. So one of the things you might want to talk to the Minister about is to what extent you might use his proposals for national standard setting to say that you will not pay for things that are below standard. You might want selectively to pay more for quality, particularly in the early days of this policy, but if you take that to its logical conclusion, it is inflationary, it is potentially quite inefficient to assume that you have to pay a lot more than the national tariff for high quality. One of the things I would be pushing a little bit harder: if we really are serious about using quality measures as a way of influencing payment, either for general practice or for hospitals, would be to say, if we have got some standards we think are really important below which we do not think it is decent to fall, why do you not do as some American payers do and say: "30% of your patients received a quality of care or an outcome that we thought was suboptimal. We are not paying for that 30%. We will pay for the other 70%"? It would be quite a tough discussion, but if you really are paying for results, given that we know that better care is not always more costly, you have to think carefully about the incentive effect of paying for quality and how you do it best.

Q29 Dr Naysmith: That also implies that you have to have some way of measuring quality of outcomes, and that is going to cost money as well.
Professor Mays: It is. A lot of the things that are being discussed are, if you like, commonplace in the research that people like me do—we have been measuring patient experience, patient satisfaction, health-related quality of life, clinical effectiveness, symptomatology, for 25 or 30 years, often to the incredulity of practising clinicians, who say, "Why are you doing this?" We know that the aftercare is good, we know our patients get better and people like us say, in return, "Show us, prove it."
Dr Naysmith: You probably assume that because they do not come back they have been cured, but that is not always the case.

Q30 Jim Dowd: They could be dead!

Professor Mays: Yes. So the proposals in Darzi on quality measurement are a triumph for health service research and the application of social science to health services. People like me would applaud it. It has not been done routinely over 100% of patients in all areas of care ever, so it is a huge task to move it up from a research activity to a routine, relatively low-cost, high take-up activity. This is the other thing. Response rates need to be decently high, particularly if you are then going to relate resources to those patients' responses. You are going to need 70-80% responses to patient reported outcome questionnaires, for example, and there are some quite interesting dynamics when patients say, "Actually I have had my care. I am out of the hospital. Thank you very much for the care, but I do not particularly want to fill in these forms and post them back or go online."

Q31 Dr Naysmith: Professor Field.

Professor Field: I would support what Nick says. What I would say for primary care at the moment is the QOF, which is a series of proxy measures of quality, is making a difference. There are papers in the pipeline showing it is starting to address some of the inequality issues in the provision of care, but it is how we move to those outcomes, and I think the paper does not go into the detail because you need expertise outside to help us develop those outcome measures.

Mr Pruce: I would lay down a query over the metrics and the development of metrics. I was involved in a number of the national audits that Royal Colleges have developed, including one on evidence-based prescribing in older people, and we found it very difficult to come up with measures of good prescribing that could be measured. I have here a previous consultation on performance indicators that had hundreds. Most of them did not actually get to outcomes and were what was easily measured. They did not measure true outcomes. The problem is, if you end up measuring the wrong thing, you skew healthcare, and I am very cautious about these metrics that are being developed.

Q32 Dr Naysmith: There is also a lot of talk about providing personalised healthcare plans and personal budgets to improve patient outcomes. Is the NHS equipped for this kind of innovation?

Professor Field: No. I, as well as the advisory board, are pushing hard to pilot the budgets, because there is evidence in social care that if you empower the patients to make those decisions, they make much more cost-effective and appropriate decisions based on what they really need. I felt it was something we should try for long-term conditions.

Q33 Dr Naysmith: So there is evidence for it.

Professor Field: There is evidence for social care, but we have not done it, for all sorts of reasons, for healthcare here in this country.

Q34 Dr Naysmith: Would you be willing to try it?

Professor Field: Yes, from a college's point of view we have debated this, and we support piloting that to see how effective it is but putting an evaluation around it—just sprinkle it out and wait and see.

Q35 Dr Naysmith: So the plan will be discussed with professionals and then money would be given to the individual to go and purchase the care from somewhere?

Professor Field: Yes, and I think that needs to be done---. When you have got a long-term condition, you have got health and social care needs and what your needs as an individual would be would be very different to yours and, therefore, it needs to be built into a project where it is evaluated so that we can learn the lessons.

Q36 Dr Naysmith: Do any of you have anything to add?

Professor Mays: Just that there are many different ways of doing it. You can actually hand cash over and say, "Go forth, here is some information", you can give people a budget and say, "From a range of services that we specify, what would you like to choose?", and you can say, "Work with your principal professional adviser to deploy a budget". So there is a spectrum of degrees of freedom, degrees of direction, degrees of information. To be fair to Darzi, I think he presents that as experimental and he says we are going to pilot it, so I think that is spot on. It seems to me it is robust innovation and, if they wait until the pilots have been evaluated, that would be a welcome innovation.

Mr Pruce: I would agree with that, but we find that lots of patients have difficulty navigating the Health Service, possibly more than they do social services. So it would be right for some people, but some people would find it incredibly difficult to navigate and to work out exactly what they do need, particularly when it comes to medicines. I think doctors and pharmacists have enough difficulty navigating medicines. So the expert patient will benefit from it, but it does need careful evaluation before roll-out.

Q37 Sandra Gidley: Professor Field, you just mentioned the QOF, but the review proposes "a new strategy for developing the quality and outcomes framework, which will include an independent and transparent process for developing and reviewing QOF indicators". I would like to ask you to start with, what evidence-based interventions you think would incentivise improvements in prevention?

Professor Field: It is a very hard question. I can talk about the policy of where we are, and the policy is important, because I chair the expert panel for QOF now and our expertise comes from the University of Birmingham and Manchester and elsewhere. What we are frustrated about is that when we find evidence and that goes forward to the negotiators between the employers and the BMA, always the evidence-based interventions come out and sometimes there is pressure from both sides. So, from a policy point of

view, we would support it becoming more independent. We are concerned about NICE because the track record with primary care is not great. The guidelines that they produce for primary care are not implemented by GPs across the country.

Q38 Sandra Gidley: Is that because they do not read them?
Professor Field: As well as the SIGN guidelines in Scotland, partly because there is so much to read when you go into the surgery. You have to force your way through the door behind NICE guidelines, but SIGN guidelines, with more college activity in Scotland, are used by GPs more. So from a policy point of view, we support NICE doing that, but they need more college input. We support independent advice, and what I would say to your question directly is we would have to base it on what the evidence is, and I am not an expert on the evidence, so I would seek advice on that.

Q39 Sandra Gidley: What you seem to be hinting at is that what we have at the moment is not really based on evidence.
Professor Field: A lot of it is based on evidence, some is not on as hard evidence. Some of the indicators which have better evidence have not been allowed into the QOF, and, as you are probably aware, we are piloting nationally a practice accreditation, provider accreditation system. Alongside that, we are also piloting some of the indicators. One of the problems is that when indicators and ideas are put forward, many times they are not actually evidence-based because they have not been piloted to see what the effect will be. So, what we are advocating is a more evidence-based approach to it, and why we are supporting NICE working with the college and academic bodies is to make sure the QOF is based on evidence. The other problem with QOF, of course, on prevention, is that it is too great a proportion of GP's pay. What it needs to be is a lower proportion so that you can really start to look at how you influence change.

Q40 Sandra Gidley: Professor Mays, you were nodding at one stage.
Professor Mays: Was I?

Q41 Sandra Gidley: Involuntarily obviously.
Professor Mays: To be fair to the architects of QOF, on the spectrum of health policy it was one of the more evidence-influenced policies that one has seen, but, as you say, because we still have a national GP contract, it is always going to be an industrial relations issue as well. They can invent an independent panel that will review the evidence and suggest measures or proxies that can be used to pay GPs and practices to their heart's content—after all, that is sort of what happened before, as Steve was saying, Birmingham and Manchester Universities were feeding in information about indicators—but then it is an NHS Employers versus the BMA slug-fest as to how they appear in a contract.

Q42 Sandra Gidley: We have some nodding here.
Professor Mays: And, ultimately, because it is turning these evidence-based indicators into hard cash, the BMA will be looking at what effect is it going to have on the distribution of income across practices, for example, never mind the health benefits—that is a separate issue. Unless you can completely recast the IR side of this, and maybe you could, maybe you could say, "Actually we are going to use QOF-like contracts, but they are going to be local contracts, we are not going to have national bilateral negotiations any more."
Professor Field: There is an issue on QOF about the content. When we move towards provider accreditation, the management parts of QOF, there are ways we can move management out and focus on more prevention and on healthcare itself, clinical care. I think Nick is absolutely right, the problem is the inevitable negotiation between an employer and a union, and what we have got to try and do is make sure that this is based on what the patients need to improve the quality of care. The problem is, if the percentage per income is so great, it makes that much more of a hard bargaining between employer and union. That is one of the problems.

Q43 Sandra Gidley: I was going to ask what could be dropped from QOF to provide preventive care. Would the answer be management or is there more to it?
Professor Field: I think management will have to move out eventually, but as a college with the BMA watching—

Q44 Sandra Gidley: They are up in Scotland. Do not worry about that.
Professor Field: It is not our responsibility to get involved in terms and conditions of service. We are involved in trying to improve the quality of care for patients. It is for others make those decisions.
Professor Mays: One thing which would be good in principle would be that at the moment, as I understand it, historically the weight given to different indicators in the QOF is related to their workload implications, rather than their ability to improve health or reduce inequalities or improve patient experience. It would seem to me one sensible thing one could put into the negotiations would be that to pursue the logic of the evidence-base you would pay more for things, consistent with Darzi's notion of paying for quality, that were more health promoting, irrespective, in a sense, of the workload implications. Up to now people have basically calibrated the QOF points on how much staff time an activity would take rather than whether it is a good thing or not. It is understandable, and I would do the same if I were negotiating for the doctors. I would be saying, "Yes, but how much is it going to cost me?" From the NHS point of view I would be asking, "How much health gain am I going to get?"

Q45 Dr Taylor: To Steve and Nick. How good a measure of quality are PROMS?

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Professor Mays: In the research environment, with some development work that has been going on in the last few years, it is still, if you like, a nascent industry and, of course, it has largely been applied in surgery, but in terms of validity, very good.

Q46 Dr Taylor: Even though I think you said earlier many people do not bother to fill in the surveys and forms?
Professor Mays: I said, I think, that maintaining a high response rate is going to be a real challenge when we do it on a routine basis outside research studies. As to how they are going to be administered, presumably they are going to be administered by the providers themselves, (or is it going to be an independent agency that collects the data?), I do not know, but response rates become critical when you start allocating money based on those responses.

Q47 Dr Taylor: So, in theory, good?
Professor Mays: Absolutely fantastic.

Q48 Dr Taylor: You also mentioned that you thought that where quality was not high people should think of paying less. Can PROMS data be translated to payment by results?
Professor Mays: The implication is that a range of quality measures, not just PROMS would be used to adjust payment—so if it was a hospital or a speciality in a hospital—different measures could be used to generate some sort of index. So you might have some weight for patient experience, some weight for the PROMS by results, some weight for other more conventional effectiveness measures like readmissions, and you could generate some kind of quality index which you could then use. So PROMS would be part, I suspect, of an overall measure of quality. Of course, the big argument would be: which dimensions of quality and which measures do we include and how much weight do we give to each? I can imagine that would be a fascinating dialogue when you start using to it drive resources.

Q49 Dr Taylor: Has it been done anywhere?
Professor Mays: It has been done to a small degree in the States by certain health payers, it has been talked about a lot in the States, but to give you an indication of how far England is intellectually at the cutting edge, when the QOF was developed in the GP contract, the amount of interest from the US was absolutely enormous. So, once again, we are being heroic in health policy. We might not be great at implementation, but by golly we have plenty of good ideas.
Professor Field: I do not think you should underestimate the effect of the QOF on changing the culture in general practice. On the union, the BMA side as well as the college, it has made a real change across the board. The problem we have is that patients do not know what is good and what is bad and what high quality and what is not high quality. So it is not just the PROMS, which I theoretically I know the research is there, but in primary care it is not there. What is important to do very quickly is to give as much information to patients as possible in as digestible form as possible so that patients can make a real choice about the quality of their care and where to access it. I think that is one of the big problems in the system, and that does come out throughout Darzi's papers. It is high-quality service, cost-effective service, but in order to do that, you need to tell people what is high quality. That is something we need to work on with NHS choices, as we are with Dr Foster.
Jim Dowd: Can I start by declaring an interest. I am not a member of any Royal College of any kind whatsoever!
Sandra Gidley: That is a lack of interest.

Q50 Jim Dowd: It is disinterest as opposed to uninterest. I want to test something that Mr Pruce and Professor Field were saying earlier. For years pharmacists have been regarded as an unused resource in primary care. In response to an earlier question, the question of whether 50 plus million consultations could be avoided if pharmacists were used more actively, which my colleague to my immediate left here tells me would be something like one in six of all current consultations, is not the problem a structural one without co-location? Unless you change the gate keeper and say to patients, "Look, do not come and see me next time. Go and see your pharmacist first and, if he or she refers you on to me, then that is fine", where they are not on the same side, does that not become extremely difficult to achieve?
Mr Pruce: If I can respond to that. Pharmacists already do this. It is down to a patient whether they see a GP or whether they go to a pharmacy and treat themselves. We saw a rapid increase in the number of people coming to pharmacies, particularly on Saturdays when GPs surgeries are closed at weekends. What we do is we talk to a patient, talk about their conditions. We try and work out: is this something where the patient can treat themselves or is it something more serious that needs to be referred on, and we refer on to GPs where necessary. You do not necessarily need to know of a GP. If patients go on holiday and they go to a local pharmacy, we will still refer them back to their GP, who may be hundreds of miles away. So, yes, it is better if you have a relationship, but that does not mean co-location. As I have mentioned before, the King's Fund Report suggested that co-location is not the answer to everything and does not mean relationships work any better necessarily. It is about one professional being able to make a judgment on whether it is safe for this particular patient to treat themselves or if they need to be referred to someone else.

Q51 Jim Dowd: But the Saturday issue you raise will, of course, be addressed by GP-led health centres, which will be open on Saturdays and Sundays.
Mr Pruce: Hopefully, yes, but people still choose to go to a pharmacy, they choose not to wait for an appointment with the general practitioner, they choose not to disturb the GP.

Q52 Jim Dowd: Or else they end up inappropriately at A&E?
Mr Pruce: Absolutely. What we want is the most appropriate health professional seeing the patient and referring if necessary; so that could be achieved through a national campaign. If you have these sort of symptoms, check it out with your pharmacist first, which is what NHS Direct is tending to do, to refer patients with minor conditions to a pharmacy first so that they can then assess the patient and refer on, again, if necessary.

Q53 Jim Dowd: If pharmacists were able to prescribe, would that not save even more time?
Mr Pruce: I would argue pharmacists can prescribe, because we are able to supply medicines that no other healthcare practitioner, apart from a doctor, can. There is a group of medicines that can only be supplied through pharmacies. If there was a national minor ailments service that had a set number of medicines that pharmacists could supply on the NHS, that would be incorporating pharmacists much more into the NHS Service. We have a number of pharmacists that can prescribe. It is about 1,000 so far.

Q54 Jim Dowd: Out of?
Mr Pruce: Out of 47,000.

Q55 Jim Dowd: It is not a great proportion.
Mr Pruce: Not yet.

Q56 Jim Dowd: You look quite animated, Professor Field. I am not sure whether you want to add something.
Professor Field: I am just interested in the debate.

Q57 Jim Dowd: That is why we are here, of course!
Professor Field: There are two issues. One is about the patients. Inevitably, as healthcare becomes more complex and technology advances, we will be able to produce much more of a rules-based system for a lot of the care we are providing now. Inevitably, the emphasis will move from not having to see a specialist through to being managed by a generalist, to being managed by a pharmacist or a nurse where appropriate, to the patient taking care for themselves. We can see that with diabetes. Everybody died early in the early 1900s because we did not have insulin. When insulin came in you needed endocrinologists to manage them all because it was so difficult. Now, particularly in the States—we do not quite have it here yet enough—insulin pumps and managing your own sugar provides fantastic care, better care than having to go to see an endocrinologist at interval. I predict that patients will inevitably, over the next years, be moving more towards managing their own care with advisers, and that should be a pharmacist or a doctor where appropriate. GPs need to be freed up spend more time with more complex problems. We are skilled diagnosticians and risk managers. Pharmacists have different skills. We would support prescribing from an evidence base on some conditions. We do not want to move radically to what they are trying to sell very hard in America, which are things like the Minuteman Clinics, where you have, say, ten conditions or 20 conditions, and where they give antibiotics out for ear infections or sore throats. They call that access; we call it lack of evidence. There are all sorts of sexy things you can do about access for patients, but they have to be based on evidence. That is where I think pharmacy and general practice are coming from absolutely together. We have supported prescribing at pharmacies right from the start.

Q58 Jim Dowd: The main thrust of this section is about choice and trying to identify choice. Professor Field has talked about managing care packages. That is all based on information and knowledge. The review advocates the introduction of patient involvement in this, but Lord Darzi has stated that this does not mean specifying an individual practitioner either at GP level or at consultant level. If that does not exist, how real is the choice likely to be? How do we give people enough information to exercise informed choice?
Professor Mays: Threaded throughout the review is a whole lot of proposals about extending information available to patients and to health professionals. The report talks about augmenting the NHS Choices website and NHS Evidence which is like an encyclopaedia of what we think we know. In that sense I would say the review's heart is in the right place. It is very much about saying that we must provide more and more accessible, more palatable, more digestible information, both for professionals and for patients. The assumption, also, which I think is good, is that professionals in a sense are under informed, given the range of things they have to do. I suppose the real practical question is how soon would the vast majority of the population become familiar with these databases and with these information systems and be able to use them. Certainly, reading Darzi, I gained the impression of a world in which health professionals and patients and prospective patients are quite familiar with spending several hours every day sitting down at a computer, reviewing graphics and bar charts and diagrams showing them how good things are or what is the best way of doing things. It is a lovely vision of a rational consumer world but it did not seem to me to tie in quite with how you feel when you feel ill, and whether you are going to be in that position. It did seem to me, again, a very worthwhile social experiment to see whether the English Health Service can really use new technology and the distillation of what we think we know in a way that other health systems have not done. I notice that we do have quite good information systems and quite good databases and so on, and we are trying to use them in a more creative way than some other countries, so maybe we have made a reasonable start, but you can be sure, from what we know about the various pilots in hospital choice, that support and interpretation of data for people making choices, particularly when they are distressed or sick, is really, really important. One of the things, for example, that the London

Patient Choice Pilots did three or four years ago was to provide what they called patient choice advisers. Some people rather mocked that and said, "This is a new health profession that we are creating," which is an appropriate criticism, but all of this information needs to be interpreted. That may be provided through some sort of expert system, where the patient can sit at a screen and touch the screen and listen to people attempting to explain what these differences in MRSA rates mean in terms of the odds that you as a patient will come out of hospital with an infection. I have no doubt that with new technology we can do that, but I suspect that we will also need to provide opportunities for people to have a conversation with a human being about whether these data are credible, whether they are meaningful. Obviously one response is to say, "That's why people have GPs"—and maybe pharmacists and others—"in a primary care team." So, as well as the websites and the portals and all the sorts of things that Darzi talks about, there is the question of the human professional and advisory time and effort that would be required in this new world. I am not saying it is not going to be worthwhile, but support is a big part of it, because we do know that making choices can be quite stressful. Darzi describes choice as intrinsically good in all situations, whereas we know that it is not always particularly easy. When choosing which mobile phone company to go with, I do not find that stress-free. I find it bewildering and irritating, but if I was also sick at the same time, I think I would want someone to talk to as well as going to the requisite portal.

Q59 Jim Dowd: I accept that explicitly. One of my local GPs who was talking to me once said that the internet was effectively the hypochondriac's charter, because people go on there, find something and say, "That's what I've got," and go in and say to him, "Look, this is what I've got," despite evidence to the contrary. Is the point not the final point you were making, that the issue of choice in itself is a good thing even though it may risk—as the expression has it—a suboptimal outcome. Even if the professional knows that the exercise of that choice will not be in the patient's best interests, if exercising choice is an end in itself then we will just have to live with that. Is that right?
Professor Mays: If you are doing a detailed textual analysis of Darzi, I think you might find there is a little bit of tension in the document between to what extent we are encouraging choices from a menu of evidence-approved treatments and procedures on some NHS website or whether we are encouraging choice, which includes, as you say, a preference to do things which are not necessarily indicated. When it comes to the point of treatment, the Darzi review tends to assume that you will be in some way limited by the evidence on outcomes. In terms of choosing your GP, for example, there is more of a focus on having a plurality and, essentially, letting competition generate information for patients that ultimately they can judge, so that it is not entirely constrained. But I do think there is a tension.

Q60 Jim Dowd: Finally, is there any evidence that increased choice improves quality of outcomes?
Professor Mays: It is limited. The problem we have at this point is that the evidence is mostly from systems not like the NHS, so they are not universal tax-based systems which have, also, a strong emphasis on equity. The way we introduce choice in the English NHS as a requirement at the point of referral, for example, to a particular range of providers, reflects our concern to make sure that it is a fair choice and that everyone can participate. The systems that have a lot of choice in them are not like the English NHS. I think it is very hazardous to extrapolate from other more pluralistic systems to the NHS, although the NHS itself is becoming more pluralistic and there is more *de facto* choice.

Q61 Jim Dowd: Shall I take that as a no, then?
Professor Mays: You can take it however you want.

Q62 Jim Dowd: So what value is it?
Professor Mays: It suggests that there is a degree of doubt. You cannot uniformly assume that choice will improve outcomes. I think it is assumed in the Darzi document that choice is intrinsically valuable and that it puts professionals on their mettle and, thereby, they will improve quality.
Professor Field: It does depend on what you mean by choice as well. The individual patient will have choices about being treated and not being treated—which we forget.

Q63 Jim Dowd: But that exists now, patently.
Professor Field: Often healthcare professionals want to do what they perceive is best for that patient. The choice might be that the patient does not want anything to happen and that is not explicit in the communication with the patient. It is far more than just which hip surgeon you refer to in which hospital and with which MRSA rate. It is whether you know when you go into a surgery or to a pharmacy that you can access emergency contraception; or whether you know when you go into that surgery that you are going to have an unbiased discussion about termination of pregnancy or whether you know somebody is going to try to do something. It is much more than referral to secondary care. It is so important that we put the focus of care on the patient. From a college's perspective, that is why we are pushing very hard for the federated model of different practitioners working together, why we need an integrated care model. Just choice because it is competition might not be the best for the patient.

Q64 Dr Stoate: Do you think Darzi's creation of integrated patient pathways really will improve co-ordination between primary and secondary care?
Professor Field: I think we can already see evidence on the ground in Bolton, with the management of diabetes. I can give you lots of examples of how that can work and we need to disseminate good practice—so, yes.
Dr Stoate: That is what I wanted to know. Thank you.

Q65 Dr Taylor: Is Darzi introducing unnecessary layers of bureaucracy in trying to achieve clinical quality? With the Coalition for Better Health; quality accounts; quality boards; national quality frameworks; quality observatories; modular credentialing, is this going to achieve what previous work has not achieved?
Professor Field: I do not know.
Mr Pruce: I do not know. The devil is in the detail. It is how it is implemented.
Professor Field: We need to do something to reduce the variation in care. In some parts of the country, primary and secondary care is the best in the world; in other areas, it is not, it is third world. We need to improve the quality of care across the board, trying to sort out where care is not good and try to use some of the good things that are happening and disseminate those across the rest of the country. If those structures do that, fantastic. The jury is out.

Q66 Sandra Gidley: Does anybody have a clue how world-class commissioning differs from practice-based commissioning and if either are properly achievable? Complete silence.
Mr Pruce: We would like practice-based commissioning to be world class. At the moment it is not.

Q67 Sandra Gidley: What does it mean?
Professor Field: If you take the words out, it means that if you could try to provide high quality care by getting general practitioners and other healthcare professionals, including specialists, to design those pathways of care that you need, then that is going to be a success. For me it is moving towards a more integrated model, as Howard was suggesting, I guess. How do you plan the pathways of care for the patient, recognising that patients have complex problems? For me it is not just about buying appropriate operations from X, Y and Z; it is about putting the patient at the centre and trying to provide the best quality care. If that is world-class commissioning, fantastic. Practice-based commissioning take-up has been patchy around the country, partly because GPs, many of them, do not understand what it is; partly because we hear through the grapevine and our networks that PCTs think they are losing their influence if they hand over commissioning to groups of healthcare professionals. That is all tied up with the argument of who provides the care. I think one of the things we need to do is to work very carefully on how we implement, based on what is needed locally. All of the Darzi review—and I would support the thrust on quality, as I said before, and on clinical leadership which we have not mentioned—has to be about the quality of implementation. I do believe that with this document, or four documents—we have not talked about the NHS Constitution, which I think is an excellent document—how we can get that implemented locally is key. I do not think at the moment we have the quality of clinical or managerial leadership to make it happen. That is what really worries me.

Q68 Sandra Gidley: To sum up: locally delivered, local use of a range of health professionals to get an overview, but ensuring implementation.
Professor Field: Absolutely. The thrust for commissioning is right, but moving towards integration, I believe, over time.

Q69 Sandra Gidley: Is there any agreement or disagreement on that?
Mr Pruce: Practice-based commissioning is an unfortunate term because it suggests it is only about GP practices. I think it is beginning now to move away from that, and recognising you need all the players involved, including patients. We need patients. We need all the professionals who are likely to be able to be involved in commissioning, involved in those groups. Very few have done that yet.
Professor Mays: It seems to me that the improvement and the effectiveness of commissioning as an activity in the Health Service partly depends on what happens on the supply side. It partly depends how much either contestability or competition there is. Why people often say that commissioning is the weakest link in the NHS is that commissioners often have very limited room for manoeuvre. Typically, until very recently, they were confronted, for example, with a local hospital that was virtually a monopoly and with strong political and popular support. Therefore, even if the evidence or their own priorities or their own consultation suggested they wanted to change the pattern of care, if that in any way affected the viability or integrity of certain aspects of that hospital they found it extremely difficult and did not get much support from within the rest of the NHS hierarchy. I think we are moving towards a messier, more pluralistic, possibly more costly, supply side, with a lot more duplication. I think that is part of a deliberate long-term strategy, maybe to make commissioners lives a little bit easier—because if they have very little choice as commissioners, they are also very handicapped. Yes, by all means build up their capability, but do not forget they need to have some options on the supply side.

Q70 Charlotte Atkins: Mr Pruce, your society has very much welcomed the speed up of the NICE appraisal of drugs, but what implications does that have for the NHS in terms of extra costs. Your society made the comment that the "NHS must approach these issues with its eyes wide open". Would you like to expand on that and say what you think the implications are for the NHS?
Mr Pruce: If you speed up the appraisal process, it means that medicines that are highly innovative are likely to be available to patients quicker. That is a good thing. If NICE is able to speed up its processes so that decisions are made, you will not have patients waiting for years and possibly ending up challenging PCTs over the funding of them. We have to think carefully about the balance between highly expensive innovative medicines and, if you like, the bread and butter medicines that are used for the majority of patients. You do get a potential skewing towards the highly innovative new medicines. I have

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worked in the Health Service for many years and had to manage complex, strict drugs budgets that could be skewed as soon as a new medicine came out. The NHS needs to come to some decisions over what it is going to fund and what it is not. It is a very difficult area to make decisions on.

Q71 Charlotte Atkins: But will it get rid of the ludicrous situation we have at the moment with Lucentis, where you have people potentially going blind because PCTs are unwilling to bite the bullet and say, "Yes, while we are waiting for NICE to change its guidelines, we will fund the extra amount to fund those drugs." You have people there who are desperate, perhaps, to pay themselves, even when they cannot afford it, because they are worried about the time span and the fact that they are likely to lose their sight.
Mr Pruce: Absolutely. That is why the decision process should be speeded up, so that people are not waiting for years for a decision on that. They can plan, and if it does end up that NICE says no then they can work out if they can afford to fund it themselves and what the implications are. But to be in limbo is the cruellest possible thing to happen to a patient.

Q72 Charlotte Atkins: Will it help ensure that pharmaceutical companies reduce their prices?
Mr Pruce: That is something for the Government to deal with in its negotiations with the pharmaceutical industry.

Q73 Charlotte Atkins: With Lucentis we have this issue about a deal; that if it is not effective, the NHS does not pay. Do you reckon it will have more of those sorts of deals?
Mr Pruce: I certainly hope so. It sounds like a good deal for the NHS and it suggests that the pharmaceutical companies are very confident in their products.
Charlotte Atkins: Thank you.
Chairman: Could I thank all three of you very much indeed for coming along and helping us with our inquiry this morning.

Witnesses: **Professor Adrian Newland,** Vice-Chairman, Academy of Medical Royal Colleges, **Mr Niall Dickson,** Chief Executive, King's Fund, and **Mr Nigel Edwards,** Director of Policy, NHS Confederation, gave evidence.

Q74 Chairman: Welcome to our first evidence session on looking at the National Health Service Next Stage Review. Would you introduce yourselves and the position you hold for the sake of the record, please.
Professor Newland: Adrian Newland. I am President of the Royal College of Pathologists but I am representing the Academy of Medical Royal Colleges today.
Mr Dickson: Niall Dickson, Chief Executive of The King's Fund.
Mr Edwards: Nigel Edwards, Policy Director of the NHS Confederation.

Q75 Chairman: Perhaps I could ask a question to all three of you. Very briefly what are the strengths and weaknesses of the review? What input did you have into the Next Stage Review as individuals or institutions?
Mr Dickson: In a way, one of the greatest strengths is a negative, which is that there was no top-down reorganisation and no dramatic change in direction. Either of those things would have been a disaster for the Health Service. The fact that they have embraced information and seen that as a key driver of quality and the emphasis on quality will be widely welcomed throughout the service. Enshrining choice where it is appropriate seems to me, again, an underlining of a trend that was already underway but is a positive one. Finally, a clear signal that responsibility for shaping the quality of care is going to be or should be led by staff at local level. On the weaknesses side, the first question is, I guess: How much is all this going to cost?—a question that one of the earlier witnesses asked. I know Lord Darzi has said that there will be some costs to cover the national bit, and he is going to reveal that in time, but they have not done that as yet. I am still slightly cautious about his notion of clinical engagement. I think the rhetoric is absolutely there. A real effort was made during the review to engage forward-looking clinicians, but I do not think we should con ourselves into believing that the whole of either the medical profession or, indeed, other professions are all now absolutely engaged and onside on this, and have read the report and are part of this movement. I think we have to keep a sense of realism. Part of bringing about change is getting hold of those who are engaged and getting them to lead the process through. It is not so much a criticism as a warning that we can convince ourselves that everybody is all into this and is driving it forward, but I do not think there is evidence of that yet. I have a slight worry that there are—inevitably in a document like this—some contradictions, and particularly around the national/local side of things. In the first place, we have the ordering of health centres—which, again, came earlier in the review—that we will have a health centre in every single PICT area. That is classic top-downism and yet we are told that classic top-downism is all over now. Likewise, I have a little concern around the way that they are looking at taking on leadership. There seems to be a concentration at national level. Again, I have been assured that it does not mean that at all, it just means there will be a lot more money for it, it will be devolved through the system, but I think we will have to watch that. Likewise, of course, there are quite a lot of new powers for SHAs and their relationships with primary care trusts. If they go on being what they have been in the past, traditionally, which is performance managing, very much a stick beating the system, then the NHS will continue to do

what it has always done, which is look up the system. We desperately want to stop people looking up the system. We want to start making them look out towards their patients and to the local public. That leads me to my final point, which is that I think there is still something around local accountability. There are some welcome adoptions of some of the suggestions which came out of the Local Government Association Commission, which I chaired and which Richard sat on as well, but I think they could have gone further. I am slightly worried that they will talk the talk. We need to move towards a situation where members of the public know what a primary care trust is—changing their name will help—and that they understand what these people are doing, the amount of public money, their money, they are spending, and the kinds of choices that they are making at local level. I am not sure there is enough in this report to drive that forward, but there is an opportunity within the consultation to do that.

Professor Newland: We were certainly pleased that many of the building blocks that Darzi proposed to develop quality are areas on which the colleges and the Academy have worked quite a lot over the last two to three years. In terms of the input from the Academy: of the 2,000 clinicians that Darzi has talked about consulting, a number were our members. The Academy was also involved with the colleges at a high level in terms of discussing with Darzi what we were doing and what we wanted to do, but I think there was a gap in the middle with the involvement of the colleges in developing some of the areas to take this forward. I think that is a gap in the Next Stage Review: it is strong on aspiration but fairly light on the detail of how it will be achieved. I think we, like Niall, are worried about the disconnect between what happens at a local SHA level and what happens nationally. We are worried that consistency of standards may not be spread out across the SHAs, because SHAs may have different aspirations. We would certainly want to have more input into using the colleges' influence and the Academy's influence to try and homogenise those quality standards across the SHAs and point out where there are differences and how we should bring those all up to the same standard.

Mr Edwards: I would agree with that. We did a piece of work with the Joint Consultants Committee, which is the Academy and elements of the BMA, about a year ago, looking at what the medical profession and managers thought a reformed healthcare system would look like. We discussed that with Lord Darzi. Much of what we were being told was needed, is in his report. Most of it relates to systems to measure quality, and quality that matters to patients and clinicians rather than to external performance managers and regulators, so that is very welcome. In terms of weaknesses, I guess one of the issues is that, because this system very much relies on information of quality and professionals responding to the signals which that sends them—although there is a lot of emphasis on patients doing that, the international evidence is that it is largely going to be the professionals, as they are competitive and often want to strive to do better, who will respond to that—that takes time, because many of the measures are not in place or not in place everywhere. In community services and out-of-hospital services those measures do not even exist. There is a task to define the measures, collect the data, and then start having the conversation about quality. Quite a long lapse of time is built into that, which is pretty inevitable. Of course, since that will take time, and policymakers are often impatient, there is a fear that people will forget that the underlying driver for this was a relatively long-term project dedicated to improving quality and will want to start doing things again. Understanding that some of this may take some time is a bit of a risk. I think there is still a risk around some of the promise around NICE and NICE drugs that are of some concern to us. I would echo both the points that Niall made. There does need to be an intermediate tier but there is a danger of creating a very powerful one which causes people to continue to look up. Most of these strategic health authorities are about the size of Denmark in population terms. "Local" is not really a word that you would use to describe them. They have an important role. The difficult challenge for them is how to do the often incompatible tasks of development and improvement with performance management. The latter tends to corrupt the former. The second question is the extent to which we have clinical and other engagement right. There is very big agenda for local managers and local clinical leaders in making all of this happen. Indeed, that is probably the major lever for change. Whether we have enough of that and whether we have enough engagement I think is a question that is open and certainly is patchy around the country.

Q76 Chairman: Could I pick up on one thing you said about the issue of quality of care. The Prime Minister said when this was published, "the challenge of ten years ago was capacity, the challenge today is to drive improvements in the quality of care." Have we spent an increased £45-£50 billion in the last few years without making significant improvements in quality?

Mr Edwards: No, I disagree. I think there have been very significant improvements in quality. One of the difficulties is that quality was not seen as the major driver by most of the people in the NHS, it was seen as hitting a series of targets. I do not want to sit here and reel them off but, collectively, between the three of us, we did come up with a very long list of quality improvements. Probably the biggest single one would be the huge investment in the prescribing of statins which we have made. Over £800 or £900 million has gone into the prescribing of statins. It has probably saved a very large number of lives and it has certainly improved the quality of the way that we manage people with ischemic heart disease. Then there is the cancer strategy stuff. There are also areas which have been neglected. We perhaps have not improved maternity, as a topical example that we might talk about today, but, in general, I think we could say that there has been an improvement in quality. The trick that has been missed over the last

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ten years perhaps is not capturing the profession's real enthusiasm for wanting to improve and wanting to do better and often wanting to do better than their colleagues.

Q77 Chairman: On that last point about the profession, quite clearly costs have been a major issue and there is a lot of money gone into the National Health Service. Do you think this review will use the amount of funding that has gone into improved outcomes and to redesign services? Redesigning services is a central part, I suspect, of it, in which the clinicians will be either engaged and it will happen or perhaps not.

Mr Edwards: If redesigning the services is the project, then I think people are less likely to get excited about it than if it is improving the quality of care. There is something about how one describes this in terms of getting people engaged. When one looks at the financial environment in which the Health Service is going to be existing in the next few years and imagines that in an environment in which there is much more transparent information about how you are doing—and, indeed, some of your payments may be linked to how you are doing—it is likely that people will want to get more engaged in that. The thing we often fail to get people to understand in the Health Service is that many of these improvements in quality will produce huge reductions in how much it costs to provide the care. A lot of the cost in health care is reworking things that were done before, salvaging mistakes that could have been avoided, and the cost of patients waiting about for things to happen. The sort of redesign that will deliver improvements on the quality rate, the sorts of quality measures that are being talked about here, ought to provide a real incentive to get people to redesign their care in ways that help them do better medicine. If the story is about that, then there is much more chance of getting people engaged than, "We've got to do this because we have a financial target" or "We've got to do this because the regulator tells us to."

Mr Dickson: Responding to your first point about the Prime Minister's comment, all governments rationalise what they do. Did Alan Milburn sit in 2000 and say, "I'm just going to expand the service. I'm not going to bother about quality at all"? Of course not. In a way, their post hoc rationalisation diminishes some of the things that have been achieved: the creation of NICE, the introduction of national service frameworks. Some of these things were national things which were partly designed to create equity but, also, to introduce notions of quality into the service across the board that had not been there before. I also think there are probably quite a few areas where you can say—though difficult to measure—that there have been increases in quality. For example, if you increase the number of nursing staff, you may well reduce the stress of the team and you may improve the quality of nursing care, but that is quite a difficult thing to measure and I think we have not been very good at measuring it. There have been some quality improvements. There have been quality improvements in cancer care and in coronary heart disease, and Nigel mentioned statins as a good example of that. So I think they have done some things in the past, but I agree with Nigel that the focus probably has not been enough. It comes back, in a way, to the fact that the need to try to make sure that the money was spent on something that they could measure meant that there was a lot of emphasis on the access, which was an important issue for patients, and they drove the system hard in order to do that. I think it is right—now that we certainly have a much better position, not a perfect one, in relation to waiting times—that more emphasis is put on quality. It will be important to get the right data to drive this, because if we do not have the data it will not work.

Professor Newland: I think it is harder to show quality in comparison with simple targets. A lot of things have happened. As Niall has said, quality has not just happened there, it has been happening for many years and there a number of very good examples. The Cancer Networks have been highlighted: they have shown, quite clearly, that when clinicians take charge, look at the balance of services that care can improve. They can reorganise the services themselves. We have seen the same in coronary heart disease; we are seeing it in strokes; we are seeing it in diabetic management. More global systems such as accreditation of services—well established in pathology, there in psychiatry, developing, as you heard earlier, in general practice—are areas where we have worked to improve services. I think the establishment of confidential inquiries has also begun to look at outcomes. The emphasis on patient safety, I think, is also looking very clearly at what we are doing. Certainly, with the Academy pulling together, the colleges developed a document 18 months ago on reorganisation of acute services for David Nicholson. That very much presaged and was later mirrored by some of Darzi's suggestions on how you look at specialist services through to care in the community. We are very much signed up to the development of patient pathways and integrated care in that way. From that point of view, we are fully behind that, and I think these will show, over a period, of time the improvements that we hope. It is turning around the tanker: it takes a while.

Q78 Dr Taylor: You have all mentioned doubts about clinical engagement. Nigel mentioned the importance of better medicine. We have known for a long time that there are tremendous variations in clinical practice. The Academy paper states that "a disappointing feature of the NHS has been its comparative failure or tardiness to close gaps in performance". Why has this not been addressed? We have been told by our advisers that Barbara Castle told us about this in 1976, and advocated reductions in clinical practice variations. Why have we not got to grips with this?

Professor Newland: A lot of this reflects resources and local priorities, whoever decides those local priorities. We can see from Darzi's work in London, in Health Care for London, that if you start at the west end of the Central Line your life expectancy is

seven years better than at the east end of the Central Line. I do not believe that is because the quality of care at the hospitals in the East End is any worse. A lot of that is to do with social demographics and the money that has been put into dealing with those.

Q79 Dr Taylor: But local priorities should not dictate clinical practice. If there is a right way to do something and a less good way to do something, why are we not getting everybody? Clinical freedom is okay, but it is a bit of a sacred cow if there is a best way of doing something and a less good way. Why are all doctors not doing things the best way?
Professor Newland: I think many doctors know the best way to do things and would like to do them and we have the guidelines and the enthusiasm to do that. What we are allowed to do is sometimes developed by local priorities and it is not always clinically led.
Mr Dickson: I am sure that is partly true, but I also think we are undergoing a revolution. That revolution is about the medical profession and some of the other healthcare professions moving away from the idea of individual mastery and individual decisions about something, to a profession which is much more about guidelines and about evidence and about data. The data sometimes has not been there. Sometimes it has been there. Somebody quoted a *Lancet* article from the 1950s in which it was said that there were still bits of the NHS that were not following the advice at that particular time. It does sometimes take an awfully long time to bring in new bits of practice. I think this is where the digital revolution will have an impact, because it enables information to be brought quicker to professionals. It enables it to be put in digestible forms. The huge volume of information means that even a specialist now cannot possibly know everything within their own specialty. I think the onus will be on people not to give up the uncertainty which is at the heart of a good medical practitioner—dealing with uncertainties is what it is all about—but it does mean that people will be expected more to follow guidance, that there will be standards that are set more by the Royal Colleges than they have been in the past and they will be more prescriptive. Only in that way, by exposing what is going on and by having good minimum standards, and higher standards as well, will you be able to drive up standards in individual units and services.

Q80 Dr Taylor: Would one of the roles of the Academy be to try to enforce guidelines?
Professor Newland: One of the roles the Academy has very recently taken on is the national clinical audit and patient outcome programme, which I think will also later encompass some clinical accreditation as well. We have developed that in conjunction with the Royal College of Nursing and Long-Term Medical Conditions Alliance. That is going to be a very important role of ours, both to highlight the guidelines have produced but then to look at outcome through mechanisms such as that group.

Q81 Dr Taylor: Is it not a criticism of the colleges or the Academy or both that we have not really addressed this in three decades?
Professor Newland: It is a criticism that has not been taken up to the same degree that it should have been. Many of the individual colleges have had audit programmes which I do not think have been promulgated to the wider world in the degree that they should. I think that it is one of the roles the Academy has realised it has to take on to make sure that what individual colleges are doing is put out as best practice and is incorporated and is part of routine daily work.

Q82 Dr Taylor: Are clinicians as difficult to herd as cats or is there a way of doing this?
Professor Newland: I think that is probably fair comment.
Mr Edwards: I was going to quibble with the idea that a variation in resources is a reason for a variation in clinical practice, which I think you dealt with. There have been two or three issues. The first has been a complete lack of transparency, and often not even measuring what has been done. The second, if you do measure it and make it available, has been a lack of willingness to challenge, including by the professionals themselves. The Royal College of Physicians has introduced excellence guidance on strokes and yet many of the people who have fellowships with it still operate services which completely fail to the standard that their own college sets. It may be unreasonable to expect the colleges to do this—they have no particular managerial line to their members—but it does seem to be possible to be a fellow of a college and operate a service that really is quite below standard. A bit of leadership from the profession would perhaps have obviated the need to have to set out some of the requirements for this. But, it having been done, it does seem to be, as Professor Newland said, a resurgent Academy and a real role for the colleges, working with NICE, to now take some of that leadership role. I think people would welcome that.

Q83 Dr Naysmith: Is there not a role for continuing professional development and accreditation in this? It certainly works with the GPs. Would it not work more widely?
Professor Newland: I think that is part of what has come through with the way we are trying to develop revalidation. I think clinical professional development is an important role in that. The point I was going to make there was that, yes, the colleges, the Academy and the specialist societies do set standards, do set standards, do set guidelines in conditions. It is how those are applied on the ground, both being picked up at local appraisal but also through local peer review. I think we have the example of the Cancer Networks, which have really shown quite remarkable changes in practice. I give the example in the North East Thames, where it went from six units that did surgery for gynaecology/oncology down to one. That was developed by the clinicians themselves. Having looked at the figures, having looked at the outcome data, they realised

that the best way to do it was to concentrate resources rather than look at individual ambition in terms of the hospital. When clinicians are given that information, they will make those decisions and will follow it. It is a question of giving them the information and encouraging them to get on with it and giving them the resource to reorganise.

Q84 Chairman: You mentioned revalidation there, which is still waiting in the wings, as it were, to be introduced at some stage. Do you think revalidation will improve clinicians and their practices or should it?

Professor Newland: I think it should do. I think it depends how it is developed and what the building blocks are. Certainly a number of colleges, my own included, are looking at clinical audit as part of the revalidation process. We are looking at interpretative quality assurance schemes, so that you can do revalidation and present documents that are relevant to your current day practice, not popping off to a meeting and ticking the box that you have been to a meeting and therefore you have learned something. This is in your everyday practice. Every three months or so, you do an exercise that then becomes part of your electronic record that you present at your appraisal every year, and after five years you pool all that together. That means that we can pick up people who are failing early and deal with that. It becomes part of routine practice; it is not a once every five years two-day exercise where you scrabble all the bits of paper together. We want to make revalidation an integral part of routine, everyday practice. If we can do that and if we choose the right things, it will work.

Q85 Dr Stoate: Just to pick up on that point, for the last ten minutes we seem to have been avoiding the issue. The fact is that for the last 30 years we have known that there are variations in quality. We have known there are good GPs, bad GPs, good consultants, bad consultants. You ask any GP in the land and he will tell you which are the good consultants and the bad ones. He will also tell you which are the good practices and the bad practices. The PCTs all know which are the good practices and the bad practices. Yet for some reason we have never managed to do anything about it. Nigel made the real point, that there are still people carrying out suboptimal clinical care in things like stroke management and it is not being picked up. What are the colleges doing in terms of progressing this? Just developing new tools of validation has been going on for the last 30 years and we have not got there yet.

Professor Newland: The colleges and the Academy are in a position to lay down standards to review audit but they do not have a managerial role on the ground. It would be nice if we could, but, as charities, it would be impossible to do so. I think we can lay down clear standards of what we think practice should be, however, and then that is for the local trusts, PCTs, commissioners to take on board.

Mr Dickson: I think this is why Darzi is a real hope, in the sense of having more information around. When information is all closed away you as a doctor may know about all the GPs, but I, as a patient, do not have a clue. In fact you may be a really nice chap but a bad clinician—which may be the judgment of some of the doctors as well—but once the information is out there, that the patient reported outcomes are very poor for that clinician or that practice, then certainly the pressure will start to come on the system. Once Pandora comes out of the box—and I am unclear how quickly this is going to happen or whether the quality of data is going to be good enough, and those are caveats—I think we are on a journey here. I think your question should not be able to be asked in ten years time. Somebody will not be able to ask that question, because it will have started to be exposed.

Q86 Dr Stoate: I would not mind betting that in 30 years time we come back and say, "Those chaps in 2008 recommended something that has not happened yet."

Mr Edwards: We do need to be real. This operates as a bell curve, and it may well be that the difference between good and great, the middle of the bell curve, is relatively small differences in practice but multiplied over large numbers of patients. We have been very bad at dealing with the tail. I am aware, however, that a number of trusts which have been focusing on quality in the last ten years have really got to grips—often using disciplinary procedures—with poor practice by their clinicians. Obviously, it is not just doctors; although it has tended to be doctors where that has been hardest to deal with because of the various bits of employment protection that they have uniquely enjoyed. It is still a case in primary care, as you will know, that the levers are not as well developed as they might be. There are some new ones in here, and, to some extent, that is also the reason that lies behind some of the focus on using some competitive tools and choice in primary care. Whether that will be effective, we will have to see. I would say that there are signs of increasing use of managerial methods to address poor performance. That tends to be supported by, and often in the acute hospital setting led by, the medical director. Signs of hope, I would say.

Q87 Dr Stoate: I am prepared to accept that, but bear in mind that quite a few of Harold Shipman's patients thought he was an all round decent chap and the fact that he had murdered a few people should not take that away from him. We have to be a bit careful with consumer satisfaction.

Mr Edwards: Consumer satisfaction sometimes is quite a good clue that there are other things going on as well. Most disciplinary issues have been about clinical practice. Doing the wrong thing; not having the right skills.

Professor Newland: We increasingly find through the colleges, with the guidelines and standards and workload advice that we put out, that these are being increasingly used by local trusts to look at performance locally. We have had a lot more requests for advice over the last three to four years from local trusts about local clinical activity.

Q88 Dr Stoate: Fair enough. I am prepared to watch this space, but I am not at all satisfied that anything much has changed since Barbara Castle's day. I would like to talk about a new theme which is being bandied around, patient records and outcome measures. Niall mentioned those a minute ago. What evidence is there that linking PROMS to payment by results would do anything to deliver quality?
Mr Dickson: I think we should be careful about it. The first point—and Nigel has made the point already—is that the assumption that providing a quality service costs more is wrong. Often, by providing a quality service you may be able to save money. I think we need to see the detail of how they are going to make this best practice tariff work. Instinctively, the idea that you should reward quality seems a good one, but whenever you introduce these financial incentives, you have to watch for perverse behaviours. The NHS Institute looked at cataracts, for example, and found that 60% of providers were over tariff, but it also found that once you improved quality you saved costs, you reduced the amount it cost you to do. There are already incentives within the system for people to save money by providing quality care.

Q89 Dr Stoate: Yes, but what evidence is there that PROMS will improve quality?
Mr Edwards: There are a variety of different things proposed in the review. One is payments based on patient experience. That is probably the one that is most worrying, because we do not yet know how much of that is under the control of the organisation. There is certainly evidence from MORI that suggests that certain areas, particularly of high levels of ethnic diversity, have trouble creating services that satisfy their patients, so we could end up penalising the people who have the biggest problems, so there is an issue with those. The evidence for payment by results system (called pay for performance system in the US) is a large study run by the centres for Medicare and Medicaids CMS, with 200 hospital groups looking at five different conditions. It does appear that these incentives, which were relatively small, did produce significant improvements in quality. There were two things that seemed to be affected here. First, hitting the indicators was the way you got paid, but to hit the indicators you needed to redesign the way that you did the pathway for coronary artery bypass grafting or community acquired pneumonia, so you got quality improvement across the board. The second was the effect of publishing these data nationally: there was a prestige advantage in doing that. We do not know what the effect was on the things which were not being incentivised. In other words, did all the effort that was put into improving the pathway for myocardial infarct mean that the chronic obstructive airways disease, which was not part of the incentive scheme, suffered from that. There is no evidence on that, but obviously it would be a danger. I think the Department of Health have discovered incentives in the last few years, and it has come almost to the point where they believe it is the only answer. I think it has to be part of the package, and if you only rely on these incentives to drive up quality you will be disappointed. There was enough evidence to make it worth trying these out and piloting them. There is probably not yet enough evidence to adopt them. There are some hazards, particularly around the patient experience based payment, and these are methodological problems rather than issues of principle.

Q90 Dr Stoate: That is the point. There are a lot of unknowns here. The document says, "From no later than 2010, payments will reward outcomes under the scheme." Do we know they will be sufficiently robust by then? Will we be relying on them? Will they measure the right things?
Mr Edwards: There is an ordered dilemma here, because unless you start collecting the data and making it feel real people will not bother doing the data collection properly. There is plenty of data collected in the NHS which we know is slightly ropey, because people suspect—in fact probably quite rightly—that quite a bit of it is not ever used so why bother collecting it. The dilemma for policymakers is how to make this feel real. One of the other proposals is to move from a payment based that is based on averages to one based on best practice. I think that has some real logic to it. At the moment the tariff price paid in the NHS is based on the average practice. The average includes everything from the excellent to the potentially dangerous, I suspect, and setting a tariff that says "This is the quality that NICE says the best looks like" is quite a useful way of sending a signal that what you do clinically really matters in terms of the success of your organisation.
Mr Dickson: In answer to your question about 2010, I think it will be a huge challenge, not least because they are only starting to collect PROMS from 2009. Obviously it takes a full year and then it takes time to get the data together, like everything else in this, so I think they have set themselves a very challenging target there.
Mr Edwards: BUPA already use PROMS, of course, quite successfully.
Mr Dickson: It is for the NHS to get themselves geared up in order to do that, but it will take time.

Q91 Dr Stoate: How much will it cost to collect PROMS?
Mr Edwards: BUPA reckon £2.95 per questionnaire.

Q92 Dr Stoate: That is fairly specific.
Mr Edwards: Very specific. They are a business. I think they are specific. Nick Black from the London School of Hygiene, Nick Mays's colleague, thinks it is more. The question is whether you need to do a 100% sample.

Q93 Dr Stoate: Our advisers tell us it is more like £10.

Mr Edwards: £10 is the sort of figure that—

Q94 Dr Stoate: So £2.95/£10—near enough.
Mr Edwards: One is BUPA and one is the NHS might be the simplest answer to that. We are doing it, of course, with a different population. One of the reasons for the price difference may be that BUPA have it slightly easier in terms of their relationship with the patients that they have. I do not know if they do, but they certainly could make it a condition of whether or not you are allowed to claim for whether or not you fill in your form. I think it would be highly useful for another reason, not just to produce quality. It is a well-known problem that, as supply expands, we start operating on people for whom operations are not the thing they should be receiving. The two most critical examples are cataracts and transurethral resection of the prostate, both of which have a strong probability of producing worse outcomes for the patient, making their health centres worse after the procedure than it was before. There is an added benefit here from the Commission point of view: it will also allow us to ensure that what we do does make people better.
Professor Newland: It takes quite a while to understand the outcome data. I think we saw that from the cardiothoracic surgery. We need to start collecting the data so that we can then interpret what it means, but whether by 2010 we will be in a position to judge funding by outcome I think is a moot point. Again, we would be very worried about using patient-related experience as a significant part of that. It is important to guide services, but whether that is important for funding I think is a moot point.

Q95 Stephen Hesford: Traditional model GP practices versus Darzi GP-led health centres in terms of choice and better access? Which is it? Discuss.
Mr Edwards: There is a middle way. Most healthcare systems have been trying for many years to get primary care doctors to practise in larger practices. There is a whole range of good reasons for that: you can back them up with diagnostics; you can put specialist services in; you may even get specialists to come and work with them; and you can give them better diagnostics, particularly imaging. There is definitely an upside, therefore. The downside is obviously an access one. Liverpool PCT has what I think is an interesting compromise: to largely keep the pattern of surgeries that they have—the 50-minute pram push rule that has operated for some years—but then to provide centres that those surgeries can have access to and to get the smaller surgeries to work in networks. I think there is a middle way, therefore. In fact, my reading of a number of things that Lord Darzi has said permits that. In other areas, particularly large market towns, you will probably find things that look very much like Darzi polyclinics already in place, and they work very well and people seem to appreciate them. The principle from our point of view is that this needs to be designed locally with the participation of the local public, the patients who use these services, and the clinicians, both primary care and secondary care, and it is not to be a standard answer.
Mr Dickson: At the risk of saying very much the same thing—our reports are fairly similar—there are three dimensions to this: access, quality and cost. Trying to impose something from the centre is a bad idea. I think the Government's instincts were towards that and they have retreated a bit from that. I think that is to be welcomed. There is a genuine access issue about shutting down lots of small practices and expecting elderly people who will go frequently to a general practitioner without any need for any further referral or need for diagnostic care and everything else, and saying to them, "You must walk"—or you must struggle—"further, into possibly a less domestic institution which may feel more alienated from you." If you are going to do a bit of that—and you have to trade all these things off—you have to look at that alongside the quality of care. I think Nigel is right on the model of single-handed general practitioners who have no other form of support. There has been a general scaling up of general practice, and I think that is to be welcomed, but that is not the same as necessarily congregating everybody into a big building. It is a question of trading those things off. In some areas it might be the right thing to do, but it should be looked at in each area. The other problem is that some of the models of polyclinic from America and Germany which the Government have been keen to tout are based on very different numbers of specialists; for example, a lot more specialists, and they have often talked about bringing specialists together who were working in their own offices rather than already being congregated in a hospital. There are dangers in simply doing a bit of policy tourism and saying "We'll just have that model here." We may not have the numbers of specialists and they may already be working together. The final concern—and this applies whenever you bring professionals together—is that simply bringing them in under the same roof does not necessarily mean that they will work better or that they will start working together. That is not an argument for not doing it but it is an argument, if you do it, to really think it through. It is not a question of saying, "X just open your office there and Y have your office there, and then it will all be fine". You have to really change the pathway of care and integrate the way in which those services are offered if they are going to be effective.
Professor Newland: I would agree with all those points. I think the College of General Practitioner's approach to this is really very measured. We would look on some sort of change of service as a way of linking generalist and specialist care. That does not necessarily mean people going to sit in buildings; it is how you develop the integrated pathways. There is a lot of care that takes place in outpatients in large hospitals that does not need to, but it is how you move that out, how those patients are looked after, how those results are integrated into the patient record, who looks after them, who interprets them. I think that also brings an issue of payment by results—which, as it stands, is really payment by activity. There is currency in bringing the patient back to outpatients and not dealing with them at

home via a postal blood test. That would be far better for them, but does not bring the money into the unit that is then supervising it. There are a whole number of issues there that we would need to look at. Pulling specialists and generalists together and looking at the integrated pathway of care is the important way forward.

Q96 Stephen Hesford: In my patch, for example, we are looking at one of the GP local health centres on Wirral. It is going to be co-located with the local teaching hospital—in effect, taking over from the walk-in centre. It is not thought it will in any way destabilise current GP practice. It is an additional thing. I am not sure any of our witness have dealt with the positive possibilities.
Mr Edwards: It depends what you are trying to achieve. There will be parts of the country, where it has been very difficult to get practices to open late and at weekends, where maybe they are not as responsive to the needs of improved quality as you would like. In those cases, it might be that a certain amount of destabilisation is precisely what you do want to achieve. In other areas, where you have very good general practice—and we are really back to what Steve Field was saying—which is very proactive, trying to improve quality and open late, why would you want to destabilise that? You would want to develop that. In other cases, as you say, these types of centres can also be used to complement other bits of policy. In Hertfordshire they are trying something similar there. The point is, however, if you try to impose a single model then you might destabilise areas which you are trying not to destabilise and in other areas not solve the problem.

Q97 Stephen Hesford: Is that what you think, that this looks like a single model?
Mr Edwards: Fortunately, it is being locally interpreted. In distinguishing between areas where there may be problems because implementation has not been handled very well or it has been rather top-down, from areas where there were complaints because of a certain amount of what you might call competitive pressure, not destabilisations—one should always be suspicious of providers who claim to be being destabilised, I think: in general they are much more stable than they often appear—those might be not accidental poor implementations. Some of them may be having the deliberate purpose of trying to point people in the direction of improvements.
Mr Dickson: I think one has to distinguish between what is additional. The 150 centres are meant to be additional, and in that sense additional is good and that is fine. The original polyclinic model, which was about shutting down GP practices—it was not being corralled, but they were being encouraged to move into this—is a different approach, and I think you would apply different criteria to them. The only thing I would say about the 150 health centres is, as Nigel said, that there are areas in the country in which our traditional approach to general practice has simply not provided an acceptable level of service and, therefore, doing something to deal with that is good. But it would be better were it more locally determined than saying, "I've thought of a number from Whitehall and decided that there will be one in each area of the country." It just seemed an odd way of doing it.
Professor Newland: When you have PCTs of one million and PCTs of 200,000, also mixing it slightly up.
Mr Dickson: It was more that I was worried about. I think the need for some additional capacity, particularly in parts of the country, and to try new models and, frankly, to bring in new providers, I am all for it because in that sense a bit of destabilisation, a bit of challenge, and apparently somebody said, "Oh, it's terrible, some of my patients might leave and go to this shining clinic." Well, jolly good. If that is what they want to do and they get a better service or get a good service for the first time ever, that would be fantastic.

Q98 Stephen Hesford: Professor Newland, you may have a slightly different perspective.
Professor Newland: I think there can be no single model. That was unfortunately what came across initially, when the term polyclinics was discussed, and, indeed, many PCTs have interpreted that. Certainly in the East End of London, 30% of practices are single handed, which, by all definition, is not satisfactory. However, many of the patients out there do like them, and if you pooled all those together into a single polyclinic, because of the distance they would have to travel—and these are people who tend not to travel more than a few streets—they would probably not go and would end up in the A&E department of the local teaching hospital. There is a GP practice sitting in the A&E department, but it would soon be swamped. We also have the model of several very good, larger group practices that deal with excellent care along the lines promulgated for the bigger polyclinics. But I think that we have to look at how general practice has provided in those sorts of areas. The single practices have to be federated, have to be brought together, so that at least there is some strength in having a network. Whether you physically move them together is a moot point. Of course it is a challenge for the PCTs to make those single-handed general practitioners work with others, and many of them would feel very threatened with the idea of having a close colleague looking at what they are doing.

Q99 Stephen Hesford: Does it affect the role of gatekeeper of GPs at all? Do you have any concerns on that?
Professor Newland: I think it could improve it, to be perfectly honest. If you are working with colleagues, you can discuss, meet and share practice. To have someone in the practice who may have a specific interest could improve what you offer individuals.

Q100 Jim Dowd: Mr Dickson, the Darzi report mentions practice-based commissioning and, apart from a lot of generalised good intentions and assertions, does not really go into much detail about how it would strengthen the role of practice-based

commissioning. Do you see anything in here which will increase activity amongst drugs-based commissioners?

Mr Dickson: No, you are right, there is not a huge amount of detail on it. The commitment was to reinvigorate it—which is an admission, I think, that it has not taken off in the way that people thought it would. We are doing a study on this, so I am in the unfortunate position of not yet having seen the results of it, but we are working this through. It does seem that on the one side you have a lot of general practitioners saying that PCTs are either not really encouraging them to do it or are not interested in doing it and are not promoting it. On the other side, some PCTs are saying that a lot of GPs are really much more interested in the provision side than the commissioning side. I think we need greater clarity about what practice-based commissioning is and what we expect it to do. It is clear that the Government does have a commitment to it going forward, so it is going to be there, but I think we need to be clearer about what is the right role for strategic commissioning. There are certain things that need to be done at a much bigger level than the practice—although I think even practice-based commissioning is now seen rather as a consortia of groups of practices coming together. But some of the decisions need to be made at a much bigger level; for example, cancer services are probably better organised and commissioned across a region. "Corral" is not the right word, but if you can bring consortia together to inform the commissioning decision, that is a good thing. I do think that probably more could have been said in the document about the role of clinicians—even secondary care clinicians—in terms of advising and shaping the way commissioning works as a whole. The short answer is that the picture does not appear very successful at the moment. I think the Government are acknowledging that. The right incentives to make the system work are not in place and probably the right attitudes are not yet in place. Is there some potential for it going forward? The Government are certainly committed to doing it. One cleaner way would have been just to say, "Well PCTs should just do this and they should find new ways of involving clinicians." I think there are some GPs who are really enthusiastic and who really want to get hold of this. If we could get them absolutely onside and make sure there were enough of them in a critical mass to set up these consortia, then I think you would get a real benefit in the delivery of commissioning.

Q101 Jim Dowd: Essentially the PCT has the potential to produce but it is just not delivering at the moment. You mentioned lack of clarity, about there not being a single common definition of what it is supposed to look like, but why do you think the reception to it across the broad band of GPs has been so uneven? Some are very keen on it whereas others just do not want to know.

Mr Dickson: Yes. I think there are still probably some bruises post GP fundholding. I think there are some people who remember that experience and think, "I don't want to go there," and, also, the extremely patchy involvement of PECs, the clinical committees that were attached originally to primary care groups and then primary care trusts, and a feeling among some GPs that they had been excluded from the process. I think relationships between general practice and primary care trusts are extremely variable, therefore. In some places, it is really good and you can start seeing it well, and in other places it has not been so good. I suspect that is the reason.

Mr Edwards: I think a combination of, initially, not terribly well defined policy and then the major reorganisation of all the primary care trusts that were supposed to be implementing it can explain some of the issues. I would agree with Niall that there are some GPs who are interested in being integrated providers, where they take on more responsibility for managing the budget and providing services, and others who are interested in more strategic commissioning—and these are not mutually exclusive, obviously. The way the policy is written at the moment does not really deal with that conflict. There are some issues about how to make that work.

Q102 Dr Stoate: Are they right to place such store by it for the future?

Professor Newland: I think there is a real potential for practice-based commissioning in conjunction with payment by results to influence the development of integrated pathways, because I think that primary care really has a vested interest in how it deals with its patients, how it links the community, primary care and secondary care, together. So I think you are talking about people who have an interest in how the process works. Part of the problem with PCTs, the 150 PCTs, is that that is a lot of experience that is not there in terms of commissioning at the moment. You have to have a consortia of PCTs to do it. It in my own specialty, pathology, which is 3% of the budget or slightly less, or even in cancer, which is 6% of the budget, these are small areas that PCTs may not even concentrate on because they are swamped by a bigger picture. Therefore, I think those areas are much more likely to be dealt with properly by primary care than practice-based commissioning.

Q103 Dr Naysmith: Following up on PCTs, I think you were here in the previous session when we were talking about PCTs and what world-class commissioning status meant. One of our previous witnesses said, and I think you heard it, that to understand it you had to take the words away. He was not being subtle and suggesting that it was meaningless; he was suggesting you have to take the words apart and look at them individually. Is there any evidence at all that PCTs are near achieving world-class commissioning status?

Mr Dickson: No. I think we are in the lower foothills. World-class commissioning is a device by which the Department of Health is trying to drive, in a number of ways, the quality of commissioning through the system. The weakness of commissioning, or purchasing, as it has been called,

has been around since the regional purchaser/provider split. In 1990 it was seen that purchasing was going to be the way in which reform was driven and quality was driven up and so on, but for a variety of reasons it has disappointed. A lot of the reason why it has been disappointing is because (a) we have not invested in it; (b) we have not given it the status it deserves; and (c) there have not been the skills and the data around in order to do it. To be fair, there are the beginnings of seeing that some of these things are in place, but is it happening ion the ground? No. In particular areas there will be some really fantastic commissioning, where they really have some data, they have the evidence and they now have to drive it through. But in a lot of areas you are talking about still an under-resource. They spent far too little of their budget on commissioning itself, so most of their budget is going out to the providers.

Q104 Dr Naysmith: We found that recently with our dental inquiry. It was very clear that some PCTs took the commissioning of really good dental services seriously and others were total disasters. Is Darzi's prescription for improving PCT commissioning the right one? Is it going in the right direction?
Mr Dickson: He does not say a huge amount on this.

Q105 Dr Naysmith: Should he have said more?
Mr Dickson: Not necessarily, because of repeating what they have already done in terms of world-class commissioning—that project, as it were—of getting some independent sector help from other countries, from people who have developed greater expertise from this to work alongside PCTs. I would certainly like to see PCTs devote more of their resources to this than I think they will going forward, because they will not be able to commission successfully on the basis of the kind of money that they are putting in now. I would also like to see them move away from having a provider arm at all. In this, we are not allowed to be top-down at all, so they have used that as an excuse to say, "We will encourage but we're not going to tell PCTs to get rid of their provider arm." If they concentrated exclusively on commissioning and that was how they were judged, I think they would have a better chance than being sometimes distracted, which they have been in the past, about trying to manage quite complex and difficult provider services which would be better run by somebody else.

Q106 Dr Naysmith: We ought to move on to the next topic, patient pathways, which has already been touched on a little bit. The review advocates the creation of integrated patient pathways for patients suffering from chronic diseases such as renal failure, chronic obstructive pulmonary disease and heart failure. Do you think the review adequately addresses how you are going to co-ordinate public and private NHS providers in both primary and secondary care in a way which will improve patient care which could become very complicated patient pathways?
Mr Edwards: As care is becoming more complex, and patients tend not to have just one condition very often, the co-ordination of complex cases is a real issue. Whether that is provided by a hospital, a tertiary centre or by a private provider is probably not the key issue here. The key issue is: Is there someone who is supposed to be responsible for doing that? Traditionally, that has been the GP. The anxiety is that with some of these very complex patients the GPs have lost hold of them: they have been sucked into the system. I had understood, and I may have missed it in the report, that there were supposed to be some proposals about how to improve the case management of those patients. That would make a very big difference, because, although they are a relatively small proportion of the total number of that the NHS cares for, they do consume a very, very large amount of resources. 2% of the patients generate 17% of the GPs workload generally, and that kind of very heavily geared ratio applies in these other settings too. It may be just as difficult to talk to an NHS organisation as to a private one. The question is having the machinery to do the co-ordination well.
Professor Newland: I mentioned earlier the links between specialists and generalists. Certainly in chronic conditions, we increasingly recognise that to provide safe care there has to be significant collaboration between providers. There has to be access to results, there has to be access to information. It does not necessarily matter where the patients are being looked after, provided that information is available to all and there is co-ordination. The treatment of one condition may not be appropriate to someone who has a different co-morbidity. It is how you handle those balances and that information exchange. I know it is not there at the moment.
Mr Dickson: I would endorse what has been said. I think the work that has been done on patient pathways is a real advance and there is a lot more still to be done. It is not about the nature of which organisation. We get hung up in the sense of whether it is one organisation or another or, indeed, whether we should put all secondary and primary care practitioners all into the same organisation. I do not think that is the issue. The issue is: Do you have clear pathways? Do you have IT systems that allow you to communicate? From the patient's point of view, is the care—to use the jargon—seamless: are they able to move from one bit of care and back to another without their notes being lost and with different professionals giving them different bits of advice? They have to be signed up together to what this pathway of care is and now when it is appropriate to refer up or down the system.
Mr Edwards: Having said that, there are advantages to integration. The review contains a rather welcome proposal to experiment with a variety of integrated organisations which can improve some of those co-ordination things enormously. It will be very interesting to see how those develop. We would certainly welcome those.

Q107 Dr Naysmith: The next question was going to be how much does all this cost, but I suspect that would not be a very useful question to ask since I

suspect nobody will know the answer to it.

Mr Dickson: The SHAs should be able to answer some of the questions about theirs, and Lord Darzi should be able to answer some of the stuff around the national level, so I think you should arrive at a figure eventually.

Professor Newland: The Academy document on acute care services showed how care could be spread out through the various organisations. In many ways, that could save money. If you are not having to take the patient up to secondary care for follow-up all the time, it saves money for the service. It particularly saves money and time for the patient, which is often not included in the equation at all. I think there are savings in the system. Better integrated care does not necessarily cost more money.

Q108 Dr Naysmith: If you wanted to create improved patient pathways, which three policies would you prioritise to make sure it happens?

Professor Newland: IT links are crucially important. The development of guidelines for care is crucially important, so that people know how they are following. Good quality patient information, presented in a way that patients can understand and absorb, is also important. That the patients should know what should be happening to them. That the practitioners are aware of the pathways they should be following. (That will be available on NHS Choices. They will be able to go to lab tests online to see what the tests mean; they will be able to go to various other things as well to get good quality information.) And that the various organisations providing care are linked up.

Q109 Dr Naysmith: I am not sure whether that is three or five, but there were some good suggestions there.

Mr Dickson: I think it was at least five! Those are the obvious ones, to which I would add that there does need to be cultural change to bring this about. That is quite significant, I think. You can put in place all these different pieces, but unless there is an understanding within the system of how these pathways work, of people to think a bit beyond their own silo, their own specialty, their own practice, and to see care in that continuous way, which very largely was not done, it tends to be a pass the parcel kind of thing rather than seeing that I have continuing care for that patient when they have moved up or down the system. I would obviously endorse the information being there. Patients in future will become better informed than they are now. It is quite hard to estimate how quickly this will happen, but already we have seen it through the Expert Patients Programme and through people with long-term conditions who are starting to recognise that, in a way, they are the world expert on them. Having more informed patients will help this process through. Perhaps, thirdly—you asked for three—it is about understanding the nature between the practitioner and the patient being a different one, so that, instead of this mastery: "I give you this and you go off and do it," it is something that we are doing together. Part of that doing together is me helping you as a practitioner, helping you navigate the system and understand how it works. A lot of the reasons why things break down is that there is complete bewilderment by patients about how the whole thing operates.

Mr Edwards: You asked for three. I thought you wanted one each! Doing this without feedback is of no value at all. As we discussed earlier, we can write all the guidance and all the pathways we like—and we do not expect everyone to fit the pathway, and the reason we train people for 15 years is because we need them to exercise judgment about when they do not fit the pathway—but giving people feedback on the results and the level of compliance that they are managing is probably the key component that is missing from what we have just heard.

Q110 Sandra Gidley: I have a few questions on choice, which is the recurrent buzz word. Does the review provide any meaningful proposals for extending choice?

Mr Edwards: Most of the choice policy already exists. What is interesting is that the review continues a trend to redefine choice as simply being the choice of where you go to be more about the choice of what the options available to you are. I just see it in a line with what we have had before. It does not make any major steps. I would not have expected it to. We already have most of the policy in that area.

Mr Dickson: There is a subtle change, but I think quite an interesting one. It enshrines a right to choice in the Constitution. It gives you, a patient, a right to choice in the system which was not there before. Although that is a signal rather than anything else, I think it is an important signal to the system that this is something that is going to be built in. The NHS will not go back to being a one-size-fits-all monopoly. The psychological effect of the choice of provider is important. I know people say, "What's much more important is being able to choose whether I want drugs or cognitive behavioural therapy," and that is absolutely right, having choice within a treatment is important, but, somehow, saying to the system that choice is very important, that when you have that patient in front of you giving them options about what is the right thing for them as well as them being able to choose whether they go to you or somebody else, is something that is new to the Health Service. It will change culture within it—and rightly so.

Professor Newland: I think it enshrines choice. We are not going to go back on that and, indeed, should not go back on that. But, as the review admits, it needs a fully informed patient to make the choice of what they want, who they are going to see, what is going to happen to them, what the results are, and often the ill patient, as we heard earlier, is not interested in that and they want guidance and advice. Often they want their general practitioner to help guide them in that, and the general practitioner often knows from his own experience where to go. In many ways, without the information that they do

not really have available in the easy way, it is hard to look at choice as something that is currently guiding care.

Q111 Sandra Gidley: There is a lot also about quality. Is there any evidence that choice improves quality? Or are the two potentially counterproductive?

Mr Edwards: There is probably international evidence that choice can improve quality.

Q112 Sandra Gidley: I am sorry, "There is probably international evidence"? That does not sound very definite.

Mr Edwards: I am racking my brains.

Mr Dickson: There is in other industries.

Mr Edwards: Yes, there is in other industries. The problem is what you mean by quality. There is a tendency to improve the quality of things that are very visible, such as the quality of the reception area and the amenities in your room. The evidence is probably less good and less sure about improving the overall quality of clinical care. The effect of publishing data on the success of cardiac surgeons in New York certainly seemed to produce a significant improvement in the quality of the work that they were doing, but whether that was choice or the effect of peer review, with very poor surgeons deciding to exit the system altogether and those who were in the bottom end of the distribution going and retraining, is questionable. It is very noticeable that President Clinton had his operation done in the unit ranked 28 in the publicly available ratings, so there is a question about exactly how far patient choice drove that improvement, which is why I am being slightly equivocal about it. In other industries, however, there is fair amount of evidence that that is the case.

Mr Dickson: There is a lot of emphasis on this. The publication of data—because clinicians themselves are quite competitive and people do not want to be at the bad end of things—may be one way. Sometimes it is the threat of choice. It does not necessarily mean you get huge movements of patients going over, but it may be that a unit says, "When we look at where we are, we are not very attractive as we are," and therefore that may be a spin on this. It is quite a difficult thing to isolate, and I suspect it will be quite difficult to isolate going forward because we are introducing data, we are introducing the idea that clinicians will be able to compare their own performance with others, we are introducing patient access to some of that data, and we are introducing choice. If there is a welcome improvement in quality and a pushing up of standards, it will be quite difficult to pick out which of those has had an effect. I suppose the other way to look at it is to turn it around: Would a service that people have to go to, where there is no option about where you go to, be likely to be a responsive service? Is it likely to be one where people are looking to best possible practice? I think the answer is that it is less likely to be like that if it does not have at least some degree of choice.

Q113 Sandra Gidley: It does not say much for professionalism, though, does it?

Mr Dickson: I think professionalism is part of that. Professionalism is, again, another driver. As Julian Le Grand would say, the knightly bit is very important: it is what drives people. As does the knightly bit when I compare myself with Dr X next to me, who seems to be doing better, or with another unit that is doing better than mine. The competitive nature of practitioners means that when they see their unit is not doing so well as others or that there is a threat that the patients may go elsewhere, it is a further chivvy. It does get people to challenge, in a way that Dr Stoate was mentioning earlier when he was asking: "How is it that for 20 years people are still going on doing the same things as they have always done and not modernising their practice?" If they started watching their patients go somewhere else—or the threat of that, more importantly—or if they were able to compare, they would be much more likely in those circumstances to respond.

Professor Newland: I would take issue with some of Niall's comments. I think the degree of professionalism amongst practitioners is such that they do want to provide excellence. We have seen that within the Cancer Networks, that once we start looking at results—and these are not always results that are exposed to the general public, although perhaps they should be and will be—many practitioners stop doing operations if they are only doing a small number a year where the results we know are not going to be as good. By the nature of that competition, the way that practice is delivered has changed.

Q114 Sandra Gidley: Arguably Cancer Networks have reduced patient choice in some ways.

Professor Newland: Yes, they have, but I think at the same time have improved quality. When we look at patient choice there are a lot of things that are important to patients in terms of choice that are not necessarily outcomes of operation. They often assume that they are going to be very much the same, but there are issues like accessibility, how you can park, how easily your relatives can get to see you, and a number of those things are important as well. We find through the networks that patients will travel 100 miles for a one-off major operation, but for routine, day-to-day, week-by-week follow-up they want to go locally. They will travel if need be; they will stay locally if at all possible. I think that has been driven by the profession looking at what they are providing as well. As you say, that has reduced choice but maybe it has reduced choice to a smaller number of higher quality options.

Mr Dickson: Perhaps I could say that there are huge numbers of circumstances where patients do not want choice at all. Certainly, if I am thrown in the back of the ambulance, I do not want the driver to turn around and say, as in the cartoon, "Where to, Guv?" There are areas of health care where, absolutely, if you are feeling very unwell and so on, you may indeed want somebody who will both

literally and metaphorically take your hand and help you through the process. But there is a place for choice within the system.

Chairman: Could I intervene to say that Mr Edwards has to leave us. Could I thank you very much indeed for coming along this morning.

Q115 Sandra Gidley: Personal budgets. A big potential for choice. Is the NHS ready for that?

Mr Dickson: It is probably ready to have a pilot. I think the intention is commendable; the idea that, again, you hand over control to people. There are certainly quite a lot of lessons to learn from social care, both the cultural resistance, because direct payments have been quite slow coming in, and we are only now doing a randomised control trial into the effect of individual budgets. We are still learning in the social care sphere how to do this. I think there are some differences between health and social care that we have to be careful about. The first thing is that people will, especially in health care, need real support in order to make decisions about how they go about that. Of course, if that support then becomes the practitioner basically making the decision for them, you have not advanced a great deal further. I suppose the other concern one would have would be if a patient said—and you were handing over control to them—"I want to do this thing and it is not particularly evidence-based but I think it is a very good idea." Is that right in our healthcare system? I think we would really need to debate that. At the most extreme case, you might say that if somebody was an alcoholic you would not hand them over some money and say, "That's fine, just head off to the pub." There are other, for example, unproven therapies which somebody might say, "That's what I want to use my budget for." Related to that, what happens when the budget runs out? How do we deal with that? There are quite a lot of unanswered questions. Perhaps the big one, which is very topical at the moment, is the question of co-payment. If you convert it into money—and I do not think that is what the Government are suggesting, but that is the logic of the thing—and say to somebody, "There is £1,000 to manage your long-term condition," then if I have additional resources I could say, "Yes, I'll take that £1,000 and I'll top it up with my £500" and now I have £1,5000. That would fundamentally undermine a basic principle of the NHS, which is equity of care. You could see that, for example, in various forms. The NHS might at the moment prescribe a form of group therapy and say, "If you join this group, then it gives you that help." A lot of people might say, "I'd rather have one-to-one," but that is not on offer in the NHS. If it were converted it into money, I could then say, "I'll use my money and I'll top it up and I'll have individual therapy." There are lots of questions to answer. The principle is right. It reflects some of the things I have been saying already, which is that we need to hand over more choice and control to patients, and I think they will increasingly demand that, but I think we also have to be clear about what the limitations and the restrictions on a health budget might be.

Professor Newland: I think handing over more choice and control to patients is an important way forward. Personally held budgets, at a time when we have not sorted out commissioning arrangements or tariffs, is a moot point, as to whether something like that could be introduced now. Introducing something now, even necessarily on a small scale, while we are dealing with the other things would be very difficult. A lot of patients come to see you because they have found something on the internet and when you tell them it is not available they tend to think you are saying that on a cash basis, not because it is a clinically made decision. Until we have more information, more reliable sources of information that we can use with the patients, and having dealt with issues such as availability and tariff cost, then I think it is difficult to introduce at the moment.

Q116 Charlotte Atkins: I am now turning to local accountability. Mr Dickson, does the review address the tension you describe in your submission between national standards and local decision making?

Mr Dickson: It does in place and it does not in others. The faster process for NICE, for example, does not remove the postcode lottery. It will address a bit of it at a particular point of time. The creation of the separate SHA regional plans appears to almost enhance the notion that there will be differences around the country and formalise them. The Government's answer to that is to say that we will have minimum standards across the board and they will be enforceable but that beyond that you will have better standards or a different emphasis. One of the regional plans does not mention cancer at all; the other one says, "We're going to get faster, quicker, better at cancer than anywhere else in the country." I think there is a tension between national and local. I think the Government are right, in a sense, that setting standards at national level is right. Certainly as an NHS patient and as a taxpayer I expect a minimum standard of care wherever I go within the National Health Service, and that is right. One of my queries, if you have local variation, is who is accountable for that and how is that accountability expressed. I do not think the Government have yet fully addressed that issue. Nigel mentioned that an SHA is a bit like Denmark. These are completely artificial creations. Nobody walking down the street is saying, "Ooh, I'm in the South Central SHA." There is no concept of it. Accountability really has to be at a local level. Partly that means you are going to have some national accountability for the standards that you are doing, some national accountability for how you are performing locally, but, also, much stronger local accountability. That is the point I made about the Local Government Association. I am still not convinced that the Government have done enough to strengthen oversight and scrutiny committees and the role of how public involvement will start to work within the system.

Q117 Charlotte Atkins: Hopefully that would mean that SHAs would not be forcing local primary care trusts to sign up to contracts they did not want. For instance, for an independent sector treatment centre that local patients, through choose and book, decide they do not want to participate in.
Mr Dickson: I think that is right. The days of national procurement have probably gone. On the other hand, I would not argue that ISTCs have been a disaster in all their places. It is a question of saying that these local bodies are responsible for commissioning at local level and they should be held accountable at local level as well as at national level for their performance. It is more about what they produce at the end of the day rather than how they do it. The emphasis has been too much at looking at how they do things or telling them exactly how to do things rather than holding them to account for what they have produced.

Q118 Charlotte Atkins: Your submission mentions taking greater account of local views and giving a clearer account of decision making to people they serve, but how do you do that? You may have local campaigns, as we had, for instance, on Herceptin. Is that the local viewpoint or is that the local viewpoint of the individual who is desperate to have a particular operation and the PCT is not deciding that they are a local exception.
Mr Dickson: There are two aspects to this. First of all, at the local level. Involving people is complex and difficult, but there are examples of PCTs which have done it and which have involved local people through a whole variety of mechanisms. The trouble is that often the involvement comes when they are about to shut down a hospital or move a service and so on, and that is their consultation period. We need to have organisations that have an ongoing dialogue with their local population, where people are aware about quality issues of services. Perhaps I could show you how poor this is at the moment. For the LGA we did a national opinion poll and asked people, first of all, whether they knew what a PCT was or did. More than half the population did not know. We then asked them what did they think they bought. 46% of the population said that they knew what PCTs bought or did. The top four things that they said they bought or did—the first three obvious—were hospitals, GPs and healthcare services, and the fourth was emptying dustbins. That is not a criticism of the public but it does demonstrate just how far we have to go if we are saying these bodies are locally accountable in any way, shape or form. I do not think simply having a national accountability—which I am all in favour of retaining, not least for national standards—is sufficient. We need to strengthen local accountability at local level.

Q119 Charlotte Atkins: Do you think the review covers that satisfactorily?
Mr Dickson: They have adopted a couple of the recommendations that we put in our report. I think they probably need to go further. Again, they have resorted to this idea of, "We can't be top-down about this, so we'll let the PCTs do whatever they want to do." I am not sure that is right. There is a difference between being prescriptive and centralist when you are saying, "I want you to provide this service in that way," as opposed to saying, "I expect that local people will have this degree of control, this degree of accountability, and anything below that is not acceptable." There is a consultation period now, so they could be a bit more prescriptive. One of the very simple ideas that we put forward was that the local government should be involved in the appointment of PCT chairs and non executives. Again, they have said that this is a sort of good idea and that they will encourage it to happen and look at how it might happen, but it looks like they are more likely to say, "Well, PCTs which want to do that, absolutely fine" or "SHAs that want to do that, absolutely fine," rather than saying, "We think this is a system that should happen all across the country." As a taxpayer I think I have a right to some sort of local involvement. That sort of thing it is perfectly right for a government to be prescriptive about, as to how the mechanism should work to ensure a degree of local accountability.

Q120 Sandra Gidley: Links do not appear to be working as a way of doing that.
Mr Dickson: Yes. In that report we were very anxious, certainly, not to start reorganising every thing, to say, "We should change the structure of PCTs," because I think there have been at least five or six reorganisations too many. We have a set of systems, including Links, oversight and scrutiny committees, practice-based patient groups and so on. A whole range of things are in place. If I were starting with a blank sheet of paper, I would probably not start with them, but, given that we have them, we should be trying to find ways in which we can strengthen them and make them real. Some of that is about resource. Traditionally we have not resourced community health councils properly. There is a danger we do not give the status to oversight and scrutiny committees or resource them; that being on Cabinet within local government is the place you want to be rather than on scrutiny—and this is a wider issue than health. I think scrutiny committees have real potential if we are prepared to put some resource into them. And they could move away from the world you described a moment or two ago, a sort of antagonistic "Oh, they're just trying to knock us down." Once you start having a more intelligent debate, and so you say to people, "This is about services, it is not about buildings," then I think you will improve the quality of debate locally, and you will probably have less conflict then you would otherwise have.

Q121 Dr Taylor: Just to conclude that, I think all members should read the LGA Health Commission Report: *Who's accountable for health?* Coming back to clinical leadership, because we just touched on that briefly, the submission from the Academy says clinical engagement, clinical leadership, is a major underlying weakness of the NHS. How can it be improved?

Professor Newland: I think we have seen over some years now that clinicians, in particular, have pulled back from leadership. You have those involved in the colleges, you have people who are involved with management and leadership locally in small units. However, without that middle tier, people tend to be involved with leadership for statutory roles but not really for taking the profession forward and leading by example. I think we recognise that through the Academy, and the work we have done over the last two years with the NHS Institute in developing a leadership programme. That has now been accepted by PMETB and the colleges are now incorporating that as part of their curricula. I think it is a way forward of showing trainees—so you catch people at an early level—that leadership is an important part of practice. It is not purely becoming a doctor and providing care; part of providing care is how you mould and develop the service. One of the issues over the years has been that medics have looked at managers and the transient nature of their posts and have not wanted to swap a secure clinical post for what they perceived to be an insecure management post or leadership post. I think we have to try to break down those barriers and we have to try to inculcate the attitude towards leadership that this is crucial to what we do. That is part of what we now have the opportunity to do, with the work from the Academy, with the National Institute, and we are starting to do that. It is early days.

Q122 Dr Taylor: A much wider front of national clinical leadership. The Chief Medical Officer, before us some weeks ago, was quite clear that he did not regard himself in that role. Has the Academy ever regarded it as having a role of national clinical leadership?
Professor Newland: It is fair to say we have over the last two to three years. In the early years of the Academy, the first two decades of the Academy, it was very much a forum for conveying information, for the colleges meeting together to discuss issues, of being a body that liaised with the Department of Health but never saw itself in that role. Over the last three to four years we have realised that each individual college, whereas it is important for its own specialty specific area, really cannot say anything about areas that cut across all colleges. I think the work that we have done over the last two or three years is trying to move away from that. I think that has been accentuated by the debacle of MMC and the Tooke report. It highlighted, at that stage, where we felt individual colleges should make their own responses, that we were remiss as an Academy for not realising there were wider issues that we should have challenged. We made that mistake: we will not make it again. We are trying to involve ourselves very clearly with many of the other issues that are now going on.

Q123 Dr Taylor: Could you give us some examples of the wider issues that the Academy should speak for the profession about?
Professor Newland: I have already mentioned the reorganisation of acute services document that we have produced. We are doing a lot of work on revalidation at the moment, to make revalidation relevant and flexible for individual practice. The audit and Quality Improvement Programme that we are doing is crucial. I think the leadership work that I mentioned is also something that we are doing. They are four quick examples. The work that we are now doing with MMC on developing training, we have managed to pull a lot of that back from the brink. The process this year has been a lot smoother and a lot of that has been the Academy's co-ordinated and cohesive influence on the body.

Q124 Dr Taylor: You mentioned earlier that "colleges lay down standards but cannot enforce". Did they lose that ability when they no longer inspected hospitals? One of the things as a practicing physician one used to dread were the visits from the Royal Colleges to inspect you, because if you failed you would lose your accreditation for training. That struck me as an absolutely vital part of quality control. Why did that go?
Professor Newland: I think you are absolutely right. It is something that we hear quite frequently from our members out in the hospitals, that when we used to come and visit this was an information that we could use with the management to achieve what we wanted. That has been lost. It was lost because of the general feeling that there were too many colleges wandering around at different times, taking up too much management time in visiting. Those visits were questioned and that stopped. I think there has been a major loss to the service. Within pathology, we have clinical pathology accreditation. The radiologists are developing that, the GPs are developing a similar scheme, and the psychiatrists have a scheme as well, so I think there are various areas where we are beginning to take that forward. The vehicle for taking that forward is the healthcare management improvement programme that I mentioned earlier, which we are developing with the College of Nursing and the Long-Term Medical Conditions Alliance. It will allow us to work to develop the Darzi suggestions of accreditation, looking at clinical accreditation and looking at the accreditation of services such as pathology, radiology and anaesthetics that have plant that you need to go and look at. Part of those accreditation visits look at outcome, they look at turnaround times, they look at quality assurance for the practitioners. They have a wider remit than purely tick-boxing services.

Q125 Dr Taylor: There are things in Darzi that could help with this.
Professor Newland: Yes. I think they are mentioned briefly in accreditation and there are vehicles there that can take those forward.

Q126 Dr Taylor: This awful phrase "modular credentialing".
Professor Newland: That is a slightly different step from revalidation. Modular credentialing is essentially part of post CCT training, whereby your

specialist may want to develop expertise in a different area and there will be a module in which they can be credentialed in that. It is a buzz term at the moment, but it has some relevance to practice. That is slightly different from the accreditation.

Q127 Dr Taylor: In your submission, when you were talking about leadership, about seeing what it needed, making it happen and recognising new opportunities, it went on to say, "Clinical leadership is also about opposing changes that are judged harmful, but coupled with soundly argued alternatives." Are there any of those in Darzi that you were thinking of when you wrote that?
Professor Newland: Not really. It was more of a general description of the quality of clinical leaders. It is important that they are in a position where they feel free to be able to challenge changes in practice by unsupported evidence; to challenge policies that are contradictory that may lead to fragmentation of the service; that may look at effects on the training of juniors; that look at perverse rewards. That is really where that was aimed.

Q128 Dr Taylor: Is there any recognition of loss of leadership on individual wards, where consultants no longer have the facility to take the nurses to task if something is not up to standard.
Professor Newland: I think that went years ago. Unfortunately.

Q129 Jim Dowd: The NHS Constitution—a good thing, a bad thing? Do we need it? Do we not need it? If it is a good thing, what has the NHS lost over the past 60 years by not having one? What should be in it and what should not be in it?
Mr Dickson: I think it is a good thing. I think they have done a good job in putting it together. What has the NHS lost by not having it? I think it should provide greater clarity of the deal. What is the deal between taxpayer and patient and state? I think setting that out is a good thing. There are an awful lot of rights and very few responsibilities, I have to say, in this. I understand why that is, because the responsibility side is difficult, because enforcing the sanctions is more difficult. But having some responsibilities there is good in itself, just as a recognition that we, as the people using the service, do have a responsibility to look after our own health but also a responsibility in how we use and handle the service. What could be added or removed? I think there is still a little bit of confusion in what the letters "NHS" mean inside the Constitution. I would like greater clarity around that. The Government may not want to say this very clearly, but I think we are moving from the notion that the NHS is a state-run service to something which is in a way much more powerful, which is that the NHS is a guarantee of free, comprehensive care when I need it for me and my family—that sort of deal—and I think they should be more explicit about that. Any organisation—and hopefully we will get a lot more third sector/voluntary sector involvement in providing services and so on for the NHS—is absolutely bound and should be bound by the NHS Constitution, by the values behind it and how they treat their patients and all the rest of it, and the equity that lies behind the NHS deal. For those two reasons, I would like to see that a bit clearer within the document. The bit I find hard to answer—and I think I am an optimist on it—is what impact will this have? There are two disaster scenarios. One is that nobody takes a blind bit of notice of it and it is just a lot of waffle. The other is that it is somehow misused. That was the argument used against the Patients' Charter. But I think we are in different times. The NHS is not as strained as it was at the time of the Patients' Charter. Inevitably there will be individuals who will misuse this and so on, but there is some emphasis for staff within this, certainly in the background documents to it as well, so I think they have the balance about right. I hope that it will be something that people can identify genuinely where the service should be giving them service and where it is falling short and enable them to challenge in a sensible way. If it does that, that is a good thing. It keeps the service on its toes. Also, in a more diverse and arguably fragmented system, where you have lots of different providers, having this single thing that says, "Yes, this is something that we all share and these are values that we all share," is really important.
Professor Newland: I would reiterate many of Niall's points. I think it is important that we look at it at the moment. The balance between rights and responsibilities needs to be looked at in more detail: at the moment patients have rights but no responsibilities, and it seems that the staff in the NHS have responsibilities but few rights. I think we need to balance those. Crucial at the moment is the issue of what the NHS can be expected to provide. We see this debate all the time now, in what our relationship is with the third sector and with the independent sector. The whole issue of co-payments that we are currently discussing has to be teased apart. I would like to see the document starting to define what you can rightly expect from the NHS.
Chairman: Thank you. Could I thank you both very much indeed for staying the long haul with us this morning.

Thursday 17 July 2008

Members present:

Mr Kevin Barron, in the Chair	Stephen Hesford
Charlotte Atkins	Dr Doug Naysmith
Mr Peter Bone	Mr Lee Scott
Jim Dowd	Dr Howard Stoate
Sandra Gidley	Dr Richard Taylor

Witnesses: **Professor the Lord Darzi of Denham KBE,** Parliamentary Under Secretary of State, Department of Health, **Mr David Nicholson CBE,** Chief Executive, NHS, and **Dr Jonathan Sheffield,** Medical Director, NHS South West, gave evidence.

Q130 Chairman: Good morning, gentlemen. Could I welcome you to our second evidence session of our inquiry into the NHS Next Stage Review. I wonder if, for the record, you could introduce yourselves and the position that you hold?
Professor Lord Darzi of Denham: Ara Darzi, I am the Parliamentary Under Secretary for Health.
Mr Nicholson: David Nicholson, NHS Chief Executive.
Dr Sheffield: Jonathan Sheffield, Medical Director of University Hospitals Bristol Foundation Trust and lead for the Clinical Need South West Review.

Q131 Chairman: Once again, thank you very much for coming along. I have a few questions by way of introductory remarks in relation to this session. The review really provides very little detail in terms of the cost that it is going to have. Could you tell us why?
Professor Lord Darzi of Denham: Firstly, to start off with, as I made it clear in the interim report, this review is all about service transformation. Let us remind ourselves, with the CSR settlement back in October last year with the 4% increase, in real terms we will be spending somewhere in the region of £110 billion by 2010/2011. This review is all about the transformation of the service and how could we get better quality care out of the investment we are making. As far as cost goes, it is costed within the system and, at the same time, also some of the proposals in the enabling report are costed as part of that package.

Q132 Chairman: There have been detailed economic reviews of these. When you say it is within the package, we have got general inflation running at higher than 4% now and the economic outlook does not look great at this particular time. Are you sure that it is sustainable within this three-year term?
Professor Lord Darzi of Denham: Health inflation always has been higher than consumer inflation. I think that has been historical and we have all known that. Just compare ourselves where we were eight years ago. We have doubled the budget and we are keeping up with a number of European countries when it comes to expenditure. We are in good shape; we have a surplus. I think we have done reasonably well, if we look at the CSR settlement of 4%, in contrast to other public sector bodies, and I think we should live within the context of the funding that we have.

Q133 Chairman: You probably heard that last week some of our witnesses were quite critical of the lack of detail in terms of implementation of the Next Stage Review. Given the history of implementation within the National Health Service for the last 60 years and one week, are you happy that it will be implemented or do you think that what we are listening to here is warm words of good intent but that the likelihood of it being implemented is not very strong?
Professor Lord Darzi of Denham: I think the process in itself is very different in relation to the Next Stage Review. If we look at the contents of the review, we have the ten regional reports, and I had the privilege of attending the launches of the ten regional reports, and what is different about them, which is very unique (and I certainly learned something from it myself and I think the Department of Health also learned something from that exercise), is the tremendous amount of ownership in the review and the content of the local reviews and the pride in relation to what they have done. Let us not forget, there is fairly detailed implementation planning in every regional report and how they are going to make these changes happen based on the eight pathways. At the same time we will be holding the PCTs accountable in coming up and translating the regional report into strategic plans, which will be published in the spring of next year. At the same time we also have the enabling document that I published on 30 June with some of the enabling policies. These will be implemented and there will be an implementation board within the department. It is very important to realise that that implementation board is going to work very closely with the regional reports in making sure that some of the national policies are implemented. I think, if you also look at the two other documents that we published on the day, we have published the *Next Stage Review: High Quality Care for All*, but we also published *Workforce Planning*, an indication document in itself, which also has an implementation plan, and, similarly, the *Primary Care and Community Strategy*, which was published the Thursday after that report, also has an implementation plan. I am sympathetic to your concerns when it comes to implementation, but I think we have a completely new process here and we should never forget that a significant chunk of this report is about local implementation and clinicians and non-clinicians at a local level who have taken the ownership of

making this happen.

Chairman: We are going to move on to one or two of those areas now, starting with quality.

Q134 Dr Stoate: Thank you, Chairman. I would like to congratulate you, first of all, Lord Darzi, on what is an excellent report and I think has been widely received as an excellent report, so I would like to congratulate you and your team on a splendid effort. However, you will appreciate it is our job to pick this to pieces and to look at some of the detail, which is always challenging. I would like to start with questions on quality. You suggest throughout your report that quality is at the forefront, and that is to be welcomed. However, we are all aware that there are unacceptable variations in quality, particularly amongst clinicians and other groups within the Health Service, which has been present probably for ever, and certainly most recently reports have been written pointing this out. What have you done and what can you do to address the really thorny problem of variations in quality?

Professor Lord Darzi of Denham: I agree, there are variations in quality, and I think we need to also put into context that throughout this year, which has been a fascinating year for me, all the business and where you go across the country, you will also come across some centres of excellence, you will come across services that you will find very hard to find even in Europe and across the Atlantic as far as the quality of care they provide. There is a uniformity issue, and think that has been acknowledged in the ten regional reports. What is interesting about this, I think one of the clinicians described it as a movement *per se,* for the first time that I could remember clinicians at a local level challenging themselves in the care they are providing and trying to see through the evidence base how could they transform services at a local level, and that is why I believe, if you look at the local and regional reports, there is a tremendous amount of aspiration and ambition. In some of them the ambition far exceeds anything I thought of back in October when I was in front of you. The eight pathways also provided a process through which we got clinicians and non-clinicians from all sorts of different backgrounds for the first time in some parts of the country, probably in the areas that you are referring to, sitting around a table and really challenging themselves: how do they break some of the boundaries that exist between primary and secondary care? How do they really break down the boundaries between health and social care? How do they even break down the professional boundaries that exist between our nursing colleagues, pharmacists and medical communities? Their aspiration, purely by breaking these boundaries, is to improve the quality of care at a local level, but I think whenever we say this we should also remember (and I say this as someone who has been working in the Health Service for the last 18 years), if you look at any of the quality parameters that we currently measure, I think we need to measure more, and I am sure I will come to that point. We have seen tremendous improvements when it come to outcomes of care. Within the last even five years, just look at the management of coronary heart disease. In the days of the NHS Plan I remember people thumping the table and saying, "We need more cardio-thoracic surgeons." Within a year of that emergency angioplasty came in. Within 18 months of that, this country led one of the biggest trials in the use of statins and, following that, you voted for a smoking ban. All of these changes have had a tremendous impact on mortality rates, for example, in myocardial infarcts a 42% reduction. Okay, we had to catch up a lot, but a 42% reduction is the most steep reduction that we have seen in any other country that measures these quality outcomes.

Q135 Dr Stoate: That has been welcome, and you have quite rightly pointed out the huge increase in quality across the piece, which is undeniable, and we are, as you say, amongst the best in the world now in many areas of medicine. The difficulty I have got is the variations; not the overall quality, which is undoubtedly going up, but the variations. We heard last week from witnesses who said that they had seen people practising, not even best practice, not even NICE guidelines, nowhere near the level they should be practising at, and yet, nevertheless, carrying on providing that service apparently unchecked. So I am not worried about the overall quality, which I think is good, and I am worried about the variations in quality, which I do not think is good.

Professor Lord Darzi of Denham: I agree with that, and that is the whole purpose of the report. At a local level to look at the eight pathways and challenge clinicians for the first time, "What is the evidence base in transforming your services?" I agree with that. There is got to be a huge cultural change in making that happen. That is why one of the outlooks in the report, something we should all be very proud of in this country, which has been copied elsewhere, is the creation of NICE post the NHS Plan. The National Institute of Clinical Excellence is now recognised internationally. I think what you are saying, and I could not agree more with you, is how do we get all these guidelines and standards out there down to the front-line and really implementing evidence-based care? I think we have identified the process, which is the eight different pathways, and these 2000 clinicians have truly engaged in this process. I think we need to help them next, because the story should not end. I think we need to keep the spirit of the review. These people, who have charted the paths of the best models of care based on the latest evidence, should actually start getting more engaged now in commissioning these services. I think that is a very strong point. The second, which is in the report, and I do not yet believe we have really appreciated its magnitude, is the transparency in the system: clinicians being accountable to the quality of care but also publicly reporting that and using that information, which I believe as a clinician too. To be fair, a lot of clinicians in these centres that there is high quality care, these organisations not just use the information to empower patients but they also use that information to improve the system.

Q136 Dr Stoate: A final point about quality of accounts. Do you think it is realistic to assume that the quality of accounts will ever be given the same status as financial accounts? Can you see a position, for example, where a trust that would do well on quality of accounts would get away with not doing so well on its financial accounts?
Professor Lord Darzi of Denham: I think they will take it seriously. I have no doubt it is in one area of provision of any service in which quality matters most. It matters to the patients who are using the service and, secondly, it matters a lot to those delivering the service. Something which people sometimes underestimate is the pride as a clinician, whether you happen to be a nurse, whether you happen to be a doctor, whether you happen to be a pharmacist, whatever, in the quality of the service they provide. So I think the boards will be held accountable to that, and I think we will make sure that happens. I think the question you are raising about quality and finances is an interesting one. If you really look at the facts and the evidence—and I came across this when I was looking at the Healthcare Commission information—those who are providing the best quality care also are the most financially stable organisations, and there is an interesting correlation there. If you look at the top ten from that, you will come to that conclusion. Any good organisation has to live within the means of its finances and also provide the best quality care. Health economists call efficiency all about that. Efficiency is to provide the best quality care within the financial means that are available to you. That takes time. If you read the report, we are shifting that into what we call service lines and really making clinicians, not just accountable to the quality, but clinicians also need to transform from being commentators on the resources to actually being also in charge of those resources. I think if you combine those two together, you will come up with a fairly powerful lever really looking at finances and quality
Mr Nicholson: Can I add to that? Each chief executive in the NHS is an accountable officer, and we send that out to them. The change we have introduced there is that their accounting responsibilities used to be entirely financial. We have now made them both financial and quality of care. So chief executives are accountable as far as quality of care as well, which I think will bring it much closer into the centrality of the way we manage things in the NHS. The second issue is in relation to the quality of the accountants themselves, which, of course, will be overseen by the Care Quality Commission, the regulator, and the regulator will obviously want to look and satisfy themselves that they are doing what they said they would do.

Q137 Dr Naysmith: Good morning, Lord Darzi. I want to stick with this variation in quality of care that Howard has been on just now. One of the methods that you recognise or suggest should be used to address variations of quality is the use of mortality results from hospitals. Of course, we all know that the data about mortality rates in hospitals can be misinterpreted and misused and can sometimes be misleading. On their own, they can be misleading. So how do you intend to ensure that data are used properly to assess quality?
Professor Lord Darzi of Denham: Sure. I think you raise a good point about mortality figures. That is the data that is available now. I personally believe that it is probably one of the crudest, bluntest instruments that you can use. It is also an end point, and I think really in modern medicine measuring mortality rates is irrelevant. I think really when you are talking about quality of care, it is not irrelevant, it has relevance in certain conditions—coronary artery disease, for example, if you are having cardiac surgery, if you are having cancer surgery—but let us not forget, in modern medicine a large number of procedures have no mortality rate.

Q138 Dr Naysmith: Why are you recommending this method of assessing quality?
Professor Lord Darzi of Denham: What I am recommending there is measures or metrics that will measure safety, measure effectiveness (and I will come back to that point) and also patient experience. Safety measures as we know them: we do measure healthcare acquired infections, being a good examples of that. Untoward incidents: we have the National Patient Safety Agency that measure that. I think the main crux of the report is to look at the effectiveness side, and within that effective side it is not a new thing for clinicians to measure outcomes. You are right, within outcomes the mortality rate was one way of measuring it, but I believe there are other outcome measures and there are a large number of national databases that professional bodies have been involved in for many years in which I think probably, if you are critical, you could say that clinicians have not been as compliant in really entering that information. For the next decade, what I have said in the report, which is the component of quality measure which is important, is also the personalisation of care, which is one of the principles: in other words starting to measure patient-related measures.

Q139 Dr Naysmith: We will come to that later on, but sticking with the mortality tables at the moment, would it not be essential to cover both those clinicians, mostly orthopaedic surgeons, who operate both in the private sector and in the public sector? Should not their datasets be combined so that people can know what they are like in both sectors?
Professor Lord Darzi of Denham: You are talking about purely mortality rates.

Q140 Dr Naysmith: Purely mortality rates, yes.
Professor Lord Darzi of Denham: We have those mortality rates. That is available; it is in-house. All that information is available and we actually published it in *NHS Choices* recently.

Q141 Dr Naysmith: You published what these people do in their private work. That is what I am asking.

Professor Lord Darzi of Denham: Within the context of the new regulator which is CQC, one of the principles of the creation of the CQC is not just the integration of health and social care but to look at the whole healthcare provision, whether that happens in the private sector or in the NHS.

Q142 Dr Naysmith: These figures are published alongside the National Heath Service figures?
Professor Lord Darzi of Denham: The *Choices* website that we published recently, that NHS data.

Q143 Dr Naysmith: Whether you are using mortality tables or not, what measures should be used against poor clinical practitioners who are identified as delivering poor quality work?
Professor Lord Darzi of Denham: Maybe Jonathan might come in in a minute, but if I could take you back to the Care Quality Commission—it is quite fresh in my mind because I have to take it through the Lords after you have taken it through the House of Commons—there are two reforms when it comes to reforming the accountability of clinicians in the Health Service. One of them is the reforming of the GMC, the creation of the Independent Adjudicator, which has been warmly received by the GMC (General Medical Council), and the second one is the change of the burden of proof from criminal to civil. So we have the mechanisms now in place to tackle issues of clinical competences, and so on and so forth.

Q144 Dr Naysmith: Traditionally, it has taken a very long time to investigate and decide what is going to happen to a clinician who gets into trouble with his or her trust, sometimes years, and you suspend well prepared, well educated and expensive consultants for years.
Professor Lord Darzi of Denham: I agree, and you have made the case, and that is exactly the case which was made in reforming the General Medical Council, and a lot of it was based on the recommendations of this committee and others in how we reform the General Medical Council to meet some of the challenges which are facing us.
Dr Sheffield: As a medical director, that is the meat of my job in a large part.

Q145 Dr Naysmith: I can remember some of the United Bristol Hospitals Trust myself, but it was before you were there, I suspect.
Dr Sheffield: Absolutely, yes. Mortality to me is a useful indicator, but it is not the ultimate indicator. Certainly we monitor mortality throughout our organisation as a way of being assured that we have got good services, and one of the things that I found fascinating in the recovery of our particular organisation was that, as our efficiencies improved, as our reference costs have dropped from being 17 points above the national average down to below the national average, we have seen an improvement in our hospital standardised mortality ratio and it is almost a parallel line. We have gone from average hospital standardised mortality ratios down to some of the best mortality figures in the country, so there is a definite link between running efficient services and improving outcomes, but we also look at a whole range of other outcomes and certainly in very specialist areas we are very keen to develop those even further, because I need that information as a medical director. A lot of our processes around management of alleged or assumed poorly performing consultants has to be an iterative process anyway where, first of all, you have to look into the evidence in detail, and a lot of that is carried out internally, and quite frequently it is an educational process and a change in practice that is dealt with within the organisation rather than the ultimate sanction of going to the GMC. I think certainly acute hospital trusts now are much better at managing these problems internally and making sure that we get consistency of quality from our consultants.

Q146 Dr Naysmith: Should not the medical colleges have taken more interest in this in the past. They are signed up now, I assume?
Professor Lord Darzi of Denham: My views on this: everyone's business should be quality. It is not the medical colleges, it is the Department of Health, it is me working as a clinician, him working as a chief executive and, ultimately, it should be the business of anyone who comes to work, whether you happen to be a clinician or a non-clinician. I think the creation of the quality board is to bring all these stakeholders in, whether that happens to be NICE, whether that happens to be the regulator. Really it is defining what standards of quality are and at the same time, if you see through Chapter 4 in the report, the report is all about measuring.

Q147 Dr Naysmith: The point about all of this is that there have been reports over the last 20 years all saying we want to get quality in. We still have not got it. What makes you think that you are going to get it?
Professor Lord Darzi of Denham: I think we have done a lot actually; I really think we have done a lot. Look at the *NHS Plan* in the year 2000. Did we have any? We had no regulator, remember. We had no such thing called NICE setting standards. We had nothing called National Service Frameworks. To take the example of reducing the mortality rate of coronary heart disease, that was based on the National Service Framework. We had no clinical governance. Your clinical governance was a couple of clinicians coming in and doing their audit meetings. So a huge amount has been achieved in the last eight years, and we have also brought measures, you are right in saying, these measures that I referred to earlier. Quality has three aspects to it: it has the structure, it has the process and it has outcomes. The structure we fixed. If you look at the data we had back then—use me as an example—in 1994, when I was appointed, I was the only colorectal surgeon in my unit. Now, as I say in my report, there are four colorectal surgeons, one nurse consultant, two nurse specialists and two stoma nurses. We have fixed the structure—in other words the ratio of doctors and nurses to the number of patients we are treating. We have also dealt with processes—waiting times. It was

a free-for-all back in 1994. You went in in 18 months or more. Intermittently you had to check your waiting list to see how many patients had dropped out from the waiting list. We now have a process metrics which says in 18 weeks that is the treatment plan that you should have. I think what we have missed out on is the qualitative outcome based patient-related metrics, and that is what this report is all about, because through that is the process in which you engage clinicians in measuring, as Jonathan said, not just death rates but actually qualitative metrics which have two purposes, as I said earlier, empowering the patient but, more importantly, I believe, system improvement, service improvement.

Q148 Dr Naysmith: I think what I was really trying to get at is the mechanisms you are going to use. Once you have assessed quality and discovered there is a clinician who is not coming up to scratch, is it going to be easier to dispense with his or her services? That is what I was really leading to. You are telling me that it is, that you have got the tools that you need to do that.
Professor Lord Darzi of Denham: Firstly, I think it needs to be beyond the clinician. We really need to challenge ourselves in measuring quality based key performance, and that is why patient-related measures are more significant: because they measure the whole of the journey. I could do a very good operation on a Friday evening. On the Saturday morning I could go and see the patient.

Q149 Dr Naysmith: I think some of these things will be explored.
Professor Lord Darzi of Denham: If the painkiller, if the analgesia ran out the night before, that patient would only remember the amount of pain they were in for three hours, they will not remember the procedure, so we need to find metrics in which to measure the whole of the team working. The answer to your question—if there is a problem in our team performance—you are absolutely right, there is a local governance and accountability structure in making sure that that is dealt with.

Q150 Mr Bone: I think patients will be very surprised to learn that under your NHS whether they live or die is not the number one priority. My father went into an old TB hospital for a heart by-pass—certainly not the quality you would like to have seen but it saved his life. I think that is a little bit more important than your overall measure of quality. Surely mortality is the number one aim not a new relevance?
Professor Lord Darzi of Denham: You are right, mortality is a very important figure, but what I said is it is a blunt tool, it is an end point. It is valid in patients having coronary heart disease, but let us not forget in a large amount of care we provide in the NHS mortality is not a factor. We need to find other metrics in which we measure the quality of care we are providing. I could not agree more with you. In coronary heart disease the mortality figures are there. In actual fact we have achieved a lot over the last eight years by making that information openly available, and we have seen similar changes---. I remember in New York, New York City published all their cardiac mortality, and you will see improvements, but there is a large amount of, not just procedures, care delivered out there which we need to find the right metrics or measures in which we improve the quality of that care.

Q151 Chairman: Could I go back to the issue of data collection and sharing. In relation to activity data and mortality data, I am advised that *Healthy Choices* actually collects NHS data only and that the private sector contract with Dr Foster to collect their data but these are not integrated. Is that right or not?
Mr Nicholson: In the information that is produced for *Healthy Choices*, and all the rest of it, the data is for those patients who are treated as part of the NHS, some of which can be treated in the private sector. So that is that bit of data. The second bit of data is the data that is produced by private hospitals for private patients, not to do with the NHS, and that is not part of that data, but, of course, when we introduce quality accounts every hospital will have to produce a quality account, whether it is public or private sector, and the regulator will insist that they produce that information.

Q152 Chairman: So that will be the change?
Mr Nicholson: Yes.
Chairman: While we are on this subject, I ought to mention that we have actually just agreed terms of reference for an inquiry into patient safety. We will be publishing the terms of reference within the next week and we will be starting the inquiry in the autumn. I just thought I perhaps ought to put that on the record, given we are in public session. Could I now move on to Richard.

Q153 Dr Taylor: Good morning. Before I move on to my next bit, one point about quality. You have mentioned the various innovations and the ways of measuring. One thing we have lost that to me was absolutely vital is the inspections for accreditation by the Royal Colleges of every unit in the country. Would you comment on the value of those and whether there is any likelihood of that being brought back, because, as you know yourself, Ara, you can judge the quality of care by looking at a patient's notes and seeing whether there was a record of when they last spoke to the family or the details?
Professor Lord Darzi of Denham: Sure. The answer to that I will say in what I have captured by being around for the last 12 months and doing the visits. They had a purpose in those days. These were the days that we did not measure anything. A couple of people from the colleges walked in, looked around: "What are you doing? How many junior doctors do you have? What are your rotas?", and a decision was made. We really need to move on. The Care Quality Commission now has registration very much enshrined in law. Every provider needs to have a registration. I also believe, and I have had numerous discussions with the colleges, that we need to have a system. The last thing we want is another cohort.

Look at the colleges. Are we going to invite 18 different colleges to visit a single organisation throughout the year: one day we are going to have the surgeons, one day we are going to have the physicians, one day we are going to have the A&E? We need to find ways in which we can collect the measures of quality and the colleges may use that for accreditation purposes. I think the colleges have a very important role to play if there are issues of quality rather than just wandering in purely for accreditation purposes. We need an intelligent accreditation, if there is such a thing.

Q154 Dr Taylor: I am going to move on to patient reported outcome measures, which have got to be in place by 2009. We were told last week that this was really very ambitious. Professor Mays said it is very much a nascent industry and, of course, it has largely been applied in surgery, and then they went on to question, really, "Who is going to administer this system. Presumably they are going to be administered by the providers themselves, or is it going to be an independent agency that collects the data?" "I do not know." That was Professor Mays. Can you give us any idea of the detail of how these outcome measures are going to be recorded, coordinated, used?
Professor Lord Darzi of Denham: If I could go back, there are clinical outcome measures and, as I said, a large number of clinical teams across the country contribute to national databases and national audits in relation to that. I think what we want to do through this report is increase the compliance in entering data. The patient reported outcome measures (PROMS) that you are referring to, I think the best investment we have made was actually in this report. I do not know if you have come across this report. It is good reading actually. It has come from the London School of Hygiene and Tropical Medicine, and that was done jointly with the Royal College of Surgeons. You are right, it started with a number of elective procedures, and what we will be introducing is the findings of these reports, which are the four PROMS. If I am correct, I think they are hips and knees, varicose veins and hernia procedures. The answer to that is that the data collection has to be done by the provider, but the capture of the data, some of the recommendations here are to have that externally collected. From the first couple of agencies there is a reasonable summary of what they have learnt through this exercise. So they have a validated tool, which is PROMS, which means patients' views about their health before and after an intervention, but they have also added to that a quality of life questionnaire which has been validated too. I think we have the validated tool to implement that from April 2009, but we need to challenge ourselves to expand that in other areas, because surgery is not just what the Health Service provides, you are absolutely right, and there are other tools. There is the PASOS tool, which is patient experience of chronic illness care, which is developed in the US. Again a large number of patients have been through the validated tool. What this will do is really ignite the interest in starting to introduce these tools and measures into the system.

Q155 Dr Taylor: You do not think we are trying to go too fast at this. Previous things like the dental contract, *Modernising Medical Careers*, are things that are seen to have been rushed into.
Professor Lord Darzi of Denham: Yes.

Q156 Dr Taylor: Do you think we have got time to develop this?
Professor Lord Darzi of Denham: I think it is a gradual introduction, but, on the other hand, it is very different than the two examples you gave. This is what excites clinicians, and there is nothing new about this. This is what clinicians did before; this is what clinicians continue to do. I take your point, a gentle introduction to the service, not only that is important, but I think we need to do this in partnership with the service. So the next challenge we have between now and April, through the clinical working groups, the providers and others, is really to engage in this process. In 2009 it will be the four PROMS which I referred to earlier.
Mr Nicholson: Can I add a general point? I think the thing about this report which makes it different to ones that I have seen produced in the past is that there are quite a lot of gradual introductions of things. That is why we are going for four conditions on PROMS, not everything, because we do need to learn and test as we go along. That is something, I think, we have learnt to our cost in the past.

Q157 Dr Taylor: That is very encouraging, that you have learnt that the "big bang" approach does not always work?
Mr Nicholson: That is true.
Professor Lord Darzi of Denham: Can I bring in Jonathan as well.
Dr Sheffield: From the point of view of where we are at the shop floor level, there is a great hunger, particularly on the clinical pathway groups, that we get these results, that we understand how good our services are, and we are desperate to get these measures in because we want to see what our outcomes are. It is very difficult in some circumstances of healthcare to get that feedback. If you are a consultant in a big hospital, you might only see the patient once or twice a year and never see them again, so how do you get your feedback about the quality of care? So the use of clinical dashboards is something that will be welcomed at the grassroots level.

Q158 Dr Taylor: Finally, have outcome data been linked to *Payment by Results* anywhere yet?
Professor Lord Darzi of Denham: Yes, there is the evidence for that as well. There is two pieces of information on that. Firstly, the American healthcare systems have been using the *Pay for Performance* as an example, and *Pay for Performance*, if that pay is to clinicians, I think the evidence base is not there to support that it will improve quality. In actual fact, there might even be

perverse incentives in there, but if you are paying a bonus on quality to organisations or teams, then certainly there is the evidence base. Probably the last one was the publication of the *New England Journal of Medicine*, which looked at a properly designed randomised study in which bonus quality payments did have an impact on quality improvement, but, interestingly enough, not on those who provided high quality care, because they continued to provide what they do, but mostly around those are nearer to the baseline and really shifting them up to where they need to be.

Q159 Jim Dowd: Richard has moved seamlessly into the area that I was going to look at and, in fact, stole one of my questions, but I will speak to him later about that! The issue of data collection, the accuracy of it, obviously is a benefit in itself for the NHS to know where it is effective where it needs improvement, but if you are now linking it to *Pay by Performance* it adds a completely different dimension to the importance of the accuracy of that information. Is the experience in *Pay by Performance*, whether in the US or the UK, where it is being practised, that it is a sufficiently refined tool, that there is evidence that penalising poor behaviour drives up quality and rewarding better performance has a beneficial effect on patient outcomes?
Professor Lord Darzi of Denham: We are not penalising those who are poor. We are actually putting a positive incentive in the system and rewarding the quality of care. The publication I was referring to is this *Public Reporting* and *Pay for Performance* in hospital quality improvement, which is the relevant document which I referred to published earlier. There is plenty of evidence. If you do it at an organisational level, yes, there will be quality improvements. I think you are right in suggesting, as I said earlier, if you are paying individual clinicians, then you will see some of the perverse incentives. For example, you will get fragmentation of care between clinicians competing for that. That in itself is poor. There is some evidence to suggest in the US that you may actually increase your volume, not necessarily the evidence base—in other words throughput or procedures which may not actually have the evidence base in supporting them—but at an organisational level, rewarding for quality, there is the evidence base there and I am fairly convinced that will have---. You are right, I think, back to Dr Taylor's point: how do you implement that and how do you link that too is the area that we need to put more thought and more depth into.

Q160 Jim Dowd: You say we are not penalising anybody for poor performance, but did the department not introduce a series of fines for trusts where their *c.diff* rates were at wide variance to the expectation just last year?
Professor Lord Darzi of Denham: That is proposed on safety issues, and I could not agree more. The Bill has gone through Parliament. The CQC will have enforcement powers in making sure, if there are issues of safety---. If I could take you back to last October, most of the discussions on the debate last October, in this committee, were about safety related to healthcare acquired infections, and we have to make sure that that is a given. Safety has to be a given in every healthcare provider. I have absolutely no problem in penalties associated with minimum safety standards in organisations, and I think we should all support it. I think what we are trying to do is to really reward quality of care based on the patient experience and also the outcomes, and that is a completely different phenomena of what we are really talking about when it comes to safety.

Q161 Jim Dowd: One of the issues we looked at in the new dental contract was the fear that as you provide incentives, whatever you care to call it, *Pay for Performance*, you actually skew the activities of the practitioners and they actually then start to do those things which are the most profitable for them and avoid those which are more expensive, and the issue of unnecessary procedures then arises. How do you guard against that?
Professor Lord Darzi of Denham: You are right, and that is the case I am making. The bonus that we are introducing is not for individual clinicians, it is actually for the team and the whole provider side of things, rather than individual clinicians. I think what you point out, which is something I have learnt talking about the science of incentives, it is no different than if you discover a new drug: any new drug has a therapeutic component, but, I tell you, it has a side-effect and you need to make sure that you manage the side-effect of that. That is why we strongly believe that we are not really putting this incentive purely on an individual clinician's pay but actually making it as a team and, more importantly, if we can challenge ourselves further to make it across a pathway.

Q162 Jim Dowd: What about the danger, I suppose, of incentivisation, where an area that has been incentivised attracts a disproportionate amount of attention and activity and an area which has not been is neglected?
Professor Lord Darzi of Denham: The whole purpose here is to introduce incentives across the whole system. We are linking into the tariff, as you correctly pointed out, the PBR. The other thing which we need to make clear here, if you do not receive the bonus—it is about 2.7% in the uplift of the tariff—that is irrelevant in organisations providing large throughputs of cases, but it is a very small component of the tariff uplift is what I am suggesting. It is not actually replacing the tariff by one single quality bonus.

Q163 Mr Bone: I would like to ask about the cost of patient outcomes and measuring it, but just following on from what you said at the end there, I can understand incentives and payments in a private system, but I cannot see how it is going to work in a state system because the state provides all the funding anyway. How do you square that circle?

Professor Lord Darzi of Denham: The state provides care, you are absolutely right, but we are incentivising public service providers in improving the quality of care. As I said, it is a 2.7% bonus payment for these organisations who are providing—I go back to Dr Stoate's comment—the highest quality of care, who are also measuring the experience of the patients going through, and I cannot see a difference. I think what you are referring to in the public sector, which is a fee for service where an individual clinician would be paid, is completely different and I could not agree more. We are introducing this within the context of a service outcome.

Q164 Mr Bone: Going on to the cost, we have heard some wide variations of the cost of measuring patient outcomes. One of the issues was just a questionnaire and the cost of inputting it, someone was saying, from £2.50 to £10.00, which does not sound a lot but if you multiply it by every patient it becomes quite a lot of money. What estimate have you made of the cost of measuring patient outcomes through PROMS and other measures?
Professor Lord Darzi of Denham: This paper says it is £6.50 and this was a trial, if you wish to call it that, and it was an added work to the NHS' work at the time. The costing was £6.50. I think, if you ask the private sector—and I did ask one or two of the private providers who do measure or have introduced PROMS into their system—it costs them about £2.50, as you pointed out earlier. It is one of these where scale will have a significant impact, I think. Let us not forget, there are automated ways of capturing this information, and I have no doubt in a large-scale automated way we will reduce the cost of that, but people do get hung up about cost. I remember when we first started, the cost of the review: was that money worthwhile? At the end of the day, if you are measuring something in which you are going to improve the quality of care, that is completely a trivial matter. If you do not listen to what the user of the service thinks of the services that you have just provided—that is number one—number two, if this is going to drive quality based and more effective treatments (and let us not forget, more effective treatment is cheaper ultimately), if we really could get a lot of the guidelines, a lot of the evidence-based interventions really implemented through this process of measuring it, I think at the end of the day we will save more money than actually treating some of the morbidities associated with care.

Q165 Mr Bone: I could not agree more, measuring the patient outcomes and improving quality. We have slipped in the European league down to 17 out of 27 and most of the countries below us are poor Eastern European countries, so we have got a long way to go and this must be the right way, but with these forms, I can see problems with my constituents, because I have a lot of Asians whose English is not particularly good. Most people, I guess, going through the system are elderly. Certainly in my father's case, he had slight Alzheimer's and had great difficulty in filling in these forms. How are you going to ensure that you get a really proper response to it so you have got the whole set rather than just all the middle-aged people who are filling them in quite easily?
Professor Lord Darzi of Denham: I agree with you, and in actual fact you probably could say they are the ones you need to measure because they are the ones who do not usually tell you and probably have not had---. Again, interestingly enough, if you look at the London School of Hygiene Report, there is another group actually. The drop out rates were quite high in patients with cataracts, who could not see the form, and you could see that difficulty too, and their suggestion here, and I agree, it is reasonable, is to get an interviewer, to get someone proactively going out to that subgroup of patients and managing them. There are ways in which we need to manage that and we need to really look at to that group of patients in doing that.

Q166 Mr Bone: Because it would not be satisfactory just having the articulate people filling them in.
Professor Lord Darzi of Denham: We do not want a system which goes out and asks the patients with a smile on their face, we need to make sure that we capture it properly.

Q167 Charlotte Atkins: Moving on to the GPs Quality Outcomes Framework, the review proposes a new strategy for developing and reviewing the QOF indicators?
Professor Lord Darzi of Denham: Yes.

Q168 Charlotte Atkins: What evidence-based interventions would incentivise improvements in prevention?
Professor Lord Darzi of Denham: The answer to that is, firstly, it has to be evidence based. Are we referring to the changes based on prevention and well-being? In that specific area, we need to identify the evidence base. That is why we have asked NICE (National Institute of Clinical Excellence) to do that as an independent body, and I have made the comment about where I believe NICE is, and NICE will be doing that, and I think patients will do that, obviously, in conjunction with the some of the professional bodies in making that happen. We have not done that exercise yet. There is some data. We asked Health England, if I am correct, which is a group that brings a number of stakeholders together, which includes the Academy of the Medical Colleges, the London School of Economics and others, who have been looking at this for about a year or so, and in their submissions to us they shared with us some of the evidence base in the US. I think, whatever you do in that area, you need to base it on two important parameters. Firstly, the clinical prevention of disease burden and, secondly, it has to be cost-effective, and aspirin chemoprophylaxis is one good example which both reduces the disease burden but also is cost-effective. That is where the expertise of NICE comes in. I can tell you, that is not something the Department of Health can be doing.

Q169 Charlotte Atkins: Having said that, a decision has been made, for example, for osteoporosis not to be in the QOF and there is no consistency, over the country as a whole, to pick up, for instance, on early fractures and follow those up to ensure that those people are then screened for something as simple as osteoporosis, which is very extensive among more elderly people, and try to eliminate the devastating impact, for instance, of hip fractures which can, of course, lead to death.

Professor Lord Darzi of Denham: I could not agree more with you. That is why QOF and the QOF points were never done in the most transparent evidence based way, they were done between a university and the colleges, and that is why we are getting an independent, NICE being the champion of evidence based, and really scoring the evidence base based on the---. Osteoporosis might be one of them. Ultimately what happens once NICE makes those recommendations is for the NHS employer, if I am correct, to actually negotiate that with the primary care community in deciding on the QOF points.

Q170 Charlotte Atkins: It demonstrates a huge variation in practice over the country. For instance, in the south-west I believe that quite a lot of good work is done on both falls and osteoporosis, but it is very, very patchy. In Glasgow there is a lot of good work going on, but it depends really on a postcode lottery here as to whether you are going to get sufficient follow-up and preventative measures to ensure that bone fractures do not become both disabling but also the basis for an early death.

Dr Sheffield: It was a source of discussion in our acute care group when we were discussing trauma, and we were absolutely clear that one of the measures that we would want to see was the assessment of any person with a fracture over 50, whether or not they had osteoporosis, so we could put in prevention from having further fractures. The ability to transfer that to the next stage, to primary care, would be fantastic from the orthopaedic surgeon's point of view, because we recognise that that has to be something that we do routinely in the prevention of many of the fractures as they have come into the acute sector. So we were very signed up, and I am sure clinicians would be very signed up to putting that type of measure into any form of assessment both of primary care and secondary care.

Q171 Charlotte Atkins: It is a matter of co-ordination between primary and secondary care, and it does not happen, does it?

Dr Sheffield: I think that is something we have to work on. One of the things that was really clear to us as a clinical group—because we had GPs on our acute care group as well—was that we have in recent years not had such good links across sectors, and we believe that actually the clinical forum is the ideal place to have these discussions and to be able to deliver the improvements by introducing our own standards.

Professor Lord Darzi of Denham: You are making absolutely the right point there, but what you are trying to do is to find the evidence base. What are the areas which have the greatest impact on the health of the nation when you are talking about prevention and well-being, and there is a systematic way of doing that. If you look at the US data, as I said earlier, osteoporosis, the first will be aspirin chemoprophylaxis, childhood immunisation will be the next one. That scores ten and osteoporosis scores about four or five. I am not suggesting that that is less relevant, but what is the evidence based on having the biggest impact on the health of the nation? That is the process that this report has introduced in getting NICE not just to do the appraisal of the evidence, but also to do the weighting of the evidence base. Following that exercise, you are right, we need to make sure that these become minimum in the QOF points and making sure that it is throughout the service, whatever we decide are the priority areas in which we are going to look at prevention and well-being.

Q172 Charlotte Atkins: Once these preventative measures have been introduced into the QOF, should other QOF measures be dropped, or is this in addition to the existing QOF incentives and measures?

Professor Lord Darzi of Denham: That is a decision that has to be made between, as I said, NHS Employers and whoever negotiates on behalf of the profession. I suspect it is the BMA.

Q173 Charlotte Atkins: But are you concerned that unless it is in the QOF, doctors are not incentivised, whatever people say, to actually carry out the appropriate checks?

Professor Lord Darzi of Denham: I agree. We have made a commitment there. It will be part of QOF. I cannot believe it is going to be extra points in QOF. It is going to be looking at the whole QOF globally and deciding with our primary care colleagues. We feel strongly in the report we have made the case for that. We need to move into prioritising our well-being and prevention over the next decade and that is where we see it and, ultimately, the negotiation with our primary care colleagues will be done between the employers.

Q174 Charlotte Atkins: What about PROMS. Should they be in the QOF as well?

Professor Lord Darzi of Denham: PROMS?

Q175 Charlotte Atkins: Yes?

Professor Lord Darzi of Denham: Well, that depends if you happen to believe, and I happen to believe this, and we published three years ago the White Paper Our *Health, Our Care, Our Say.* We made a very strong case and the evidence base was there to support the shift of a lot of care near to the patient's home and, ultimately, it is the primary community setting that is going to be delivering those, and if these include interventions in the way which patients experience matters, the answer is, yes.

Q176 Charlotte Atkins: The BMA tells us that they have a very high satisfaction percentage in term of patients, but it is very clear, I think, to any MP that there are individual GPs where there are issues that patients raise about access, about being able to book appointments and about the general experience they get within the surgery. Are you therefore committed to having PROMS in the QOF?
Professor Lord Darzi of Denham: PROMS is one way. We do patient satisfaction surveys, and we have just published the one on this year. If you look at that data, there is actually very high satisfaction in primary care, and we have to acknowledge that—that is very good—but you are right also in suggesting that there are issues relating to access. In actual fact, I think the satisfaction with access has dropped in comparison to last year, and we are addressing that, as you also know, within the interim report, which I spent a good deal of time discussing with you last time, in the new investment in primary community services, in enhancing access, in the creation of the so-called health centres.

Q177 Dr Naysmith: Can we move to the area of personalisation of medical services and patient choice, and can I ask you to begin with a slightly philosophical question. Do you consider choice to be an intrinsically good thing, or is there evidence to suggest that choice improves clinical quality and effective outcomes?
Professor Lord Darzi of Denham: I could speak as a clinician and as a patient. The answer to that is absolutely, yes. Choice is the most powerful lever that a patient has, and I will say that for a number of reasons. Firstly, I think choice is only meaningful if that choice is informed. We introduced choice three or four years ago, which you very adequately supported at the time. Choice in those days had a slightly different meaning. Patients were exercising choice of which provider they went to to get the quickest treatment. That has gone. Everyone now is providing care within 18 weeks. So choice needs to move on. I feel as a clinician that choice needs to be based on the informed information on the quality of care that I will be receiving. I have had a fascinating year here, I can tell you.

Q178 Dr Naysmith: You believe it from your own experience?
Professor Lord Darzi of Denham: No, patients as well.

Q179 Dr Naysmith: Is there evidence?
Professor Lord Darzi of Denham: Yes, there is evidence that those patients who exercise choice of healthcare are actually more in charge of their health, and there is the evidence of the British—

Q180 Dr Naysmith: But does it produce better outcomes for the patient as opposed to not having choice?
Professor Lord Darzi of Denham: It certainly is one of the most important levers in improving the quality of care from a provider perspective, and certainly those patients who exercise choice, as I said earlier, feel more engaged, more empowered to have control of their health, but that is only relevant if you are actually exercising—

Q181 Dr Naysmith: You have still not answered my question. Is there evidence to suggest that this improves clinical outcomes?
Professor Lord Darzi of Denham: Yes.

Q182 Dr Naysmith: There is?
Professor Lord Darzi of Denham: Yes. If it is informed choice.

Q183 Dr Naysmith: What is the source of the evidence? How can you say that it is evidence-based? Where is the evidence-base?
Professor Lord Darzi of Denham: A lot of evidence from the US will suggest that patients exercising choice---. To be fair, I think we should also put this in context. I will come back to that point about what choice means in different healthcare systems. Exercising informed choice does drive the competition between the providers in creating and providing a higher quality care.

Q184 Dr Naysmith: So it is more cost-effective as well?
Professor Lord Darzi of Denham: The cost-effectiveness element of it, I would not like to be quoted as having the evidence based on the cost-effectiveness of it, but certainly it drives up the quality of care. What is interesting about choice, following this report and certainly legislating for choice, is I cannot believe there is a single healthcare provider or an insurance scheme in the world that actually gives its patients free choice. That is a very unique and extremely powerful thing that the NHS has. I can also tell you that if you are privately insured in this country, you will not have the same choices as you have as an NHS patient, but we need to get over that health literacy of what choice means and move that on into informed choice.

Q185 Dr Naysmith: Yet you have stated that choice does not mean the right to choose a particular GP or a particular consultant. How meaningful is it if that is the case?
Professor Lord Darzi of Denham: We have moved on from a single provider: the idea that you are going to come and see me individually. I made a reference to the team I work in. The idea that you are going to come and see Mr Darzi at St Mary's or the Royal Marsden Hospital are well over. We work as part of a team. I have four colleagues. We all provide the same quality of care. It is a team effort, and I think the leadership of that team will ensure that the quality of care across the team is exactly the same, and that is the culture we are moving into, and I am sure you will come into and reinforce what happens in Bristol.

Q186 Dr Naysmith: Before you answer that, it has been the practice for a very long time that you are sent by your GP to see a particular consultant and you turn up and you are seen by a more junior

member of the team. That never used to bother anybody on the providers side, but people used to think, "Why am I not seeing the proper doctor that I was sent to?" You are saying it is going to be even more like that in the future. It is a team. You will not be referred to a consultant; you will be referred to a team?

Professor Lord Darzi of Denham: Yes, I am saying you will be referred to a team who are providing that service—individual consultants providing a service. There might be a specific reason why the GP may wish to see that individual within the team of four, for example. I may have an interest in doing specific, if I could use the example, ultra low rectal cancers, and within that team we know that I will do those. That is really what is happening across the country. If you go to any of the clinical teams, whether you happen to visit—

Q187 Dr Naysmith: That is why you are saying that patients should not have the right to choose a particular GP or a particular consultant, because it is now a team effort.

Professor Lord Darzi of Denham: It is a team effort. The GP may have further information based on the team and the sub-specialisation interest of that team in managing that care. We really need to capture this. The days of one single individual with his or her houseman running a service are over. We are talking about multi-disciplinary teams. You cannot run a service now if you do not have the competencies when it comes to your specialist nurses, it comes to your dedicated out-patient facilities.

Q188 Dr Naysmith: In many parts of the world you can just choose to go and see a consultant of your choice, and you see the person whose door you knock on and you can appoint them.

Professor Lord Darzi of Denham: Within that team you will still have the preference of an individual treating you. We are not going to put blocks on that. Within that team you may choose to have your treatment by an individual. Ultimately, you are talking about the operative procedure here, or you are talking about out-patients, but care is no longer just that, care is across the board.

Q189 Dr Naysmith: I have got another question to ask you, but I would like to hear what Dr Sheffield has to say about Bristol particularly.

Dr Sheffield: In Bristol in particular you could say that some consultants would still like to have that individual referral, but the truth is that it is impossible for GPs to know the individual special interests of every single consultant, and so referral to a team is a much better methodology and then triaging the letters to make sure that they go to an appropriate specialist in that area, because the sub-specialisation that is going on within all our major areas of care within our organisation are meaning that it is very frustrating for patients to turn up to see one consultant who does not deal with that condition any more. The fact that you can actually refer to a team and then the team decides who is the most appropriate person helps enormously. We are moving much more towards team discussions also about what the appropriate treatment for that patient is. So, no matter by what route you are referred into the hospital, there is often a team discussion between consultants of various specialties about what the best method of treatment for the patient is. It is an old-fashioned model of working just on a one-to-one basis with consultants when we know that if you have a major operation it is not just the quality of the surgeon, it is about the quality of the anaesthetic, the quality of the nursing care, both pre-operatively and post-operatively, and the quality of the aftercare in the community that is important towards the final outcome for the patient. So it is very difficult to justify a single person to person referral.

Q190 Dr Naysmith: Can I move on to another question? To what extent should we be prepared to live with the risks that are inherent in individuals being given greater choice and control over their care? For instance, does this mean they will be allowed to make inappropriate or non-evidence based choices within budgets? That, of course, would be a waste of NHS resources. How would we control that?

Professor Lord Darzi of Denham: You are talking about personalised budgets?

Q191 Dr Naysmith: Once you give personalised budgets to people and they are in control of their own care.

Professor Lord Darzi of Denham: Absolutely. That is one of the outputs of the report. That is back to Dr Taylor's point. That is one of the areas in which we have got to pilot these. This is not a national roll-out. You are right in raising issues about the type of treatments and who is going to support the patient making those decisions.

Q192 Dr Naysmith: Will there be different pilots, different models tried out?

Professor Lord Darzi of Denham: Yes. There are three different models. One of them is the notional budgets where patients know what the cost of their treatment is, the second one will be a hard budget. I think the evidence base, certainly if you look at the US literature, will suggest a single commissioner, in other words a clinician or a nurse, who will help you with that budget, but we are also suggesting we might try the cash payments with that. I think what we need to do is, firstly, we need to decide what areas, what conditions we need to pilot these in, and we need to do this with the voluntary sector. There has been a tremendous amount of lobbying for this in support when it comes to the Long-term Conditions Alliance, Diabetes UK, the Neurological Alliance. Once we really decide with them what conditions are there, we really need to support that with the evidence base to ensure that issues of the nature that you refer to are not—

Q193 Dr Naysmith: Will you give an undertaking now, and probably Mr Nicholson needs to be involved in this as well, that you will not roll this out without evaluating the pilots properly and making sure that they work?
Mr Nicholson: It is absolutely written into the *Next Stage Review*, and that is exactly what we are going to do. We are going to evaluate them and see what works and see what they say. Absolutely.

Q194 Dr Naysmith: It is interesting that you mention the Diabetes Society because they are quite concerned. While welcoming what you have just said, they want to be sure that somebody who does not want to take part in this sort of scheme, who just wants to be treated in the slightly old-fashioned way of taking their advice about clinicians, is still going to be allowed to do that?
Professor Lord Darzi of Denham: Absolutely.

Q195 Dr Naysmith: We can reassure them on that.
Professor Lord Darzi of Denham: Absolutely. This is not an opt-out scheme.

Q196 Mr Scott: Lord Darzi, why have you insisted on one GP-led health centre for each primary care trust irrespective of patient need? Would it have been better to let each primary care trust decide whether or not they wanted a GP-led health centre?
Professor Lord Darzi of Denham: I announced that in October, rather than this report of the 150 health centres, and I remember debating this with you on 25 October when I last met the committee. This is additional new investment that the Government is making in really building up the quality in primary and community services. This is additional to the services. The question you are asking is how do you distribute that. We have 152 PCTs. They are our commissioning routes. This is how allocations are made, and that is how we have allocated the funding, but what happens with these health centres, the type of services they provide, has to be a local decision, as you correctly pointed out.

Q197 Mr Scott: So you do not think it would be more cost-effective to use the £250 million on under-doctored areas of social deprivation?
Professor Lord Darzi of Denham: We are. Out of the 250, if I could just come back to you, there is 100 million—you are absolutely right—in areas of not just social deprivation, in areas where we know we have a huge disease burden that we really have to tackle, and I think I showed the evidence base in October, the correlation between the number of general practice colleagues and the disease burden but also the QOF points, the QOF scores, and the 100 million is to invest in new primary care services, not health centres, primary care services, in these specific areas. That leaves you with the 150 million, which as you correctly point out, is the health centre money. So we are tackling both issues of access and additionality in addition to really meeting some of the needs at a local level when it comes to inequalities of health and healthcare.

Q198 Mr Scott: You scaled down from the original proposals the GP-led led health centres. For example, there is no mention of a review of treating acute services in these proposed centres?
Professor Lord Darzi of Denham: That is a local decision, Sir. The one thing we said about the health centres, and that was based on the improving access needs, which Ms Atkins referred to earlier, where we wanted to have centres that are open eight until eight seven days a week, and that is what we have tagged the funding with to the 150 health centres, but the provision of other types of services is based on the local needs, local decisions, actually based on the local reviews.

Q199 Mr Scott: Can I press you on that. That would mean that if locally they felt that the district general hospital was the best way of treating those needs,. there would be no change to that whatsoever?
Professor Lord Darzi of Denham: Absolutely. Urgent care provision is a local decision. It is based on the eight pathways and what they wish to provide to meet their urgent care needs.
Dr Sheffield: There was a source of big discussion in the south-west and we were particularly keen, and we did not want to undermine the district general hospitals, but there is an issue in the A&E departments out of hours with a lot of patients coming that were really probably better treated within the primary care sector. If we give the example of mental health, an awful lot of patients come to A&E because there is a lack of access to mental health services out of hours. The provision of these health centres, if the local PCTs decided that they wanted to provide liaison psychiatrist services within those health centres, they would be absolutely welcomed by the acute hospitals because it would provide a much better service for those patients and would reduce the burden on the accident and emergency departments. We had a discussion saying that there is no reason why these urgent care centres should not be absolutely adjacent to the A&E departments. It was just a way of filtering patients to a more appropriate environment than the rough and tumble of an A&E department when it is very busy with major accidents.

Q200 Mr Scott: So you would see it as complementing rather than replacing?
Dr Sheffield: Absolutely.

Q201 Sandra Gidley: Could I just pick up on this £150 million and the health centre in every PCT. I fully support the aim that they go in under-doctored areas; how many actually have?
Professor Lord Darzi of Denham: Since we made the announcement?

Q202 Sandra Gidley: How many PCTs have actually placed a GP-led health centre in the most under-doctored areas?
Professor Lord Darzi of Denham: Again if I could separate the two, the £100 million was for new primary care provision in the under-doctored areas, and that is exactly what we are procuring for. The

health centres are for the PCT to decide where they are located geographically. The health centres are not part of the investment in the under-doctored areas. The £100 million is; the £150 million is different.

Q203 Sandra Gidley: Given that the problem has been acknowledged, do you think it is the right way to spend £150 million in that case, because for example Hampshire is a very large PCT and Basingstoke, which is at the centre of Hampshire but nobody from about half an hour distant will go to it, is not under-doctored, so I cannot quite see the point. There are other areas where they could probably benefit from two good GP led-health centres where there are real health needs and real under provision. You are talking about under provision being linked with poor health outcomes.
Professor Lord Darzi of Denham: The geographical location of that is still decided by the local PCT.

Q204 Sandra Gidley: You keep going back to this word 'local' but no local people have made a decision in this. It is just a few bosses sitting in an office in Winchester deciding what happens to the whole of Hampshire for example, replicated around the country. Is it not token localism?
Professor Lord Darzi of Denham: Every PCT, and there are numerous examples of PCTs across the country, have engaged with the local population in deciding that and have also engaged with primary care colleagues in making decisions about that. In some areas, you are right, there have been some challenges, and that needs to be done in a more open and transparent way. The motive of this is to increase the capacity of primary community services, to provide more choice for patients, to improve access but at the same time to tackle some of the inequalities in healthcare.

Q205 Sandra Gidley: Okay, we will see. Just before we move on, the BMA seem to have a problem in differentiating between a poly-clinic and a GP-led health centre. Can you tell us the difference for the record?
Professor Lord Darzi of Denham: Yes. Poly-clinics was a description of a differentiated health centre for London. That is where poly-clinics are all about and that was in the London report. I made the case for these at the last meeting on the 24th which is in your publication. They are very different, they are providing a wider range of services and that includes integration with some services in social care and it also includes some degree of vertical integration. That is one point I would like to make for the record. The second point I would like to make for the record is that the London report was the first report to describe what we call a federated or a networked model of poly-clinics. In other words, a number of GPs remaining in their same practices and working jointly will have access to a centre which provides them with out-of-hour services such as urgent care provision, mental health services, diagnostics, and others, so that is a London solution. Interesting, if you look at the nine other reports, they have other solutions. Let us not forget, if I could make the case for London, the challenges for London's primary care are very, very different from the rest of the country and also it has been historical. When I was asked to do the London review, the first thing I did was read all the reviews which were done by people before me and the same old story comes up time and again in primary care: we need to make investment, we need change. This was what Londoners chose to have. This is what clinicians in London, including primary care colleagues in London, wanted to see happen. The BMA may have interpreted that in different ways but back in July when it was published they were supportive of it. For all sorts of other reasons I think there is a confusion or there is a confusion being created between poly-clinics in London and these health centre elsewhere.

Q206 Sandra Gidley: Thank you for that, that is clear, and hopefully the BMA will be taking note. There have been some suggestions that the real purpose behind the drive towards GP-led health centres is to provide more independent sector provision. What evidence is there that this sort of mixed economy of primary care provision will be more efficient than what is currently available in the NHS?
Professor Lord Darzi of Denham: Firstly the purpose of this is not to introduce the private sector. The purpose of this is improving access and enhancing the quality of care in primary community services. I think it is very important that we all realise that. It is also worthwhile to make the point within context and say that GP colleagues run independent businesses. Let us not forget that; and they are independent businesses. What I want to see out of this and what the Government wants to see out of this is the best healthcare provision at the best value, and many GP colleagues across the country are coming together and putting in very strong bids for these, I understand, as is social enterprise, as is the private sector. Ultimately what we want to do is to provide the best healthcare and the best value to the taxpayer and the patients who use the services.

Q207 Sandra Gidley: The report does not cost anything though so how can we actually know whether this additional provision is providing value for money? Would it not have been better to pilot it?
Professor Lord Darzi of Denham: Piloting primary care centres? We have had them since 1948. Actually I have brought it with me.

Q208 Sandra Gidley: I have seen that.
Professor Lord Darzi of Denham: If I could just read to you.

Q209 Sandra Gidley: They have waxed and waned.
Professor Lord Darzi of Denham: Firstly on the first page here it says "choose your doctor now". This was on 5 July 1948 and the last paragraph says "special premises known as health centres may later be opened in your district. Doctors may be accommodated there to provide you a wide range of

services . . . " and you might be interested in this " . . . including dentistry and other services on the spot". I promise you I did not invent this.

Q210 Sandra Gidley: They say there is nothing new but is not the difference that then you chose your doctor and you could choose to do that and now I understand that you do not have to register with these new GP-led health centres. That is the bit that is untried and untested and for which we do not have the economic case.

Professor Lord Darzi of Denham: I will make two points on that. You are right, these health centres will provide services to those who are registered and also to people just walking in and out, a walk-in service. We felt that was important because some patients are very gratified by the services they are receiving from their GP practices and they want to stay there—and that doctor/patient relationship is a very important one—but at the same time, for all sorts of personal reasons, they may only have the ability to go to care out of hours or at the weekend, and they will have access to these health centres. That is one and the second one is this also builds new capacity because, you are right, in areas in which a patient may not be a happy with the service, they will have the choice of moving on into another practice. We are doing that also through reforms in the system itself. Patients will be allowed to register where they choose to register.

Q211 Sandra Gidley: How do you respond to my local GPs who despite being some distance away from the new centre feel that the new GP-led health centre will destabilise the local health economy, they cannot see how the income streams are going to work without patients registering and feel that ultimately in a couple of years' time people will be made to make a decision to register with one of these centres. Are their fears unfounded?

Professor Lord Darzi of Denham: A large number of general practice in this country provides excellence in healthcare, let us not forget that, and those have absolutely no fear. It is an interesting story because it came round at the same time as the independent sector treatment centre programme was created, and I happened to be the adviser to your Committee in those days, and there were exactly concerns that it was going to affect the business of my hospital or the hospital next door. That has not happened. We need new capacity in primary care and we need to be proactive. I would like to see the NHS in the next year proactive in meeting its challenges. Historically we have always been reactive. The NHS Plan was reactive because the NHS was falling apart. Let us look at the challenges facing us such as the changes in lifestyle diseases. Did we predict ten years ago we are going to have an obesity epidemic, no, ageing population, all of all are living five hours longer a day—

Q212 Sandra Gidley: It seems like it!

Professor Lord Darzi of Denham: Long-term conditions—one of the successes of the NHS is to convert an acute illness into chronic illness. You need to ask you question: in 2008 are we ready in our primary community services to meet those challenges? That is why we are investing proactively there. I truly believe that is important and I also believe that if you are going to have the biggest impact on the health of the nation, you are not going to have it in the hospitals I work in; it has to be in primary community services, so that is where we are coming from and we need to work in partnership with the professional bodies and the BMA in trying to address these challenges for the future, so this is not a threat; this is an opportunity.

Q213 Sandra Gidley: Okay, moving away from GPs we have had 90 walk-in centres introduced over the past few years which in many areas have been well-used. Is it not confusing for patients to have walk-in centres in one place and a GP-led health centre where they can go or does this mean that we might see the end of walk-in centres because they have not quite achieved what they were intended to?

Professor Lord Darzi of Denham: I do not think so. Firstly, you have acknowledged that walk-in centres have been a success and I agree with that. I was not sure when they first came out but there is a huge amount of satisfaction in there. Essentially what you are saying, and I agree with you, is one size fits all does not exist any more, and what we need to do is to give the choices to the patients depending on their circumstances, their own needs, where they wish to go to, but ultimately what is important—back to 1948—is everyone will have a registered doctor. That should never be eroded. If you have extra services on top of that, why not?

Q214 Sandra Gidley: This may be a difficult one to answer but if GP-led health centres prove to be as successful as you hope, where do we go next? Will there be more money for more in the future?

Professor Lord Darzi of Denham: I have no doubt that in years to come we will need to look at resources in primary community services. PCTs have allocations on a yearly basis. Primary care colleagues have always been engaged in changing and improving services but that is a local decision. We have made this investment and we have no intention of further investments within the next three years in relation to that, but that is a local decision as to what primary care colleagues wish to do. We are increasing capacity and I think we need to work with them in really getting us ready for some of the challenges that I have referred to already.

Chairman: We are now moving on to speeding up the NICE process. I wonder if we could speed up our process as well. We are one and a half hours in now and we have still some time to go on questions. Richard?

Q215 Dr Taylor: To me this is really one of the most important bits of the whole report—speeding up NICE. Some commentators have told us that NICE is doing extremely well out of the Darzi review and, I believe, having its budget tripled to £90 million per annum. This is absolutely excellent if it really does make the NICE process quicker because if we could

get NICE results within a very few weeks of drugs becoming available, then this would solve all sorts of problems. Do you think even with the extra money NICE will be able to do this? Will they have the technical expertise in their staff?
Professor Lord Darzi of Denham: Absolutely, but firstly again I have acknowledged the role of NICE and if you look at the report it is all about rewarding excellence and quality and NICE is one of these organisations that really has taken off, if you look at the last eight years where we are in relation to appraisals compared to Europe and the US, the US health system is creating a NICE. The answer to that question is, yes, I have had meetings with both with Chief Executive and the Chairman of NICE and they feel with the extra resources they have that will expedite the approval of drugs. However, it is not just the money. We also need to build into the system the intelligence, working in partnership with industry and others, as to what is in their pipeline before it even comes out and the evidence base needs to build in partnership with NICE and then really get that through NICE. I do not think we will meet your aspiration of a few weeks because let us not forget that every decision NICE comes up with has to have a public consultation because that is part of their process and their appraisal and that will be maintained. I think we will be down to three to six months ideally whereas now it is about 18 months. I am delighted that you like the proposal.

Q216 Dr Taylor: But we are getting away from the delays in referral to NICE?
Professor Lord Darzi of Denham: Yes, absolutely, that is what I am saying. Even before the drug comes out we need to capture that intelligence.

Q217 Dr Taylor: Right. In the recent NICE report we did we tried to get them to clarify the difference between technology appraisals and guidelines, one being mandatory and the other not, by actually changing the title. I am going to stray onto the NHS Constitution for a moment (although we are coming back to that later) and I think we are told: "The NHS Constitution will enshrine in law a universal right to approve treatments if they are clinically appropriate for individual patients." Does that mean those that have a technology appraisal behind them?
Mr Nicholson: That is correct, yes.

Q218 Dr Taylor: Do you not agree with us that it would be rather useful to get NICE to change the titles because guidance includes technology appraisals and guidelines as well as the public health things and nobody realises what is a technology appraisal which is mandatory and what is a guideline which is not.
Professor Lord Darzi of Denham: I am more than happy to talk to them about language; no problem.

Q219 Dr Taylor: Thank you. Another thing that came out of our first NICE report was that local decision-making is really sometimes at odds with the central directive. I always remember across the river at St Thomas' implantable defibrillators became a 'must' they had to do' and they would much rather have had more nurses in A&E than these implantable defibrillators, so is there always going to be a conflict between this sort of local decision-making and the centrally issued directives of the technology appraisals?
Professor Lord Darzi of Denham: I will tell you this as a clinician—if that is the guidance that is the best evidence in management of a condition. All clinical colleagues will aspire to deliver that, that is the way it is, however we also need to exercise our professional judgment and our clinical competence. You do not fit patients to technologies; you actually try to fit technology to the patient and that is where local professional judgment comes in. The whole report is about clinicians exercising their professional judgment in this new framework that I am describing.

Q220 Dr Taylor: And if we get NICE working quickly would this in your opinion be an answer to the top-up fees conundrum?
Professor Lord Darzi of Denham: That is a completely different debate. I think it will have a tremendous impact on it because we are expediting drugs. Herceptin will be the one that comes to memory. If we had a much more pro-expedited process in getting the drugs through, yes, it will have a major impact.

Q221 Mr Bone: If you go back to Wanless and the interim report we had a very useful little table which said take-up of drugs and diffusion and it said USA: take-up, rapid, diffusion, rapid; France: take-up, late, diffusion, rapid, but when it got to the UK it had UK: take-up, late, diffusion, late, so are your proposals going to bring us closer to the US standards of rapid take-up and rapid diffusion?
Professor Lord Darzi of Denham: The answer is yes because we are expediting the process of approval, but at the same time those ten reports are looking at the evidence base, the pull effect in really getting that option through, and the report also described what I described as the pioneering NHS. I think I referred to being much more proactive in resources. We also need to be proactive in the up-take of new technology. One thing about healthcare—and I gave you the cardiac example earlier of angioplasty, statins and smoking—is that things happen at a tremendous speed. We need an NHS that is exploiting these technologies to the advantage of their patients and that does not mean it is always more expensive because in the nature of these things, they are much more cost-effective and I think that exercise of the ten regional reports has really highlighted the appetite for taking the latest guidance from here and making it happen locally, and getting a reward for it.

Q222 Jim Dowd: Can I look at issues around leadership and the workforce. Being an NHS manager has never been easy. Probably today it is even more difficult than ever, particularly given the tabloid view of NHS managers being parasites on all the decent clinicians who are trying to deliver the

service. You have sitting next to you in Dr Sheffield an ideal example of somebody who has made the transition from clinician to manager. How do you intend to realise your proposals to make this far more the norm than it is at the moment?

Professor Lord Darzi of Denham: Firstly let me just say the aspiration of the top manager in the NHS is to have more clinicians working in there and what I am doing is meeting his aspirations in the report. I am sure David will come in because he led this piece of work. If I could just describe one bit of the report which really has engaged the profession. Clinicians, whether you are a nurse, a healthcare professional or pharmacist, you are not just a practitioner; you are a partner; you also are a leader, and we need to bring more of that into the provision of the service lines whatever that happens to be. For that both clinicians and non-clinicians need both management and leadership skills and the report is all about building up that structure and that resource in making more and seeing more people like Jonathan really leading services because—and I made that point earlier—you can really bring in and converge the quality of care with the use of resources and doing that in partnership with management.

Q223 Jim Dowd: Would that extend to the non-execs as well?

Professor Lord Darzi of Denham: In the development of their skills?

Q224 Jim Dowd: Yes.

Professor Lord Darzi of Denham: Absolutely. There is a major scheme—and maybe David will comment—on forward development.

Mr Nicholson: As the chief parasite in the NHS I can say that! This is such an important issue for us. It seems to me it is the issue that got missed out when three or four years ago people talked about reforming the NHS, they talked about the technical aspects of reform, payment by results and all that sort of stuff, but the real issue is leadership, and it seems we are quite unusual as a health system in this country of having relatively few clinicians in the most senior posts and I think it shows in terms of the focus of our work. There is a short-term set of issues that we can deal with but there are also some long-term ones, and I think the report addresses both. The long-term ones are all about building in management training expertise and understanding at under-graduate level for doctors in particular and nurses and other clinicians and to bring that right the way through their training so there is a whole series of things for us to do in there. Then at the top level there is identifying clinicians particularly at the moment and our aspirations are that within three years on every shortlist for a chief executive job in the country there will be at least one appointable clinician who will be available for appointment. To do that we are doing a lot of work across both the regions and nationally to get people ready for doing so because although most doctors do provide leadership and most doctors do believe that they are the best managers money can buy, sometimes they need a bit of education, training and support to get them into the position where they can actually deliver.

Q225 Jim Dowd: Are those the only attributes that need to be nurtured to improve the quality of the NHS product or are there others?

Mr Nicholson: No, there are all the rest in the report but leadership is a crucial part of it that we need to invest in to make it happen.

Q226 Jim Dowd: It is the leadership rather than the performance. There is nothing missing per se, it is just we need more skills amongst the leadership and we need them to be spread more widely?

Mr Nicholson: We need to do that. We need to bring people from outside of the NHS as well. There is a whole pool of people with expertise in local government, the voluntary sector and the private sector that we can bring into the NHS, and we are developing processes to enable us to do that. The issue for me in leadership terms what I want to get to is a place as what I would describe as being spoilt for choice. When we get to the most senior jobs instead of just having one person who we can appoint and that is all, we should have a choice, and that is what we want to do.

Dr Sheffield: As someone who has been at that interface I would say that it is very easy as a clinician to criticise the general manages but they go into the NHS with the same values as clinicians: they want to help patients. It is quite insulting sometimes the language that we use as clinicians towards general managers. They just have a job to do that is about managing the total healthcare system. Where it works best is where there are strong leaders both in general management and clinically and where they work really well together as teams. There is a huge issue about how we all work better as teams at all levels within our organisations.

Professor Lord Darzi of Denham: Leadership is a loose term that has been used before. What is leadership? You have to have a purpose; what are you creating the leadership capacity for? You will see across the report this is leadership for quality. Whether you are a clinician or a non-clinician you are here to provide quality care based on the resources that are available to you, based on the evidence base and based on the vision that you put together.

Q227 Jim Dowd: You proposed identifying and mentoring the top 250 managers in the NHS to spearhead this improved approach. 250 out of 1.2 million people who work to the NHS does not seem a very significant number.

Mr Nicholson: This is just the national effort. Every region now has a whole set of programmes there to deliver support, health education and leadership at the regional level and the local level. That has already started and there is not a region in the country now that does have all that, so we are tackling a huge number of people. We identified the top 50 organisations in the country, either the biggest or most complex organisations, because

what we believe is first of all we need to improve the quality of leadership in those organisations and we can all get better and we need to invest to make that happen. Also we need to make sure that we have enough people coming through the system to populate those jobs in the future. The market simply will not deliver the people that we want; we have to nurture and support them through the system. We are focusing on that nationally but there is a massive programme going on regionally and locally.

Q228 Jim Dowd: I will not ask you if there is a parallel programme to turn managers into clinicians. How difficult can it be?
Mr Nicholson: It is a good point.

Q229 Stephen Hesford: In terms of accountability, the review talks about increased local decision-making which we would all support but there is a potential concern that the chosen bodies, the SHAs, are said to be large and impersonal and also potentially lack expertise, so if those criticisms at all are fair, is accountability going to be what we want it to be?
Professor Lord Darzi of Denham: I think we need accountability across the system. The report describes accountability across the system. Firstly let me start with the process. These were ten regional reports actually working with clinicians, in Bristol or wherever, regional and granular to PCTs and providers in capturing clinicians across the system in health and social care and bringing them together and creating these visions. Next, you are right, we need to transfer that into what I would I described earlier as the PCT strategic reports because we need to get down to the system because the SHAs are too high up, you are right, and we need to get that even lower than that. I think accountability will be in that system. How do we get the clinicians who designed the eight pathways now to be involved at a commissioning level to commission these pathways? Let us not forget that one of the most powerful processes we have all gone through in these reviews is that each of the pathways, each of the local visions have engaged locally with the public and patients. If I am correct, the figures are near enough 60,000 people who have been involved across the country in contributing to this report somehow or another. You are right, accountability has to be local, I believe probably at the level of PCTs and good PCTs will push that even further to the providers.
Dr Sheffield: As a clinical group we were very clear at the end of the process of writing our report that we wanted the PCTs to own the document. All the clinical pathway groups that we have put together are really very keen to be involved in that process so we have been going out to the individual PCT groups and explaining the reasoning behind our report and why we think these targets are so important, so we were really keen that the PCTs owned it and the PCTs would manage the implementation of our report and that we also would offer ourselves available for advice as to the reason why we came to that. We have worked very hard on making sure it is a document that is owned throughout the South West rather than in Taunton in the SHA headquarters. We felt very much that we had come from all points of the South West into groups to deliver the report and we also feel now we have a responsibility to take it back out into the communities throughout the South West to deliver it. I am quite sure that is the process that is going on up and down the country at the moment.

Q230 Stephen Hesford: Is there guidance to PCTs which tells them that they can have this ownership and should have this ownership as opposed to they might have it if they want it?
Mr Nicholson: The process that we are working through with PCTs at the moment is that by the end of this year they are to put forward their strategies for the next three years of healthcare development in their PCTs, informed by the kind of work that Jonathan has just talked about, and to produce a proper operational plan next year. It is entirely a matter for them to take account of the national and regional work to take it forward and that is their responsibility as PCTs.

Q231 Stephen Hesford: Will a chief exec of a PCT be performance managed on this to make sure that this is driven through?
Mr Nicholson: What we expect PCTs to do is to set out the direction of healthcare in their locality, to set out what targets they want to set locally, what ambitions they have for driving things locally and then we would expect the SHA to ensure that the PCTs deliver what they said they were going to deliver.

Q232 Dr Stoate: I would just like to follow up on something Stephen said. What happens if there is a difference of opinion between the PCT and the SHA about what should be delivered locally. Who actually wins if the PCT's aspirations and the SHA's aspirations do not fall into line? What happens?
Mr Nicholson: It is quite difficult to work out under what circumstances that might happen given that in most of the country, and I am sure it is the same in the South West, and in London in fact, PCTs recognised and accepted Healthcare for London as the direction forward. It would be quite difficult in those circumstances for a PCT to then say that they supported Healthcare for London and then to do something completely different.

Q233 Dr Stoate: If there are 32 PCTs in London what if one of them had said, "We do not want a poly-clinic thanks very much, we are doing very nicely as we are," what would have happened then?
Mr Nicholson: If they had accepted Healthcare for London—

Q234 Dr Stoate: What if they did not? What if they said, "We are not having anything to do with it"? I am trying to make a hypothetical point but it is a real point because if for example a PCT had been vehemently opposed to poly-clinics, and said, "We are perfectly happy with the situation we have got,

we do not want anything to do with it, we are not signing up for this document," what would have happened then?
Mr Nicholson: If they had not signed up for Healthcare for London? They would have had to have gone through the process of modifying Healthcare for London in those circumstances because they needed to get everyone to sign up to it. That was the whole point of the process that they went through.

Q235 Dr Stoate: I am slightly concerned and all I want to try and tease out is which takes precedence if there genuinely is a deadlock. Is it the SHA that gets its way or would it be the PCT that gets its way?
Mr Nicholson: At the end of the day it depends on the scale of it. If for example a PCT decided it did not want to implement 18 weeks, the PCT absolutely would not get way its way. It is a national thing that we expect to be driven through the system and that was the case. If they wanted to put a health centre or a clinic in a place which was slightly at variance with the national model, it would depend on the variance of the judgment between the SHA and the PCT and what was sensible; it would be a dialogue.
Professor Lord Darzi of Denham: Ultimately it is the evidence that would win. PCTs are the commissioners who are sitting there providing services on behalf of the local populations that they are serving and it is the evidence base that is important. That is the evidence base when it comes to what clinicians have done and that is why we believe that the clinicians should be engaged in making these things happen.

Q236 Dr Stoate: That is fine. I want to come on to commissioning. We had some trouble with this last week. What is World Class Commissioning and if we saw it how would we know?
Professor Lord Darzi of Denham: I think you will see it when you see world-class quality of care, you see the end product. It is the means of achieving that end product, so that is what I see World Class Commissioning leading to—a first-class service—which is commissioning based on evidence and commissioning based on the needs of local populations. As you know, the Department published that organisational development tool last year with a number of competences, ten or 11 competences, and they are mostly process-related but I think we also need to hold the PCTs accountable to the health outcomes of the populations and that is where the evidence base comes in.
Mr Nicholson: We have defined it through the 11 competences. I do not want to bore you with all of them, but they are quite clear about what World Class Commissioning will look like. We will then measure the PCTs' performance against all of those 11. You will be able to see where your PCT stands on each of those 11. You will be able to make your judgement and you will be able to see where they are making progress and where they are not.

Q237 Dr Stoate: That is fair enough. Obviously I appreciate we are right at the beginning of this process and last week we were told that we are in the foothills of World Class Commissioning which sounds like a rather nice place to be. When will we see the benefits of this programme?
Professor Lord Darzi of Denham: When PCTs commission the type of services that are evidence-based which are improving the health of the populations that they are—

Q238 Dr Stoate: When will we get some noticeable, tangible improvements? When will we start to see these results?
Professor Lord Darzi of Denham: Firstly let us acknowledge that PCTs are about 18 months/two years old, where they are at the moment, and some of them have matured significantly but some of them also need some support and some help in building up some of their competences. The Department is involved proactively in helping them through that by whichever means are required in raising those competences to the level that we have described in our framework.

Q239 Dr Stoate: So it is an on-going process but you expect to see some results reasonably soon?
Mr Nicholson: We would expect to see results this year.

Q240 Dr Stoate: That is fair enough, thank you.
Professor Lord Darzi of Denham: And we will be publishing their performance as well. We are back to quality counts. They will be publishing their competences and where they score.

Q241 Sandra Gidley: In our recent inquiry into dental services that we did, a number of problems with commissioning were highlighted and World Class Commissioning actually requires the transformation of PCTs from acting as payment agents to hand out the money to being more analytically based and a bit more hard-nosed when they are commissioning. I think some PCTs have struggled with having the right staff to do this. Where are they going to come from?
Mr Nicholson: If you look across the country as a whole I think the skills that PCT staff have are improving. The investment that we are making in leadership and management development will improve the quality of the people that we have got. That is the first thing. The second thing is that we are investing in independent and private sector and voluntary sector organisations of people to help us do this through the FESC process. In every region of the country now there are PCTs that are bringing in that expertise, whether it be through companies like Humana or organisations like the Terrence Higgins Trust, we are seeing a significant change in the nature of commissioning through that investment. The third area is that we are seeing increasing pooling of expertise between PCTs. That can be shown at its most obvious in the West Midlands where you have a West Midlands-wide agency which supports PCTs with analytical and procurement

support, or by the plans that are being developed in London. You are seeing across the country that sort of pooling going on.

Q242 Sandra Gidley: Is it good enough yet?
Mr Nicholson: I think we are on a journey. I do not know whether we are in the foothills because I think some people are really quite near the top already. We have a lot to do to make it move from islands of excellence to one where most parts of the country are in this place, but we have now got a mechanism and we have clearly identified what success looks like, and we are going to measure PCTs as they go through.

Q243 Sandra Gidley: Do you accept that some of the problems with commissioning are down to the lack of competition on the supply side?
Mr Nicholson: The supply side?

Q244 Sandra Gidley: Well, there have been rumours that GPs have been quite keen to commission for themselves and there have been some correlations pointed out between GPs with a special interest and what special services are commissioned, strangely, for example.
Mr Nicholson: This is all new territory for us in terms of a PCT being responsible in some way for managing the various elements of a healthcare system rather than managing particular functions. We are learning from that. There is no doubt that there are some parts of the country where there is not enough supply-side competition to improve the standards and give patients choice in the way that we want and that is part of the responsibilities of PCTs. In fact, it is one of the competences within World Class Commissioning to be able to demonstrate where there is supply side competition, is it effective, and where there is not, what you will do as a PCT to inject more competition into it.

Q245 Sandra Gidley: My next question was going to be what is being done to create greater competition on the supply side. Is the answer that it is a competency or am I getting that wrong?
Mr Nicholson: The first thing is that competition is a means to an end, it is not an end in itself, and you have to analyse your market or your system to work out what the nature of the competition is that you want and how you want to make it work and that is a competency of PCTs to be able to identify that in order to make the local decisions that they need to do and to either create competition or create level playing fields where they need to take things forward. It seems to me that is the direction that we are going in and we are really at the beginning of all of that.

Q246 Sandra Gidley: Will this ultimately mean greater use of the private sector?
Mr Nicholson: It will certainly mean different models of service and different models of care. I do not know whether it will mean more private sector; it depends very much on how the private sector responds to the kind of challenges that they make. We will certainly make the process more transparent and open and will give more and different providers the opportunities to come into the system and provide services. Whether or not it will be successful will be a matter for local determination.

Q247 Sandra Gidley: It all seems a bit vague to me, I am afraid.
Mr Nicholson: It is not that vague. It seems fairly straightforward. If you have got a part of your system where there is no choice and no competition whether it be in pharmacy or whether it be in dental or whether it be in general practice and you believe as a PCT that your analysis shows that competition and an alternative supplier would improve quality and improve choice, then you make investments to make that happen. That is straightforward to me.

Q248 Sandra Gidley: I think, as we have heard, we are in the foothills so we will probably be re-visiting this when we have climbed a little higher. Last question: how do you expect PCTs to counter the incentives that payment by results give to acute trusts to increase their activity?
Mr Nicholson: It is a double-edged sword really because the incentives work the other way as well of course. Payment by results is a fantastic incentive by PCTs not to refer inappropriately patients to the secondary care sector and so the incentive works both ways. One of the things that we need to do when we set the tariff, the contract and the rules, which is part of a national responsibility, is make sure we get the right balance in that. I think people would say that the new contract that we established this year shifts the balance significantly to commissioners, and we think that is the right place for it to be at this present moment in development.
Professor Lord Darzi of Denham: Adding to that also, going out and reaching a local population and looking at the health outcomes and needs and that is what I said, if we are really going to be proactive we need to look at prevention and well-being. PCTs need to proactively go out and make that happen.

Q249 Sandra Gidley: But CQC is not going to be looking at that aspect of things, is it, it is going to be looking at the whole picture?
Professor Lord Darzi of Denham: CQC will be looking at the quality of commissioning but their performance management will be by the SHA.

Q250 Sandra Gidley: It will not be looking at health and well-being; it might be looking at health outcomes but it does not really have a remit to look at the more public health aspects.
Professor Lord Darzi of Denham: We will have that in the operational framework.
Sandra Gidley: That is reassuring.

Q251 Dr Stoate: In your report you write that you are going to give stronger support to practice-based commissioning, which I think is probably quite a sensible idea. The problem is how exactly are you going to strengthen practice-based commissioning

because at the moment many GPs that I meet are fairly confused about what it means in terms of workload and even how to go about the process.
Professor Lord Darzi of Denham: What I have heard talking to primary care colleagues is that in some areas it has worked and in a lot of areas it has not really taken off. You are absolutely right, most of that is based on, "Give us more freedom; give us the tools; give us the information. How can you commission if you do not have the information? Give us the infrastructure," and some have said, "Give us the competences." We work with FESC for example in bringing that into practice-based commissioning. I think there is the appetite there in some areas and I think the incentives are now aligned and that is what we are saying in relation to the report. And I think if we can really engage them with the regional reviews here, a lot of GP-led PBC groups contributed to the different pathways across the country. I think that is one way of giving them more freedom to get on and do what they need to do.

Q252 Dr Stoate: I am sure that is true but GPs often lack the knowledge, as you say, and the information and the necessary skills to make it happen and some PCTs, frankly, have not been as helpful as they might in this area so what can you do to try and drive this process further because in many areas—and I speak to a lot of GPs and I am sure you do—it does seem to have stalled in that no-one quite knows where to move on to?
Professor Lord Darzi of Denham: It depends why it has stalled and what you are saying to me is some GPs want to get on and just provide care; they are not interested in the commissioning element of it.

Q253 Dr Stoate: That is a slightly different area. The King's Fund has told us that many GPs simply do not want to get involved in this, they would rather provide clinical care than commissioning, and that is reasonable, but even in areas where GPs want to get involved in commissioning, certainly in evidence I have had personally from people I have spoken to, that it is just not happening either because of lack of knowledge, the PCT has not been supportive, the PCT has lacked the necessary skills itself, they have not been able to take the decision necessary, and it is all taking a lot longer than it should. What can you do to try and kick-start it?
Professor Lord Darzi of Denham: Through the primary community care strategy. There are very clear proposals on how we develop practice-based commissioning in these areas in which, as I said, most of that is based on either bringing competences from outside, building them the infrastructure, giving them the right tools and making that happen and putting the right incentives in attracting primary care. One of the proposals, as you probably know, is the integrated care organisations which there is a huge amount of appetite for because that combines both some of the commission aspect and the provider aspect based on certain rules.

Q254 Dr Stoate: Although GPs might invest, they might employ people, they might set the systems up, what they are slightly concerned about is if the goalposts move in a year or two's time and the priorities change. It might be very difficult for them to then change what they have already set up simply because they have invested so much in it. Is there something you can do to try and make sure that is not a problem?
Professor Lord Darzi of Denham: We made that commitment back in July. We said there is no structural change and we did not make any structural change and we need to give the system time for maturity.
Mr Nicholson: We know there is a big issue about consistency of purpose in all of this. Some of that of course is out of our control in terms of government and changes and all of that kind of stuff that goes on. We know that a key issue for success in all this is relationships, and one of the downsides of the reorganisation of the PCTs in the past was that all those relationships, that trust that has been built up over time with practitioners and people gets broken when you move everyone around. That is why this thing about keeping the organisations unreorganised from the top down is absolutely vital to make it happen. We also say in the report that PCTs are responsible for making sure that practice-based commissioners have the right support and information and we are going to follow that up through the World Class Commissioning assurance framework to make sure that they do do that, so there are things that we can do.

Q255 Mr Bone: Lord Darzi, do you see yourself now mainly as a politician or as a surgeon?
Professor Lord Darzi of Denham: You cannot teach an old dog new tricks but you can at least put them on the path. I am still a clinician, I am practising, I am very privileged to be in that position. I am also very privileged to be given the opportunity to lead 2,000 colleagues across the country in producing the report in front of you.

Q256 Mr Bone: My apologies to the surgeon part of you, but to the politician part of you I am going to talk about the Constitution. Is this not just purely new Labour spin just done to collect the headline and it has no real practical benefit whatsoever?
Professor Lord Darzi of Denham: If you describe telling patients what their rights and responsibilities are as Labour spin, then we have a problem. I will say this to you as a clinician because you have asked the question: looking at the rights and responsibilities personally I was stunned about three months ago when I looked at this document that is being developed at what the rights and responsibilities of patients are and what the rights and responsibilities of the staff are. As a clinician working in the NHS for 18 years a lot of this was foreign news to me. I knew about consenting patients, I knew about dignity and respect, and I could not agree more with that, but some of the rights in there certainly were not familiar to me. This is all brought together into a document to really

empower the patients and that is probably why you have seen that it has been very, very warmly received by patient groups, by the voluntary sector and others, and I think it has been a great success.

Q257 Mr Bone: The serious point I wanted to make about the spin was that these already existed and I think you have confirmed that, but your argument is that bringing that together in one document is useful. However, when I looked at the Constitution it seemed to say to me that the hospital or PCT "must take regard for" or "may take this into account". It was not like I would regard a constitution where they absolutely had to do something and if they did not do it you could take them to court and say they have not complied with the Constitution. The word 'Constitution' seemed to me to be not wholly accurate in that regard.
Professor Lord Darzi of Denham: I will bring David in because he chaired this group. There are legal rights in there, including a new right for choice, and I think that is the most transformational change.

Q258 Mr Bone: But when you read further on it says "must take into account" but it is not prescriptive in that regard.
Mr Nicholson: This was quite a tricky set of issues to deal with because what we did not want to do was to create something that became a lawyers' charter. We did not want that; we wanted it to be declaratory, is the term that is used. The power of the Constitution in that regard, you have got the bit that sets out what the rights and pledges and responsibilities are, which again I think is powerful because they have not been set down in that way before, and things like the right to NICE drugs and that sort of thing does change the nature of the relationship between patients and the service. If you turn something from a duty ie the NHS gives you something, that is different from saying you have a right to it. I think that begins to change the nature of the relationship between the citizen and the NHS which I think is really a powerful message that is in there. The Constitution is renewed every ten years but underneath it there is the guidance document which is renewed every three years and that absolutely does give you the detail. That is where we have tested it with members of the public and we have talked to members of the public about all of that. That is where they think it is powerful because what it then says is exactly what we mean, what does access mean. It gives you much more detail and people will find that very powerful.

Q259 Mr Bone: I think you have confirmed from what you have said that it is declaratory, which would seem to indicate that it is not what I would call a constitution. It may be an aspiration, it may be a wish but it is not strictly a constitution in that regard. Just moving away from that point, the budget of £100 million, have we been talking all today just about the English NHS, by the way?
Professor Lord Darzi of Denham: Yes.

Q260 Mr Bone: We have only been talking about what is happening in England?
Mr Nicholson: Although on the Constitution Northern Ireland, Wales and Scotland have signed up to the overall principles.

Q261 Mr Bone: But generally we have just been speaking about England. The value for money of the £100 million that is spent on the English NHS a year is not even mentioned in the Constitution, I do not think; is that an omission? Should the Constitution not be to provide value for money? Should that not be in there?
Mr Nicholson: If you look at the pledges to both staff and patients, intrinsic in it all is value for money. There is not a right to value for money that is set out in the Constitution directly.

Q262 Mr Bone: You would accept that the NHS by the way it is set up is one of the most inefficient health systems you can have in the whole world, so you would have thought that should have been in the Constitution.
Mr Nicholson: That is simply not the case at all. It is one of the most efficient healthcare delivery systems in the world.

Q263 Mr Bone: Measured on finished consultant episodes over the last few years? Measured outcome has gone up 23% and expenditure has gone up 82%.
Mr Nicholson: Measured by almost any of the international people who have looked at it—

Q264 Mr Bone: Can I get back to what I should be talking about which is the Constitution.
Mr Nicholson: If you look at the principles that guide the NHS, I would have thought "the NHS is the committed to providing the best value for taxpayers' money and the most effective and fair use of finite resources" and "public funds for healthcare will be devoted solely for the benefit of people that the NHS serves," are pretty powerful statements about value for money, to be frank.
Professor Lord Darzi of Denham: Could I just add to that point you have just raised about efficiency as well, that is the bit that annoys many clinicians working in the Health Service, this very simplistic way of looking at inputs and outputs: input is cash; output is volume. This whole report is about quality. If we are able to measure the quality improvements we have seen over the last eight years we will have a completely different view or perception of what the NHS is. We really need to move on from measuring just volume; it is the quality of care. Volume is part of that—do not get me wrong—but there is a bigger picture here and that is what matters to patients. If you tell patients, "You're my number 101 I have done this year," they would not give a care about being 101, what they want is the high quality care they are going to receive.
Dr Stoate: What we need to start to do is count the number of people that we do not send to hospital because we have prevented them getting ill in the first place and they have not needed their heart bypass operation.

Q265 Dr Taylor: You are quite good at inventing words: 'declaratory' is rather new to me.
Mr Nicholson: I have to say I did not invent that. There is a whole subculture around constitutions that I will not bore you with.

Q266 Dr Taylor: What about 'modular credential tools'?
Mr Nicholson: I did not invent that one. Cleverer people than me did that one.

Q267 Dr Taylor: We are coming on to integration of services and I thought you were having rather an easy ride until Peter got going! The people who do not give you an easy ride, talking about integration of services with the elderly, are Age Concern—or is it Help the Aged—it is Help the Aged, I am terribly sorry. The conclusion in their submission to us said: "Although in many ways wide-ranging, this review of the NHS has failed to comprehensively address the needs of its principal constituents: older people," because you have said that the increasing number of old people is one of the drivers. Then they go on: "There is an overwhelming sense that at regional level developments will be pursued in silos which does not really cover elderly people who have got multiple needs. The concept of integration both within health and between health and social care services is largely missing." Can you talk to us a bit about integrating things for patients with multiple co-morbidities, multiple needs and integrating health and social care.
Professor Lord Darzi of Denham: On that note Age Concern was very supportive of what we have said, not the organisation to which you have referred.

Q268 Dr Taylor: This is Help the Aged. I get terribly muddled up between the two.
Professor Lord Darzi of Denham: Age Concern was very supportive of what we have said and I would be rather happy to send you a quotation on that. I think what you raise is an issue, and it was a dilemma that I thought about back in the age pathways. I think where you are coming from is should we have had a pathway looking at elderly patients. If you look at the report across the system of the eight pathways, with the exception of the maternity pathway and the birth pathway, all the pathways deal with the elderly patients that we serve, but at the same time throughout it, as I said at the beginning of this Committee stage, clinicians kept challenging themselves on how do you break the boundaries between primary and secondary, between health and social care. In most of the enabling reports—and if I could hand over to Jonathan he will describe what happened in the South West—there is a significant bit ,I will give you examples, personalised budgets, integration. Looking at pathways of care have always been a process of bringing groups together, but Jonathan may address some of the issues at a local level.

Q269 Dr Taylor: Just to break in a moment, the profession of the geriatrician is absolutely vital as somebody who sees right across all the co-morbidities. Is there any threat to that?
Dr Sheffield: Absolutely not. I am surprised at those comments, if I am really honest, because the vast majority of people that we treat in the NHS are elderly. If you look at the care pathway groups, apart from newborn and maternity, you would regard most of them as integral in the care of the elderly. If you look at three of the four that we are going to look specifically at the quality outcomes in—cataracts, fractured neck of femur and stroke—they are very much essential parts of elderly care, and even looking at issues around trauma, again fractured neck of femur was a main focus of our discussions, so I am puzzled at that comment, if I am really honest, because it was very much a focus of discussions, certainly in the acute care group that I led but also within the mental healthcare group where they were discussing how they deal with the dementia strategy. I am surprised at that comment because it is integral to care.
Professor Lord Darzi of Denham: One problem we have had with this report is the system is hard-wired in reading the national report. It is amazing, despite the whole process of the review, it is the local reports that people focus on, so people automatically read the enabling report. The enabling report had a purpose which was to support the ten regional reports. I have tried my best because similar issues I have heard in the last week or ten days, yesterday for example, groups raised the issue about diabetes or mental health, and it is very important that we really describe the process and get them back to the ten regional reports.

Q270 Dr Taylor: Help the Aged do welcome the emphasis on quality and dignity but they say the Government needs to be explicit about the areas of care that are particularly important for maintaining dignity during periods where individuals have lost independence.
Professor Lord Darzi of Denham: Yes.

Q271 Dr Taylor: Is there anything in the report aimed specifically at that? The high-quality workforce, which I think is good, does have bits about the details of doctors, the details of what nurses should be providing.
Professor Lord Darzi of Denham: Absolutely and within the matrix that I referred you back to—patient reported measures—where all of that aspect of care which I highlighted in the interim report, personalised care and what we mean by that, not just integration around your care but respect, dignity and all the factors that go with that, these are the basic principles of care. I cannot see anyone coming to work if they do not have those very basic principles. If you are involved in providing care that is what you need to be doing.

Q272 Dr Taylor: Absolutely so really you do think you are looking across co-morbidities of elderly people in the report?

Professor Lord Darzi of Denham: Yes.

Q273 Jim Dowd: Nobody can dispute the scale and ambition of the undertaking that you have pursued over the last 12 months and I do not think that anybody can have anything but the highest praise about the way you have gone about it. We can argue about what it actually means and whether it translates into fact. I just want to focus, and it might seem like nit-picking but it was barely mentioned in the report (I think Dr Sheffield mentioned it once in passing earlier in this session) on the care of the mentally ill. It links very much with what Richard was saying about the elderly. It is barely mentioned in the report. Where capacity for example is impaired or is not as apparent as in other circumstances, the notion of informed choice and personalised care actually does lose some of its gravitas as it applies to everybody else. What improved role can you see for people being treated for mental illness?

Professor Lord Darzi of Denham: I think it is the same discussion as we had earlier. Again, if you look at the ten regional reports you will look at the mental health pathway. In actual fact, in my experience of going across and reading the regional reports, mental health output is one of the most powerful, no question about that, and not only that, they even challenge themselves more and not just producing a mental health pathway but challenging their colleagues in the wellbeing pathway, in the acute pathway, in the maternity pathway and the children's pathway about the mental health needs in these different groups. I am fairly confident and I think if we can really re-engage those reading that they need to read the ten reports to makes sense of the enabling report, is the way I see it. The enabling report though does have things about mental health, introducing tariffs for example. It has been a fairly complicated thing to calculate the tariff in mental health. I think that in itself will take away some of the obstacles that you were referring to. The other thing which I think was interesting is that one of the policy ideas is the introduction of care plans and we have learnt that from mental health because they were the first to use care plans in their pathways, but maybe Jonathan would like to say something about their local mental health pathway.

Dr Sheffield: Our local mental health pathway has a very strong voice. They not only consulted amongst clinical experts and managers, they also had a separate consultation with patients who had been through the process, so that came out very strongly. What was interesting was that whilst we were working remotely in our own care pathway in the acute sector, mental health came up time and time again as being an issue that we had to deal with. Our own mental health group also wanted to do a separate work stream on people with learning disabilities because they felt that was a group that was missed out many times in the report, so we have got a separate pathway around learning disabilities because they are amongst the most disadvantaged people that we have in our community. We have made it quite clear that it is their access to normal healthcare services that is really important so introduction of a personal care plan to them is really integral to us delivering good care, certainly in the South West, but in my discussions with other chairs of the groups in the other regions, time and time again mental health came up as being a real issue for us in all streams of the review.

Q274 Jim Dowd: It does need a degree of concentration on it because certainly it has been regarded previously as being the 'Cinderella' service, and of course the people who are actually involved in it are the ones least likely to know their rights and to pursue them.

Dr Sheffield: Absolutely but they do have good representative groups and some of these people were present at our public consultation meetings and made the points very strongly. One of the things that we have discussed as a group in looking at programmed assessments of the whole mental health programme is the fact that there is a clear push for the introduction of more psychological therapies into the healthcare of people with mental health problems. What we were looking at is how we can address that by looking at the whole programme budget for mental health as they have already done in Norwich where they have demonstrated there are a large amount of resources but they are maybe not necessarily targeted in the right play. That is an area that the mental health group was very keen to develop.

Professor Lord Darzi of Denham: You are aware of the investment we have made in cognitive behavioural therapies in the last CSR and also a recent publication from the OECD comparing us and scoring us very high on mental health. We are doing very well on it.

Q275 Dr Naysmith: One other area where healthcare needs are neglected often is in prisons. Did you take prisons into account in the South West?

Dr Sheffield: Certainly in the discussions around health, the public health group very much considered how we actually look into social marketing, and certainly prisons would be one area where we would target where there are high instances of HIV and AIDS.

Q276 Dr Naysmith: PCTs are now responsible for prison healthcare which they did not used to be.

Dr Sheffield: Absolutely and the individuals that were involved in the public health part, the Staying Healthy group, were very keen to target that area.

Q277 Dr Naysmith: That was not the question I was going to ask and it is again to Lord Darzi You have emphasised quality as the most important thing you are most interested in and getting away from the old money in at one end and volume out the other. What are one or two or three impediments that you see to you achieving what you hope to achieve in raising quality, if any?

Professor Lord Darzi of Denham: Firstly, we need to make this happen. What are my aspirations in relation to this?

Q278 Dr Naysmith: What I am saying is what do you see as standing in your way to achieving this, if anything?
Professor Lord Darzi of Denham: That is probably difficult coming from me being out there and seeing those reports and the amount of enthusiasm out there. I think we are at the right time to make this happen. We have the resources to make it happen; I believe we have the talent to make it happen, and we need to have much bigger aspirations than we have ever had before. We do have in this country first-class services in a large number of organisations competing internationally. We want to make that as uniform as we can in really achieving a first-class service.

Q279 Dr Naysmith: I am sure that is right but what I was trying to get at was I might have suggested, for instance, the BMA have criticised some of the things in your report; would that be an impediment?
Professor Lord Darzi of Denham: Not at all. I know the BMA, I am a member of the BMA and I just look forward and I move on and what matters to me is what matters to patients.

Q280 Dr Naysmith: What are the measures and by when will you and will we be able to judge whether you have been successful or not? Are you going to measure it and by when will you be able to do that?
Professor Lord Darzi of Denham: It is all about measuring because you can only improve things if you measure them. I would like to see at a national level really comparing ourselves with some of the OECD countries and agreeing with them some benchmarks in which we can really compare ourselves, like with like though because this is a difficult exercise and ultimately aspiring to provide a first-class service.

Q281 Dr Naysmith: I know you have put a tremendous amount of work into this, that is obvious, but you really need to know how you are going to say we have achieved something in two years' time or three years' time or four years' time. You say you are going to use OECD measures?
Professor Lord Darzi of Denham: Some national matrix. I think at a national level we need to have a matrix which look at the NHS on a yearly basis and how well we are doing, not just quantitatively also qualitatively and really compare our progress on a year-by-year basis. In a formalised way we need to work with universities and we need to work with colleagues elsewhere really to develop that matrix, but at the same time I think we really need to have the ambition of saying in actual fact a lot of services we provide are far better than a lot of our European counterparts and I hope to work with stakeholders in the next six months to decide what this national matrix is to compare ourselves.

Q282 Dr Naysmith: But you are going to develop this matrix and start measuring and make sure that the money being spent is being well-spent?
Mr Nicholson: There will be an annual report produced which tracks the change in the quality matrix.

Q283 Chairman: Could I just clarify something, in the section of questions that you were asked on commissioning I think you were asked about the lack of competition on the provider side and actions that you would take. Would it be if you were taking actions it would be regulated so that both the private and the public sector had a level playing field in terms of being a provider?
Mr Nicholson: There are two things. First of all the decision would be taken locally. We have moved away from the national independent treatment centre programmes run from Whitehall. We have moved away from that so it is very important that the decision would be taken locally, but what we expect in individual PCTs and organisations to create a level playing field, and that is exactly what we need to do so that both the public sector and the independent sector have a fair ability to compete for the work when it comes up.

Q284 Chairman: Would that be done by regulation or by hope?
Mr Nicholson: No, we have set up an organisation called the Co-operation and Competition Panel—for which we have just advertised for the chair and director—and that will be the organisation that is responsible for making sure that the rules are taken forward. It will not be part of the national regulation system already put into place.

Q285 Charlotte Atkins: You just mentioned the ISTCs but some of the contracts are still live until 2011-12 and where PCTs are getting very little benefit from those ISTCs, for instance the one in Burton near my constituency, where they are just getting 20% or 30% utilisation out of that contract, they are still tied into that contract until 2012. That does not create value for money for local PCTs who are trying to determine their own priorities.
Mr Nicholson: As I say, we have moved away from letting contracts like that in the future.

Q286 Charlotte Atkins: Yes, but they are still locked into them until 2012.
Mr Nicholson: And increasingly across the country we are delegating the responsibility for managing the contract to PCTs. I cannot say what the position is in relation to Burton.

Q287 Charlotte Atkins: But the SHAs were the organisations that actually locked them into those contracts which are not giving them value for money.
Mr Nicholson: As I say, we are delegating responsibility and there are other parts of the country where people are being able to renegotiate contracts to the satisfaction both of local circumstances and the individual independent sector. I cannot comment on the Burton one.

Q288 Charlotte Atkins: Maybe you could write to me on that one.
Mr Nicholson: I am more than happy to write to you about Burton.

Q289 Chairman: When the organisation that is going to make sure there is a level playing field is set up, could you drop us a note about how local PCTs will be expected to operate within their advice? The last question, you will be pleased to know, is that we understand there has been a change in the running of the Healthy Choices website quite recently and we wondered if that was likely to impair progress in terms of information on that site?
Mr Nicholson: No, we think it will accelerate it. We have produced a level playing field and we had a whole series of very good bids to run it, and we are absolutely confident that the successful bidder will be able to accelerate progress in that area.
Chairman: Could I thank all three of you very much indeed for coming along. We would hope that the publication of the report into this inquiry—and we have not yet finished taking evidence—will be before the end of the year. Thank you.

Thursday 16 October 2008

Members present:

Mr Kevin Barron, in the Chair	Stephen Hesford
Charlotte Atkins	Mr Lee Scott
Mr Peter Bone	Dr Howard Stoate
Jim Dowd	Dr Richard Taylor

Witness: **Dr Hamish Meldrum,** Chairman, Council of the BMA, British Medical Association, gave evidence.

Q290 Chairman: Good morning. Welcome to our third evidence session in relation to the *NHS Next Stage Review*. I wonder if I could ask you to introduce yourself and the position you hold for the record, please?

Dr Meldrum: I feel a little lonely sat here, particularly with three SHA chief executives lined up behind me!

Chairman: Is that a comfortable position to be in?

Q291 Jim Dowd: That is in case the frontal assault does not work!

Dr Meldrum: I am Hamish Meldrum. I am a GP in East Yorkshire and I am Chairman of the Council at the British Medical Association.

Q292 Chairman: The first question is a really easy one. Is the BMA Support your Surgery campaign more interested in protecting its members than improving the quality of care for patients?

Dr Meldrum: The short answer is, no. I think that it has been misconstrued in many areas that the BMA was totally against any change, totally against GP-led health centres—that was not the case. What we were against is the way that we felt that some of the implementation was taking place, that there was a one-size-fits-all approach, that some areas certainly need additional GP services but other areas do not, and we felt that the one-size-fits-all approach was threatening what were quite good local services. Perhaps I can use my own area as an example. I work in East Yorkshire, a fairly rural PCT, a PCT which was told that it must have a new GP-led health centre. There is a problem as to where you put it; so they decided to put it in Bridlington, where actually, though I say so myself, GP services are reasonably good and it is not going to help probably about 80% of the population in East Yorkshire, whereas Hull, down the road, could perhaps do with two or three.

Q293 Chairman: Your campaign is a one-size-fits-all, is it not? Every doctor's surgery has been getting literature up and down the land for the last four or five months?

Dr Meldrum: The actual campaign only lasted three weeks, and during that time about 1.3 million patient signatures were collected. Really part of the purpose of the campaign was to try and make the public aware of what was going on. I am aware that there were certain colleagues who used their own material, which we would not support, and I publicly condemned that, but actually the campaign material we used was all checked through. We put out strong messages that it was not to be party-political, or whatever, and that there would be some areas where it was more appropriate than others and it was up to local GPs how and whether they used this material.

Q294 Chairman: It is quite interesting. This is one that was handed out by one of my GPs in my constituency. I will not read all of it out, but it says on the bottom, "You will have your opportunity in a relatively short time to let the Government know how you feel with your vote." Does the BMA think that is a proper thing for its members to be saying to patients?

Dr Meldrum: No, and I would not support that at all. Actually we put out with all the documentation something that talked about the law and political neutrality and defamation, and, therefore, I think, hinting at how people should vote in an election we would not support at all and I would condemn that.

Q295 Chairman: I have to say, I did have a public meeting with that doctor at the end of last month and he seems to think that what is happening in primary care in Rotherham is quite acceptable and is supportive of it, but it is just the emotion that people get; and I get letters back on that being put out, not particularly potentially threatening me, as one of the likely candidates in the next few years, but from people who are genuinely concerned that that doctor's surgery is going to be privatised. Quite frankly, that is not the case—the doctor agreed in public that it was not the case—but I did read out to him at least eight letters that I had, what people had said, that they thought that their local doctor's surgery was under threat. Do you think that is an irresponsible position to have engineered?

Dr Meldrum: I have tried to explain that that was not the main purpose, but there is a possibility—in the main, initially, a lot of the contracts were very much geared to the commercial sector—that if commercial GP premises are set up, in effect in opposition to existing ones, then it could put the existing ones under threat. As I have said before, we have no problem about GP-led health centres, polyclinics, whatever, in certain areas, and I think we have been misrepresented in saying that we are opposed to them full stop. We are not. What we are opposed to is the way they were being delivered, the way they were being implemented and the one-size-fits-all approach.

Q296 Mr Bone: Would you agree that the Government has a very powerful propaganda machine and can push through things at a great rate of knots, and a campaign such as Support your Surgeries raised the issue, indeed, had as many as 1.36 million signatures on it. Is it not actually your duty, if you think there is something seriously wrong, to campaign for change?
Dr Meldrum: Certainly we were under a huge amount of pressure from our members to do that. Whether I would say it is our duty: we felt there was a need to do what we did and we believe that what we did was the right thing to do and that it was successful in raising the issue and getting patients to ask what was happening in their area, because many patients were oblivious to what was going on. It may be that in doing that, as I say, in certain areas people went over the top—that is always a risk with these campaigns—but, in general, I think it did raise patient and public awareness and I do not apologise for that for one minute.

Q297 Jim Dowd: Briefly, how do you explain the total failure of your campaign to get across the idea that it was not change you were against, it was this particular form of change? Because the way it was presented, certainly by one GP in my constituency, was that the whole of the future of general practice was under threat everywhere?
Dr Meldrum: I would contest the total failure. I think the campaign was quite successful. With all of these things, you are in the hands of the media as to how they pick that up. As I say, there will be individuals who do that and who will misrepresent it, but we were very clear from the centre about what it was about, what we were trying to achieve, and in that matter I think we were actually quite successful. I cannot really answer for how other people will choose to interpret it.

Q298 Stephen Hesford: This is a BMA leaflet?
Dr Meldrum: I think so, yes.

Q299 Stephen Hesford: What it says on it is, "Support NHS General Practice. The threat to NHS general practice has not gone away." As I understood what you have just been telling us, that was not the nature of your campaign. There was not a threat, it was just how to explain where polyclinics might usefully go. How do you reconcile, "The threat to NHS general practice has not gone away", with what you have just been telling us?
Dr Meldrum: By saying that if you are going to set up polyclinics or GP-led health centres in areas where they are not needed and where you could actually support local practices instead, then that is a threat to general practice in those areas. It is not a threat to general practice everywhere, but it is certainly a threat in those areas, and I think that is not a conflicting message at all.

Q300 Chairman: We are going to move into that in the next question. While I think it is relevant, again the one-size-fits-all campaign is the issue here as well as the one-size-fits-all policy, and I think that we could talk for hours on that.
Dr Meldrum: I am sure we could.

Q301 Chairman: But we are not going to get to the end of it all at this stage. Could I say that Lord Darzi told us in July when he gave evidence that he was confident that the BMA would not be an obstacle to implementing the *Next Stage Review*. Was he right to be confident?
Dr Meldrum: I hope he is right.

Q302 Chairman: Was he right, as opposed to "hope he is right"?
Dr Meldrum: To some extent time will tell. It is whether the clinical engagement and clinical leadership that has been talked about will actually be carried out in practice. Our experience during the *Next Stage Review* process was very mixed in that we tried very hard to get local BMA representatives on most of the regional committees that were looking at these things. In some areas we were quite successful; in two areas we were not successful at all in terms of engagement. Also, I had several meetings with Lord Darzi and found these constructive and fruitful, and we very much want to work with the Government. The press release we put out at the time of the *Next Stage Review* was positive and we are keen to engage, but I cannot predict whether that experience will happen everywhere in the country and whether there actually will be true engagement. Unfortunately, the experience in the past has been that it has at best been patchy, so one has to be a little bit guarded about whether it will be successful and whether he is right.

Q303 Dr Stoate: I would like to start by putting on the record, as always, that I am a practising GP and member of the British Medical Association, to avoid any doubt about that. What I would take up with you, Hamish, is that around the country the BMA were not removing the idea that it was polyclinics for everybody and was not going out of its way to explain that 25-doctor polyclinics were precisely not what the Government was talking about. I had letters, the same as the Chairman did, from GPs up and down the country saying, "My village cannot support a 25-doctor health centre. What is going on?" The BMA, in my view, did not do enough to make it clear that polyclinics were for London and there were no polyclinics proposed outside London. Why did you not do more to counter that?
Dr Meldrum: I do think we tried to do quite a bit. One can always argue you can do more. It gets back to what we were talking about earlier, the effectiveness of the campaigning. Campaigning, I accept, is a bit of a blunt instrument, but there is an overall message you are trying to get out and, if you start trying to question little bits of it at the edges, then it does rather blunt the overall message. As I said, I apologise, I condemn people who actually misused the information that we were giving them. I

have written publicly about that and to Ben Bradshaw about that, but I think there was a feeling that there was a drive, not just in London, to set up clinics everywhere, that would be in some ways in opposition to existing services and at the same time try and encourage a lot of the commercial sector to get involved in running these, and a lot of our members felt that these were a great threat. We are, as you know, a membership organisation. We react to what our members are telling us and it is on that basis that we decide how we are going to move forward. So, yes, we lead, but we also follow what our members are asking us to do.

Q304 Dr Stoate: But there is obviously a world of difference between a 25-doctor polyclinic and a five doctor GP-led health centre. You have made your point about that. I would like to move on from there. You have said in your submission that in some areas there is little or no identified need for new GP-led health centres, and you have said that this morning, but what evidence has the BMA used to decide whether a PCT area needs a GP-led health centre or not?

Dr Meldrum: We have our local structures, our local medical committees, where we get information about what they feel about GP services, what the public opinion is of access and the quality of their present services. We all, through the Quality and Outcomes Framework, as you know, get feedback from our patients on what they believe about the present quality of services, and in many areas patients feel that they are happy with their present services and do not see a need for additional services, or, more than that, would like to see existing services improved and expanded. Rather than parachuting in a new surgery, why not develop the existing ones and build on the good practices already taking place?

Q305 Dr Stoate: That is fair enough, but the Healthcare Commission this morning says that a worryingly large number of patients cannot get an appointment within 48 hours, and in fact that number has radically increased over the last year. So although I agree, it is patchy across the country, there is clearly a need for more access to GP appointments.

Dr Meldrum: I am not saying there is not a need, and I agree with you that it is patchy. I could spend a long time analysing the Healthcare Commission's figures and how they seem to be so much at variance with other figures that we have had. Figures in my own practice, which is going to get a GP-led health centre in the town, are all in the 90% in terms of satisfaction with 48 hours access, being able to book ahead, dare I say it, even being able to see the doctor of their choice, which rather upsets me when I am only in the practice one day a week, so they are obviously not too bothered that they cannot see me! All practices have figures like that so that we can see what our patients think and whether they feel the existing services are satisfactory.

Q306 Dr Stoate: Except that the Healthcare Commission's view is that there is a very worrying disparity between what GPs are returning in terms of 48-hour access and what patient's are returning in terms of 48-hour access and the big disparity needs some explaining.

Dr Meldrum: I would take issue with that, because the figures I am quoting are what my patients are returning. I have no control, apart from handing out the survey forms. They are all dealt with by an independent agency, so I am not telling my patients how to fill them in or anything like that.

Q307 Dr Stoate: I am not suggesting that for one moment; it is just that there is a big disparity between patient reported figures and GP reported figures.

Dr Meldrum: When I was talking to Sir Ian Kennedy about this a couple of days ago, he did wonder whether actually the way the question was being asked was different, because he said in their one they had said, "Can you see your own doctor within 48 hours?", rather than, "a doctor within 48 hours", which is the actual target that we are meant to stick by. We could argue all day about statistics, but I accept your underlying premise that there is still a problem with GP access. It varies from area to area, but that really gets my point: that does not mean that necessarily the way to deal with that is in every PCT to put in a new GP-led health centre. I quoted my own example, where a GP-led health centre might benefit 20% of the population of the PCT that they are in and around Bridlington; it will do nothing for those in Beverley, Driffield, Pocklington or the other parts, who would find it far too far to travel, and why not spread the resources and build the resources in all areas of the PCT?

Q308 Dr Stoate: Yes, but if you accept that argument, then you just say we ought to have more GP-led health centres in every part of the country so that every patient gets access seven days a week for 12 hours each day?

Dr Meldrum: That is one argument. The other argument, and I think a cheaper and more cost-effective solution, would be to build on existing services, unless existing services are either not of the quality or it is not practical to do that.

Dr Stoate: I would like to move on to alternative provider medical services.

Q309 Chairman: On this issue of need, this question was asked of the Chairman of the Royal College of GPs, Professor Steve Field. I asked him the question: how do you measure need in the context of the debate we have had this year? He said it was a good question. He then went on to say—and this is my interpretation—it is a bit difficult to measure it. You could measure it by deprivation indexes, presumably, you could measure it by the number of GPs per population, and he went on to say that, unfortunately, general practitioners historically have gravitated, even before the Health Service began, to areas which might not be as challenging. There are some others, like myself, who have gone into areas, and he has actually worked in areas of

high deprivation. Constituencies like mine have very high disease burdens in the communities, and yet we have what appear on the surface to be objections to the extension of GP services. Why is it not that the College itself or indeed GPs in general, maybe the BMA as well, do not have a pattern, a matrix, that you could lay over a community and say, because of the needs of that community from the disease burden that it has, under those circumstances it is pretty obvious that we should have a GP service there? Because what Professor Field was telling us is that in general terms the pattern of GP services has not altered, not just in the last six years but even before that. That does concern me. We have differences in ill health that we have from community to community, sometimes quite close by.

Dr Meldrum: I share those concerns. I know we have got health economists sitting here too, and I think Steve Field is right, it is quite a difficult issue, both how to assess need and also how you meet that need. He is right. I suppose the reasons are fairly clear. It is often more difficult to attract good GPs into these difficult deprived areas. There are people like Steve Field, and others, Angela Lennox in Leicester too, who have done a huge amount in deprived areas, and I take my hat off to them, but we have to look at how we help that process, and I have always been on record as saying I am never going to be against additional ways of providing services, whether they be an alternative provider, the commercial sector, or whatever, if it is shown that the existing services are not up to the mark and cannot be brought up to the mark. First and foremost, we have to provide good services for patients. That is my view, that is the BMA's view and, therefore, I have always been on record as being willing to work with any government as to how to address these issues. It gets back to the earlier issue though: do not use a sledge hammer to crack a walnut and do not use it in every area where it is not appropriate.

Q310 Dr Stoate: You have just talked about APMS, saying you are not against it, yet the BMA's submission actually says that "the department's directive to use APMS implies disregard for the traditional independent contractor model and will result in poorer patient care". That is a pretty sweeping statement. What evidence have you got to back that up?

Dr Meldrum: There is quite a bit of evidence from some of the APMS-led services that they are not so good. They tend to use employed doctors rather than doctors who have a real interest. They may go through a succession of doctors too. Again, it is back to this blanket approach. Yes, APMS, as I said to your Chairman, may be appropriate in certain areas, but it is not appropriate in every area. The existing GMS or PMS contracts and, you have got to remember, about 40% of GPs work under PMS contracts which are locally based contracts, should be quite effective in many areas. It was the idea that these new ones can only be APMS that we are objecting to, because we have not seen the evidence that that is necessarily going to provide a better level of service.

Q311 Dr Stoate: One final point. The Government is establishing a Collaboration and Competition Commission to oversee the contracting for new health centres by SHAs. Will the BMA co-operate with this and do you think that is a workable model?

Dr Meldrum: I would need to know a little bit more about the detail, but we will work with anything where the aim is to try and improve the quality of services, and we will try and argue and work with anybody or anything that is helping to do that.

Q312 Mr Bone: As I understand it, the Government is planning to spend an initial £250 million of taxpayers' money of which £150 million is set aside for this ill-thought out GP-led health centre scheme, but I do not want to talk about that. I want to talk about the other £100 million that is supposed to be being put in in relation to need. How would you decide which PCTs qualify for that money in relation to the Government's thinking?

Dr Meldrum: It gets a little bit back to the question we had earlier about how easy it is to accurately measure need. First of all, you can try to measure the need of the population using deprivation, age and various other factors. Then you have to look at what the present resources are. At the moment they tend to use a rather crude measure, which is just how many doctors there are, and that tends to be a headcount figure too; it does not take into account whether they are full-time, part-time, it does not take into account the other services that they may have as well. So I think we need to be much more sophisticated about how we are going to measure need, and I would not pretend that I am any way getting that answer right, but until you do that it is going to mean that you are relying on local opinion and local information as to whether or not they feel there is a need.

Q313 Mr Bone: Chairman, would the witness agree that one of the simplest way to allocate this money would be to take the national capitation formula, and you know that so many PCTs are not receiving the minimum that the Government says on the national capitation formula, and then spread it out over those: because you have already done all the work saying this is what this area needs, and the Government deliberately under funds those areas because it is over funding other areas. Would that not be a starting point?

Dr Meldrum: I am not quite sure what you mean by the national capitation formula, whether you are talking about the general resource allocation to PCTs and the basis on which that is done.

Q314 Mr Bone: The Government spends a lot of time and money working out what every PCT in the country should get, but it does not give every PCT that amount of money because substantial numbers are over funded?

Dr Meldrum: True.

Q315 Mr Bone: And they are using what they call "damping" to under fund other areas, such as mine. Because all the work has been done, would that not be a very easy way of allocating this £100 million?
Dr Meldrum: That is one possible way, but you are also talking about how quickly you can move from a historical funding level to what might be a more ideal funding level. Of course, we believe that realistically you can probably only do that by differential funding upwards. To actually cut funding in certain areas would not, in our view, be particularly advisable; but certainly to try to target funding at the most under funded areas is, obviously, a logical way to approach it if you have got additional money.

Q316 Mr Bone: I suppose the other thing is, it is no good having £100 million unless you put that in and it makes a difference. What services should that £100 million be put into where it would make a real difference?
Dr Meldrum: That is where I have always had a particular view, particularly if you are trying to address health inequalities, that just throwing money at an area will not help. I used to sit on the advisory committee for resource allocation which looked at these sort of issues, and I have always thought that targeting at specific projects is likely to be more successful than actually just saying, "Okay, here is more money, get on with it", because unless you actually target that and unless you are sure that the management and the infrastructure and everything else there is actually going properly use that money, then it is not going to help. Therefore, targeting at specific areas which have been shown to work in the past and learning from others seems to be a far more appropriate way of doing it rather than just a sort of blanket allocation.

Q317 Dr Taylor: Like Howard, I have to declare that I am also a member of the BMA. I have to say, since being in this place I have been desperately disappointed by the impression most members seem to hold of the BMA, and that is because I feel it has tremendous emphasis on the trade union protecting the professional aspects, so I am going to give you a marvellous opportunity to demonstrate all the other things that the BMA is interested in. Quality: is Lord Darzi right that the quality of healthcare needs to improve?
Dr Meldrum: Yes.

Q318 Dr Taylor: Which actual areas should it improve in and how is it going to be done? Really positive answers.
Dr Meldrum: Gosh, I have only got 45 minutes. I would like to improve every area, is the obvious answer, because one should never be satisfied.

Q319 Dr Taylor: Pick out the specific ones. I have got my own very firm ideas where it needs to improve, but I would love to have yours.
Dr Meldrum: There is an awful lot of evidence that actually improving primary care will do an awful lot to try to help improve overall healthcare.

Q320 Dr Taylor: In what ways?
Dr Meldrum: Barbara Starfield and others have done a lot of work on that.

Q321 Dr Taylor: In what ways do you improve primary care?
Dr Meldrum: It is properly funding and resourcing it, it is making sure you have adequate resource, and am not just talking about doctors, I am talking about nurses, I am talking about health visitors. Again, there are a lot of areas in public health that have been Cinderella areas which you need to address, some of which can be addressed through primary care but some of which need to be addressed by wider public health measures. Mental health is another obvious area where in many places the resources, particularly for rapid intervention before mental health problems get too bad, are very patchy. I have got a long list that I could go through.

Q322 Dr Taylor: So prevention in mental health. I accept that, but you say improvements depend on funding. We are not going to get more funding, so how can one improve?
Dr Meldrum: I think you could still make better use of some of the funding. I am not pretending that we have always got the most cost-effective healthcare system. Despite our overall results, and this was something that people have tended to focus on in GP access results and health commissioning, things like cancer waiting times and various other things have improved and we are doing that still on a lower percentage of GDP than most other developed countries and under half the overall spend of the United States, which has, overall, poorer results than we have. So let us not under play what we are doing, but let us also say that we could still do a lot better, and some of that could be done by increased efficiency. I accept that.

Q323 Dr Taylor: In your submission, the bit on quality, you say, "The emphasis in the final review report on driving quality is to be welcomed", and you go on to say no wholesale re-organisations, but a significant number of organisational additions, a new medical director in each SHA and a new National Quality Board and SHA Quality Observatories. What do you think about these extra bodies?
Dr Meldrum: My innate feeling about creating a lot of bodies is that you only do it if they are going to be useful, but I think there does need to be better co-ordination—this is what I was getting back to about more efficient use of resources—and it is not just within healthcare but it is between healthcare and education, transport, social care—all these sorts of things, certainly if you are going look a lot at the preventative work. I am passionately interested in trying to improve the overall health of the public and I believe that is only going to happen by proper joined up work really through all government departments to actually try to achieve that.

Q324 Dr Taylor: So proper joined up working, pathways that can cross between getting it right?

Dr Meldrum: Yes.

Q325 Dr Taylor: Over the years there have been lots of efforts to try to improve quality and outcomes. Do you think the *Next Stage Review* is going to be any more successful?
Dr Meldrum: I certainly hope so. I know that there have been criticisms, and I have been one of the critics of some of the aspects of the *Quality and Outcomes Framework* in general practice, but I think, leaving aside some of the funding issues which we may get on to, I think overall it is felt to have been a considerable improvement in the areas where it applies because it is using an evidence base, it is using a degree of patient experience as well, and we are working very closely with Bruce Keogh and his team and the colleges to try and establish a set of quality metrics particularly for secondary care and also to look at the influence of patient outcome measures as well. So we are very supportive of that work so long as it is evidence-based and it is done in conjunction with the profession, because I think that is what is going to make it successful in delivery. The profession have got to believe in it, but if they believe in it they will run with it. Most doctors actually get out of bed in the morning and hope to do good work with their patients, and actually what challenges them is to try and make sure that they are doing it better than their colleague down the road. I think that is the best incentive to improving quality.

Q326 Charlotte Atkins: Following on from those comments and staying on the quality theme, do you think that patient recorded outcome measures (PROMS) should be part of the GP QOF and what elements of the existing QOF should be dropped to accommodate the patient recorded outcome measures?
Dr Meldrum: There is already a degree of patient experience in the QOF and, of course, there is another survey that does, but I agree that it is not completely linked to clinical outcomes. We are certainly willing to look at that. I think mainly the QOF is dealing with long-term conditions. That gets a little bit more difficult than if you are just talking about a single episode of, say, elective care. If you were talking about looking at patient experience of diabetes care, there is a question of how many patients do you ask, how often do you ask them? A lot of our patients have comorbidities, so there are practical issues about the bureaucracy of trying to do it over the whole range of conditions within the QOF and how often you are going to do it, because you are looking at, as I say, long-term care, you are not just looking at single episodes of care. We are certainly prepared to look at that, but until we have looked at it and decided whether it is going to be an effective way of doing it, I would not like to say at this stage which areas of the QOF we would want to drop.

Q327 Charlotte Atkins: PROMS, I suppose, would be in place by 2009.
Dr Meldrum: I think that is primarily in secondary care they are talking about.

Q328 Charlotte Atkins: Right. So you do not think that a timetable like that could be met within primary care?
Dr Meldrum: No.

Q329 Charlotte Atkins: You do not think that would be beneficial in any shape or form?
Dr Meldrum: I cannot tell whether it will be beneficial until the actual work has been done and we have looked at some of the practical issues I have referred to, but I do not think that work can be done within the time scale that you are talking about. Whether or not it is going to be beneficial over time is a question I would very much like to see answered.

Q330 Charlotte Atkins: Can I ask you about the QOF in general? Do you think it has the right elements within it now, or have you got concerns about what it should cover? For instance, at the moment, as I understand it, it does not actually cover osteoporosis.
Dr Meldrum: No, although when the QOF was being developed actually the evidence base for osteoporosis was a little limited. At that time actually one of the most effective treatments preventing it was HRT, which of course then ran into problems. There is now going to be a directed enhanced service covering osteoporosis starting, and we had actually asked that this should be in the QOF, and part of the agreement that we had virtually reached with NHS Employers about changes to the GP contract for 2008/2009 was a degree of extended hours and having various things like osteoporosis in the QOF. The Government did not accept that; hence we got into the dispute over extended hours with them.

Q331 Charlotte Atkins: But now resolved.
Dr Meldrum: The dispute is in the past, let us put it that way, so we are addressing things like osteoporosis in other ways. The main constraints of the *Quality and Outcomes Framework* were two or threefold. First of all, it was to make sure that there was an evidence base for what you were asking to do. Secondly, that it was something that primarily applied to primary care. So it was things that GP practices were doing and could do that would have the results. That is why the majority of cancer care is not in the QOF, because it is not undertaken by GPs. Thirdly, that it could be recorded in a reasonably non-bureaucratic way and the results compared. It had to fit into that, but that did mean that quite a bit of the areas that I think are vitally important, like the quality of consultation, how do you measure that or even a lot of areas of mental health where the measurements are very subjective we have not been able to get in the QOF. You know, the length of consultation, which in some way is a sort of marker for good standard quality but it is actually quite difficult to measure. So the QOF has tended to concentrate on those areas where you can make the measurements and can make the comparisons, and I accept, for that reason, it is limiting, but in those areas I think it has produced some quite marked improvements in quality.

Q332 Charlotte Atkins: You have rightly addressed the issue about the importance of collecting better performance data in terms of improving quality, so what areas in both primary and secondary care do you think we should be focusing on in terms of gathering that better performance data?
Dr Meldrum: The short answer is all areas. I do not think we should ever try and exclude any area. There will be some, as I said before, where it is gong to be easier to do than others, but basically, certainly in secondary care, the work that Bruce Keogh is undertaking with the colleges, all the various specialties, looking at that. We have worked very closely with the Royal College of GPs in developing the QOF. They have been one of independent sources in the same way that we have used the University of Birmingham to gather together the evidence base in primary care. There is more work that can be done, but it would be wrong of me to specify two or three areas because I think eventually, if we can do it, we should be looking at all areas of trying to gather a proper evidence base so that we can accurately and fairly compare how well people, units, whatever, are doing.

Q333 Charlotte Atkins: So once we have that improved data, how do you think it will actually improve care?
Dr Meldrum: Partly the answer that I gave earlier. I think the biggest driver to improving quality for doctors certainly is to know what their colleagues are doing and to try to do better. When I got my access results for my practice, the first question I asked was, "What is the practice next door doing?", and I would have been disappointed if ours had not been better. I think that is the sort of competition that drives a lot of doctors, because they know that that leads to better care for patients, which is, hopefully, what we are all about.

Q334 Charlotte Atkins: So the pay element for the QOF is not a real indication?
Dr Meldrum: The pay element, we can argue about the amounts, and I am on record as saying that I thought more should have gone into the core aspect and less into what I would call the performance-related aspect, which is the QOF, but that is another issue; and I am conscious that Mr Farrar is sitting behind me and that was part of the negotiation we had at the time, but part of the so-called pay is to actually resource the work because actually there has been quite an explosion in the work that has had to be undertaken in terms of monitoring, measuring, making sure you get patients in to do the proper checks which then, hopefully, lead to the improved outcomes. So although the reward is based on outcomes, part of the reward is to resource the work that actually needs to be done to achieve those.

Q335 Chairman: Do you think the pay element could overcome this position where some areas do not get GPs in the quantity that other areas get?
Dr Meldrum: I think pay is a factor but I do not think it is the only factor. I think you are talking about overall resources for practices and, again, I am on record as saying that actually having good practice administration and practice management to actually support GPs, nurses and others in the work they do, and I think there are probably different issues that need to be addressed in some of the deprived areas. So I think pay and reward is a factor but it is not the only one. I think you have got to also provide better support to the clinical colleagues who are going to work in these areas, because they are very challenging and it may be that one has to think of actually not the traditional model where people will maybe spend their whole life there—there are some souls who are very dedicated and will do that—but maybe you need to think of ways of giving people a bit of a break from what can be very hard work.
Jim Dowd: Can I start by saying I am not now, nor have I ever been, nor is there the remotest prospect of me ever becoming a Member of British Medical Association!

Q336 Dr Stoate: Thank goodness for that!
Dr Meldrum: I am sure you we could find an associate membership for you of you are really keen.

Q337 Jim Dowd: Can I move to commissioning and, that rather nebulous concept, leadership. We have heard many different views during the course of this inquiry about the capabilities of PCTs to engage in commissioning according to that outlined in the review. What is your view of the ability of PCTs to meet the challenge described?
Dr Meldrum: It seems to me, a word we are using a lot, it is variable, it is patchy. I have a view on commissioning. To some extent, although I support the concept, I do not actually really like the term practice-based commissioning because I think in general commissioning needs to be a proper collaborative approach by all those who are actually involved in delivering patient care. To my mind too often commissioning has become a by-word for buying and selling units of healthcare. That is not what commissioning to me is all about. Best definition I have heard is commissioning is assessing the health needs of a population, working together to decide how you are going to deliver effectively on these needs and then measuring afterwards how well you have done it, and unless you have that process and you have a joined up approach involving primary, secondary care, involving PCTs, involving acute trusts and involving social care as well, I do not think you are necessarily going to get effective commissioning for the bulk of what we do, which is not planned, episodic, elective care, it is chronic long-term care, it is emergency care and it is primary care, and I am not sure that the market type system, which has been going now for nearly 20 year, is the best way to achieve that. The idea that by competition you will necessarily drive up quality: I have often used the analogy that if I have a stroke now, I want to know that wherever I get taken is the best. I do not just want there to be one of two centres of excellence for that.

Q338 Jim Dowd: That takes me to the second point. Would I be correct in assuming from that that you do not share the department's enthusiasm for encouraging more GPs into practice-based commissioning?
Dr Meldrum: No, I do share that enthusiasm because I do want GPs to be involved, but I think the term "practice based" is a little misleading, in that to some it gives the idea that if we just give GPs the power or even the money that will sort out the problem and the idea that you want a balanced market, you want a balance between the buyer and the seller of healthcare services. I think actually you want a much more joined up, collaborative approach for an awful lot of the work we do. I am not saying that the system does not work for planned elective care, although there is some evidence it does, but there is very little evidence that it actually works in terms of improving overall care. As I say, I do want GPs to be at the centre of that and very much involved in that but not in the way that the term "practice-based commissioning" might be thought of as saying just leave it all to GPs. We must involve our secondary care colleagues, we must involve our nursing colleagues, we must involve social care and, unless there is a joined up, collaborative approach, which in the best areas I think there is, then it is not going to work.

Q339 Jim Dowd: You are saying (and I think any sensible person would agree) the broadest commissioning and the most enlightened and well informed platform from which to conduct it, but would I be wrong in assuming you do not accept the department's view of what practice-based commissioning is or should be?
Dr Meldrum: The department seems to have almost moved on now. They are talking about world-class commissioning rather than practice-based commissioning.

Q340 Jim Dowd: We do not understand what world-class commissioning means either.
Dr Meldrum: You and me both then. I do not think it is so much that I disagree, it is just that to me it is almost a left-over term from fund holding, the idea that actually giving the practices the money will solve the problem. I was never a huge fan of fund holding, although it did have some areas where it worked. This, to me, is a rather watered down, wishy-washy version of fund holding. The dilemma I have is that I very much believe that GPs need to be involved, and I think for too long they were left out of the equation, but I do not think the way in which it was initially being interpreted, the term "practice based commissioning", quite captures how I think they should be involved.

Q341 Jim Dowd: Is that because of your fear of the fragmentation for provision at GP level?
Dr Meldrum: Yes.

Q342 Jim Dowd: And concern not for those who would do well under it but for those who might be left behind?
Dr Meldrum: Yes, it concerned me a lot about fragmentation, and I think also it seems to be based on this idea that you can have a pure split between commissioners and providers. Obviously, coming from a primary care background, that is never going to be the case. Either I provide the service myself or I commission it by referring the patient to somebody else, and that is a decision I make all the time. So there is never that sort of clear split. I think, particularly when you talk about long-term conditions, things like diabetes where you are involving the practice, you are involving community nurses, you are involving the acute sector, then you are likely to get fragmentation if you try and divide the elements of that care into paid-for packages of care, which is, in effect, the way that commissioning and the Payment by Results system works at present.

Q343 Jim Dowd: Finally, the department is looking to engage business consultants to help GPs with their business plans. Do you have a view on the advisability or otherwise of that?
Dr Meldrum: It quite difficult to answer that. I cannot sit here and say that I am not happy with the quality of support, management support that certain GPs and their practices get, particularly commissioning, and say, "But we are not being allowed help from outside", but I think there are rather different issues to commissioning healthcare services in a national health system than there are in certain business areas but I am not saying there are not skills that we could not use and learn from. So we are not completely against it, but I think we would have reservations about how effective they are going to be and how they should be used, and it can often be very costly.
Jim Dowd: As long as they are not the consultants who advised the banks in recent years, I think we would all be grateful!

Q344 Mr Scott: The BMA has been sceptical about Lord Darzi's proposals for improving clinical leadership. What would you say should be done to encourage doctors to take up managerial positions?
Dr Meldrum: I think there needs to be a change in culture and a change in environment. Unfortunately, and I think it probably happened because of successive changes and reorganisations and everything else, there is a feeling that in some areas the quality of management is not very good and that clinicians who get involved in that—I hear expressions like they have gone over to the dark side or they have sold out or they could not hack the day job. While that sort of feeling or culture is around, that is not going to be helpful. I do not think there is a single action you can do that is going to improve that, but I think over time you have got to encourage doctors to get engaged, to make them feel that that engagement is making a difference and is worthwhile but I think most doctors (and this is where we tend to different from our nursing colleague) still want to do some clinical work as well. That is the main reason we went into medicine: to be doctors and clinicians, not to be managers. That is not to say that we have not got information, we have not got skills,

we have not got talents we can bring to that. So you have got to look at how you involve doctors, and actually you have got to get away from what is the feeling, and in some cases it is a perception rather than the reality that once you get into management your career path is rather stultified, you do not get the same access to clinical excellence awards, certainly if you are a consultant, and that actually you have lost that touch with patients. So there are a lot of issues that need to be addressed and, as I say, it really is a change in culture rather than just one or two simple things that you can do to change that.

Q345 Chairman: Hamish, can I thank you very much indeed for coming along and helping us with this inquiry this morning. I am sorry you were on your own; I hope it was not too uncomfortable.
Dr Meldrum: Not at all. Thank you very much.

Witnesses: **Sir Ian Carruthers,** Chief Executive, NHS South West, **Ms Margaret Edwards,** Chief Executive NHS Yorkshire and the Humber, and **Mr Mike Farrar,** Chief Executive, NHS North West, gave evidence.

Q346 Chairman: Good morning and welcome to what is our third session on our inquiry into the *National Health Service Next Stage Review*. I wonder if I could ask you, for the record, if you could give us your name and the position that you hold?
Ms Edwards: I am Margaret Edwards; I am Chief Executive of the NHS in Yorkshire and the Humber.
Sir Ian Carruthers: I am Ian Carruthers, Chief Executive of the NHS in the South West.
Mr Farrar: I am Mike Farrar, Chief Executive of the NHS in the North West.

Q347 Chairman: I understand, Ian, that you may have to leave us early if we do not progress in the time scale that we are hoping to. I think we understand that; that is fine. The *Next Stage Review* emphasises that SHAs and PCTs are key to achieving improvements in quality. Do you agree with that and, if you do, given that the department acknowledges that PCT performance needs to be improved, how can we be sure that SHAs and PCTs are up to the challenge on improving quality? Who would like to start?
Mr Farrar: I think the first thing, the most important thing to be said about the *Next Stage Review* is actually to establish the quality of the goal that we are aiming for. My sense over the last five years has been that we have been trying to expand capacity to tackle access and we have been trying to effectively deal with some of the problems of waiting that people have had in the system. So the fact that Lord Darzi has set out a clear agenda for quality is really important. That sends a very strong signal to the National Health Service. As Strategic Health Authorities within our Primary Care Trust, we are working hard on looking at what evidence-based improvements, techniques are around. Some of them come from other sectors—things like lean processes from industry, why you can see an improvement in quality—some of them from other health sectors. We have been working on a big programme called Advancing Quality where we are very confident that we can improve the outcomes for people in a key number of big volume procedures like acute myocardial infarction, coronary artery by-pass, hip and knee replacement, community-acquired pneumonia. So there is a lot of areas where we have looked for evidence-based practice trying to deliver on this, but the starting point has got to be that we are now focusing all our energy and effort on improving quality.
Sir Ian Carruthers: I think it is good that quality has become the centre piece, but we need to quickly define what we mean by it, because in many of the papers we have not got a clear definition of quality. I would define quality as being safety, the experience of the individual, evidence-based best practice, access and taxpayer value, all of which strung together to say: how do we improve the treatment and the quality of life of individuals? I think we need to distinguish what we mean. Across some of those, like access, SHAs and PCTs have got a very good record. In safety there is much more to do. Richard Taylor asked the question earlier. I was sitting in a meeting the other day where, if I just pick drug error, one in ten people in all our hospitals today will have an error made. Many of those will be medication errors, and in the National Patient Safety Forum, within a two-hour session, the person from the Pharmaceutical Society who was there, and I am loath to quote the figure but in that two-hour session there would have been several thousand errors made to patients up and down the country. I think that it is really important that we move into the management system areas that we know about but have hitherto left unspoken. So I think this a very welcome approach. I think Lord Darzi goes a very long way towards that in making it centre stage, and I know that the report sets a lot of mechanics, but the real test is about whether we will make a difference or do we create an environment where boards and the professions see this as an issue they want to address and do we create the culture to actually handle the issues? I know from previous questions from previous transcripts one of the questions that Dr Stoate asks is: why is it that we continue to see bad practice and do not address it? I think we have got the mechanics there, but I think it is an environment and a culture and a leadership issue for professionals, managers and their boards that will make the real difference if we really do want to get quality centre stage.
Ms Edwards: To build on what my colleagues have said, I totally agree that we have made really good progress in areas like waiting times and areas that were identified, say, ten years ago by the public as needing addressing—A&E services et cetera—massive improvements. Where we have not made as

much improvement is the variation in quality, and there are big variations in quality. You heard the previous person, Hamish, talking about variations in primary care. It is not alone. Most of our services have massive variations. We have not been good enough at measuring it, we have not been good enough at holding people to account and I think one of the things that has been really helpful about the *Next Stage Review* is not just the national report but the local reports, the ten local reports, and getting the clinicians in a room together to talk about that. They knew what the areas were. It was really interesting to sit in on some of those groups and listen to them talk, and they knew where their issues were and they actually knew what needed to be done and it was very clear the will was there to do it. So in terms of our capability to do that, I think we have a real duty now. We have identified it, we have gone very public about it. For example, my report talks about 600 people a year dying in Yorkshire and Humber because we do not provide the best stroke care, not because we do not know what to do. We know what to do, but we do not actually do it, and that is what we really need to address now, I think setting that out nationally, saying we will be held to account. In terms of our capability, we are capable, I think, as SHAs and PCTs to do this. We have demonstrated that in the past. We have never been held to account before, and I think things like quality accounts and saying we will be held to account for that is a really important new direction.

Q348 Chairman: You quite rightly say there are areas. How confident are you that PCTs are able to deliver quality? There are PCTs and PCTs, are there not?
Mr Farrar: I was interested in the question that was asked of the previous witness about commissioning. A lot of people have views about commissioning. I actually think the World-class Commissioning Programme, whether we like its title or not, is the first time that we have rigorously assessed the commissioning process. A lot of the assessments of primary care trusts today have been an aggregation of their acute provider's or other provider's performance and we have never really looked at the value-added aspects of commissioning. We are about to get the best evidence-base that we have ever had about their competences in the key elements of commissioning—their procurement, their needs assessment, their engagement with the public, the way in which they use a variety of providers. So my first point would be that when we have got that forensic assessment of what commissioning strengths there are, we will be in a much better place, over and above anecdotes, to say there are some PCTs that are good and some PCTs that are bad. The key requirement then on us—I mean these are ten-year visions—to make progress in the first year, I think we have really got to identify where the World-class Commissioning Assessments show there are weaknesses and we have got to get in there and put support into those organisations, because clearly PCTs are pivotal and we cannot afford it not to be the case that every PCT can deliver on these promises. It would be unacceptable in my case with 24 primary care trusts for 16 of them to deliver what we are talking about in the north west—improving lives, improving health, but eight, a third of the region, not doing so. There is a key element at these early steps towards successful implementation that comes out strengthening and supporting commissioning.

Q349 Chairman: Presumably you would generally agree with that, would you?
Ms Edwards: Yes.
Sir Ian Carruthers: Yes, except I would like to add one point. There is inevitably—there always has been and always will be—variability between organisations to do things and in a sense you never get to the perfect state. What you can do is look first at how we can overall improve capability, secondly, how people can work together collectively so that together they can develop the way forward and work together, and, thirdly, sometimes they need external help and support and challenge from SHAs and others to ensure that they tackle these things. If you were to say to me do I think we could deliver the vision that we have in our region, would the PCTs do it, then I would say I think we have a very good chance, and I am not one to knock PCTs because I think there is a lot of growth potential still to be exploited—we create the environment and give them the support through the commissioning process.

Q350 Chairman: What do you think of the King's Fund saying that you should avoid a "top-down" approach to managing PCTs, that this is not a role for the SHAs? What do you feel about that?
Ms Edwards: It depends what you mean by "top-down". If you mean holding people to account for delivering what they promise to do on behalf of their local populations and making sure that they assess what their population needs and they communicate with them, they have that dialogue and then they deliver, I would make no apology for holding organisations to account in that way. If you mean imposing an SHA view on top of a PCT view for no evidence, then clearly we would disagree. It is one of those expressions that you can bandy about, to be very candid, unless we know what you mean by that, but it is completely acceptable that organisations are held to account in a national system that is funded by taxpayers through a government for delivering what they have promised to do. Having said that, I would recognise and expect that my PCTs would have a better knowledge of their local health environment than I would. I would expect and require them to know what their local population needed more than I did. My challenge would be, "Tell me how you have gone through that process. Tell me how you have done that. Satisfy us that you are doing those things and then we will provide any support and development that we possibly can". For most of my PCTs the relationship is developmental. There are one or two areas where we will make a judgment that we need to step in and the service is not good enough, and it brings on the point that Mike made, that if 16 of his 24 are doing really well

but the remaining eight are not then it is quite legitimate for the intermediate tier to challenge and ensure that that part of the population gets as good a service as well.
Sir Ian Carruthers: I disagree with what has been said on the holding to account. If you see the intermediate tier role as holding organisations to account on behalf of the Department, and indeed government, for delivering whatever the policy of the day is, best healthcare, for instance, because it need not necessarily be the same for each, I think that is an essential part of the system. It is the style in which you do it. As far as I am concerned, there is a spectrum of inquiring how people are doing to requiring them to do it. We only have to look back to see that not every organisation performs at the same level, and one of the failings of the NHS in the past has been to leave those who perform less well than others to deteriorate, quite often to the point where it is more difficult to deal with than if earlier support, challenge or intervention had been given. You cannot characterise it as bottom-up or top-down because there is a spectrum of behaviours from facilitation, development and holding to account to requiring people to do things which is situational. We have 14 PCTs and our relationship with all 14 is completely different. None are the same and, to be frank, it depends on how well they are progressing.

Q351 Chairman: Mr Farrar, do you have anything to add?
Mr Farrar: Only that in the north west this year we are spending £11.8 billion of taxpayers' money and for as long as we have a National Health Service (and I hope we always will because I am a huge, passionate fan of it) we have to have a system for making sure that resources are spent with a balance against national commitments from a democratically elected government as well as local inputs. What we try to do very hard is to manage that interface and make sure through strategic health authorities that we have that balance right, but I very much agree with what my colleagues have said.

Q352 Mr Bone: There is a view I think a lot of patients would share, and certainly I can see the argument, that SHAs are a complete and utter waste of time and money, that they are pen-pushers and bureaucrats spending huge amounts of money and if they were scrapped nobody would notice and if that money were put into front-line service everyone would be better off. Do you see that as a fair comment?
Sir Ian Carruthers: I think it is a comment which you can understand people making but it is based on ignorance of how the system works. If you look at the NHS, one part of it has been consistent in whatever form, which is the intermediate tier. Everything else has altered, and if you look at the Healthcare Commission report today you will see the fantastic improvement that there has been. Let me cite the financial crisis. I think it was the intermediate tier that really resolved those issues because if they had been left to the local level the progress that we have made in the last two or three years would not have been achieved, and I could cite that on lots of things. I could cite modernising, medical careers. I could cite the financial change-round. I could cite the drive on waiting lists. I could look at every aspect. I think it is wrong to say they are inappropriate or poor, just as it would be wrong for me to say (which I am not implying) that everything is done by SHAs. What we have got here is a complete system that has different functions, sees things in different perspectives and fits together, so that I think an SHA without PCTs and NHS Trusts may not be a good thing either. I think you have to see it as the whole system. It is like me when I watch my local football team. I may think the right back is awful but he may be playing in a top-class team and that is just my perception of it, so I do not agree with that view and I could point to a lot of evidence that says that things have dramatically improved because of SHAs, but I think that would be equally unfair. I think it is because the systems work and the leadership of that system in each region rests with the SHA and with the PCTs at local level. It is the combination that delivers the results, not any one part of it, and it is easy to pick either organisation as a scapegoat.
Mr Farrar: I would like to add to that one view which would be that part of the case for having the role we occupy in strategic health authorities of system management and leadership is looking at countries that do not. You can look at health systems across the world which do not have a strategic leadership role at regional level. Yes, they make improvements in healthcare but there are significant consequences. For example, I would argue that the variation in quality in the United States is much wider than it is in the UK as a consequence of not having a leader or system manager that effectively tries to ensure that the guiding principles of, in our case, equity, comprehensiveness, fair at the point of delivery, free at the point of delivery, all of those things, are in place. One of the arguments that you could put for having a clear system management role is by looking at countries that do not and, of course, the recent Commonwealth Fund Study showed that the UK was being very successful in a number of regards which I would attribute not particularly to SHAs but to having a system manager at regional level, and I think that has quite a significant impact, albeit sometimes hidden and not necessarily appreciated.

Q353 Dr Stoate: The department's stated aim is to increasingly shift care from hospitals back to primary care. I want a very short and very concise answer from you about what SHAs can do to help shift that balance from secondary back to primary care.
Ms Edwards: The first thing is to make sure that primary care is capable, available and able to take that work and that is one of the things we are doing in terms of the growth, for example, the additional investment going into primary care and getting primary care fit for purpose to do that role. That is

one element that we would do and I can talk a lot more about that but I will not because you wanted me to be concise.

Q354 Dr Stoate: That is quite a specific thing: it is all about making primary care available. What do you actually mean by that? I am still not sure how that affects the average GP.
Ms Edwards: For example, diagnostic tests. An awful lot of work can be done that is currently patients going to hospital. They have a test done in hospital that could have been much easier for the patient and much more appropriate if it had been done it in primary care.

Q355 Dr Stoate: How is the SHA going to make that happen?
Ms Edwards: The SHA can help, for example, the primary care trust go out and do a procurement. They can set them some objectives and show them good practice. They can put them together with another PCT that has already done this, gets all the GPs talking, help them very practically do that, and challenge those that are not doing that and set those examples.

Q356 Dr Stoate: Has anyone got any other examples about how at SHA level you can drive that change?
Sir Ian Carruthers: First of all, in discussion with, if you like, the process of the professionals, the community and the PCTs, in our case we have built up a consensus that that is the direction that they want to travel in. The only people who do not share the consensus quite as much are some of the NHS provider organisations. Having done that, you can create the environment where that can happen through support and challenge. PCTs each year put plans together which we have to approve and sign off. We can discuss, challenge, support, drive, whatever word you want to use, difference through those plans and the resourcing of them, because quite often investing in your local hospital may just be about retaining the *status quo* and not moving the system on in a best practice way. The planning and performance process is one thing; secondly, creating the environment; thirdly, building the consensus of people that that is the right thing to do; and, fourthly, supporting people when they get into difficulty because there quite often is an imbalance in trying to bring about change at local level because most people understand their local hospitals and their GP surgery but they do not necessarily understand the total system and how it works. If I pick an example, as a system we have more doctors employed in hospitals *per se* than any other system in the world. Because our populations have been brought up in that system, they find it hard to understand that we want to change.

Q357 Dr Stoate: What are the SHAs doing about that? It is a straightforward question. I am a workaday GP part of the time. What will they see different from SHA planning and strategy? How would one see a change in what would happen?
Sir Ian Carruthers: You should see, through SHAs holding to account PCTs to deliver the direction of travel, more practice-based services, more services in the community. For example, if you look at general surgery, 80% of general surgery could be done outside according to Lord Darzi's *Saws and Scalpels.* It could be done outside in community hospitals. You could see much more resource use in your community, and if the PCT and you sign up to that with us then we will help make it happen. You are really asking the question, why do things not happen? It is because we do not put the energy and resource and drive behind them. What I am saying is that SHAs are quite crucial in doing that where local organisations are less willing to do so, for whatever reason.

Q358 Dr Stoate: That is the important point. We have talked about primary care in the NHS for ten years and it has not happened.
Mr Farrar: Let me give you one specific example because I agree with Ian and Margaret about what we do. Effectively it is strategic direction which is important in terms of the system, how it operates. It is then performance management, so benchmarking and showing that in some parts of your patch there are services that are close to home and can be provided in primary care but which are still locked into secondary care inefficiently.

Q359 Dr Stoate: I know that. What are you doing to change it?
Mr Farrar: Let me give you a really specific example. In the north west we developed a concept called CAT, integrated Care and Assessment Treatment, which was our view in advance of Lord Darzi looking at London, by the way, that you have got this bouncing backwards and forwards of people of people who see their GP, getting referred for a test in hospital, the results come back to their GP, you have to go for your second test, and this happening six or seven times before you get to conclusion. What we developed as a kind of thought leader in the system looking at it was that we felt that that was inappropriate, we felt it was not friendly to patients, we felt it was not good for primary care or for secondary care and a waste of resources, so as thought leaders with some of the key people we had the concept of integrated care and assessment treatment centres. We then worked with our primary care trust to articulate what that meant and then helped them source a supplier for that, which, interestingly, the Government then brought in to try and create some more plurality of service and they brought in some independent providers to do that, which in the north west is not a bad thing because of the number of primary care practitioners so we needed some additional support. All of that is coming into being now. It is improving patient experience. It is a secondary service that is now available in community settings. It is much more closely integrated with primary care. That is just one example around assessment, diagnosis and

treatment, where you can see a physical change as a consequence of an SHA's thought leaders with the people on the ground.

Q360 Stephen Hesford: We are in the implementation section of the evidence session and before I come to my main question can I ask you this, and I am not sure how you are going to react to it? There are ten SHAs and we have got three distinguished chief executives here this morning, but, kind of looking over your shoulder, if you are honest, looking at your colleagues and the system across the term, has it ever crossed your mind, "They are doing a better job than I am"?

Mr Farrar: It happens all the time in a sense. We meet as a ten and we also meet with the department and the management board. We share best practice, we invest in looking at where there are particular initiatives in different patches. We try and learn from them, for example, some of the work in the south west might be material from my point of view to Cumbria. We share our discussions on how we are taking those forward. You are always looking to share with your colleagues about what they are doing. Some of those things are relevant, some of them are not. A great example is that the north west and London have just peer reviewed each other's performance. It is nothing to do with the hierarchy. We just looked at other and we said, "We share similar problems. How would we learn from the best that you are doing for what we would want to do?". It is just a constant feature of your life. We are by instinct competitive, we drive ourselves forward on saying, "If there are other people better than we are we would like to do as well as that for our populations and if we can set the bar a bit higher then that will stimulate others". There are a lot of reasons why you do that constantly.

Sir Ian Carruthers: Can I just add to that? I spend a lot of time sharing with colleagues in different parts and we can learn from all ten. Equally, we spend a lot of time looking outside the UK. I am proud to say I have never ever been to America on a study tour or anything like that. I do not go but there is a lot to learn from other people often coming to us. We recognise, or I certainly recognise, that the NHS in the public's eye is very good when it is very good and it is very good where you are, but actually, when I talk to others, it is only as good as the last untoward occurrence in any part of the country. There is something about us recognising that our collective strength is really quite important for the NHS, and that is why we have to learn from each other. We are operating on two levels—how can we make where we are the best it can be, but, secondly, how can we help each other? Mike has come down and done things for me. I have been and talked to his team in Cumbria because of the differences, so we do use that and I think there is no complacency. Hamish was talking about the good competition between GPs. I think it applies in this instance as well.

Ms Edwards: Just to reinforce that, we have paired with West Midlands recently, for example, to do a similar peer review. That sort of things happens, but it is not just aimed at the chief execs. One of the things that I think is important is that we model the right behaviour, so each of our directorates have networks. I have got a strategy director, for example, who networks with the other nine strategy directors and they have just produced a common process for a disputes and resolutions panel so that each of the SHAs have common processes. We have got no embarrassment about it not being invented here and we steal each other's ideas regularly. That is part of the modelling behaviour that it is very important we as leaders do because we want our PCTs to be doing that, we want our hospitals to be doing that. That is the culture we want for the NHS, and things like The Institute for Innovation and Improvement are all about that, spreading good practice. I think it is really important that we are seen to do that as well.

Q361 Stephen Hesford: My main question is about prioritisation of targets and aspirations. From each of you, how have you chosen your priorities and your targets?

Ms Edwards: Ours came predominantly from the commissions doing the work.

Q362 Stephen Hesford: I am sorry—what was the evidence?

Ms Edwards: The way we did the next stage review across the country was that the Department of Health provided some very good evidence and it was one of the best things about this process. We all got really detailed evidence packs which identified what the key issues of health were in the country but also specifically. Our public health observatory in Yorkshire is excellent and they supplemented with a lot of information about what were the outcomes in diabetes, for example, in Yorkshire and Humber. One of the things that came out of that was that we identified that we could have a 50% reduction in the number of avoidable admissions for diabetes. That was an example where the evidence showed that there was massive variation. Basically, it was the clinical working groups working through and we asked them what would make the most difference, basically, and they came back with the priorities. They also identified what they have called remedial action, things that we need to do immediately that they say are so glaring that we need to address them. We have a group of issues that we are calling remedial action as well as the ten-year plan. It was through that process basically—discussion, dialogue, but what would make the most difference. I did a critical challenge session with each of the clinical leads. We had, as you know, eight pathway leads and I met with the pathway lead and we had a PCT buddying them, so we put a manager with them to support them right through the process, and then I met with each of those eight leads on a number of occasions but we did a formal critical challenge session where we discussed and agreed what the priorities were and we really challenged through that process, "What are the key things you want us to do?", and at the end of each chapter in our document we asked the groups to make a pledge, "What is the one thing you really want us to do?", which they have all done.

16 October 2008 Sir Ian Carruthers, Ms Margaret Edwards and Mr Mike Farrar

Mr Farrar: We did it from four sources and it is a very similar story to Margaret's. We asked the public in terms of the number of deliveries of events what they thought the key issues were. We asked our clinicians in a very strong process in every one of the regions around jobbing clinicians rather than the great and the good, people from the coalface. We asked our partners and, of course, this was not year zero so we were already looking at what our priorities should be going back, and you look at current performance, particularly against national benchmarks or international benchmarks, and a combination of those led us to the priorities that we set. If I can give you one story of added value, going into the next stage review, I do not think people were as aware of or had identified how each of those particular dimensions was going to raise the issue of alcohol as a key factor. I would say that part of the NSR process in terms of saying did that do anything different, did it really take you in a different direction, my sense is that that would be a very good example of coming from those four sources rather than just a simple straight line source about some of their previous performance, whereas alcohol is a big issue for us in the north west.

Sir Ian Carruthers: We had a similar process. We used deliberative events. We had the clinical evidence packs, we used the observatory data. We used the knowledge and skills, not only of the clinicians but also one of the things about our groups was that we made sure that the leaders, chairmen, chief executives, leading medics of every organisation were part of the process, also local authority colleagues, carers and users, so that we got a very good feel for those. We took into account national policy and we also took into account some of the polling because an observation about what came out of that was that most doctors wanted to set more targets than anybody else and we had to stop the target-setting culture, but what we did agree on was some targets that they felt were more relevant than some of the process targets. On the other hand, 90% of the public still felt that despite the reduction in access and so much taking place it was still too long. That was often a problem for some of the professionals and we had to marry those together. However, there were some things where we had shifts, and substance misuse and alcohol would be one, but the biggest overall shift for us is that we feel that we have to do much more for carers in that we do not support carers quite as well as we can across the whole piste, particularly in the areas of mental health, dementia and so on. That is a slight problem, or just an added complication because the lead organisations for carer support are local authorities, so this is going to mean that we will have to look at it at our local level in PCTs about how they can do that, but most carers who were there were very vociferous and got across a different point. Because of the composition of the groups we felt we got a clinical view from the data, clinical inputs from the people, but this was balanced by the carer/user views because we quite often pick people who are going to have their say, and they did shape what we did quite significantly.

Q363 Stephen Hesford: In setting your priorities and targets for the producer interests, ie, the doctors, it is suggested that there could be a kind of shopping list element. Was there an element of a shopping list in it and, if there was, how did you deal with that?

Mr Farrar: To a certain extent we were organised because there was a standardised process around the care pathway groups, so at one level you were going to get a series of eight sets of recommendations from each of the care pathway groups, all of whom represented people who were interested because they worked in those fields. At one level it was slightly inevitable that you would get a broad range of recommendations about what to pursue. Margaret's point is the key one that, once having had this kind of breadth of what we should be doing, now they are being converted into action with primary care trusts' strategic plans who are consulting local populations and so the operationalisation of those priorities—I say this as one of the regions with the most significant health problems in Europe—we could effectively make progress in virtually every care or disease area and we would like to, but clearly the next phase of this, having set out a broad vision, a direction of travel and having got some clear strong recommendations about how you would take that forward, is then to build that into the PCT plans because clearly they are the people who are spending the money and resourcing this change. What then happens is that you get this immediate prioritisation, not against areas that you should be involved in but what are you going to go for first, what is the most immediate aspect, so it becomes a temporal prioritisation, and that, I think, is emerging from our PCT plans as we speak about their key priority areas. That is much better informed now as a consequence of the next stage review than it would have been two years ago when it would have been in the absence of these benchmarks, in the absence of public opinion, in the absence of expert clinical opinion.

Ms Edwards: One of the things that may have happened in the past was that certain lobby groups would have argued that the hospital was going to be the centre for this, the cancer centre, the tertiary centre, and you would have got that. This process exposed all those clinicians together, so you put them in the same room but you actually put them in a room with health economists, with statisticians with evidence, but, more importantly, you put them in a room with the public as well and we had some really good, what we call "big tent" events where our clinical leads presented to the public and listened to the public and we had a thousand people coming to different events, and that again was really powerful in terms of challenging some of these, perhaps the professional view of, "We will centralise everything" versus the public's view of wanting things local and, rather than we as managers fronting those debates, getting the clinicians to have some of that debate. We really flushed out some of the issues and it was very powerful in terms of challenging some of those preconceptions on both sides, to be honest.

Sir Ian Carruthers: Ours is a framework within which PCTs will put operational plans together and the commitment across the region is that we will do

it over a time frame. It does not mean that everyone will pick the same priorities, so there is a priority setting level that went across through the region when it was created, and there was a tendency, when I mentioned about the targets, for people to come with their shopping lists and so on, but it was neutralised because we never talked about a specific location, so there would still be one trauma centre. We never got into where it would be because our style is to say we will commission a clinician with another group to run that programme and advise us separately on it, so it took out that element. The other part I want to bring out is that a lot of the pace of change and priority setting, although we have got a programme over three years, or whatever it is, will be set by PCTs who will have different points of emphasis. In Bristol they would want to go faster on some of the health improvement things than perhaps they would in Somerset, and there is that flexibility for the PCTs to determine their own priorities and localise it, which I think is quite important, but that is all done within the framework.

Q364 Stephen Hesford: Sir Ian, how exactly will you achieve "the highest levels of fruit and vegetable consumption in England", and is this a realistic target?
Sir Ian Carruthers: When I read that and we got the question I thought, "Did we really say that?", and we definitely did. What I want to say is that there is a sentiment behind this which says improving fruit and vegetable consumption has a major impact on the prevention of cancer, heart disease, up to 20% reduction. We believe that there is a big social marketing job here about improving health through eating and a healthy diet. We also have a very successful Healthy Schools Initiative. We also have across the region a "five-a-day" scheme which operates almost everywhere which we want to build on. The real issue is, how do we measure it? In actual fact that will present a problem but we need to work on it because the Family Food Survey, for example, is a source of regional data and the Integrated Household Survey is to be improved with the local authorities and local databases, we hope, from 2009, so we hope we are going to use these types of service to handle this issue. I know fruit and vegetables would not be key in many areas but if I use the same thing for smoking, smoking prevalence is only determined by survey the same way. In the south west we are increasingly picking up smoking in the younger age groups. How do we know that? It is only because of survey, so what we want to do is drive it through the schemes. The sentiment behind it is more important but we will have a stab at measurement through the survey route.

Q365 Chairman: Have you asked food retailers whether they are selling any more or not?
Sir Ian Carruthers: The other thing that this is connected with, and this is where we are going into our wider influence agenda, is that we want a course on the sustainability agenda to impact on and get PCTs to work with local employers and food suppliers. There are some very good examples in Cornwall and so on of where the NHS is playing its part through its contracting and other things to stimulate the local economy generally. We are in touch with people and the Family Food Survey I am sure will involve discussion with the retailers, but that will be another way which we will take away, Chairman, and look at as to whether we can get some sign from retailers that it is changing.

Q366 Chairman: If you do that I would be interested to see the results at some stage, not for this particular inquiry.
Sir Ian Carruthers: I am sure it will send my Regional Director of Public Health, the lovely dark-haired lad that he is, grey trying to work it out, but it will do him good, as they say.

Q367 Dr Taylor: I am really getting quite optimistic. You have quite convinced me of the relevance of the SHAs because with the Darzi Review, unlike previous reviews, you have gone out to people and taken their advice. I felt a bit bogged down by your rather hefty document but I did appreciate the summary from the north west because you have two pages saying exactly what you did get from public and clinicians and the very obvious thing that the NHS may not need to be 24 hours, seven days a week, but why not extend it a bit beyond nine to five? Could you talk very briefly about some of the things you have picked up? You have already mentioned some of them.
Mr Farrar: Yes, and I think that is a really good example of what we got when we asked the public things. It is about public expectation. What we deal with in the north west is in many cases a rather deprived population who have been grateful in terms of service for what they have had in the past. What we were trying to do was understand what they thought would make their lives better, and some of those were, "We are not asking for the world but we would like a bit more availability at times that suit us rather than suit you", and we can deliver on that. What has been really interesting has been where we have wanted to stimulate their ambition for what we can provide as well, so the meeting of our clinical voice, our public voice and bringing in an SHA voice saying, "We can be far more ambitious than this. We should not just settle for a bit of extended access. What we would really like to do is obviously extend the access but we will try and do that with higher quality care as well so that when you do come in through the door every time, every place, you will get decent services". Those different directions of thought have been really important to us. What we did was expose our clinicians to what the public were saying and we exposed the public to what the clinicians were saying, and the real joy was seeing those conversations and people alighting on, "We can do something here. We can really get it". A good example would be that sometimes our clinicians would have said around children's services, for example, in the past, "We need a number of different children's centres", or something like that, and what they actually heard and then recommended was, "We must talk to children far more to hear what they

want". That might have been very profound at one level but it is a better place to start than trying to do better by thinking we will find something that might not be exactly what the public wants. One last example which I think is incredibly profound and which is coming out time and time again is that the more you try to give patients control of their own resources, things like social care budgets and personalised health budgets, and we have been piloting some of that, sometimes and not unusually it is an 80% variant from what they used to get, what they are wanting when they get more control compared to what we have been providing. It just speaks to this kind of process being the right way forward—much better engagement, involving people in these decisions and then responding to that rather than thinking we have to keep inventing something better that we then impose on people.

Q368 Dr Taylor: Is this the first time this has really been done to this extent? I think it is.
Mr Farrar: I think at this kind of level it would be fair to say, yes. I have been around the NHS a long time and we have had lots of strategies. This is the one that I think has probably done most to engage all those aspects of people's thoughts.

Q369 Dr Taylor: I will not ask you, Sir Ian, because a lot of yours are on quality and we are coming to quality a little bit later. Margaret, whereabouts in this huge document have you listed these sorts of things?
Ms Edwards: There is an executive summary similar to those of my colleagues and my apologies if you have not received it. Shall I summarise the eight key things that will happen?

Q370 Dr Taylor: Yes.
Ms Edwards: Healthier lifestyles, alcohol/tobacco and obesity, to halt the rise in obesity, particularly in girls. For the maternity group the main recommendation is breast screening rates, so to increase the breast feeding rates. For children one of the main recommendations is that we are going to halve the number of children admitted with asthma.

Q371 Dr Taylor: How are you going to tackle alcohol? What are you practically going to do?
Ms Edwards: If we take smoking for a second, we know what works; we know nicotine replacement therapy works but we do it small-scale. With alcohol we do not know yet what works and one of the things we are doing therefore is to say that with tobacco we now know what works. We are going to do it in an industrialised, systematic way. With alcohol we need to do some further work to identify what does work, but some things we know. For example, we know people with alcohol problems are very reluctant to turn up at drug and alcohol services, which is how we have traditionally provided the service. If you separate them out, which is one of our recommendations, people are much more willing to address the service. The other thing that our group identified was that there are certain times in your life where you are much more likely to respond. A pregnant woman is much more likely to respond to health advice and give up drinking and smoking than, say, a woman two or three years before she becomes pregnant. Similarly, before a major operation people are much more receptive. We have identified key points in people's lives and the health workers know that if they meet that woman or that man at that key point they have a great responsibility to address that at that point because that is going to be a missed opportunity that might not come back for five or ten years. We have identified the types of things that work and they work for alcohol and we are now saying we want them applied to that, but in terms of alcohol we are also doing quite a lot of pilots because there is not as much evidence base as there is for some things like tobacco.

Q372 Dr Taylor: It is very obvious to separate drug and alcohol, is it not?
Ms Edwards: It is, but we have not done it.

Q373 Dr Taylor: And who told you? Was that the users who told you?
Ms Edwards: Yes, but if you think about it, "drug and alcohol services" is a common expression across the NHS. One of the things that has come out of this is getting a better understanding. In every area we had a thing called "Barriers to Change". There is a whole section in every area about what in the past has stopped us doing this thing. We have identified for every area what are the barriers to change and part of our job now is to make sure we eliminate those barriers and that is a really good example.

Q374 Dr Taylor: And is there a list of barriers in the submission?
Ms Edwards: There is a list of barriers for each of the sections, yes.
Sir Ian Carruthers: You have talked about the influence of carers and users. One of the things that we did was that we also engaged with staff much more than we ever would have. We have 40 organisations. I think in 36 they ran day seminars which were facilitated on saying, "What should the NHS offer to you as a member of staff, to you as a member of the public and to you as a patient?". That was very informative too. The way that this has been undertaken has been very different, where you can imagine cross-sections of staff have reported to the consultant in the room handling those questions, and then we collaborated on that because on some of our groups we had BMA/RCN representation and we also had a session with the trade union movement where we got quite a different take on things.

Q375 Dr Taylor: Thank you very much, so it is optimistic?
Sir Ian Carruthers: Yes, very.

Q376 Chairman: Margaret, could I just ask you a question in relation to the recent Audit Commission Auditors' Local Evaluation Report that was published on 2 October, saying that your SHA was

the most inefficient in terms of resource allocation? What is your approach to that? Have you got some sort of plan or something that is going to make sure we get better value for money in Yorkshire and Humberside?

Ms Edwards: Absolutely. You are right: we came out lowest on the value for money element. What the report did not say very clearly, though it did refer to it later, was that one of the reasons for that was that a third of our organisations were not included because we have a proportionately high number of FTs. What you were looking at was our more challenged organisations plus the PCTs, so by definition our average was going to be slightly lower. It was only a very small percentage lower than the average but it was lower. We have been talking to our auditors about this because there are four elements. We came out significantly above average on three of the four and they were financial standing, financial reporting and internal control. For example, 54% of our organisations were excellent on financial standing. One of the things we are trying to understand therefore is that if we are excellent on financial standing, financial reporting and internal control, how does that relate to a poor score on value for money, and we are having that conversation now with the auditors because, to be very candid, we do not completely understand that, but we are drawing up an action plan for each of our organisations to address that and it is clearly an important part of the world-class commission and assessment so we are taking it very seriously. As I say, though, it is a sub-set of our organisations. If you put the FTs back in we would be performing very well and in all of the other aspects we performed extremely well. We need to understand it better and we need to address it.

Q377 Chairman: The foundation hospital is a very good point well made because they are performing quite well in my part of Yorkshire, but, obviously, putting in plans for getting more value for money implies that there is a cost to that. Has that been costed at all? Do you think you have got enough money to be able to do that?

Ms Edwards: It would not necessarily follow that there is a cost to making sure we are getting good value for money. I think we have got good PCTs. One of the things we talked earlier about was the world-class commissioning assurance process and one of the things as we go through that is that we will learn where our PCTs—and we have already got a sense of it from the early diagnostic work we have done—need some development and we will put some development in, so there may be a cost in terms of development, but in terms of the people and the resources I think we have already got those. It is just about making sure that they are doing that well. Again, we talked earlier about where the SHAs learn from each other. My director of finance is leading on this. He is already talking to my colleagues up and down the country who have come out well and we are getting some really good examples where we are saying, "Okay, we have not come out as well on that. We will start learning and sharing". Again, my colleagues do not charge. We have these conversations and we share that practice openly and willingly and I know that if I went to any one of the other nine SHAs and said, "Can I borrow somebody? Can you help with this?", it would be there immediately and that is how we have always worked.

Q378 Chairman: And obviously there is this morning's hot off the press news.

Ms Edwards: Congratulations to your trust.

Q379 Chairman: We have got two trusts in Yorkshire and the Humber that are both rated weak for both quality of services and the use of resources. What implications does that have for the SHA in terms of turning that round?

Ms Edwards: We have got seven that are rated excellent.

Q380 Chairman: I accept that entirely. I am being absolutely selective, but I think it is a wonderful opportunity to ask you, given that you are sitting here.

Ms Edwards: Absolutely, exactly, and it is a concern We have two organisations, both in the north part of Yorkshire, Scarborough and East Yorkshire Hospitals Trust and North Yorkshire and York PCT, which have unfortunately come out weak through the ratings. We have been working with those organisations. If I take Scarborough, for example, that is an organisation that has had significant difficulties. The financial position is one of the causes of the "weak". It is now in a recurrent surplus position. Our plan is that it will make a £1.9 million surplus this year. They are on target to do that. That would mean automatically that they would not be weak in future and they are beginning to pay that debt back, so we have already addressed that but we need to do more. We are working now with them on the quality of service aspects. We have put a new interim chief executive in. That is a really good example again about this collaborative working. I needed a new interim chief executive to go into the organisation. I spoke to my colleagues, and in this case it was Mike who identified one of his existing chief executives who has come over and is helping the organisation and she is helping us turn it round. Again, that is an example but she is really addressing that and we have a really robust plan. We will be appointing a number of new directors, including a permanent chief executive, medical director, et cetera, to relieve that organisation. One of the things this shows is that it takes quite a long time to turn organisations round, and Ian made the point earlier that one of the things that we really do need to learn is not allowing these organisations to drift too long, and so one of our roles is to intervene. In some cases with hindsight you can see that these organisations should have been intervened in many years earlier. This is the second year it will have a "weak/weak" and before that it was a zero starred organisation, so Scarborough has a long history. However, I would like to say that Scarborough will remain as an acute hospital. There is a need for a hospital in Scarborough and one of the concerns of

the local population when this happens is that they fear that something serious may happen in terms of the services there. We are completely committed to and are on record as saying that there will remain a district general hospital in Scarborough; we will support that.

Q381 Chairman: Presumably the costs of this can be found within your current budgets?
Ms Edwards: Absolutely, and again, because of our commitment, one of the things that we are doing and again one of the roles the SHAs can play in terms of a system management role is that we are looking across the patch. We recognise that Scarborough needs and deserves a district general hospital and at the moment we are supporting the PCT and putting additional resources into that organisation and funding for the services because we recognise that that needs to be done and that there is an additional cost to the rural nature of those services that we wish to support, so we are totally committed to that.

Q382 Jim Dowd: If I can move from the omega to the alpha of efficient resource allocation, Mr Farrar in the north west, "Advancing Quality", it is based on the US Premier system, is it not?
Mr Farrar: It is, yes.

Q383 Jim Dowd: What will the system measure and which indicators will it use?
Mr Farrar: The Premier scheme has four years of data, which is fantastic, because when we were looking to do something to improve the quality of services in secondary care in the north west we looked worldwide for who was doing something around this because we could not see, the way payment of our resource was structured in the UK, that it was really supporting the quality of services. We saw the Premier scheme. It is the most evidence-based data there is. It deals with five clinical areas but it has the potential to expand. Those clinical areas are acute myocardial infarction, congestive heart failure, coronary artery bypass graft, hip and knee replacements and community-acquired pneumonia. There are 34 standards that are detailed clinical standards, for example, aspirin on arrival after myocardial infarction, prophylactic prescribed antibiotics an hour before surgery for hip and knee replacements, which we know has a consequence in terms of improving outcomes. What we know from the evidence is that if you follow all of those standards in each of those areas, and it is 34 in total across five areas, so there are about five or six in each of those areas, effectively you will have better outcomes clinically, so lower mortality. You will have fewer medical re-admissions, you will have fewer medical errors, you will have a lower length of stay and you will have a lower overall costs of care. For the top performers, ie, those who hit perfect care, every standard every time, the more you can get up towards 100% the lower your cost and the better your clinical outcomes. Going back to the Chairman's point about value for money, what this shows, and we have got absolutely every faith that it will prove it in the north west, is that the highest quality performers effectively offer lower costs of care. It just is a really exciting scheme. We have just got our first set of data through from our seven pilots. First of all, it is massively supported by clinicians. The BMA representatives in the region really love it. They think it makes sense about why we are trying to reform care quality. It is showing us that in some areas, like AMI, we start higher than the Americans have got to in four years, which is fantastic, but in other areas like community-acquired pneumonia we are well down on where they started in the States, so we have got a long way to go and we are using the same improvement techniques that they use, so we are sharing data with their top performers in the States. NICE have approved all the standards so they are replicable in an English context, and in fact we are talking now to the Department of Health about, "Could you expand that to try and deliver on some of our commitments?".

Q384 Jim Dowd: So you are explicitly satisfied that the evidence for adopting this system was compelling?
Mr Farrar: We have seen no other scheme in the world that had that amount of really accurately assessed data, and in fact one of our concerns was that when people move swiftly into the quality area there is potential to pick up on a whole variety of indicators where the evidence base is not as strong as this. Yes, it is five areas The down side of that is that it focuses people in five areas, so the trick is to expand as quickly as you possibly can, using those techniques, into other areas. For example, having piloted those five and they are now rolled out live to all sites in the north west in those five areas, we are moving into stroke and mental health. Each of the regional strategic health authorities is potentially in discussion about could they pick up on other areas and learn the techniques, and then very quickly we can cover all the piste..

Q385 Jim Dowd: Your enthusiasm for expanding it to other areas was such that you felt that you could do that without a systematic analysis of the results from the pilots; is that right?
Mr Farrar: As the results of the pilots are coming through we are starting a baseline of assessment. Our evidence base about the desire to roll out was based on the evidence from the Premier experience in the States. What we have really been piloting is feasibility of data collection, which is quite important. Each of our pilot sites got £60,000 to help them produce the data, clinicians' ability to populate the data fields that we were looking for and in terms of whether it was going to skew or alter the clinical processes. Our evidence base for doing it everywhere is effectively the US evidence. We will see increasingly whether or not that is replicated in the north west. Our evidence base that we have been testing in the north west is really about feasibility of applying the scheme through these pilots.

Q386 Jim Dowd: And how much did it cost?
Mr Farrar: We set aside an overall budget of £8 million for this whole enterprise, which we are still using. This is on a £12 billion budget. There is £5 million for bonuses for our top performers, which we have not spent a penny of yet because we have yet to get them in.

Q387 Jim Dowd: Is that £5 million within the £8 million?
Mr Farrar: Yes, it is, and, as I say, we have put small costs into collecting the data and setting up our infrastructure around it and also we have a contractor partner with Premier, which we did through European tender, to advise us as a consultant as we develop this and to support our data. Effectively, for this whole enterprise, which could have the most dramatic impact on care in those areas, including saving about 150 lives a year and about £17 million annually, which is our estimate of what we will save, we set aside an £8 million budget of which we have not spent yet and we are two years into it.

Q388 Jim Dowd: If you had not adopted this approach what would that £8 million have been spent on?
Mr Farrar: The £8 million was a combination of some savings that we had in PCTs voluntarily putting that money in, so it would have gone in their general commitment of resources. You very kindly pointed out that we have got a well-managed financial system at the moment. We have been building reserves for future investment and so effectively our PCTs may well have added to some of their reserves for going forward rather than necessarily not being committed to other things.

Q389 Jim Dowd: I am grateful for your attribution to my generous nature because actually you are the commission who pointed it out.
Mr Farrar: Yes, but you very kindly pointed that out.

Q390 Jim Dowd: Finally, I am going to ask you how you watch the things you are not watching. By adopting this approach how do you ensure it does not lead to deterioration in other areas that are not evaluated?
Mr Farrar: That is exactly the point that I was trying to make about the speed of roll-out of the process. There is a lot of excitement amongst our clinical community and a lot of interest in now saying, "Can we replicate this in other areas?". The first thing to say is that we recognise that as a risk. The Premier experience in the way that they have done this, which is not the experience in all cases where you have had piloting, was that once you start to introduce this culture into an organisation the organisation itself starts to apply that kind of thinking to other areas, so we are confident but we will assess against risk of deterioration in other areas, and, of course, the Healthcare Commission reports continually on standards across the board, so we will be able to monitor deterioration. What is really exciting for us is that this is at a level of clinical detail which most of the healthcare standards do not get into. One, I acknowledge the risk; two, we use an independent regulator to see if that is going to fall; and, three, really we are looking at something quite different here that we intend hopefully to be able to roll out to other areas, if the evidence is as good as the States when it comes in in the north west, so you do not get this impact in other spheres.

Q391 Chairman: We have heard from Mike. Now it is Margaret's and Sir Ian's chance to tell us how your SHA is planning to measure quality improvements.
Ms Edwards: We are doing a lot of work on this. The immediate work we are doing is not dissimilar to Mike's but we are taking it slightly differently. We are looking at what they are doing in the north west but we have also got a group looking at some quality standards for us into our contracts for next year and that is a big marker about saying that from 1 April there will be additional quality standards. I should say again that we are not starting from year zero and I would be a very strong advocate of some of the other things we have done. The national target to reduce MRSA was a quality standard. The national target to improve access to A&E was a quality standard, so we have done some of those things already, and again things like the peer reviews in cancer, so we have got some things to build on. What we do not have is a systemic process right throughout the system. As you are aware from the national report, each SHA is to create a quality observatory. We are going to create something larger than that called a Quality Foundation, and that will have a number of roles. It will bring in our public health observatory. It will be the organisation that identifies best evidence, produces the data, designs the quality matrix and advises us, linking with the other nine organisations, so we will have an organisation that creates the data, creates the matrix and will be the place where, if you are a clinical director and you want to know, "How do I measure my clinical performance?", or, if you are a medical director of a hospital or if I am a clinical director in a particular speciality, "Where do I go for the best evidence?", it will tell you. It is quite difficult for a commissioner in that position sometimes to find that. It will be a body that works with them and provides that to them, so that will be one of the functions it has. Another function it will have will be the R&D. It will be the centre for R&D for the whole of Yorkshire. In terms of improvement and innovation, we are leading the way in Yorkshire and the Humber in terms of the improvement in innovation. We have, for example, led on things like the productive ward. We won most of the health and social care awards, but at the moment it is fragmented and we want to bring all that together in one place, so again, if you are a clinician or a manager working in Yorkshire and the Humber, you know the one place to go to get the really best advice. The Quality Foundation will do that as well. In a way, the most important thing and the thing that is really different about this organisation is that it will do the business processes as well. It will design

business processes. In the past we have been very good at having great academic institutions. For example, we have got York University, we have Leeds Metropolitan University. We have great knowledge in the Yorkshire and the Humber region. What we have not always been good at is making sure that goes into the business processes so that it gets into people's contracts, we measure it and report it, so it will be the job of this organisation to design business processes that make those things happen. The way I have described it is that Healthy Ambitions, which is our regional review, identifies the best practice now, say, for strokes, say, for children with asthma, and says what needs to be done, but what we do not want is to be in a position in ten years' time, when I sit down with a group of clinicians and they say, "The new thing we all know is so-and-so", but no-one has ever done it. I want an organisation that makes sure that that happens so that we are looking upstream and we are feeding it through and then putting it right into the contracts through the commissioning process. We are designing this Quality Foundation. I expect to be going out to advert for the team very soon, and we are putting a lot of resource and a lot of support from the chief executive community into it.

Sir Ian Carruthers: Three things. One is that we too are implementing innovation and improvement issues like productive wards. There are three things I really want to draw out. One is on safety itself. We have four of our acute trusts working in pairs in a process called The Safer Patient Initiative, which is a collaboration with the Health Foundation and IHI, and they are showing very good results on tackling a whole host of things. Medicines management is a very big area that is being looked at because of medication areas and so on. There is a whole set of things around safety and utilising, if you like, seriously untoward incidents and assess the things that go wrong as a springboard to putting them right, so it feels very practical. The second element is that if we look at the area of service improvement and standards we annually expect everyone to assess their progress on all the NSF standards so that we have a clear template of what is happening across every part of the region, what we need to focus on, what we need to learn, what they need to learn from each other, and that is a very illuminating process because by sharing it I think some people get a surprise sometimes on how well they fare, but usually it is where they can improve and that sets the agenda for the next year, so that is in a continuous way. The third thing is on the experience where we are about to start, on Monday, defining because, by and large, as we get better and better at it in targets in some parts of the South West, the target never matches how it feels in the system, and we want to really look at how do NHS organisations utilise the people who go through their doors to get feedback on that experience, and we are looking to link that to reward, incentive and so on; that will be pretty good. We are also wanting to implement the elements of the Lord Darzi arena which are about Quality such as Quality Observatories, and there is national work, as Hamish was mentioning this morning, to take forward the metrics, but we also have a programme where we are looking at standards in stroke, for example. We have had a tsar-type review of the whole region where every organisation has been tested against the standards of the national strategy and we are committed to taking that forward in half the time outlined in the National Stroke Strategy, and that will be published soon. It is quite interesting, when you look at the variation, just what that process has done in terms of holding a mirror up to people. In cancer, we are looking at how we can deliver the greater earlier diagnosis so that the outcome, which we really need, is longer survival, but we really need to look at our systems to see how people can get a faster diagnosis, so we are handling it on a number of levels. The part that I have not mentioned is the incentivisation and I am very interested in what Mike is doing, and the results, I would have to say because we went through them the other day, are impressive. However, it is counterculture. What he is doing is, I think, of greater relevance because it is counterculture to the literature because what the literature seems to say is that individual incentivisation may not improve quality, it skews the areas of quality that may improve, and he has acknowledged that. I think this is a very important piece of work because usually all the literature is in systems outside the UK which do not, as I think we have said before, have an intermediate tier to ameliorate this, so I think that piece of work is probably of international significance and we would want to learn on that. CEQUIN and all of these things, the incentivisation around money, I think, are positive, but I think that the thing, as I said earlier, that we need to work on is creating the environment and the culture so that, once we get the data, things are tackled because a lot of the data is there. There is a difference between having the data and doing something about it and I think that we need to move the whole of the NHS into a culture where we have a system to improve quality rather than to share data about it, and it is a cultural thing which, I think, is the most important because my biggest concern is where there is evidence and people continue to practise at sub-optimal levels.

Q392 Charlotte Atkins: That really takes me on to the issue about what is the right balance between measuring the quality of the process and actually measuring the quality of the patient outcome rather than just measuring for the sake of measuring. Has anyone got any comments on that?

Mr Farrar: Can I come in there because I have thought about the clinical outcomes, sort of measuring fairness, but the Advancing Quality Programme also included patient-reported outcome measures and we are developing new measures on customer satisfaction and patient experience where, we think, those three things together give you a broader, more important measure of quality because it is how people feel as well as the sort of clinical evidence about improvement. All of those go into, I think, people's recovery and experience of service. As to the problems nationally, as you know, there

are four areas that are going to go into the national contracts and I understand that the Department is working that up. We are using the Royal College of Surgeons, their evidence-based, performance-related outcome measurement around hip and knee, and we are also, through our work, expanding that to try and develop some with our local clinicians around coronary artery bypass graft. I think what will happen is exactly the kind of process we were talking about before where there will be a national number of areas, I think they are hernia, cataract, the knee, and there is one other and I cannot quite get there, they will be standardised everywhere, but other people, I know, in other regions are picking up on patient-reported outcome measurements and actually we will get a big quarry fairly quickly, and I think Ian is right, that the key there is to evaluate which of those are the most meaningful and then perhaps standardise out from there, so the patient-reported outcome is a key element. If we have one leg of a three-legged stool, then it will fall over than if we get two with the clinical outcome, so you need to bring patient-reported outcomes, customer experience and service and clinical outcomes together to understand whether or not people are getting a high-quality offer.

Q393 Charlotte Atkins: But then the crunch comes of how do you address poor-performing clinicians, hospitals and, for that matter, PCTs because certainly there is huge variation across the country and not a huge amount of evidence that SHAs are really addressing poor performance quickly enough.
Mr Farrar: I think the key thing on how you address performance is that you need to expose it, so that is the first thing. All of the evidence is that the first thing is that you have got to put that out into the open and expose the variation, and that in itself is very self-generating. People want to do well, they have come to the Health Service to do well and, if others are doing well, they want to do as well, but they would like to do better. The bit about the bottom end, and there is an issue for us at the bottom end of the spectrum, is that we are now setting in place a much stronger regulatory framework about what are the minimum standards, and I have been clear in my conversations with monitoring the new Quality Care Commission that regulation at the bottom has got to be unforgiving. It is not going to be understanding, but it has got to be absolutely critically unforgiving about what happens at the bottom, and I think that, if I were critical of myself over my NHS experience, I have probably understood too much on occasions and not been unforgiving enough, so I think regulations, rules-based and clear transparency are really important. There is one dimension that, I think, we have really failed to do in this country, and I think SHAs can really be leaders in this, that we have not focused our efforts on the top of the quality spectrum, but we have focused our efforts, because of reputational issues, on middle to bottom. I have had a lot of interest in sport and I am involved in sport quite heavily at the moment and, if you look at some of the elite performances in the world this year, our fantastic Olympic UK cycling team, they have focused a lot of their attention on the leading edge and challenging the leading edge to go further, so I think we are in a better position because good regulation liberates us a bit to be less concerned at the bottom because it is just very clear, it is unforgiving at the bottom end, and we need to be inspirational. We need to try and get people to really stretch their performance at the top end and not feel that there is no joy for them in going a bit further; we have got to liberate them really.
Ms Edwards: I think the point about measuring, and I talked about the quality foundation in Yorkshire and Humber, measuring, comparing and showing people about the data, it is intolerable that 600 people will die in Yorkshire or died in Yorkshire last year because we did not provide them with the right stroke care. Once you actually say that and say it that simply and that clearly, there is no debate with clinicians who say, "But I want to carry on providing this service in my small organisation, even though I can't get them a scan within two hours". I think we have just got to be much more robust about that and, on behalf of the patients, that is where our job is; it is to represent the patient and to say very clearly, "We will not tolerate", and I think we are doing that. We have addressed some of the big issues and we said that we will not tolerate waiting, we have said we will not tolerate people on trolleys for 12 hours, and we were very clear and very robust about that. We now need to say at individual practice level, by which I mean individual clinician level, that we will not tolerate some of the variations that we see, and that does not mean that we are going actually to say, "That individual clinician is a failure and needs to leave", but often it may be that they need some support and they need development. A part of our role is to identify where it is the case that we can do development and where we can improve the services. Often, it is not the individual clinician, but it is the system that we have put around them and they do not have the facilities or they have not had the training or whatever, so we need to really understand that. I think that is the next phase that the NHS is on though, that we have a period of significant financial growth and address some of, as I say, the real headline issues in terms of the public's concerns, but now the next layer of the onion we are peeling back, as I say, is some of the individual variations at the practice level of individual clinicians, and that is what we really need to address.

Q394 Charlotte Atkins: As MPs, we get letters from hospitals and other health organisations, giving apologies because someone has died needlessly and we get these mealy-mouthed letters, saying, "Well, this happened, that happened and, yes, it's no one's real fault, but it was a whole lot of circumstances", and ultimately that patient has been let down and let down extremely badly. What, I think, is very frustrating for patients is that nothing seems to happen and the NHS organisation closes over the top of the clinician or the system and says, "Oh well, we'll do better next time". Well, that is one time too late for them.

Sir Ian Carruthers: Can I just come on to that because I think that this is the nub of the issue. The nub of the issue is: how do we create an environment where boards feel more able to act, because it is not the SHAs, but the boards of the providers, and the boards of the PCTs that need to act rather than SHAs. It is for us to hold them to account for doing it, and it is not absolving us, but when will boards feel that their job is to ensure, and many do of course. I am talking about those where there is continual repeat of the types of things you mentioned, where boards feel it is their duty to act on behalf of the business and I am not saying that it is one or the other, but actually what we need is to create an environment and a culture where incidents like those that you have outlined are the same as a financial overspend. From my experience, if I wanted to persuade a board to change its practice, it could take months, but, if they wanted to do it, they would do it and I would not have to talk to them. Where they are reluctant to, you will go months and months because, when you look at the powers of intervention on these professional issues there is little that can be done, short of reporting people to the GMC which does not necessarily get a result, and the point is that there is professional regulation, but is it tough enough? The point is: where are boards tolerating practice which, we know, is inappropriate? Very often, they will defend their local team rather than act for the best thing and that is what I mean by the 'culture' and the 'environment' because, if a PCT reduced the allocation, it would generate more action in many organisations than actually a set of serious untoward incidents. If I may say so, we have examples of that in the recent past, like Maidstone, and I think the point is that we need to get them to the same cultural point so that they finance and quality are given equal focus, because the sad thing is that everyone will react to a financial position, but they will not necessarily react to a real qualitative failure. That is something that you, as MPs, have to share in by supporting services to go where they are safe, it is something that communities have to share in, it is something that boards in the NHS have to share in and it is something that people in SHAs and NHS leaders have to share in. All of us, to make the change and stop what you have said is happening, need to be uncompromising about it and the fact is that that is not always the case.

Q395 Dr Stoate: I have a very quick question really and that is about PROMS. Will it be ready in time for 2009?

Mr Farrar: I touched on that previously. I understand that the Department are working on the contract to bring that in in those four areas. We are building on that in the North West and a couple of other areas, so my assumption is yes.

Q396 Dr Stoate: Well, that is not very helpful, is it, an assumption that they might be ready? That is not really what we want to hear, is it?

Mr Farrar: Some of this is being dealt with in the Department at the moment, as we were looking at the work recently, and I think they believe they are on track to do so.

Sir Ian Carruthers: It is my understanding that they are on track, and the other thing to add as well is that we have got to recognise that it is limited only to a few procedures and I think that what we have got to accept with this is that there will be a gradual introduction as we go through. I know the aim is to link it to funding and so on and there ultimately, but I think caution needs to be extended before we go there.

Q397 Dr Stoate: Fair enough, but, if they are only in four areas, how much is all of this going to cost?

Sir Ian Carruthers: I do not know. In the questionnaire from your past hearings, I think you had a figure of £6.50 quoted, but I do not really know because I think that the policy is still being developed, but clearly there is going to be a cost.

Q398 Dr Stoate: So we are sort of six months away from it, we do not know how much it is going to cost and we do not know if it is going to be ready on time?

Ms Edwards: Well, I think one of the reasons for that is that it is at the moment being led by the Department. The Department of Health are currently doing the review, they are looking at best practice and they are looking at what has already been done right around the NHS at the moment, so they are looking at that and they are pulling all of that together. We have got a group, which is a sub-committee of the management board, which has actually commissioned that work and is getting on and doing it. It will be shared with all ten of the SHA chief executives and the Department and a decision will be made about which is the best model and how to do it, so we will start gradually, we will start with the four, and the fourth is varicose veins, it has just come to me, so we will start with those. I think that the date of 1 April is the starting point of something, and the fact that it is not the finishing point is the big message, and to have something in place and say, "We're going to start on that date and then move forward from there" is the expectation.

Q399 Dr Stoate: How useful will they be then?

Ms Edwards: My experience of these sorts of things is that they are very useful. We have funded in Yorkshire and the Humber, for example, a thing called 'Patient Opinion' which is an independent body which allows patients to go on to a website and just report their experience of hospitals, and it is one of the most powerful things I have ever seen in terms of you go and you read a patient's experience; it works for other patients in terms of looking at where they may want to go for hospital treatment, et cetera, but it also works for the hospitals. They really do take notice of what is written, in the same way that Amazon works, if you like, for books and actually seeing what other people think of things, that is how society works now.

Q400 Dr Stoate: Do you think it will drive change?
Ms Edwards: I really believe it will drive change. I think it is right we start small and I think it is right we start gradual because I think there is a danger that we say, "Oh, it's too small, it's only this", and actually that is the right thing to do, but I really do believe it will drive change, and it is the most powerful thing. When you feed back to staff, when you sit on a ward and you listen to them getting feedback from patients, it is very, very powerful and we do that quite a lot. One of the chief executives, I know, gets any staff who have ever been treated in their hospital to come in and talk to the clinicians, and again that is very powerful, and if members of their families have been treated. These are the things which, we know, do make a difference.
Mr Farrar: Perhaps we could give you an update later in terms of where we are before you deliberate.[1]

Q401 Dr Taylor: I am coming back to commissioning, thinking particularly of improving skills and leadership. The first thing I want from each of you, avoiding jargon and words like 'organisational competencies' and the sort of twee, adding years and years to life, is a primary characteristic of world-class commissioning because I want three altogether.
Mr Farrar: Can I go first, and it is not that I thought you were going to ask the question or anything like that! I think the difference between what we have done before and what we need from our commissioners going forward is for them to understand provider risk. What do I mean by that? It is the risk that is placed on providers as we ask them to transform their service. Now, what I mean by that is that, if you think about one of the most fantastic transformations of this Service that this country has seen from long-stay mental hospitals, isolated hospitals to a community-based service, that was done actually on a regional, planned basis, interestingly, with the resources to respect that you need dual running, you need to find a way to sort of manage, and invest in, new services while you are closing old ones, and there were levels of resource put in to keep the quality up while you went through that transformation and there was resource put in to train the staff to work differently. Now, I think what good commissioners want is to transform services. How they will show that through their commissioning process is by understanding, if they want an acute hospital to change the way it does business to work in community settings, the risk they are putting on the organisation, that it has to carry fixed costs until it can dispose of its assets and it has to reorientate its staff, and I think what world-class commissioning does is understand the journey you are expecting of your providers and effectively what you do, therefore, is recognise that in the way you work with them. That might be financially, it might be about the time that you give them to change, and it might be the assurance you give them in a contract over a period of time. That is very different from poor commissioning which, I believe, is tendering everything, not understanding opportunity costs of tender, not recognising that sometimes the tariff and tariff alone for a service, when you get into a change of service, needs to be enhanced to reflect that kind of transition, so world-class commissioning for me, one illustration would be if our commissioners were sensitive to, and understood, how to use their resources to lever change through understanding, and managing, provider risk.

Q402 Dr Taylor: The major changes then in mental health care happened in 1978, so that was long before the commissioning came in.
Sir Ian Carruthers: At its root, it is asking four questions. One is: do we know what our population's health needs are and what people want to see? Two: have we got a plan to deliver them which is resourced? Three: have we got the processes in place to get the taxpayer value and good quality, working in a collaborative way, where possible, with those who are meant to supply it, providing there is good tension? The fourth question is: have we got the capability in our organisation to do it and, if not, how do we get it? If you get all those simple things right, you deliver something that is quite exceptional. The problem is that people cannot get the simple things right often enough to get to that exceptional point, and that is what, I think, the whole process is about.

Q403 Dr Taylor: I will come back to that in a minute.
Ms Edwards: Mine is simpler. Mine would simply be to only buy services that I, as a patient, would be prepared to receive and to only buy services that I, as a taxpayer, would be prepared to pay for and, if you put yourself in that position and assess every service, they have to pass both tests.

Q404 Dr Taylor: This comes back to something that Sir Ian said earlier: are you actually going to penalise people when they provide the services that are not of the quality that you want?
Ms Edwards: It depends what you mean by 'penalise'.

[1] Under the terms of the Standard NHS Contract for Acute Services, providers of NHS-funded Hip and Knee replacements, Groin Hernia surgery and Varicose Vein surgery are obliged to invite patients to complete Patient Reported Outcomes Measures (PROMs) questionnaires, as of 1st April 2009. The Standard NHS Contract for Acute Services will apply to all NHS Acute providers, NHS Foundation Trusts in due course (as they migrate from other contractual arrangements with commissioners) and Independent Sector providers which are on the Extended Choice Network. The PROMs data collection also has a mandatory data collection for non-FT acute trusts, given to it by the Review of Central Returns (ROCR) Secretariat. The DH is in the process of procuring services to support the administration of questionnaires, processing and analysis of data, and reporting back to the NHS and stakeholders. This procurement process is expected to conclude in January so that contractors are in place to achieve the 1st April go-live date. The DH is also working with the NHS Information Centre to deliver the programme. The IC has a central Information Governance role. Guidance is expected to be issued to the NHS by the DH shortly.

Q405 Dr Taylor: Financially.
Ms Edwards: In some cases, yes.
Sir Ian Carruthers: It goes back to my earlier questions. I think the culture and the environment are the things that will drive change. I believe that the financial penalties are there, and there are things that you can do in incidents where, if the sorts of things that Charlotte raised before occurred, the Trust would say, "We just won't take payment for this. We need to revamp our system and we won't take payment until that occurs"; you could do that. My point about financial incentives, on an individual level they are so small that they are unlikely to make organisations move, so I think, yes, we should penalise them, we should incentivise them, but it is the education, learning, culture and environment to want to address them which will actually have the biggest impact on the qualitative issues.

Q406 Dr Taylor: When can we expect these? You have given us three very good groups of things, but when can we expect these to be in place?
Sir Ian Carruthers: Well, in my case my four simple questions are just the essence of good management actually. I know we call it 'commissioning', but I could say the commissioning process is just about the management process on one level really between organisations, and I think some of them are in place in lots of places, but none of them is at the point where they could not be improved, so I would say that some of those elements are there, but the aim of world-class commissioning is to just improve from where we are and to get as good as we can be, and of course as good as we can be needs to be associated with the results that are delivered, not the process for resourcing.

Q407 Stephen Hesford: Margaret, only buy services that people want and only pay for—
Ms Edwards: What I would be prepared to have as a patient, so, if I would not tolerate that as a patient, why should I commission it for my patient?

Q408 Stephen Hesford: And what the taxpayer should pay for, those are the two things?
Ms Edwards: Yes.

Q409 Stephen Hesford: So, if you have got a local cottage hospital which is out in the middle of nowhere, it is inefficient, but the patients love it, how do you deal with that? Do you just say, "Right, end of resources. The taxpayer should not pay for this, you are shut"?
Ms Edwards: No, because I think taxpayers often will make that choice. I think one of the things that we need to recognise and one of our roles is to identify those hospitals where actually there is a collective view that, "As a local community, we want the service there and we're prepared to pay for that service". I think sometimes we should be very honest about the fact that there may be additional costs associated with that and be transparent about it, but, as a commissioner, you may well say, "Actually we're prepared to invest more because my population . . .", and I think the density, for example, in London is nearly 5,000 people per square kilometre and I have parts of Yorkshire where it is 34 people per square kilometre. Now, in a rural area like that, you are going to need to invest in services and spend more on some services because of that and I think that is quite an honest debate to have with the taxpayer and to say, "Actually there will be a cost with this, but we're prepared to do it. Where we won't do the cost is where it affects patient safety", and I think that is different.

Q410 Stephen Hesford: But safety was not in your two things really.
Ms Edwards: I think it was. I think it was definitely there because one of the things that I, as a patient, would want is a safe service, so, when you say, "If it's good enough for me, as a patient", it means it has to be safe, it has to have good clinical outcomes, it has to treat me with respect, it has to do all of those things because I, as a patient, would not choose a service that did not, so that is what I meant, that it encompasses all those things.

Q411 Dr Taylor: Coming back to good management skills, when we were doing the dental inquiry, we learned that PCTs' commissioning skills were very, very different, and, in some of those that were bad, they had put the commissioning down to sort of the middle ranks of managers, so how are you going to improve leadership skills in the middle-ranking managers?
Sir Ian Carruthers: I think that we really need to put more in staff investment, more in development and much more into what I would call 'focused people development', into the areas where we know we should be strengthening rather than be generalist. If I can look at this as the technique of a world-class batsman, he would work on his weaknesses, he would not go and do general batting training, and I think that what we need to do is be much more focused on tackling our weaknesses, whereas we do very generalised development which has its place, and you need both to become world-class of course, but you need to work on your weaknesses.
Mr Farrar: I think there are a number of technical aspects to commissioning which Ian described, needs assessment, procurement, and to turn that to practice, but there are the ideas of commissioning and this, I think, squares very much with the Darzi vision of clinical heartbeats at the heart of everything and also squares the circle for practice-based commissioning of PCTs. Part of the answer to how do you get more intelligent commissioning by organisations is that you bring some of the brightest and best people on the patch to bear in terms of thinking, which is the GPs and clinicians working in the community, so some of that commissioning function really could fit quite nicely with the development of practice-based commissioning.

Q412 Dr Taylor: Do the specialised commissioning groups, which commission for the sort of rare conditions, work better than PCT commissioning at the moment because they have got better experts on board?
Mr Farrar: I think where I would say they have got some advantages is that they have often worked on a basis of clinical networks, so, for example, some of the decisions taken by specialised commissioning about cancer services, cancer drugs and new developments and techniques have been delivered through lots of discussion with cancer networks, the Centre for Critical Care and others, so I think that they have some advantages. I think they are pretty much on a par. Interestingly, we have just done the first pilot. We have assessed our specialised commissioning team against the same standards as world-class commissioners are assessing PCTs, and the reason we have done that is because they spend £1 billion of expenditure. If they were an organisation in their own right, they would be my biggest primary care trust.

Q413 Dr Taylor: Do you see any ways that PCTs are going to actually become accountable to ordinary people for their commissioning role?
Sir Ian Carruthers: Well, we have got a couple of primary care trusts which are developing membership schemes in the same way as foundation trusts, which always struck me as being quite a sensible place to start with membership, because actually this organisation spends your money every day, as opposed to being a member of a hospital where you hope to avoid contact with it, so actually I think membership schemes supporting PCTs is really important. I think we need to encourage more public accountability and again there are some commitments in our vision around public touchstones, so not putting out management information, but putting out information real-time about whether we are delivering on our promises in a way that people, who live on my patch, would understand, which is always my test because they tell me. I think that that has got to be a huge direction of travel for the simple reason that, if you look at what the real agenda is for the Health Service over the next ten years, it is not just high-quality care, it is actually improving people's health, otherwise we will be into supply-side solutions in five to ten years' time and the only way that you do that is engaging the population and thinking about their utilisation of the Service now. We are making a big deal of trying to get people to understand their care footprint in the way that they think now about their carbon footprint and whether you can help people try and reduce the discretionary elements of their care footprint, and you do that by engaging them in the way we spend resources, so the commissioning linked to public engagement is a massive, massive ingredient.

Q414 Dr Taylor: These weird things called 'links', are they taking shape in your area and are they going to be effective, the local involvement networks?
Sir Ian Carruthers: Well, it is early days, it is early days, and that sector has seen huge change, probably the most radically changed and most frequently changed bit of the system. We really want to make this one to stick. What we do not want is, in two years' time, another reorganisation of that kind relating to the formal way the public engage with services, so hopefully.

Q415 Dr Taylor: So you both would be encouraging them to be effective and useful?
Ms Edwards: I think it comes under the umbrella of your larger question which was: when will PCTs become accountable to the public? That is part of it. It is one of those links and it is an important one and it is being set up for them and they have also got an important link with the local authority, so it works in that sense. It is not the be-all and end-all of a PCT being able to demonstrate that it has responded to, and understands, its population's desires, wants and needs, but it is one of the mechanisms you would expect them to be using and talking to.

Q416 Jim Dowd: Briefly, the Next Stage Review highlights the need or it places great value on turning clinicians into managers. Can I just have your brief views on that. Is it worthwhile doing, is it possible and how much effort are you prepared to put into it, if it is?
Ms Edwards: I was a hospital chief executive in a former role and I went into an organisation that was known by the very complex term of a 'basket case' in that it was an organisation that had a lot of history of failing. When I got there, I realised that the main reason it was failing, and it was failing in a number of ways, was that the clinicians and the managers were not in the same place, they were not working together, they were pulling in different directions. We turned it round and we ended up actually as Trust of the Year, and the one single thing, I would say, that we did was that we got the clinicians and the managers to the same agenda. I do not really think that necessarily means that all the clinicians suddenly become the managers and certainly, God help us, the managers become the clinicians—

Q417 Jim Dowd: Well, it could not be any worse, could it?
Ms Edwards: ---but actually I think it is wider than that. It is having the same agenda, having the same objectives and actually being very clear about those value bases and then using the skills, and that, I think, does need to happen more. Part of that process is having clinicians involved in the management, and I have just appointed a medical director, for example, but I think it is wider than just saying that we will take a handful of our clinicians and turn them into managers because actually they would just move to the different side, but you have got to integrate the two elements. I think that is what it is really about and that is what the drive is, but it does seem perverse to me to have a system as big as the NHS and as wide as the NHS where we do not train any of our clinicians about how the system works, so they work in a system where they do not

actually understand how it runs and how it works. That, I think, is a real need in terms of the way we educate our clinicians to actually understand how things work so that they can understand how they can make things change and how they can make things happen, and we have not been good at doing that.
Mr Farrar: The only thing I would add to that is that I think we have to distinguish between training clinicians and clinical leaders and training clinicians to go into management roles because I think they are distinct skills at the top of the office, and I would like to encourage both. We have got an initiative called the 'Clinical Leaders' Network' which is having quite a lot of success in bringing people through sort of management concepts, not just about how they improve clinical practice, but actually getting them to, and we are very confident that, going forward, we will have quite a lot more clinicians coming on to shortlists for general management roles, chief exec jobs and operational director jobs and not just for the medical director and the clinical director posts. It is coming through, but you have got to invest in training clinicians around the management issues, not just training clinicians to be leaders of their clinical colleagues, which is different.

Q418 Jim Dowd: But certainly the position you described was really about making everybody in the organisation understand what the common purpose is, and that surely is as least as important as who is doing that. I fear that this idea of turning clinicians into managers is the kind of thing that people pay lip-service to as an abstract, good idea, but, in truth, it is not actually going to produce much change, not as much as organisations being clear about what message they communicate to those involved and of course given the fact that clinicians have a different employment status than do others in a trust, for example.
Ms Edwards: Yes, and I think we are just repeating really. For me, it is about the wider cultural thing of saying, "We have all actually got the same values. What is our common objective here? It is to provide the best-possible care. It is to create an environment that is good for you, as individuals, to work in, but it is actually mainly about providing the best-quality care". I have never found that difficult. When you actually sit down with a group of clinicians, if you start from that point, you actually find that you are in the same place. The problem we have had is often the managers might have gone in and talked about money to start with and that is just not the right way to actually engage in some of these things, and I think there is a need for us to work closer together, but it is much more about working closer than, as I say, picking one or two clinicians.

Q419 Jim Dowd: What about when either of you leaves your current post after a long, distinguished and valued career, would you imagine being replaced by a clinician?
Ms Edwards: The best person for the job may well be a clinician, as long as they understand the NHS, have the values and beliefs and are a competent manager, or, better than a competent manager, I hope they would be a really good manager.

Q420 Jim Dowd: So probably not then!
Ms Edwards: I did not say that! For me, that would not be the number one thing on the list, whether they are or they are not a clinician. Clinicians bring some real skills and other people bring some skills.
Mr Farrar: It is worth pointing out that one of the ten chief executives of a strategic health authority is a clinician, a GP, Barbara Hakin of the West Midlands, and there is no evidence to say that she is doing any worse or any better. She is pretty good and she is doing really well.
Ms Edwards: I think one of the things she does do is that she brings that to us, as a ten, and one of the things which has been very useful is that, if you look at the backgrounds of the ten of us, we have, as I say, Barbara with a primary care background, me who has worked in acute services, Mike who has done a lot in the Department of Health, so between us as well. I think that is one of the things that works really well in any team, that you bring a range of skills and a range of experience, and that, I believe, we need to keep within the ten in terms of the backgrounds.

Q421 Jim Dowd: On the use of management consultants, how widely do you use them?
Mr Farrar: I think management consultants are used quite a lot, not just in the NHS, but in the public sector. I think we have become more discerning in terms of being a much more intelligent customer of management consultants, so effectively our start point is usually, "Do we need external expertise?" There are areas where we have used management consultants to help us and there are areas where we have said, "No, we can do it perfectly well ourselves", so we do use them, I do not think it is excessive, I think we use them forensically now, and I think we only use them when we do not have the expertise inside to do the job we are asking.

Q422 Jim Dowd: When you say that you do not possess it, is that expertise that you should possess, but do not have?
Mr Farrar: Let me give you an example. I think we structure into some of our contracts with consultants nowadays a sort of skills transfer, so effectively, if we have not got expertise at the moment, then you are looking for a consultant to come with you and effectively pass on skills and expertise. Now, I am not thinking more the generic contracts, I am thinking about our contract that we have with Premier, for example, who have got three or four years on us, and part of that contract explicitly is that they will transfer skills to us, so in three years' time we effectively can do what they are currently doing for us, and that is built completely into our contract.

Q423 Charlotte Atkins: Moving on to GP-led health centres, why is every PCT obliged to have one? Are we making the same mistake over GP-led health centres as we were with ISTCs where SHAs forced PCTs to make a contribution to ISTCs even where they knew their patients did not want them?
Ms Edwards: I really do not think we are. If you take Yorkshire and Humber, we have got over 800 GP practices and we are being asked to increase by 14. It is a drop in the ocean, it is less than 2% in a time when the population, as we know, is ageing, and we have talked earlier about whether we really mean we are actually going to do the shift from secondary to primary, so to ask for a less than 2% increase is the minimum and is not an unreasonable ask, and I know there is not a PCT in my patch that cannot make very good use and appropriate use of additional primary care input. To frontload that from the Department and say we're going to do that, I think, is completely reasonable. If it had been a 30% increase imposed, I think that would have been a different debate, but it was relatively small. The example was given by Hamish earlier where he said that Hull needs three or four, and I agree, it does need several more, and it is doing them, so this is a minimum level, a starting point, and I think it was quite a strong message and an important message nationally and reinforced by ourselves, as SHAs, that investing in primary care was now a priority, and I think that is what that was about and no more, no less really, but that does not mean they will not make a big impact in those places.

Q424 Charlotte Atkins: But PCTs vary in size enormously.
Ms Edwards: Yes.

Q425 Charlotte Atkins: It seems odd, does it not, to have one health centre minimum, and I appreciate that it is a minimum, but it just seems to be odd, given that you have got a huge variation in size. I fought to keep my local one and we got it.
Mr Farrar: I think Margaret's figures are really helpful in this in terms of the size and scale of what this change involves. The North West is about 40% of that total national initiative, but we are the most significantly under-doctored area in the country. As a consequence of that, our inability to get good primary care in the right areas, people die younger, I put it as stark as that. The notion that one extra health centre or one extra practice in every area, irrespective of size, would not add to the quality of care that people get, I find that rather strange. I think it is entirely justifiable that this country expands its primary care. I think that, if we expanded primary care, we would get our life expectancy rates up higher because what happens is that the failure to get good primary care means that you get later presentation of problems, you get later diagnosis of problems and, as a consequence of that, when people hit secondary care, they are more ill, so my view on all of this is that it came out as a national initiative, but actually it has strategic importance in almost every primary care trust in the country and it is highly defensible.

Q426 Charlotte Atkins: So what is your take on the BMA's opposition?
Mr Farrar: I thought it was very interesting. I do not know whether we are allowed to comment on other people's evidence.

Q427 Charlotte Atkins: Please do.
Mr Farrar: I thought, listening to Hamish, that the case was quite sort of exposed in the sense that it is not really an opposition to the expansion of primary care, nor, if you had pushed, would you have found opposition to the notion of giving the existing GPs more time to deal with the patient care that they get because, in another voice, the BMA will say that there is a big workload pressure on primary care, so the case for expansion of primary care, I suspect, they would support. I think it is much more, from the BMA's perspective, about who is involved in providing that primary care and, because in this instance there is a slightly bigger entry door, in the past governments have often sort of said to existing primary care, "Well, we'll try and recruit more of you", but in this case, interestingly, they brought in some alternative potential providers, subject to their winning contracts because they are the best providers of course and they can deal with the quality of care, and I think it is that that the BMA is concerned about, but I do not think they have a problem, would be my sense, with the expansion of primary care.

Q428 Charlotte Atkins: So you think it is all about the BMA protecting their own interests or the interests of their members?
Mr Farrar: I think there is an element of that in there. They may have legitimate questions about process and things like that, though it is not for me to speak on their behalf. Let me go into safe ground in the North West where there are some specific examples. We have an area where all the evidence shows that you need to expand primary care and we had a very loud GP who was calling public meetings, giving out lots and lots of information, and I actually happened to be speaking and he confronted me and he said, "Well, this is a scandal. This practice is opening", and I said, "Well, do you believe that we should expand primary care?", "Yes, of course we should", "Tell me how many people on your current list will be forced to leave your list to go to a new practice", and not a single one will be forced to leave him. If he can provide the quality of care that his patients want and a new practice is opening down the road or whatever and, to be frank, the health needs of that population can justify a new practice anyway, but, if he can provide the high quality of care, then he has got nothing to fear from a new practice. I think this is something that is a new dimension to challenging primary care, but my sense is that that bit of grit in the oyster may well be what primary care needs to really improve its quality everywhere, particularly in deprived areas.

Q429 Charlotte Atkins: So how have you gone about consulting local people about where they want those health centres? What have you done in your particular SHA in terms of consulting people about the GP-led health centres?
Ms Edwards: We made sure the primary care trusts do that basically, so we have said that that is very clearly part of the criteria. When we assess their plans, that will be in them and has been a big part of the sign-up, identifying what process have you gone through, how have you consulted, and why have you decided, in East Riding, that it is in Bridlington, which is the one you heard about earlier, and we have decided that it is in Bridlington because that has some of the lowest life expectancy in East Riding and it has some of the highest long-term chronic diseases in the whole of the PCT, so those sorts of criteria and consultation with the population. We have asked the PCT basically to satisfy us that they have made the most appropriate use of the resources, as we normally would on anything, and part of that is the consultation with the public. I think it has been unfortunate that the public, I think, have been scared. The public have been led to believe that things will close and I think that is very unfortunate when we have a situation where we are opening new services which, as Mike said, it is for them to choose whether they want to go to or not, but there is a very strong belief that actually this will result in services closing. That has made consultation very difficult for some of our PCTs because they have been wanting to engage in an open and honest dialogue with the population about, "Where would you like one of these new services?" and the population think that means that, if they get one, they will lose something else, and it has been quite a difficult environment, I think, for a number of our PCTs to consult in. Again, one of the roles is that I have a very good Director of Communications who has been helping our PCTs in how you have that dialogue, how you have those meetings in that sort of environment.

Q430 Charlotte Atkins: Clearly the Department has made it very clear that the GP-led health centres will complement existing services. Have you got examples, particularly concrete examples in your own areas, about how health centres will affect existing services? Clearly there is a fear on behalf of the BMA which probably indicates to me that they have not got a huge amount of confidence in their own members and somehow that there will be problems created for their GP members. Have you had a situation in your own areas where the creation of a GP-led health centre has either had positive or negative impacts on existing services?
Mr Farrar: In the vast majority of cases in the North West, probably with only one exception, I think this has been brought in quite sensitively and well rather than the notion that everybody is up in arms because the case for expanding primary care in the North West is so strong. What we have seen, and I will give you a very good example of complementarity rather than impact, is that one of my primary care trusts was well on the road to recruiting a number of new GPs and then we had the national initiative, so they were working with us on how they would provide a complementary service, and of course this is an area with very, very high deprivation, real lifestyle issues, so what we have done is we have organised the new GP-led health centre to have a particular focus around health and wellbeing as a way of complementing expanding general primary care for treatment purposes, so I think there are good examples of real complementarity. My view is that, if you look at the list sizes in the North West and taking Margaret's numbers which are similar even on our scale, this is not going to have a major impact on existing list sizes, but will add to the public's benefit really.

Q431 Charlotte Atkins: What would happen theoretically if 20% of a GP's patients actually left his or her practice?
Ms Edwards: It would depend, I think. Some of our GPs already have very large list sizes, so in some places that would be a genuinely good thing for all parties because we know that there are real issues, and that is where we are looking to put these additional clinics and centres, so we are not looking to put them in places where there are generally very low list sizes.

Q432 Charlotte Atkins: Would that affect a GP's income?
Ms Edwards: Yes, it would.

Q433 Charlotte Atkins: By 20% or less? Would it actually be by 20%?
Mr Farrar: Effectively what happens is that they are paid on their registered population, the global sum element of that, so effectively they would see a reduction pro rata of those people. Now, that would filter through as soon as those registrations were in the system and the funding allocation caught up with it. However, there may well be compensatory benefits, so, for example, if treating 20% less patients helped them to achieve higher costs for the ones they have got, they would get compensation.

Q434 Charlotte Atkins: But of course the patient could use the health centre, but still stay with the GP.
Mr Farrar: A GP-led health centre?

Q435 Charlotte Atkins: Yes.
Mr Farrar: Yes. I think in many cases the expectation is that the GP-led health centres are not going to have lists in that sense and the allocation to practices is based on their list size, but, in the event of 20% being lost to a practice, they would lose 20% of their global sum.

Q436 Charlotte Atkins: So that is maybe one of the reasons why they are so concerned about that issue. Now, obviously one of the issues raised about increased competition is about new providers coming in and particularly we are looking maybe at third-sector charitable providers playing a much larger role in delivering services. What impact do

you think that would have on GP services and have you engaged third-sector providers to provide these services as a way of expanding primary care?

Mr Farrar: We have. It would be wrong of me because we are right in the procurement stage which we have actually selected to get down to, so the mix of people who are likely to win these new practices is actually quite varied. Probably about 60% of them are really existing consultant GPs expanding, there are maybe about 30% who are new providers and, interestingly, 10% are partnerships where acute providers are looking for some degree of vertical integration, which is quite interesting in some parts of the patch because it helps support a viable acute business, so actually there is quite a range and plurality. I think it is more the for-profit sector in that kind of third rather than the not-for-profit, but we do have some not-for-profit providers in there in the consortium, and I will not name them, but they are big, national, not-for-profit, and I think there will be some really exciting developments in this because what we have had with British general practice has been pretty good, but it has come out of the particular orthodoxy of how you do it. The BMA is a very strong leadership for that group and the Royal College actually does not penetrate quite as deeply into general practice. I think bringing new people to try and deal with this task of what a good primary care service looks like will bring different thoughts. I think customer experience may well change, and we have all got the apocryphal gatekeeping role of trying to get access and that will be challenged in a different kind of mindset with primary care, and I think we will see, again through the voluntary sector if the voluntary sector comes in, some very different ways of tackling some of the problems, so I think it can only be for the good if we can help people learn, and that is the point.

Ms Edwards: I have a very similar experience with exactly the same process, that it is a national timetable we are working to in terms of the procurement, but we are expecting a range, we are expecting some quite innovative things from what we have got so far on the table and we are expecting some good existing services that are currently bidding. We have some good services bidding outside their geographical area or actually expanding within their geographical area. One of the things this does is it actually gives some very strong messages that, if you are doing well, actually we can reward that by actually supporting you expand rather than just being the sitting tenant, which is traditionally what we have done. If you were the sitting tenant, it was not worth it unless you got the resources, but now we are asking people to actually demonstrate that they will be the best person, and it goes back to my point about who is the best person for the taxpayer, who is the best person for the patient, and those should be the criteria rather than who already has the practice in this particular village or town.

Q437 Chairman: If they do not get the lists and they operate without lists, what income do they get and how would it compare to other GP practices that operate on lists and get their income from them?

Mr Farrar: I am slightly in the dark there. We have a resource allocation over and above that to fund them to a certain level equating to a particular size to get them in there and involved, so I think the funding would have to be—

Q438 Chairman: Is that based on current expenditure of other GPs in the neighbourhood?

Mr Farrar: Unless Margaret has got an answer to that, we will probably have to get back to you.

Ms Edwards: I do not know how you actually calculate the allowance. There is a sum for them, but I do not know how that is calculated.

Mr Farrar: It is not based on the same principle.

Q439 Chairman: It cannot be on the same principle if they do not have lists, and that is what struck me when you said that, but obviously they are going to get an income as of when they open, but we are not sure how that will compare with incomes of other general practice in the locality?

Mr Farrar: We will find out the technical details of what that involves, but I think it is quite difficult to make comparisons. Because the NHS effectively subsidise all the costs of general practice through their contract for 60 years, the average cost of a GP consultation is around £12/13. Now, when you bring in new services, without that kind of level of support over that period, for example, an NHS Direct phone call, I think, was about £17/18 and a walk-in centre attendance was about £60 on average because you do not have the same sort of degree of effectively support for infrastructure costs that are built up over the years, so I think one of the things not to do would be to make a direct comparison around value for money of that in respect of value for money of current price per GP consultation because they are different beasts in a sense coming into play. You should ask for a value for money test, but I do not think saying, “Well, is it a straight comparison with the cost of a GP consultation?” is the right comparison to make.

Q440 Chairman: There are just a couple of other things, one on Darzi particularly and the other is the issue of NICE and speeding up the process. Now, what implications does that have for the National Health Service in your particular trusts? Will it mean that it will end local variations in terms of prescribing?

Ms Edwards: Firstly, it will dramatically help. It will be a help to speed up because obviously one of the difficulties at the moment in terms of consistency is when PCTs have to make decisions about drugs that are awaiting NICE approval, so the sooner we can get that, obviously the less of those there will be. Having said that, I think the thing we need to recognise is that, when we talk about variation in terms of clinical practice, there is still significant variation even once NICE have approved a drug, so actually for the approval process and for all of those procedures that NICE does not approve, so it will not eliminate the whole variation in any way, but it will be a help because there are patients currently who go through exception panels and each PCT, as

you know, has an exception panel at the moment and they have to make decisions without the advantage of having the thorough and really robust approach that NICE takes and that just makes it more difficult. I think we are very lucky to have NICE and it is very useful, but the quicker we can get the results, then the greater consistency we can get.

Mr Farrar: I think speeding up NICE approval is going to help us really. It has to because effectively PCTs are dealing with those cases in the absence of a national position, so it does not put additional pressure on the Service, it actually gives additional guidance to the Service about a NICE view, so I think it helps enormously, I think Margaret is right. It puts a premium on us sort of getting a better process for PCTs across the piece rather than variable processes, and we will try and work towards that. The key, the most important factor in variable receipt of drugs of course, even if NICE pronounces clinical behaviour, the standardisation of clinical process is the key thing that we have got to get into and, although I was talking about secondary care when I talked about advancing quality, helping a standardised process against best practice, we have got to tackle that as well, and I do not think we should blame NICE if there is variable practice because actually we have got to make sure that clinicians are pursuing best evidence-based practice.

Q441 Chairman: We live in a time of surplus in terms of budgets in the National Health Service at the moment, but just a few years ago when Herceptin was speeded up, for want of a better expression, on to the list for use in early-stage breast cancer, that had implications for my own local primary care and there was something in the region of potentially an extra £1 million out of next year's budget. Okay, it is a multi-million pound budget that they have, but that is no mean sum, but it might be quite happy if it is sitting with balances at the moment. Do you see that we could have a situation where the speeding up of NICE would have a direct correlation to costs and, if it were end-year costs or quicker than you could plan for such an expenditure like that, would that create any difficulties, do you think?

Ms Edwards: I think we have to get much better at horizon-scanning and actually identifying what is coming really and agreeing what NICE is going to look at and then we should be much better at actually projecting. When we talk about what is good commissioning, one of the things is that good commissioning is knowing what is coming and planning and budgeting for that. None of us knows exactly, having said that, what is round the corner and the next drug that may have fantastic benefits, and one of NICE's jobs of course is to tell us, as Health Service managers, what is cost-effective as well, so at least you know, when it has gone through a NICE process, that that process has been done. When you think of all the other treatments, for the vast majority of things we do in the Health Service we have not actually gone through that rigorous process, so I think you have got to balance up against all the other things we do, some of which are not evidence-based at all, yet you get a new drug where, if NICE approve it, then at least we know it is evidence-based and it is cost-effective, so in terms of our priorities for implementation, then clearly that would be a greater priority against something that was unproven.

Mr Farrar: Yes, in theory, it could, but I come back to the point that actually we are already having to handle these pre-NICE, so that would be one, but I think this Committee has got a really powerful opportunity around some of this because it struck me, when we had all the debate about access to kidney and renal cancer drugs in the summer, that what it exposed was not the failings of NICE or the structure, but actually that there has not been a kind of dialogue in the community about a value that we place on a product which might save three years of life for someone at the end of life over and above spending that money somewhere else in the system. I think that we are very fortunate in this country. We accept a body like NICE, we vest, as a citizen, our trust in that organisation making decisions on our behalf. In other countries, you would never get a NICE existing because people say, "Well, nobody's going to tell me whether or not I can have drugs or buy drugs", or whatever. Now, I think in our system we have got an opportunity to have a really strong discussion and it would help NICE and I think it would help us enormously to have a better debate in our communities and our society about the value that we place on products. We have got someone in the room who is one of the world's experts on trying to do this, but, in the absence of any kind of social construct around that, that becomes a technical exercise that people can criticise rather than something that we should all take some responsibility for.

Ms Edwards: Absolutely.

Dr Taylor: I am very glad you have raised that because one of my absolute hobby-horses is that we have got to have an open debate on healthcare rationing, whatever you call it, because we have got to get rid of some of the things that are not evidence-based that consume a vast amount of money, and it has got to be a wide, open public debate and it is something I think we should, as a Committee, engage with.

Q442 Chairman: Well, we have. We have mentioned that word on several occasions in our NICE inquiry. As a last question, a nice, easy one, how much have your acute and primary care trusts lost in the current financial crisis? Do you know?

Ms Edwards: None. We have talked to all of our organisations and they have all confirmed that they have no money in any of the Icelandic accounts. They are doing final checks, but basically there is none.

Mr Farrar: I have one confession which is the Christie Hospital, which made the news recently. They have £7.5 million in one of the Icelandic banks, of which £6.5 million was charitable funding, their charitable trust, but £1 million was NHS money.

Q443 Chairman: It is not likely to affect anything to do with the Darzi Review?

Mr Farrar: It would not at all, no.

Chairman: Well, could I thank both of you, and Ian in his absence, for coming along and giving evidence to us this morning.

Written evidence

Memorandum by the King's Fund (DZ 01)

NHS NEXT STAGE REVIEW

1. Introduction

1.1 This paper is a response by the King's Fund to the Health Select Committee inquiry into the NHS Next Stage review. The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help shape policy, transform services and bring about behaviour change. Our work includes research, analysis, developing leaders and improving services. We also offer a wide range of resources to help everyone working in health share knowledge, learning and ideas.

1.2 Niall Dickson, Chief Executive of the King's Fund has been invited to present oral evidence to the Health Select Committee on 10th July 2008.

2. Overview

2.1 It is always difficult to live up to a "once in a generation" billing, but in general we feel the report provides a sensible set of measures to improve quality and equity, and a clear signal that responsibility for shaping and leading health services lies with staff at local level. The report suggests that in the near future patients will be able to access a wide range of information about the quality of the services they are being offered, from infection levels to success rates following operations. It is anticipated that this will support patients to make informed choices and put pressure on those providing the care to improve. It should also be useful to commissioners and GPs who purchase services or advise patients on where to go for care.

2.2 In order to secure high quality care that is responsive to patients it is important that local organisations are given greater freedom to innovate, are subject to less central control, but are clearly accountable for quality and value for money. While services provided by the NHS are far from uniform, increasingly devolved decision-making could result in significant regional variations in the care provided to patients. This will be a challenge for the government to communicate to the public.

2.3 There are two significant omissions in the report—there are no estimates of cost and no indication of just how different the government expects the quality of health services to be in five or ten years time. Some of the answers lie in the regional plans but an overall view of how far and how fast the government expects the NHS to change would be helpful.

3. King's Fund Contributions to the Review

3.1 The King's Fund has been involved in the NHS Next Stage Review in a variety of ways:

(a) We provided an analysis of the London review and presented evidence to the London Joint Overview and Scrutiny Committee.

(b) We published a research report examining polyclinics and out-of-hospital care, drawing on international experience and the experiences of UK LIFT projects: *Under One Roof: Will polyclinics deliver integrated care?*

(c) Niall Dickson, Chief Executive, and Dr Anna Dixon, Director of Policy, participated in the work to develop the draft constitution for the NHS.

(d) We commissioned an Expert Working Party to examine the systems and incentives involved in the current NHS reforms in England, and their state of play, as a contribution to Lord Darzi's NHS Next Stage Review: *Making it Happen: Next steps in NHS reform.*

(e) We published the report of *SeeSaw*, a simulation-based project led by The King's Fund in partnership with Loop2, and commissioned by the Department of Health's Shifting Care Closer to Home policy team. Its purpose was to better understand how a shift in care from hospital to community settings could be achieved.

(f) We published two research papers examining national and local accountability:

— *Governing the NHS: Alternatives to an independent board*; and

— *Should Primary Care Trusts be Made More Accountable?*

(g) Niall Dickson, Chief Executive, chaired a cross-party Commission for the Local Government Association, also examining local accountability for health services, and a number of the recommendations from that report appear in the Review.

(h) Professor John Appleby, Chief Economist, and Dr Nick Goodwin, Senior Fellow, presented written and oral evidence to an inquiry by the All Party Parliamentary Group on Primary Care and Public Health—this was submitted to Lord Darzi's Review team. A final report from the inquiry is expected to be published on 8 July.

(i) Our work on medical professionalism, while not undertaken explicitly for the Review, has been quoted in the Review documents

4. Commentary on the Review

4.1 As this was an extensive and wide-ranging Review, comprising multiple documents and strategies, we have attempted in this evidence to outline our response to the main points of the Review that we would wish to draw to the Committee's attention. We will be undertaking a more detailed analysis in the coming months.

4.2 *The NHS draft constitution.* The constitution provides a positive statement of patients' rights and how they can exercise them, as well as what services the public can expect to receive. The constitution enshrines the right of patients to choose where and how they are treated and will help people take greater control of their own health care. For choice not to be meaningless patients will need robust information to ensure they can make informed choices. The NHS constitution also reinforces the deal between taxpayers, patients and the state. It underlines the reality that the letters NHS no longer describe a state-run business—instead the NHS is a commissioner of comprehensive health care, free at the point of delivery.

4.3 *Local accountability*. While welcoming the emphasis on local accountability in the report, we believe it is critical to ensure that devolving decisions to local organisations does not lead to devolved power without devolved accountability. There is also a need to be clear about what kind of accountability is being promised. PCTs need to take more account of local views and give a clearer account of their decision-making to the people they serve. In order to hold PCTs to account we need to build on the existing mechanisms the NHS already has in place, such as strengthening the role of Overview and Scrutiny Committees. Politicians need to be clear about what kind of accountability they are seeking to achieve when they talk about different measures to increase "local accountability" in the NHS.

4.4 *Regional SHA plans*. There have always been regional variations but the difference with this series of plans is that these differences are made are more explicit. There is an inherent tension in the government's desire to establish national guarantees and standards and the pledge to get rid of the "postcode lottery" over PCT provision of NICE approved drugs while at the same time SHA plans and devolution to PCTs mean that some regional variation is inevitable. The issue for the future will be how to balance what is acceptable variation to meet local needs and what is unacceptable variation in terms of quality of care.

4.5 *Individual health budgets*. The more we can tailor treatment the more likely it is to be responsive to individual needs but we need to look carefully at the implications of extending personalised budgets into the health service. Although direct payments are being used in social care, their effective use in health care presents more challenges,

4.5.1 Patients will need support in making informed choices about how to plan their own care, there also needs to be clarity about what exactly patients will be allowed to spend their allotted money on. Other challenges include—getting the initial payment level right and deciding who holds the budget; if it goes direct to the clinician then there is a danger the patient will not get the final say in the treatment chosen. However, if the budget is held directly by the patient it could allow the better off to enhance their allowance thereby creating a two-tier service.

4.5.2 This is a reform that is worth piloting and evaluating but it should not follow the government's usual pattern of using pilots as a prelude to national roll out—it should be carefully assessed and all the implications understood before any decisions are made about its use in the NHS.

4.6 *NICE approval process*. NICE is recognised world-wide as a real success for its cost effectiveness evaluations. Although its work is both rigorous and transparent there have been concerns that its decisions take too long. Moves to speed it up are good news for patients, however, NICE needs to be careful not to sacrifice rigor for speed. The changes to the approval process announced in the review should go some way to reducing the postcode lottery in access to NICE approved drugs, but the main area of dispute occurs when some PCTs are reluctant to fund drugs that have a licence but which are yet to be evaluated by NICE.Dealing with this source of variation is more difficult and may well require central guidance to ensure consistency across the NHS as well as the proposal that PCTs need to explain their local judgements regarding funding of drugs yet to be evaluated by NICE.

4.6.1 However, an even more important source of variation in access to care arises from differences in the clinical decisions of doctors about who to treat, when and how. Rates of the most common operation in the NHS—cataracts—can vary more than four-fold across England, for example. The Department of Health and the NHS need to put much more effort into understanding why such variations exist and what needs to be done to ensure more equitable access.

4.7 *Public health*. The call for comprehensive well-being and prevention services with local authorities suggests a welcome direction of travel in primary care towards managing health rather than simply treating illness. This will require significant changes in the way primary care is managed and organised with greater

multi-disciplinary working and tailored support for patients in a way that has not previously been seen. We welcome the Review's commitment to a new emphasis on preventive services. If we do not make significant strides on tackling unhealthy lifestyles, especially with regard to obesity, smoking, alcohol and sexual health, then we will have to spend substantially more on the NHS than would otherwise be the case—so much so that it could threaten the long-term viability of the service. We have seen many well meaning initiatives before—it remains to be seen whether the Coalition for Better Health will have the authority needed to make a difference and whether there will be a firm commitment to increase spending on public health at local level. The health service cannot solve all the nation's social problems but it can do more in the key areas identified by the Review.

4.8 *Leadership*. The commitment to secure high quality leadership of the NHS and maintain this as a priority by creating an NHS leadership council which will identify and support the top 250 leaders is a welcome one, as is assurance of continued investment in leadership development, with a particular focus on clinical leadership. There are two notes of caution here; the management task, regardless of whether it is done by clinicians or non-clinicians, still needs to be done. Management is much less attractive than leadership, running a complex service like the NHS, and doing so in a way which is responsive to patients and drives up quality in the way the report aspires to, will require effective high quality management. In the rush, rightly, to ensure clinicians are engaged and involved in leadership, caution needs to be taken to ensure the management task is not neglected and that managers are not undermined, overlooked or vilified. Equally clinicians cannot have all their time diverted to tasks which could be done as well, or better by professional managers—these too are skilled and values driven individuals whose work in the NHS should be recognised. The crucial thing is to get the right people, using the right skills, at the right time.

4.8.1 Secondly the implementation of these changes needs to ensure the balance between central and local drivers for change is realised; how the balance between national and local activity and control is secured, is as important in leadership development as it is elsewhere in this report. The creation of "Leadership for Quality Certificates" will not be seen as a universally positive step forward if the time, effort and money that will inevitably need to be invested to make it happen is seen as detracting from good progress already being made at local level.

4.8.2 There is rightly some caution about launching a further national programme. The last three attempts to secure a national approach to developing the most senior leaders has been marked by less than impressive outcomes. Securing the development of the top 250 leaders across the NHS as a central responsibility is a brave move. Confidence in the NHS to deliver high quality services for its populations is undermined if the message on identifying and developing the very best leaders is that this work remains the responsibility of the Centre. The welcome move to realising local control and autonomy over the development of services, and the move away from top down imposed targets could well be seen as a model for leadership development. Many of the SHAs have now established, or are on their way to establishing, creative and intelligent approaches to locally developing talent. The role of the Centre in leadership development needs more thought, and establishing a council who will capture and nurture what is already working well, as well as develop new approaches, is an appropriately measured response.

4.9 *Primary and Community Care Strategy*. If the vision for primary and community care is realised it would be a real step change in the nature of primary care towards managing health and providing enhanced continuity of care. However, while more prominent in this Review, such sentiments have been a regular theme in previous efforts at reform which have had limited impact. It is an essential move in the right direction but the agenda is challenging. It will require strong leadership, the support of professionals, and the right mix of incentives. That will mean appropriate governance arrangements, commissioning and pay for performance mechanisms.

4.9.1 *Choice of GP*. GPs are in a unique position being given in effect contracts for life, with little or no competition for patients and a guaranteed income stream—their strength is that they are small businesses that on the whole provide good value and are much loved by their patients. But the government is right to say it must be easier for patients who want to change their GP to do so—indeed every patient should know that it is their right to do so and that the system will make it easy for them to switch.

4.9.2 This is unlikely to lead to large numbers of patients switching GP but for some who feel uncomfortable, for whom trust has broken down or the relationship is not working the chance to move easily and still be able to access out of hours care will be of real benefit. The vast majority of excellent GPs will welcome that.

4.9.3 *Community services*.
The spotlight on community services is welcome—this is an area which has been neglected for too long and which would benefit from close examination of working practices, levels of expertise and staff deployment. Extending the same kind of evaluation and regulation to the work of health visitors, district nurses and those who attend to patients in their homes that is applied to other parts of the health service, is absolutely necessary as part of the new drive to improve quality

4.9.4 *Payment to GPs*. Moving standards of the quality of practice management out of the Quality and Outcomes Framework (QOF) and into an accreditation scheme is a sensible move. It will strengthen incentives within QOF that relate to health outcomes and disease management. It may also mean that smaller practices may need to coordinate or merge their management functions with others in order to obtain accreditation.

4.9.5 The Minimum Practice Income Guarantee (MPIG) remains an anomaly in the payment system to GP practices and the government is right to begin moves to remove it. Some practices that could be adversely affected in the short term are likely to be protected from any reduction in income as rises in practice payments accrue.

4.9.6 *Out of hours care*. Out of hours care has not been addressed in the review. This is a major omission given the poor way it has been handled in recent years. Patients should not have to wait for another "once in a generation review" to see this tackled.

4.9.7 *Polyclinics*. The government is right not to present a one size fits all model for the delivery of GP services. Polyclinics may be the right answer in some areas, they will not be right for others. That should be a matter to be decided locally on a case-by-case basis using the best clinical evidence available together with a full assessment of the costs and the impact on patient access.

4.9.8 *Integrated care organisations*. "Integrated care" should mean improved continuity of care, removing the artificial divide between health and social care services and enabling health professionals in different organisations to work together to provide more personalised and efficient care to patients. If this is what the government is aiming for then that is to be welcomed.

4.9.9 However, there is a tension between integrating care across community, primary and secondary care on the one hand whilst on the other promising patients in the draft constitution the right of greater choice not only over treatment but over providers. If "integrated care organisations" are also commissioners of care there is a potential conflict of interest which could reduce patient choice rather than increase it.

4.9.10 *Practice-based commissioning*. Current evidence shows an overall lack of progress with practice-based commissioning and lack of active GP involvement in the scheme. The evidence suggests GPs are more interested in providing services rather than commissioning them and some PCTs are less supportive of practice-based commissioning. Whilst the strategy will hold PCTs to account for the quality of their support, our research has found that PCTs themselves need more capacity to provide such a role effectively. In particular the quality of data on which to give GP commissioners real budgets is in some cases so poor this would not actually be possible. Better articulation of the practice-based commissioner's dual role as commissioner and provider is essential to manage inherent conflicts of interest. Until practice-based commissioning really gets off the ground the jury is still out on whether it can achieve all its objectives.

July 2008

Memorandum by the British Medical Association (DZ 02)

NHS NEXT STAGE REVIEW

The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors from all branches of medicine all over the UK. It has a total membership of over 139,000.

Executive Summary

- The emphasis on quality in the review reports is welcome, but proposes a number of organisational additions, new structures and other quality initiatives, which will require adequate resources.
- The BMA supports the call for greater clinical involvement at all levels in the running of the NHS and stronger clinical leadership, but has reservations about how easily this will be achieved in reality.
- We continue to have serious concerns over the procurement of new GP practices and GP-led health centres across the country, particularly in areas where there is little or no identified need for the new services.
- The government's continued efforts to stimulate the internal NHS market through the extension of patient choice and competition do not have the support of the BMA. We consider this approach to be a major barrier to effective collaboration between different parts of the NHS and the development of more integrated care pathways that will improve the patient experience and health outcomes.
- We welcome the creation of NHS Medical Education England (MEE) and call for it to be properly constituted, given real powers, a strong input from the medical profession and from doctors in training in particular.

- Workforce planning is an area that has been largely neglected in recent years. The increased emphasis and responsibility for workforce planning at a local level with PCTs and service providers must be augmented by strong and expert direction and oversight at a regional and national level. The new structures proposed to achieve this have a very challenging task ahead.
- One notable difference of opinion between the Department of Health and the BMA on the NHS constitution is our proposal that the NHS should operate under the guidance of an independent Board of Governors and Executive Management Board.
- Our concerns over the NHS Next Stage Review process are outlined in a BMA position statement submitted to the Committee as supplementary information.

Introduction

1. The final proposals of the NHS Next Stage Review have only recently been published and the BMA has yet to complete a detailed analysis of the findings. What is more, the review reports—"High quality care for all", "A high quality workforce" and "Our vision for Primary and community care"– are fairly light on detail. This written evidence will not therefore address specific recommendations rather it will focus on some of the general themes and ambitions that underpin the review and the early proposals made in the interim review report in October 2007. It will also outline some concerns over the review process as a whole.

2. Four papers supplement our response, all of which are attached separately. These are as follows:

- The BMA's position statement on the NHS Next Stage Review, June 2008;
- A letter from the BMA's General Practitioners Committee (GPC) to Lord Darzi following the announcement of the "Equitable access to primary care" procurement programme, December 2007;
- The BMA's paper *Towards a model for healthcare delivery*, June 2008; and
- The BMA's paper *An NHS constitution for England*, February 2008.

Emphasis on Quality

3. The emphasis in the final review report on driving up quality is to be welcomed. Whilst the report is mindful not to propose any wholesale reorganisations to existing NHS structures, it does however contain a significant number of organisational additions—such as the appointment of a new Medical Director in each SHA—and new structures or bodies, for example the new National Quality Board and SHA Quality Observatories. The time and effort that will necessarily go into implementing these proposals, both at a national and regional level should not be underestimated.

4. In order to be successful, we believe that any quality initiatives should be accompanied by adequate resources and the report does not make it clear whether or not this will be the case. We would be interested to receive further detail on the funding arrangements from Lord Darzi and the Department of Health.

Call for Greater Clinical Involvement and Leadership

5. We are very much in support of the call for greater clinical involvement at all levels in the day-to-day running of the NHS and stronger clinical leadership. How this ambition will be achieved in practice and whether or not the proposals set out in the report will really enable and motivate grassroots doctors to take up such positions is debatable. Certainly experience on the ground so far makes it difficult for us to believe that this aspiration will easily become a reality. A series of regional BMA meetings to discuss SHAs' vision documents arising from the regional review process highlighted considerable doubt among doctors over whether changes to local services would, in practice, be led by local clinicians, as was pledged in Lord Darzi's second interim report, *Leading local change*, published in May 2008.

Procurements in Primary Care: New GP Practices and GP-led Health Centres

6. Whilst many of the ambitions and proposals contained within the final review reports are very positive and can in principle be supported, it is difficult to separate these from early proposals made in the interim review report in October 2007 regarding the procurement of new GP practices and GP-led health centres. These early proposals continue to cause the BMA serious concern as detailed in two supplementary papers, the BMA's position statement on the NHS Next Stage Review and a letter from the BMA's General Practitioners Committee (GPC) to Lord Darzi following announcement of this procurement programme.

7. In brief, the BMA's concerns over the proposed procurements are as follows:

- imposition from the centre of a one-size-fits-all approach;
- lack of evidence to support national roll-out of the GP-led health centre (or polyclinic) model;
- little or no identified need for the new services in many areas and the subsequent waste of resources;

- the government's commitment to invest solely in "new" primary care services rather than giving PCTs the option to use the funding to improve existing services and/or infrastructure is short-sighted and will not provide value for money;
- the over-emphasis on stimulating markets and competition within the NHS through developing new practices, rather than supporting existing ones;
- central directive to use the APMS (Alternative Providers of Medical Services) contract, in a process which is geared towards the commercial sector and thus, the implied disregard for the 'traditional' independent contractor model;
- commercial organisations holding APMS contracts applying a salaried or locum staffing model often resulting in a high turnover of employed doctors, threatening continuity of care and quality of service;
- potential destabilising effects of new services on existing GP practices and hospitals; and
- insufficient funding being made available to PCTs to pay for the new services.

8. It is of course extremely important that there is enough capacity within primary care and general practice to meet the health care needs of patient populations; however, in many areas, the proposed procurements will result in significant over-capacity. Against the back-drop of finite NHS resources, we would therefore question whether the costs associated with procuring and running new services in areas where there is little or no identified need, can really be justified.

As an aside, the commitment made in the final review report that patients would have a right to receive NICE-approved drugs and treatments regardless of where they lived will add to the financial strain put on PCTs as a result of the new procurements.

Extension of Patient Choice, Competition and the Internal Market

9. The final review report puts great and repeated emphasis on the importance of extending patient choice, underpinned by the assumption that as a result of such an approach, providers will compete against one another in order to attract patients, thus driving up quality and driving down costs. The government's continued efforts to stimulate the internal market do not have the support of the BMA as we consider such an approach to be a major barrier to effective collaboration between different parts of the NHS and the development of more integrated care pathways that will improve the patient experience and health outcomes.

10. The BMA's paper *Towards a model for healthcare delivery* explores these issues in more detail and offers an alternative to the market model currently favoured by the government.

Workforce Planning, Education and Training

11. We are pleased to see considerable attention being given to this important area and welcome in particular the creation of NHS Medical Education England (MEE). We do have some reservations over MEE's ultimate efficacy and authority and call for it to be properly constituted, given real powers, a strong input from the medical profession and from doctors in training in particular.

12. Workforce planning is an area that the BMA considers to have been largely neglected in recent years. Whilst we hope that the proposed establishment of a national Centre of Excellence and regional MEEs to oversee workforce planning conducted at PCT and service provider level will prove an effective model, this is an area of uncertainty. Putting increased emphasis and responsibility for workforce planning at a local level runs the risk of a predominantly short-term view being taken of the service's workforce needs, based on the relatively short commissioning and strategic planning cycles of PCTs and local authorities. Whether or not the new national and regional structures being proposed can provide the strong and expert direction and oversight required to make such an approach successful is yet to be seen.

NHS Constitution

13. As part of its Caring for the NHS campaign the BMA developed proposals around an NHS constitution earlier in the year. We welcome the government's intention to consult widely on and introduce an NHS constitution; the BMA will feed into this consultation in due course.

14. One notable difference of opinion between the Department of Health and the BMA is our proposal that ". . . the NHS would operate under the guidance of a Board of Governors and Executive Management Board responsible for the stewardship of the NHS in England and delivering the service within the strategic framework developed by the Secretary of State and approved by Parliament."

THE NHS NEXT STAGE REVIEW PROCESS

The BMA's views and concerns over the review process are set out in a position statement for the Committee's consideration.[1]

July 2008

Memorandum by the Royal Pharmaceutical Society of Great Britain (DZ 03)

NHS NEXT STAGE REVIEW FINAL REPORT

The Royal Pharmaceutical Society of Great Britain (RPSGB) is the professional and regulatory body for pharmacists in England, Scotland and Wales.

It also regulates pharmacy technicians on a voluntary basis, which is expected to become statutory under anticipated legislation. The primary objectives of the Society are to lead, regulate, develop and represent the profession of pharmacy.

The RPSGB was created in 1841 and is due to undergo a demerger in 2010, when a new regulator—the General Pharmaceutical Council will be created.

A new professional leadership body is expected to be created at the same time to represent the views of all aspects of pharmacy.

The RPSGB has requested to give evidence to the House of Commons Health Select Committee with regard to the recent publication of the next Stage Review Report by Lord Ara Darzi.

NEXT STAGE REVIEW

Listed below are the issues in the Report on which the RPSGB is most able to contribute:

Commissioning

Prior to the publication of Lord Darzi's review we raised concerns that Practice Based Commissioning needed more robust accountability arrangements as a part of World Class Commissioning. We were particularly concerned that many practice-based commissioning (PBC) groups have not engaged with pharmacy and echoed the Audit Commission's concerns about the quality of the financial infrastructure underpinning these groups.

We have been disappointed by Primary Care Trusts' (PCT's) lack of engagement with pharmacy to deliver improved patient care through pharmacy. The government have repeatedly said that they want to make better use of community pharmacy. However, this has not translated into action at the local level. The All Party Pharmacy Group Inquiry Report *The Future of Pharmacy* described the patchy and inconsistent take-up of Enhanced services under the community pharmacy contract as resulting in "postcode" pharmacy.

The Government's Next Stage Review, led by Lord Darzi, has given assurances that there will be incentives for a broader range of clinicians to get involved. Assurances have also been given that PCTs will be held to account for the quality of support given to PBC. However, there is no guidance about which clinicians should be involved and no assurance that pharmacists should be amongst them. We are not yet convinced that PBC groups or the PCTs that are to provide support are smart enough in their approach to ensure that World Class Commissioning lives up to its promise. Being smart includes using all the tools available to them, amongst which pharmacy is key.

We have reviewed the SHA Vision statements that form the outputs of the nine SHAs clinical pathway groups. We compared the outputs of each of the clinical pathway groups from the SHAs and looked to see where the SHA had identified a potential role for pharmacy. What we found were remarkable inconsistencies between SHAs. For example, in the "staying healthy" clinical pathway only East Midlands, South Central and West Midlands identified the importance of pharmacy. However, the Next Stage Review said that vascular health checks would be rolled out through GPs, Pharmacies and community clinics and went on to say "In particular, we believe that pharmacies have a key role to play as providers of prevention services."

This inconsistency between national policy and local implementation is of great concern to us.

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[1] http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFDarzipositionstatement/$FILE/BMApositionstatementNHSNextStageReview.pdf

"Polyclinics"

The Primary and Community Care Strategy restates the government's commitment to use community settings to deliver selected services traditionally provided in hospitals, without prescribing a particular organisational model. We support the development of community-based services and believe that this offers advantages to patients.

We have been concerned that much of the thinking around these moves has been associated with providing care in large health centres or "polyclinics". The Kings Fund report *Under one Roof* highlighted that simply bringing together a large number of healthcare professionals under the same roof does not necessarily lead to better collaboration. The co-location of a large number of healthcare professionals could bring some advantages if the issue of ensuring true collaboration is addressed. The Society's experience of existing Health Centres that have a pharmacy incorporated into them is that they can lead to better integration of the pharmacist into the primary healthcare team but equally it can leave the pharmacist as isolated as if they were several miles away from the Health Centre.

Our main concerns about co-location in large health centres (polyclinics) is the knock on effect on the rest of primary care. Some patients and carers will inevitably have further to travel to access their GP if large polyclinics are established. This may make them more reluctant to travel to see a GP. The centralisation of services into one area will also distort the pattern of dispensing, particularly if the polyclinic has an on-site pharmacy, which is where patients will tend to get their prescriptions dispensed. The majority of pharmacies are dependent on prescriptions for about 80% of their turnover. The effect of a new pharmacy in a polyclinic taking a large proportion of the prescription volume could make some pharmacies unviable. This, in turn, would further reduce access to healthcare advice and medicines from patients and carers located at a distance from the polyclinic.

We have called for impact assessments on the creation of polyclinics to include social, economic and healthcare factors. The full impact of aggregating services into one building must be assessed before decisions are taken that could impact on the poorest and most deprived communities.

The federated model suggested by the Royal College of General Practitioners has much to recommend it as a model. Our major concern is that PCTs will take the "easier" approach of simply building a new building without adequately considering the more managerially complex solution of encouraging a federated model.

Emphasis on helping people stay well

It is right that the NHS emphasises helping people stay well. Pharmacy has a central role to play in helping the NHS meet this challenge.

Community pharmacies are one of the most accessible parts of the NHS family. In England, 99% of the population lives within 20 minutes of a pharmacy which puts pharmacy in a unique position to offer access, advice and prevention. Community pharmacists are expert health professionals available to see without appointment and can provide guidance and advice on a variety of conditions and public health issues. Pharmacists have significant healthcare knowledge and will refer patients to their GP when necessary. Importantly, they see patients who are ill and people who are well. This gives them the ability to access a cohort of people who never or rarely see their GP.

Vascular risk assessments are within the pharmacists' skill set and we agree with the Government that these should be rolled out through pharmacies. Pharmacists have provided stop smoking services successfully for a number of years and a number of pharmacies have also successfully provided obesity management services. The major limiting factor to these services has been the inconsistency of local commissioning. We had a number of reports of PCTs commissioning stop smoking services only to remove funding for them once the PCT target had been reached or when funding became tight. This makes it difficult for the pharmacy to provide a consistent service and impossible for the pharmacist to plan his business.

The Primary and Community Care Strategy reiterates the commitment in the *Pharmacy in England* White Paper to the growing role of community pharmacies in offering treatment for minor ailments. We believe that the development of this type of national service could significantly free up GP time. Research suggests that 51.4 million GP consultations a year are for minor ailments alone that could be handled by a pharmacist. This represents 18% of all GP consultations and could release significant amounts of GP time to deal with more complex care. If there were a shift to self care and self medication, people could be helped to embrace individual autonomy and be encouraged to take more responsibility for their own health.

We welcome the commitment in the White paper to public communication initiatives and we see the opportunity for more effective and efficient management of minor ailments through pharmacies as an important part of such communication.

NICE Appraisal Process

We welcome the speeding up of the NICE process for the approval of new medicines. NICE was established to end the postcode lottery of access to medicines. It has done much to achieve this but the process of approval has sometimes taken up to three years which is far too long. This has led to a variety of interim decisions being made by PCTs including refusing to fund a medicine while NICE is developing its recommendations, through to a limited use of the medicine. This puts unreasonable pressure on the PCT staff (often pharmacists) who have to make these difficult decisions and creates unreasonable delays to patients being treated with new medicines. It has sometimes led to patients funding their own treatment when a PCT has refused to fund a medicine while NICE is making a decision.

The role of NICE is to give the NHS certainty based on an examination of the evidence base. This is a role that is best undertaken centrally rather than in each PCT. NICE should attempt to do this at as early a stage in the life of a medicine as possible so that patients are not denied important innovations.

Data Access and Capture

In order for the vision in the Next Stage Review and the *Pharmacy in England* White Paper to be realised, there has to be a commitment to improved data access for pharmacists. Once they have access to the summary care record (which is already available to nurses) they will be able to work more collaboratively with GPs. Services such as vascular risk assessments, long term condition monitoring and medicine use reviews delivered through pharmacy will then be integrated with the rest of primary care without the disconnect that currently exists.

As part of this, the data recorded by pharmacists in both their public health and their monitoring roles will be available to GPs and will provide vital information for forward planning in the development and delivery of services at the PCT level.

The RPSGB is working with Connecting for Health to ensure that the issues thrown up during a large-scale IT project of this nature are resolved efficiently and an effective system is introduced.

Overall, the Next Stage Review offers real improvements for patients and the public, utilising the most under-used resource in primary healthcare—pharmacy. By using pharmacy-led services more effectively, the number of GP appointments can be reduced by 51.4 million per year, giving GPs more time to see those cases that require their attention.

As with the introduction of any new initiatives in healthcare, the devil will be in the detail and the ability of all healthcare professions to work together will be paramount to the final outcome.

July 2008

Memorandum by the Academy of Medical Royal Colleges (DZ 04)

NHS NEXT STAGE REVIEW

This brief submission outlines key aspects of the Academy's work that are pertinent to Lord Darzi's Review.

NHS Next Stage Review

1. Lord Darzi has identified a way forward for a 21st century NHS which is clinically driven, patient centred and responsive to local communities. The purposes of the Academy and its members are wholly in keeping with the aspirations of the review and the values that are the core of Lord Darzi's proposals. He is concerned to enable the NHS to deliver high quality care in every way to every citizen. So too are the Academy and the Medical Royal Colleges

2. We share the vision to make an NHS that, through sustained improvement, is exemplary in quality, is fair, patient-centred and personalised, effective and safe, and uses the resources available as efficiently as possible.

3. The means of making progress are not merely issues for organisations; they concern everyone who has a part in our system of healthcare. Drawing on our collegiate strengths, and in the closest possible partnership with other bodies with like interests, the Academy will play a full part towards achieving this vision.

4. Although detail of implementation has yet to be worked through, essential elements for achieving the sustained improvement in quality that lies at the heart of Lord Darzi's proposals are in place and functioning. Examples are shown in the work of the Academy (outlined in the Annex) and, much more comprehensively, in the work of the Colleges in their specialist domains.

The Academy

5. From its origins as the Conference of Colleges and subsequent evolution the Academy has provided a forum for discussion and collaboration, and a path for communication between the constituent bodies and between them and Government. Further development has enabled it to assist the common aims of the Medical Royal Colleges and Faculties and of the Health Departments by undertaking a wide range of work to maintain and advance standards of education, training and practice and health service delivery. Thus the Academy interlinks with the Colleges and its work is conjoined with theirs.

6. This work comprises many aspects of education and training, work on revalidation, a focus on quality improvement alongside greater effectiveness, close patient engagement, a strong new emphasis on clinical leadership and participation in management—including financial management, strengthening of current modes of team working—particularly multidisciplinary team working, and continued attention to matters both of acute care and of long term care and the shift to delivering as much care as is appropriate in the community outside hospital.

7. The Academy undertakes specific work at the request of the Department of Health and works in partnership with statutory bodies, government agencies and with voluntary bodies. It makes collective responses to Government and Departmental statements and consultations.

8. An emerging role of the Academy is to facilitate and contribute to processes that are common to all the Colleges. The Academy offers means of focusing relations between the Colleges and bodies that have wide national remits, among them professional and other educational bodies, regulatory bodies, government and NHS organisations.

9. Familiar examples are the collective approach to issues arising out of reform of professional regulation, the policy to modernise medical careers and the manner of implementation, the findings and recommendations of the Tooke Inquiry, and now to issues arising out of Lord Darzi's Review.

The Colleges

10. Education and training, career-long development, founded on the best evidence, are the basis of quality of care, quality that is assured by the processes of appraisal (and in future by revalidation) clinical audit and service accreditation. These activities are at the heart of the Colleges' work. They demonstrate unwavering commitment to care that is clinically effective, personal and safe—the exercise of a modern medical professionalism.

11. Through their membership the influence of the Colleges and associated specialist societies permeates the NHS. This influence embodies the discipline of a modern medical professionalism. It will reinforce Lord Darzi's vision, giving it a secure foothold.

Clinician Engagement, Clinical Leadership

12. A major underlying weakness of the NHS, now widely acknowledged and being addressed, has to do with the need to engage clinicians more fully in management and leadership roles within the NHS, and to bridge gaps in thinking and behaviour between clinicians and management, and with government.

13. We welcome the clearest possible commitment to strengthen the involvement of clinicians in decision making at every level of the NHS. As the review has shown, change is most likely to be effective if it is led by clinicians and based on evidence.

14. Lord Darzi affirms repeatedly that quality improvement requires leadership—leadership at all levels and across all disciplines. Leadership is about seeing what is needed and making it happen, recognising new opportunities and realising them; knowing that improvement demands change—change that at first will often be resisted. Clinical leadership is also about opposing changes that are judged harmful, but coupled with soundly argued alternatives.

15. Not only is clinical leadership vital at the point of delivery of clinical care, but also at every other level of organisation, whether of service commissioning, education and training, research or shaping of policy and implementation. It brings a commitment to continuous improvement—not only of clinical practice but also of the service at each level where improvement is necessary.

16. As Lord Darzi says, if clinicians are to be held to account for the quality outcomes of the care that they deliver then they can reasonably expect that they will have the powers to affect those outcomes—empowered to set the direction for the services they deliver and to make decisions on resources. There must be freedom for leadership to flourish.

Education and Training

17. The Academy is clear that excellence in postgraduate medical education and training should be at the very heart of the NHS. The review offers a clear vision for the future of education and training of the whole workforce and offers a strong foundation for rebuilding trust between the profession and government.

18. We are glad that the new body Medical Education England is to be set up. It will give the profession the strong voice and scrutiny function that are essential to safeguard this key element of high quality care, with a clear focus on improving the quality of NHS education and training. The Academy, as a UK body, is conscious that there is a UK dimension to many of the training issues MEE have been asked to address and a mechanism needs to be put in place to deal with that.

Performance

19. A disappointing feature of the NHS has been its comparative failure or tardiness to close gaps in performance—differences in health and well-being across the population and differences between the quality of healthcare that is possible with current knowledge and resources and what is actually achieved.

20. Improvements depend on shared motivation and coordinated efforts at every level, from national formulation of policy to local institutional and service function. Yet we know that despite high achievement by some, there are wide differences in performance, both within the NHS and in comparison with countries at similar stages of health service development.

21. Professional bodies, notably collegiate bodies and specialist societies, have led in measuring comparative performance against standards that are relevant to patients in important parts of health care. We support the development of comprehensive sets of clinical performance measures and commend the work undertaken by Colleges and specialist societies to identify clinically relevant metrics in their fields.

Conclusion

22. The aims of Lord Darzi's review are simple and plainly put. We share the high aspiration and promise contained in the review; and will play a full part to ensure they are sustained throughout implementation.

Professor Dame Carol Black
Chairman

July 2008

Annex

Work of the Academy of Medical Royal Colleges that is pertinent to Lord Darzi's NHS Next Stages Review

Work enabled and supported by the Academy is undertaken in partnerships between the Colleges, often with other national agencies, including the Department of Health and statutory agencies, and patient and lay groups. The wide scope of this work reflects the drive for quality that is at the heart of Lord Darzi's review.

Improving Quality in Health and Healthcare

Ensure that the medical workforce has appropriate skills and competences required in an evolving NHS by enabling, promoting and supporting:

- excellence in education and training and lifelong learning;
- excellence in practice;
- revalidation and recertification;
- working in partnership, with patients, people in other disciplines and managers, and across outdated boundaries; and
- clinical leadership at each organisational level, with new responsibilities and new accountabilities.

Recent, Current and Projected Work

The Department of Health asked the Academy to coordinate and oversee allocations to the Colleges for continuing development of methods and processes for the recertification of medical practitioners.

The Academy is working with the NHS Institute on the development of a competency framework for medical leadership. This framework is now complete and implementation is the next step.

The Academy and the Institute have set up a jointly chaired steering group to explore the establishment of a Faculty for Patient Safety and Quality Improvement. A recent stakeholder meeting has shown considerable enthusiasm for such a Faculty.

The Academy is working with the Audit Commission to develop guidance for hospital doctors on NHS financial management.

The Academy was part of a consortium, with the Long Term Conditions Alliance and the Royal College of Nursing that successfully tendered for the National Clinical Audit for Patient Outcomes Programme from the Department of Health.

The Academy's Specialty Training Committee held a Forum on Modular Specialty Training following the publication of the Department of Health's response to the Tooke Report.

The report *Acute Healthcare Services*, prepared for the Department of Health, provides guidance on reconfiguration of acute services which is of benefit to Colleges in the maintenance of standards and to the public in assuring that guidance is available to inform local reconfiguration decisions.

The Academy is working with E-Learning for Health to develop e-learning for the trainee Foundation Programme. Includes modules for multi-disciplinary teams, and on self-care competencies. Generic e-learning modules are also being developed for use within academic training curricula for doctors in all specialties.

Work on the future medical workforce, involving all Colleges and Faculties, is designed to inform workforce planning.

The Intercollegiate Cancer Committee has prepared a report on educational initiatives to improve the effectiveness of cancer multidisciplinary teams. A wide range of stakeholders, including non-medical health professionals, participated in this work.

Setting core competencies for health inequalities. For incorporation into curricula for all specialty training programmes, subject to PMETB approval.

No Health Without Mental Health: A review of the mental health content of the training curricula and CPD requirements for all specialties.

Managing Urgent Mental Health Needs in the Acute Trust: A guide for practitioners, for managers and commissioners.

A project on training for Medical Examiners.

A project to strengthen College communications.

Proposed work under consideration.

A project: Discovering Best Practice with Care Closer to Home (to be led by the Royal College of Physicians, London).

A project: Good Practice for Patients in Team Working (to be led by the Academy Patient/Lay Group).

A project: Safe Practice in Medicine (to be led by the Royal College of Surgeons of Edinburgh).

6 July 2008

Memorandum by the NHS Confederation (DZ 05)

NHS NEXT STAGE REVIEW

The NHS Confederation represents more than 95% of the organisations that make up the NHS. We are the independent membership body for the full range of organisations that make up today's NHS across the UK. Our members include Primary Care Trusts, NHS Trusts, NHS Foundation Trusts and independent providers of NHS services.

The NHS Confederation welcomes the opportunity to give evidence to the Health Select Committee on the NHS Next Stage Review.

Introduction

The final version of the Next Stage Review mostly consisted of what the service was asking for. We welcome the main aims of changing how patients relate to the system and using measurement, standards and the motivation of professionals to drive change.

The NSR comes after a long process of deeply interconnected reforms. Without a willingness to unravel what has gone before any review will be heavily dependent on the path originally chosen earlier in the decade. A review that takes account of the accumulated history of reform requires a careful approach that

refines what has worked, recognises what is wrong and is honest about what needs to change. For this reason the review has met our expectation of being consistent with the current direction of reform. The review makes no proposals for major reorganisational restructuring. This is welcome.

Implementation

We believe that implementation will be the most difficult part. The review is very dependent on high quality local leadership taking responsibility for making change happen. To enable this to happen requires a change in the style of leadership from the Department of Health's performance management system: this has been promised and it will be important that it is delivered.

SHAs have acquired a number of additional tasks and an expanded role in the system. They will have medical directors, clinical advisory groups and responsibility for innovation prizes, clinical leadership fellowships, leadership development, workforce planning and a number of other potential levers of influence on providers. This creates the challenge of being a performance manager, system manager and a facilitator of improvement. These roles are difficult to combine and there is a danger if these new levers create doubt about the ability of providers to be in control of their own destiny.

Quality

The collection and publication of quality and outcome data will undoubtedly be a major driver for improvement. This differs from previous approaches because the definition of quality and its measurement is intended to be clinically led and rather than being done for an external performance manager, it is for the clinicians themselves and their organisations. Providing patients with a complete description of what they should expect in the Constitution, NHS choices and the various prospectuses that are proposed could also be a significant driver of change.

The development of appropriate measures is being undertaken very rapidly. This is a very major task with some significant methodological challenges. It will be important that clinicians are fully engaged in the process of developing these metrics.

If quality is to be driven through patient choice, publication and benchmarking it will be important that the role of the Care Quality Commission does not expand to create any duplication or overlaps in responsibility for quality.

The proposed role for NICE in the development of standards and the provision of evidence is welcome and will assist the service in ensuring that the most appropriate standards are used in the design of services.

High Cost Drugs

The public are clearly very concerned about post code variation in the provision of high cost drugs. The speeding up of NICE appraisal processes will help to reduce the differences that occur between PCTs whilst they are waiting for a NICE determination. The policy of mandating the funding of NICE approved drugs was already in place, although putting it in to the Constitution may help to raise public awareness. Our concern with this policy is that it fails to take account of the fact that NICE tends to examine drugs that are high cost. NICE approve drugs on the basis of their cost effectiveness compared to other drugs in the same area. This can mean that drugs approved by NICE are very much less cost effective than treatments already in use that have not been examined by NICE. Withdrawing funding from these more cost effective areas is not a good use of resources.

Primary Care

We support the recommendations in the review about the direction of reform in primary care. Whilst primary care is generally good there is a need to improve its responsiveness and accessibility and to deal with the quality of the poorest services. The debate on polyclinics has been confusing. The key objective must be to create primary care services that meet the needs of local population which are well organised and have more access to diagnostics and specialist support. Some of this may be achieved by a commercial procurement, more often it will be by expanding existing services.

The review promises to refresh practice based commissioning. In general policy development in this area has not been very successful and the Confederation will be feeding through ideas on making the most of this policy and adapting it to local needs.

Workforce

The Committee has previously commented on the long term problems of poor workforce planning in the NHS. The NHS Confederation had hoped that the changes to the workforce planning and education commissioning system published in the NSR would establish a system in which local employers had a more central role in identifying future workforce requirements. This would mean creating a system based upon employers working with other key stakeholders such as commissioners and the clinical professionals, building from the bottom up. We were disappointed to find that this is not what is proposed and that the new system lacks sufficient clarity of roles and how employers fit into the system.

We do support the proposals set out in respect of "tomorrow's clinicians"'.

Joining up Policy

Both inequalities and social care are the subject of parallel exercises. It will be important that the development of metrics will include these areas too. There is little mention of the role of the independent and third sectors. The Confederation wants to see true devolution to strong local autonomous organisations with commissioners and providers drawn from all sectors working effectively at a local level. Therefore we hope that the lack of mention can be interpreted as meaning they are now seen as an integral part of the provider system and the debate has moved on.

Conclusion

Our general conclusion is that the review does contain a large number of proposals that will provide the NHS with the tools to drive improvement. Because Lord Darzi has rightly avoided large big-bang changes in favour of more carefully thought through quality improvement there is a danger that policy makers will become inpatient. It is now important that the NHS is left to implement these reforms and others still in train and is not subjected to further initiatives and reorganisations.

July 2008

Memorandum by the Royal College of Surgeons of England (DZ 06)

The Royal College of Surgeons welcomes the House of Commons Health Select Committee's inquiry into the NHS Next Stage Review and is pleased to have this opportunity to contribute.

An important aspect of the review by Lord Darzi is the particular emphasis on the quality of the service from both a patient and clinical perspective. We are pleased that there is a commitment to putting the clinical voice at every level of the service and hope to see this vision translated by the Department of Health and Strategic Health Authorities into meaningful clinical engagement and change based on the best clinical evidence.

We would like to recommend that the Committee consider the following points when conducting its inquiry:

— The College is leading on publishing outcomes from surgery that should be used by surgeons, patients and hospitals to ultimately improve safety and quality. We believe the publication of the results of surgery is important both for patients making meaningful choices about their treatments and for surgeons wishing to compare themselves with their peers. The recent publication on NHS Choices of mortality rates for four procedures is a positive move but should be seen in the context of the limited value of mortality rates, for the majority of procedures, for both patients and surgeons, as mortality rates are very low (for example in hip replacement the mortality rate is less than one patient in 2,000). Ultimately we believe the publication of outcomes as a combination of patient reported outcomes measures, routinely collected administrative data and the results of clinical audits will lead to improving the quality and standards across surgery. For example in the near future we believe it should be possible to build on the publication of mortality rates for hip replacements to include how pain and mobility of the patient had changed following the procedure as well as the performance in clinical audits of the unit which compare the care given against best practice. This shows how data might evolve to become more meaningful to both the patient and the surgeon.

— The need for national planning on areas of clinical importance where provision of services cuts across SHA boundaries, such as the provision of countrywide trauma care. The College has called for a national trauma plan that would identify 12–16 very large specialist centres across England with all major specialties located on site. This network should be linked with local referring hospitals, which will manage less severe injuries.

— The establishment of Medical Education England (MEE) is a positive move for medical education following on from the recommendations of the Tooke Report into Modernising Medical Careers. The implementation of MEE and the involvement of the medical community and its specialities

nationally and regionally will be essential. The College welcomes the acknowledgement of the validity of apprenticeship and mentoring models in clinical education for practicing surgeons and believes that this should be extended to trainees.

We enclose as supplementary information a detailed response that we prepared for our membership in response to the publication of the review. Should the Committee wish any clarification or expansion of our views we would be happy to respond to any written queries and also to provide oral evidence to the Committee. I am copying this letter and attachment to my successor John Black who will succeed me as President of The Royal College of Surgeons of England on the 10 July 2008.

Mr Bernard Ribeiro CBE PRCS

July 2008

Annex

NHS NEXT STAGE REVIEW

RESPONSE FROM THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

Summary

The Royal College of Surgeons welcomes the publication of the next steps review by Lord Darzi. The College is pleased that the report incorporates many of the policy suggestions we submitted to the review including the importance of outcome measures which builds on the work the College is leading on publishing outcomes from surgery that should be used by surgeons, patients and hospitals to ultimately improve safety and quality. We also welcome the establishment of an independent body for medical education which can take forward the recommendations in the Tooke Report into Modernising Medical Careers.

Background

It is widely acknowledged that the health needs of the population are very different to those when the National Health Service was founded in 1948. In surgery the basis for the service has moved from broadly trained surgeons treating a wide range of conditions to one in which modern technology has made it necessary for surgeons to specialise; treating complex and rarer conditions but still requiring generalist skills to deal with ever increasing numbers of emergencies in a population living much longer. During this period the rise in the incidence of long term conditions, such as dementia, arthritis and conditions influenced by lifestyle (eg heart disease and obesity) has become a major drain on health service resources.

Measuring outcomes

The College is leading the publication of outcome data and together with the Society of Cardiothoracic Surgeons has pioneered the use of both surgeon and patient reported outcome measures. We believe the publication of the results of surgery is important both for patients making meaningful choices about their treatments and for surgeons wishing to compare themselves with their peers. Outcome measures should also have a role in the commissioning of surgical services by Trusts. For example the College has just embarked on a major project studying patient reported outcomes for five common operations in every independent sector treatment centre and a sample of NHS hospitals in the country. More than 500,000 patients a year will be covered by this study and, with the first data starting to come in, early results will be published at the end of this year. Patients and surgeons will start to demand more sophisticated information as the initial data is published over the coming years.

The publication on NHS Choices of mortality rates for elective and emergency abdominal aortic aneurysm (AAA) repair, total hip replacement and total knee replacement is welcomed as a first step. However, mortality rates have a limited value for both patient and surgeon as, for the majority of procedures, mortality rates are very low (for example in hip replacement the mortality rate is less than one patient in 2,000). Surgeons are rising to the challenge of assessing and gathering the right information which will allow meaningful conclusions to be drawn by both patients and professionals. Many surgeons also routinely assess their practice against the best internationally so they can innovate and improve their own practice. Ultimately we believe the publication of outcomes as a combination of patient reported outcomes measures, routinely collected administrative data and the results of clinical audits will lead to improving the quality and standards across surgery.

Trauma Care

Trauma is severe physical injury caused by events such as road traffic accidents, explosions or crush injuries that require specialist care from a multidisciplinary group of professionals. It affects disproportionately the young and is a leading cause of death for the under 40s. High quality trauma care can prevent death and long-term disability as part of an emergency service that provides the best and most appropriate care for critically injured patients. Based on evidence, such as in the United States where positive outcomes for major trauma patients have been shown when patients are taken to a hospital that has the appropriate specialist resources, the College has long pressed for a national trauma system of care. The College has called for a national plan that would identify 12–16 very large specialist centres across England with all major specialties located on site, linked into local managed clinical networks of referring hospitals within the region to manage the less severely injured.

We are pleased that our proposal for the networked model that incorporates national and regional needs has been supported by many Strategic Health Authorities in their recently published local aspirations. We look forward to working with government and colleagues in emergency medicine and other medical specialities to develop standards to build a national trauma network for the National Health Service. This is an area where individual local solutions will not work in the best interests of patients.

Children's surgery

Increased specialisation in major regional centres and falling numbers of general surgeons with an interest in paediatric surgery makes the local delivery of routine children's surgery difficult. The College through its Children's Surgical Forum, which includes representatives from the specialist surgical associations, other medical royal colleges, the College's patient liaison group and the Department of Health, has set out solutions to this approaching crisis. It is encouraging that the development of networks of local and specialised hospitals proposed by the Forum is included in some of the Strategic Health Authority reports such as the East of England. We hope for further discussions on how a national approach to children's surgery will improve quality and safety, make training more appropriate, and ensure care can continue to be delivered locally whenever possible.

Medical education

The College fully supports the Tooke Report into Modernising Medical Careers and is pleased the recommendations not addressed by the Secretary of State for Health's response in March 2008 have been taken on board by the review. We welcome the commitment of the review to establish an independent body chaired by an independent doctor to oversee and scrutinise postgraduate medical education (NHS Medical Education England (MEE)), which should provide a single focus for taking forward all the recommendations of the Tooke Report. We are also pleased that the curriculum based training developed through the Intercollegiate Surgical Curriculum Programme will continue and that change to the structure of training will not happen overnight allowing time for detailed discussion. We look forward to our involvement in the establishment of MEE to ensure central issues of quality assurance and planning happen nationally with effective local translation.

Memorandum by the Better Local Healthcare Campaign, Haringey (DZ 07)

NEXT STAGE REVIEW

Executive Summary

1. The Better Local Healthcare Campaign consists of local people from the London Borough of Haringey who are interested in and committed to NHS managed and run high quality healthcare.

2. Our prime concern is that the Department of Health and local Primary Care Trusts, including Haringey tPCT, are proceeding with action to centralise GP services into GP-led health centres, or polyclinics, without having carried out proper impact assessments on the implications for patients and the public and for primary care services. Centralising GP practices will make it much harder for people who are unwell to access their GP services easily. The effects will be especially acute for people on low incomes without their own transport, and for those with mobility problems.

3. In Haringey, (a borough with poor transport links) the tPCT is proceeding with plans to move many GP surgeries into polyclinics, which would result in the concentration of community health care on just fifteen sites, following closure of 47 out of a total of 62 GP practices. These plans have not been predicated on proper impact assessments or on meaningful consultation with local people.

4. Before further action is taken to centralise GP services into health centres or polyclinics, a full and detailed impact and risk assessment should be carried out by the Department of Health of the implications for health service users and the public, particularly for people in potentially vulnerable circumstances. This should be followed by meaningful public consultation, in which the advantages and disadvantages of different options are made clear and the results published, so that decisions are taken on the basis of a rigorous evidence base and proper engagement with the public.

5. We recommend that the Committee asks the Department of Health to provide information on the nature and content of the evidence base that has been used as a basis for the proposals for GP-led health centres, and what risk assessments have been carried out—especially in relation to the potential risks of these plans for people with mobility problems, those on low incomes, and others in vulnerable situations.

Introduction

6. The Better Local Healthcare Campaign comprises residents from Haringey who are interested in and committed to NHS managed and run high quality healthcare. The group's aims are to oppose the privatisation of the health service, to preserve healthcare free at the point of delivery regardless of ability to pay, to support the core principles of the NHS and to defend the healthcare rights of vulnerable groups within the borough.

7. The proposals for over 150 GP-led health centres, or polyclinics, put forward in Lord Darzi's interim report and latest report are predicated upon healthcare taking place in homes, polyclinics, local hospitals, major acute hospitals, planned care elective centres, and specialist hospitals. We note that the proposed reconfiguration is substantial and will disturb the existing infrastructure. Also, once such changes have been made in the way that healthcare services are provided, it will be incredibly difficult to turn the clock back and undo them.

8. A rigorous assessment needs to be made and properly debated with all interested parties before changes are made that may risk the lives, health and well-being of patients and the public. We recommend that:

— Such a substantial reconfiguration of healthcare services requires a thorough impact assessment.

— Patients and the public should be able to examine the results of this assessment.

— At a local level they should be able to participate in an assessment of the implications for present and future services users and for all aspects of existing healthcare and social care services.

— Informed participation should take place before decisions are taken and changes are made.

9. We observe that supporting evidence presented so far has been patchy and unconvincing. Consultations have been conducted in an amateurish and half-hearted fashion. For example, there has been no meaningful consultation or engagement with patients and the public on the implications of centralising GP services into health centres or polyclinics. Of course people will answer in the affirmative if they are asked whether GP surgeries should be open for longer hours. However, their reactions may be different if they are told that the price for this will be moving GP services further from people's homes with consequent barriers to access for many people, especially those on low incomes and/or with mobility problems.

Implications and Risks

10. The interim and final reports by Lord Darzi stated that the Department of Health would invest additional resources to enable local NHS services to develop over 150 GP-led health services to supplement existing services. However, the reality is that these centres will replace existing GP services, resulting in centralisation rather than supplementation.

11. The evidence for this is already to be seen in the London Borough of Haringey where the strategy would concentrate community health care on just fifteen sites, following closure of 47 out of a total of 62 GP practices.

12. If these centres did represent additional or supplementary services, they could well be a welcome development as residents have been experiencing reduced access to healthcare services such as physiotherapy and podiatry, but centralising GP surgeries will reduce access. It is those who are disabled and face difficulties with mobility that will have the greatest difficulty, exacerbating healthcare inequalities already very bad in Haringey. This contradicts Department of Health policy of bringing services closer to home.

13. There is a substantial risk that people most in need of primary healthcare will be denied access if these services are centralised in polyclinics. Patients with a long-term condition (LTC) account for 80% of all GP consultations, and more than 70% of those over 75 have one or more LTC compared with 20% of the 16–44 year-old age group. The numbers suffering from LTC are expected to rise in the next 10 years, according to the technical paper that has been published alongside the consultation document. The fastest-growing sections of the population are the 40–64 age group and the over-85s, who commonly have higher health needs than younger age groups.

14. Travelling to and from polyclinics will present considerable difficulties to people who are unwell, who may have mobility problems, and who may not have access to private transport or feel well enough to drive. The journeys may involve changes of buses and/or tubes. It is a glaringly obvious point but it seems necessary

to emphasise that, when people need primary care services, it is generally because they feel ill or unwell. In these circumstances, we should be looking at proposals that seek to minimise travelling distances to GP services.

15. The risks involved with the wider and potentially serious implications of these proposals have not been sufficiently explored or explained. For instance, are A& E centres going to close? What are the implications for patient safety? Will people be transported across London depending on which of these services they need if their condition changes or deteriorates, with consequent risks to their lives and health? The proposals risk leading to further fragmentation rather than co-ordinated care close to home.

16. Nor do the proposals sit well with government policy to reduce carbon emissions, and the serious challenge that global warming presents, as they will potentially lead to a significant increase in the number and length of journeys required by patients in order to see their GP. The healthiest and 'green' option is for GPs to be within walking distance from home.

17. Questions also arise about the low volume of some of the procedures to be provided in polyclinics, such as emergency surgery and elective surgery procedures. It is not clear that sufficient consideration has been given to the implications for the viability, cost, standard of clinical care to be provided through polyclinics.

18. The developing role of technology is also neglected; improved digital communications facilitate: collaboration between peers, immediate communication of test results and access to expertise. Such technology makes the location of treatment less important than an infrastructure established so that healthcare personnel can work together effectively.

19. A recent report by the King's Fund summarised the potential risks for quality associated with the development of polyclinics:

- "In practice, co-location alone is often not sufficient to generate co-working or integration of care.
- Although evidence suggests that quality of care for most services shifted out of hospitals is comparable, this is limited to a small number of specialties. There is also evidence that quality may be decreased in certain cases.
- The limited inspection and accreditation of out-of-hospital care is a serious deficit in quality assurance.
- Specialists working on a sessional basis in multiple community sites may experience professional isolation, threatening professional development and motivation.
- Primary care services will need to be carefully planned to ensure continuity of care".[2]

20. The King's Fund report also highlighted the following risks for access:

- "Physical accessibility of primary care is likely to be reduced for most patients if their GPs move into polyclinics, particularly in rural settings.
- Potential gains in the physical accessibility of secondary services could be marginal in urban settings and may be lost if polyclinics are located away from natural transport hubs.
- Provision of specialist services in polyclinics would need to be carefully planned to ensure efficient scheduling of specialist staff time".

21. The report also contained the following warning:

> "If a substantial centralisation of primary care were pursued, the consequent reduction in access to these services would be a major sacrifice."

22. This is a major flaw and one that we have continually highlighted to Haringey tPCT.

The Bigger Picture

23. The reconfiguration of community healthcare services is part of a larger plan for NHS in London and the whole of England, that are set out with the express purpose of improving healthcare provision.[3]

24. We note that effective decision making requires feed-back in order to monitor outcomes. Survey results and population statistics are not sufficient. Unfortunately, more useful first hand observations from front-line services are neglected. Healthcare service users and healthcare professionals, who could make a valuable contribution to planning, have no direct participation in local decisions. Primary Care Trusts now commission services from providers; this further distances board members from the actual delivery of healthcare.

[2] *Under One Roof: Will polyclinics deliver integrated care?*, King's Fund, 2008.
[3] *High Quality Care For All*, NHS Next Stage Review Final Report—Summary http://www.nhs.uk/ournhs

25. Overall planning is further hampered by providers having conflicting commercial obligations. Tight budgetary constraints are clearly defined for Foundation Trusts; in contrast, their obligations to the local community are unclear. Confused loyalties frustrate collaboration between providers to achieve effective healthcare provision.

26. Academic statisticians have reported on the doubtful evidence for current Department of Health policy.[4]

The Situation in Haringey

27. We hope that the following information on the situation in the London Borough of Haringey will be helpful to the Committee.

28. In the west of Haringey a very thin and inadequate "consultation" exercise has been carried out by Haringey Primary Care Trust (HtPCT). The mode of consultation was criticised for the vague nature of the proposals, poorly designed questionnaire and inadequate recording of residents' responses at public meetings. The whole exercise lost the public's confidence. It was claimed that the responses gave overall support to their general strategy. In fact from a resident population of 216,000 just 123 responses were returned, of which not one was supportive, and there was widespread opposition at public meetings.

29. Haringey is a borough with the fourth most diverse population in London. The diversity index is 0.75 which means that of two people chosen at random from Haringey, there would be a 75% chance that they would be from a different ethnic background from each other, even if this means that neither of them is white. In fact, less than half the population of Haringey is white. Almost half the school population speak English as a second language. 15O languages are spoken in the borough, Turkish and Greek are prevalent. There are just 7% Asians living in Haringey whilst over 20% of its population is from Black ethnic minority groups. There are over 216,000 people living in Haringey making it one of the most densely populated boroughs in the Capital.

30. The demographic nature of Haringey is changing more rapidly than neighbouring boroughs with a rapidly rising immigrant and refugee population and the accompanying health problems which stem from the poverty and deprivation experienced by these individuals in their countries of origin.

31. The "consultation" carried out by HtPCT so far focused on the strategy or framework for primary care, not about the services to be provided at the proposed polyclinics at Hornsey Central and elsewhere. Even this exercise was seriously flawed as respondents were asked about hypothetical changes that were themselves vague.

32. Haringey tPCT has singularly failed to present concrete information about the precise nature of the services to be centralised in the GP-led health centres, or polyclinics. To our knowledge, the tPCT has not referred to a sound evidence base of unmet need or carried out a joint strategic needs assessment of health and health-related services. Nor has the HtPCT published any detailed impact assessments of the effects of these proposals for local people, particularly regarding access and travel. On May 21st 2008 the HtPCT announced a reconfiguration of GP practices. Haringey community services are thus very much in flux.

33. The Campaign has regularly put the following questions to the HtPCT, which has so far failed to produce a satisfactory response:

- Assessment of the likely effects for service users of the changes, particularly because of changed location of GPs and of GP services, and how this relates to policies aimed at provision of care closer to home.
- What services will definitely be provided at Hornsey Central Health Centre.
- How the proposed provision of services will be an improvement on the current situation.
- Which services will be NHS-provided and which services will be offered by private providers.
- Which services will be available permanently at the site and which will be provided by mobile visiting facilities.
- Full justification/evidence for any proposed changes in the range and location of provision.

34. Haringey PCT is under no illusions about the impact that poor access to services is likely to have on vulnerable people. Indeed, in a recent Equalities Impact Assessment report (November 2007) carried out collaboratively between the Council and the tPCT, the following conclusion was drawn:

> *"The Primary Care Strategy could have a negative impact or reduce access to primary care if the implementation of the strategy means that travelling to get to health services is made more difficult. This will have a disproportionate impact on people with mobility problems including older people, disabled people and those on low incomes who would suffer more from additional travel costs. We must develop a strategic approach to addressing travel arrangements for these people."*[5]

[4] *Can we Safely Ditch the District General Hospital?*, Sally Ruane, Radical Statistics #95, and other articles in *Equity & Accountability in the NHS*, Radical Statistics #96 www.radstats.org.uk

[5] http://www.haringey.nhs.uk/foi/foi_docs/6908_equalities_impact%20assessment.doc

36. The Campaign has consistently stressed to the tPCT the importance of evaluating the effects for travel and local transport. Yet the tPCT is proceeding with plans to set up a polyclinic on the former Hornsey Hospital site in West Haringey, with poor transport links: the former hospital has already been demolished and a new building is currently being constructed to house polyclinic services.

37. It is extraordinary that this building work is underway before proper work has been undertaken on the implications of centralising GP and related services. Local people have not been given information on what services will be provided, or the effects for access to their own GP.

38. Haringey tPCT's consultation document did not provide a detailed explanation of the cost implications of the proposals. However, according to the accompanying technical paper, the cost of each polyclinic will be £20 million per annum. The polyclinic currently being developed in West Haringey will have to be funded out of the PCT budget with consequent pressures on service provision.

Meeting Core Standards

39. Core Standards are set out in the *Healthcare Commission's Standards for Better Health, core and developmental domains*.[6] The three given below are clearly not satisfied in the proposed centralisation of GP services into fewer GP-led health centres, or polyclinics.

C19 states:

> *"Health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services."*

C18 states:

> *"Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably."*

C17 states:

> *"The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services."*

Relocation of GPs will reduce the accessibility required in C19, consultation was inadequate as required in C17 and C18 has certainly not been demonstrated. The Department of Health needs to address the consistency of its advice to Haringey tPCT.

Conclusion

40. The experience in Haringey, where the tPCT is proceeding with the development of GP-led centres or polyclinics, does not give patients and the public confidence that the proposals will lead to improvements in access to and quality of services. On the contrary, we are extremely concerned that the result will be to make access more difficult for many people, especially those in vulnerable situations.

41. It is extremely worrying that such fundamental and far-reaching changes are being proposed and, in the case of Haringey, proceeded without a sound evidence base and evaluation of risks. Before further action is taken to centralise GP services into health centres or polyclinics, the Department of Health should carry out a full and detailed impact and risk assessment of the potential implications for health service users and the public, particularly for people on low incomes, people with disabilities and others in potentially vulnerable circumstances. This should be followed by meaningful public consultation, in which the advantages and disadvantages of different options are made clear and the results published.

July 2008

Memorandum by Help the Aged (DZ 08)

NHS NEXT STAGE REVIEW

1. Summary and Introduction

1.1 Help the Aged welcomes the opportunity to comment on the process and outcome of the NHS Next Stage Review. In preparing this response we have worked in close collaboration with members of the British Geriatric Society.

1.2 England's ageing population has significant implications for our health system as people over the age of 65 are the largest users of many NHS services. They occupy the majority of general and acute beds[7] and are more likely to visit a GP than other age groups.[8] With a few exceptions, health professionals in most disciplines will come into contact with older people.

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[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665

[7] Audit Commission, Healthcare Commission, & Commission for Social Care Inspection 2006, *Living Well in Later life: A review of the progress against the NSF for older people*.

[8] General Household Survey 2005, Table 7.

1.3 From the individual's perspective, the NHS plays a vital role in maintaining independence, well being and quality of life. Very often it is also the gateway to a range of other services and support.

1.4 It is essential therefore that any plans for the development of the NHS take into account the needs of its largest and growing proportion of users, both in terms of quality, availability and management of services.

1.5 This submission represents a summary of Help the Aged's views on the extent to which the NHS Next Stage Review appears to be responding to the needs of older people. We focus on four areas.

1.6 *Managing the complex needs of frail older people*: As the age group most likely to need the support of the NHS it would make sense that services are designed with their needs in mind. System developments which do not take into account the multiple needs of this group through integration and coordination of disciplines risk undermining progress achieved in individual areas of specialism eg full benefits of innovation in stroke services will only be felt if there is coordination with intermediate care services and community-based support, including that of social care.

1.7 *Getting the basics right and maintaining dignity*: The dignity of a patient is fundamentally linked to the overall quality of care that they receive. It cannot be seen in isolation from the wider quality agenda. The Government needs to be explicit about the areas of care that are particularly important for maintaining dignity during periods where individuals have lost independence. This is particularly important for older people who are more likely to suffer lapses in care. These areas must be monitored on an ongoing basis as part of quality assessments.

1.8 *Availability and accessibility of services*: People over the age of 65 rely on health services to support their independence and wellbeing. However we know that there is a huge disparity in the commissioning by PCTs of services from which older people in particular will benefit. The availability of incontinence and foot care services are two examples. Help the Aged is concerned that the current policy of decentralising decision-making will only aggravate these disparities as some PCTs fail to prioritise the health of their older populations. Access to GPs is especially vital. Without careful analysis of the impact of GP-led health centres on older people's access in every area, local implementation may result in poorer access to what may be considered a lifeline service for many frail older people.

1.9 *Healthy Ageing*: It is never too late to take action to improve health, whether it is preventing the onset of ill health or managing the effects of disease. People of all ages, including those in later life need to be advised and educated on how to make positive lifestyle changes. We also need to develop better ways of delaying or mitigating the deterioration in quality of life associated with chronic diseases such as dementia, osteoporosis, musculo-skeletal conditions and the loss of hearing, vision and mobility. A degree of age blindness has to date allowed tacit acceptance of poor or non-existent services for health conditions associated with, but not inevitably part of ageing. While the Government recently announced a "prevention package", there are gaps: continence services and physical activity for example are not mentioned despite the varying quality of services and often low uptake of opportunities. If the Government is serious about this agenda, it needs to be much more comprehensive in its commitment to improve and integrate services.

2. Managing Complex needs of Older People

2.2 People over 85 are 14 times more likely to be admitted to hospital for medical reasons than the average 15–39 year old.[9] These individuals are likely to have complex care needs and are on average almost twice as likely to suffer from co-morbidities as younger people.[10] Their cases need to be managed carefully through multidisciplinary assessment and intervention, drawing on the skills and capacity of both health and social care professionals. An integrated service framework across the spectrum of acute, intermediate, community and social care would ensure optimal outcomes.

2.3 Unfortunately, there is little evidence that this NHS review has encouraged all areas to plan services with the complex needs of frail older people in mind. While developments in the care of individual conditions such as heart disease, stroke and cancer are undoubtedly welcome, planning each pathway without reference to the wider health and care needs of individual patients will ensure that silo cultures are maintained within the system and those individuals who need the support of a range of professionals and services will suffer long delays and poorer results.

[9] Department of Health, High quality care for all: NHS Review Final Report.
[10] Handbook of Clinical Psychology in Medical Settings, J Sweet *et al*,1991(an average of four comorbidities for patients aged 65 and over, compared to 2.4 for younger patients).
[11] Health protection agency, Annual Report on Healthcare Associated Infections, 2007.
[12] Healthcare Commission, 2007 adult inpatient survey results, May 2008.

3. Getting the Basics Right and Maintaining Dignity

3.1 In 2007, the Annual Report on Healthcare Associated Infection showed a 7% increase in reports of C. Difficile in patients aged 65 and over.[13] showed one in five people reporting not receiving sufficient help to eat their meals. Overall 22% of people did not feel they were always treated with respect and dignity in hospital.[14]

3.2 The dignity is of a patient is fundamentally linked to overall quality of care received, from maintaining hygiene and nutrition standards to communicating effectively with patients and ensuring privacy. It is the outcome of high quality care.

3.3 In an ever more sophisticated and fast-moving environment, some of these essential aspects of care can however be forgotten. All too often it is older people who bear the brunt of such lapses. We know for example that the risk of malnutrition in hospital increases significantly with age.[15]

3.4 The review has rightly drawn attention to the need to get the basics right with a focus on tackling healthcare associated infection. It also emphasises quality of care, compassion and dignity.

3.5 These issues cannot be viewed as mutually exclusive and managed as isolated concerns. Staff need to understand that dignity is not a separate programme of work—a "nice to have" campaign—but is integral to the wider quality and patient safety agenda.

3.6 We cannot afford to let dignity become a throwaway term, used by everyone but understood by none. Help the Aged suggests nine care areas which contribute to maintaining dignity: eating and nutrition, privacy, communication, pain management, personal care, autonomy and choice, hygiene, social inclusion, end-of life care. Only if providers are held to account across all these domains as part of the commitment to monitor quality can we be sure that we are truly to make progress on ensuring dignity in care.

4. Availability and Accessibility of Services

4.1 People over the age of 65 rely on health services to support their independence and wellbeing.

4.2 Increasingly PCTs are being given the freedoms and flexibilities to make their own decisions concerning how best to meet the needs of their population. This philosophy is very much embodied in the vision for primary and community care.

4.3 Help the Aged would be interested to understand better the evidence which suggests that local decision-making leads to better outcomes for all and a reduction in health inequalities because on the face of it this policy seems to be resulting in a postcode lottery for services.

4.4 The commissioning and availability of services valued by older people in particular is already highly uneven:

— One third of us will develop incontinence at some point in our lives,[16] many in older age. The National Service Framework for Older People called for integrated continence services to be established by 2004 This is important as many instances of incontinence are treatable. However in 2005, a National Audit of Continence Care demonstrated that only 38% of primary care and 26% of secondary care sites offered an integrated continence service.[17]

— Access to and availability of low-level foot care services is notoriously patchy: A study for Help the Aged estimated that 25% of people over the age of 65 who need professional foot care were not receiving it and that to provide this level of services would require nearly doubling the size of the podiatry service.[18]

— Recent figures on attendance at NHS dentists demonstrate that many PCTs are failing in their duty to secure provision of these essential services: In the 24 month period up to December 2007, 0.7 million fewer people were seen by an NHS dentist than in the period leading up to the end of the old dental contract.[19]

4.5 We cannot foresee that less guidance for PCTs on what services should be offered locally will lead to an evening out of current availability.

4.6 This is of huge concern in particular as we see moves to reconfigure GP services on whom older people very often depend to gain access to wider health and social care services. Some PCTs left to commission GP-led health centres "according to local need" are pursuing a centralised model. This is likely to have the impact of moving the GP further away from homes. Currently 9% of households with people over the age of 75 report access to the doctor as very difficult.[20] A centralised model will only increase this proportion.

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[13] Health protection agency, Annual Report on Healthcare Associated Infections, 2007.
[14] Healthcare Commission, 2007 adult inpatient survey results, May 2008.
[15] BAPEN, Nutritional Screening Week Factsheet, 2007.
[16] *Talking Incontinence: understanding urinary incontinence*, Research into Ageing fact sheet, 2005, Help the Aged.
[17] National Audit of Continence Care for Older People, Royal College of Physicians, November 2005.
[18] Help the Aged, *Best Foot Forward*, 2005.
[19] NHS Dental Statistics for England Q2: 30 September 2007.
[20] *Housing in England 2005–06*. A report principally from the 2005–06 Survey of English Housing, Department for Communities and Local Government, 2007.

4.7 Furthermore, such a move could threaten other services. Pharmacies often depend on proximity to a GP for their main business of dispensing prescriptions. Relocation of a GP could put this at risk and in so doing threaten those additional services provided by a pharmacist including medicines use reviews, general health advice and diagnostic tests.

4.8 As communities lose their post offices and local shops, older people are being hit hardest. Where the current policy of decentralising decision-making is not accompanied by a requirement to guarantee continuity and accessibility of services in a local area, we are at risk of seeing them further contributing to this trend of disintegrating communities.

5. Healthy Ageing

5.1 The proportion of people aged over 75 with a limiting long-term illness has recently reached 50% for the first time since 2002.[21] People are on average living longer, but this has not been accompanied by an increase in healthy life expectancy.

5.2 It is never too late to take action to improve health, whether it is maintaining health, preventing the onset of ill health or managing the effects of disease. People of all ages, including those in later life need to be advised and educated on how to make positive lifestyle changes. For example despite the benefits of physical activity in preventing and mitigating illness and disability, rates of participation decline steeply with age. Only 11.9% of adults aged 65–74 achieve recommended levels, falling to 6% in the 75–84 age range.[22]

5.3 We also need to develop better ways of delaying or mitigating the deterioration in the quality of life associated with chronic diseases such as dementia, osteoporosis, musculo-skeletal conditions and the loss of hearing, vision and mobility. A degree of age blindness has to date allowed tacit acceptance of poor or non-existent services for health conditions associated with, but not inevitably part of, ageing.

5.4 While the Government is making welcome moves to support older individuals through the recently announced "prevention package", its approach needs to be more comprehensive.

5.5 We need more advice and education for older individuals on how to make positive lifestyle changes, in particular around physical activity and nutrition. We also need better assessment and treatment of conditions associated with later life such as incontinence, falls and bone health and dementia. PCTs developing commissioning plans in light of this review need to consider the range of services, advice and information required to support healthy ageing. They also need to ensure they are integrating with social care sufficiently to provide a rounded package of support in later life.

6. Conclusion

6.1 Although in many ways wide-ranging, this review of the NHS has failed to comprehensively address the needs of its principal constituents: older people. While undoubtedly older people will benefit from proposed improvements in most areas, there is an overwhelming sense that at regional level developments will be pursued in silos within institutions without reference to the multiple needs of the majority of individuals using the services. The concept of integration both within health and between health and social care services is largely missing.

6.2 Furthermore, the failure to offer clear guidance on expectations of PCTs beyond a set of high level principles risks at best a postcode lottery of service availability and at worst a large scale disregard for the needs of older people.

6.3 Overall, the hands-off approach adopted by the Government in carrying out this review and making recommendations raises some serious questions over how the next ten years will play out for the rising numbers of older people requiring health services. If older people continue to disproportionately bear the brunt of poorly planned and coordinated services it will be indication that Government is abdicating its responsibility to look out for the interests of all users.

About Help the Aged

Help the Aged is the charity fighting to free disadvantaged older people in the UK and overseas from poverty, isolation and neglect. It campaigns to raise public awareness of the issues affecting older people and to bring about policy change. The Charity delivers a range of services: information and advice, home support and community living, including international development work. These are supported by its fundraising activities and paid for services. Help the Aged also funds vital research into the health issues and experiences of older people to improve the quality of later life.

[21] Office for National Statistics, General Household Survey 2006, 2008.
[22] Active People Survey results.

Help the Aged would like to thank the British Geriatric Society for their support in developing this response.

July 2008

Memorandum by the Royal College of Midwives (DZ 09)

NHS NEXT STAGE REVIEW

1. Executive Summary

1.1 The RCM is generally pleased with the NHS Next Stage Review, particularly Lord Darzi's personal Final Report. What clinicians and service users have fed into the process has backed up the Maternity Matters strategy, published last April.

1.2 Lord Darzi has paved the way for a tripling of midwifery preceptorships for new midwives. His report also has the potential to create a wave of new social enterprise organisations, which will help to expand the choices available to women during pregnancy. Lord Darzi's focus on quality, on promoting healthy living, and on choice and control all resonate with the aspirations of midwifery practice.

1.3 We do however have concerns. Some SHA visions are weak. Even when they are not weak, it is unclear how implementation will be monitored. The RCM seeks reassurance that where maternity and newborn care clinical pathway groups have been ambitious, but their ambition has not made it into their SHA's final single-document vision, their recommendations will still be honoured and implemented. We would also like those SHAs whose plans do not include a timetable or details of how they will implement Maternity Matters to be asked to be more specific.

1.4 We want to see the promises of additional resources for maternity care being implemented. Unlike some other parts of the NHS, building capacity in the system is still a concern in maternity care. With a rising number of births and ambitious new guarantees being made to pregnant women, which will be deliverable on an ongoing basis from the end of next year, we still need to build capacity.

2. Lord Darzi's Final Report

2.1 It is important to state first and foremost that the RCM broadly welcomes the outcome of the NHS Next Stage Review, particularly the Final Report.

2.2 The RCM is very pleased with Lord Darzi's summary, in that Final Report, of the common message emerging from the clinical working groups on maternity and newborn care: "The maternity and newborn groups were clear that women want high quality, personal care with greater choice over place of birth, and care provided by a named midwife."

2.3 This confirms absolutely the strategy for NHS maternity services in England, set out by the DH in the Maternity Matters document, published in April 2007.

2.4 The way forward for maternity services is now crystal clear. There can no longer be any doubt whatsoever about how the NHS in every part of England must approach the provision of maternity care. The direction set out by Maternity Matters 15 months ago has now been reiterated by Lord Darzi, after months of unprecedented engagement with service users and healthcare professionals.

2.5 In terms of midwifery-specific recommendations, the RCM especially welcomes Darzi's commitment to a threefold increase in midwife preceptorships. This will enable many more newly-qualified midwives to learn from their more experienced colleagues during their first year of practice. We have been calling for some time for extra investment in this area, and so we are very pleased to see Darzi commit to that. Units that are short of midwives can find supporting those who are newly-qualified a particular challenge.

2.6 The RCM also welcomes not only those themes in the Final Report that are midwifery-specific, but also many of the more generic themes and also some of the innovations.

2.7 We are pleased to see the emphasis on the shift from concentrating on quantity of healthcare delivered towards a focus on the quality of care. Midwives do not have any control over the quantity of their workload. The number of pregnant women, for example, is not something that anyone can or would reasonably wish to control. Maternity care is also something that cannot, in most cases, be neatly scheduled, unlike elective care. The focus of midwifery is, and always has been, about the quality of care, not its quantity. Indeed, the RCM itself was founded in the nineteenth century to campaign for legislation to enable all women to have access to skilled midwifery care.

2.8 Darzi's focus in the Final Report on promoting good health, and not just treating illness, is also something that will appeal to midwives. Pregnant women are not ill; they need care, not cure. Again therefore this attempt at an institutional shift from an illness service to a health service is one that will chime with midwives. We hope however that this will lead to genuine change, and is not simply the trotting out of a hackneyed phrase.

2.9 Choice and control over care is also a promise that will be welcomed by midwives across England. Indeed, it is proposed that the right of individuals to exercise choice over their care will be asserted in the proposed NHS constitution. As stated earlier, pregnant women need care, not cure. More so than a great many others using the NHS, they are well-placed to exercise choice and control. As can be seen from the quotation from the report, above, choice is one of the common messages that emerged from the clinical pathway groups on maternity and newborn care; this feedback from clinicians and service users alike confirms the wisdom of the Maternity Matters strategy that set the course of maternity care for the coming years.

2.10 It should be recognised that for many people, their first significant experience of NHS care is that received from maternity services. Involving them in decision-making and putting them at the centre of care provides a blueprint for their use of services well into the future.

2.11 In terms of innovation, we wholeheartedly support Darzi's attempt to open the way for midwives and others to set up social enterprise organisations. By ensuring that any staff who transfer to such organisations get to keep their NHS pension, he has removed what heretofore had been an absolutely fundamental barrier. This has the potential to expand choice for pregnant women in how they access maternity care, and is to be welcomed.

2.12 We would wish to point out however that although the pensions barrier will be removed, there remains the question of what will enable these organisations to spring up. There is a need for business support to nurture these new organisations. The RCM is very keen to work with the DH and NHS employers to explore how we can make this happen for midwives.

3. The Regional Visions

3.1 The RCM does however have some policy concerns about the NHS Next Stage Review overall, but these concerns focus not so much on Darzi's Final Report, but rather the vision documents produced by the individual SHAs.

3.2 Before moving on to the SHAs, we would state that whilst Darzi's aspirations are commendable, the next question is one of delivery.

3.3 he RCM had hoped that each SHA would use the opportunity presented by the NHS Next Stage Review to work out how to implement the Maternity Matters strategy in their region. As has been stated, Darzi, in his Final Report, is in no doubt about the future direction of maternity care. His vision chimes perfectly with that of the strategy.

3.4 *Maternity Matters* was published in April 2007, with a national choice guarantee for all women in England, deliverable from the end of 2009. 15 months have now passed since its publication, and 18 months remain before the choice guarantees set out in it are deliverable to all women in England on an ongoing basis. *The Maternity Matters* blueprint will be a real challenge for the NHS in many areas, yet we feel that SHAs have missed this golden opportunity to work out how to implement it.

3.5 Take, as an example, NHS North East's vision document. The list of "actions/next steps" for maternity and newborn care leaves a lot to be desired.

3.6 The first is a promise to address health inequalities, but without any specifics or any deadlines. The second is an undertaking that women in the North East will have excellent information about the range of options available to them, without any specifics whatsoever about how this might be achieved or any minimum guarantee of what options would or should be available.

3.7 The third promise is to develop regionally agreed standards and apply them in a systematic way; one wonders why this was not done as a part of their work. The fourth undertakes to deliver one-to-one care during labour. This is commendable, although again there is no deadline for delivery, and we would have welcomed the use of the specific term, "one-to-one midwifery care".

3.8 The fifth action/next step is guaranteeing consultant cover. It is a pity that there is no similar guarantee on midwifery staffing levels, despite the fact that earlier in the document, it is accepted that, "No service is currently able to provide one-to-one care for women in established labour 100% of the time." Indeed, we note that *Safer Childbirth* (2007), a document produced jointly by the Royal Colleges of Anaesthetists, Midwives, Obstetricians and Gynaecologists, and Paediatrics and Child Health, is used in the SHA's vision as a justification for the guarantees on consultant cover. *Safer Childbirth* also calls for a midwifery workforce equal to one full-time-equivalent midwife for every 28 births per year, as a minimum. On the latest available figures (2006), the NHS in the North East failed to achieve this minimum midwifery staffing requirement, yet it does not address this in its vision.

3.9 The final action/next step is the promise to establish a formal regional maternity and neonatal care network, with similar sub-regional networks also promised. Again, no deadline for this is given.

3.10 At the other end of the ambition spectrum, NHS South West's vision document, *Improving Health: Ambitions for the South West*, is worthy of praise. It includes specific undertakings to enable women both to access their local midwifery service directly and to achieve the choice guarantees on antenatal care and place of birth, set out in Maternity Matters. Indeed, the document promises to achieve this nine months before the Maternity Matters deadline. It also undertakes to increase substantially the proportion of babies born at home and the proportion born in midwifery units by 31st March 2011, to increase the normal birth rate and reduce the caesarean section rate year-on-year, substantially to increase the breastfeeding rate by 31st March 2011, and to achieve UNICEF Baby Friendly accreditation for all maternity units by 31st March 2010. These are their headline maternity and newborn care undertakings. They focus on promoting choice, normal care and healthy babies, all within challenging yet realistic timeframes.

3.11 We have presented here visions that, in our opinion, tend towards either ends of an ambition spectrum. If we were to go through each region's vision document for maternity and newborn care, you would find that they tend towards the under-ambitious.

3.12 These are our policy concerns: that SHAs have, in some cases at least, not been sufficiently ambitious in their visions for maternity and newborn care in the coming years, and that they continue to allow their Maternity Matters implementation timetable to slip.

3.13 Given this, and the emphasis on local decision-making, will women in some regions have to tolerate a maternity service of a quality that is not as high as the service available in other English regions?

3.14 Additionally, even where the vision is positive, challenging and ambitious, what mechanisms exist to ensure that an SHA implements its vision? Are they all now bound to them, and, if so, who or what will keep them to their word?

4. The Clinical Pathway Group Reports

4.1 Putting the single-document visions to one side, much positive work seems to have been done at the level of the maternity and newborn care clinical pathway groups. The reports produced by the groups at, say, NHS South Central and NHS South East Coast are excellent pieces of work, with some clear and very welcome goals.

4.2 The RCM is curious about the status of the reports from each SHA's maternity and newborn clinical pathway group. We want to be reassured that these reports carry as much weight in terms of the long-term workplan of the SHA as the overall single-document vision. Is this the case, or did they merely feed into the vision, with no longer-term standing within the SHA?

4.3 We also find it curious that the single-document visions do not necessarily reflect the good work carried out by these groups. We would like to ask why that is.

5. NHS Next Stage Review: Our Vision for Primary and Community Care

5.1 Much has emerged from the NHS Next Stage Review. Not only do we have Darzi's Final Report, the SHA visions and the reports from the clinical pathway groups in each region, there is also the NHS Next Stage Review: Our vision for primary and community care, published by the DH on 3 July, a few days after the Final Report.

5.2 Many of the themes in this vision document—quality, choice, capturing the patient experience, health prevention and promotion—are similar to the proposals contained in the Final Report and are generally welcome. Many of the proposals in this vision document, such as giving people access to a wider range of services in the community and investing in more health centres, are both reasonable and uncontroversial (polyclinics are noticeable by their absence).

5.3 What is disappointing is the almost total exclusion of maternity services and midwifery from this vision for primary and community care. The vision document itself contains only one passing reference to midwives and nothing about maternity services. This is particularly disappointing given the numerous mentions in other government policy documents, such as the 2006 White Paper on health and care services in the community, Our health, our care, our say: a new direction for community services, about encouraging women to access midwives in more visible community locations.

5.4 Remarkably, the DH also published a summary document of this on what it means for nurses, midwives, health visitors and allied health professionals in which midwives again get only one mention.

6. Capacity: Still an Issue for Maternity Care

6.1 We also continue to have concerns over the resources available to maternity services to deliver the first-class quality of care that midwives genuinely want to give the women for whom they care. The promise of choice too frequently proves illusory when resource constraints bite.

6.2 The Prime Minister in his Preface to the Final Report writes, "If the challenge 10 years ago was capacity, the challenge today is to drive improvements in the quality of care."

6.3 For maternity services, capacity remains a challenge. In January, the DH announced an extra £330 million in investment in maternity care to help implement Maternity Matters. In February, the DH announced that the NHS needs to increase the midwifery workforce by 4,000 by 2012 to keep pace with the rising number of births. These promises of additional resources are very welcome, and we welcomed them publicly when they were made, but they are also admissions that maternity care is not as well-resourced as it needs to be.

6.4 According to the answer to a recent parliamentary question, there were 33.7 live births in England in 2006 per full-time-equivalent midwife. According to *Safer Childbirth*, referred to earlier, this should be much lower, at 28, as a minimum. In fact, the ministerial answer to the parliamentary question on this gave figures for five years, 2002–06. At no time did the figure even go as low as 31, and the latest (2006) figure was the worst of those stated.

6.5 Clearly, we are not yet where we need to be in terms of capacity. However welcome the plans for maternity care set out in both Maternity Matters and Darzi's Final Report, it runs the risk of hitting the buffers if the extra investment is not put in and put in fast. We welcome the additional resources announced, but the Department must ensure that there is no backtracking on those commitments, and that if the number of births continues to rise then yet more resources will need to go in.

6.6 On that point, we are receiving early intelligence from those on the frontline of delivering maternity care that the additional financial resources announced in January, and which were meant to be in the system from the beginning of this financial year (a quarter of which has already passed), are not materialising. These were for the implementation of Maternity Matters and the problems trusts are apparently having in accessing them gives the RCM significant cause for concern.

6.7 We will shortly we sending a request for information, under the Freedom of Information Act, to all Primary Care Trusts in England to clarify whether this early information reflects the picture nationally.

7. Conclusion

7.1 In conclusion, the RCM broadly welcomes the outcome of the NHS Next Stage Review, especially Darzi's personal Final Report. It reinforces the Maternity Matters strategy. It paves the way for a threefold expansion in midwifery preceptorships, and has the potential to create a wave of new social enterprise organisations. Darzi's focus on quality of care, on promoting good health, and on choice and control all chime with long-standing midwifery practice.

7.2 We are concerned by the weakness of some SHA visions, and how implementation will be monitored. We want reassurance that the ambitious recommendations from maternity and newborn care clinical pathway groups will not be ignored simply because they did not make the final cut into an SHA's vision.

7.3 We need reassurance that the promises of additional resources will be honoured. Capacity generation is still a concern for maternity services. With a rising number of births and ambitious new guarantees being made to pregnant women, which have inevitably raised expectations of the service, we still need to build capacity.

Royal College of Midwives

July 2008

Memorandum by the Royal College of Nursing (DZ 10)

NHS NEXT STAGE REVIEW

1. Executive Summary

1.1 On Monday 30 June 2008 Lord Ara Darzi's final report on the future of the NHS was published. This landmark report was intended to coincide with the anniversary of the NHS and to set out a vision of the way forward with NHS services over the next 10 years.

1.2 Overall there are many positive messages and recommendations contained within each of the review reports for the nursing profession. Indeed many of the issues raised and suggestions made by the RCN have made their way into the contents of these documents. It is a significant achievement for the profession that nurses have such a high profile in the documents.

1.3 The purpose of this position statement is to provide a summary of the key points raised in each of the three documents. The RCN commentary is based on existing RCN policy positions and statements or work already in progress. This should not be considered as a comprehensive response to the NHS Next Stage Review and the RCN will be discussing the contents in detail with Government over the next few months. With the NHS Constitution a full consultation process has now started and the RCN will be seeking comments from members.

1.4 Before proceeding it is important to recognise that over the last year a substantial number of RCN members have participated in the Government's engagement events at a local, regional and national level. The collective efforts, hard work and constructive input to these discussions from our members are acknowledged by the RCN and the profession as a whole. However, now begins the vital process of implementation and the challenge of transforming the good intentions into reality.

2. Introduction

2.1 With a membership of over 390,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

2.2 The RCN welcomes the opportunity to make a written submission to the inquiry of the Health Select Committee.

2.3 For the purpose of this submission the RCN will comment on the key findings of the three reports launched as part of the NHS Next Steps Review Process; the NHS Next Stage Review Final Report, High Quality Workforce and the NHS Constitution

3. The Review Process

3.1 Throughout the year long consultation process the RCN demonstrated its desire to play a leading part in working with Government on health service reform and to express an enduring commitment to the NHS. During this process we have made significant efforts to influence the thinking around and outcomes of the review and have made representations to Lord Darzi and other Government Ministers as well as senior leaders within the Department of Health.

3.2 The RCN has been pleased with the level of engagement afforded to the nursing profession in the consultation process. The RCN has been engaged in a number of local events and one to one meetings between Lord Darzi and RCN Chief Executive and General Secretary Dr Peter Carter. The RCN also held a national consultation event, attended by leading nurses which Lord Darzi attended.

4. Quality

4.1 There is a fundamental emphasis running throughout the report on moving from high-quality care in some aspects to high-quality care in all

4.2 The RCN welcome the recognition that future healthcare provision should aim for a more quality based approach and that nurses play a lead role in its shaping and delivery. This is something that the RCN has been campaigning on for many years.

4.3 The overwhelming majority of care provided by the NHS is safe, but the RCN believes the ambition must now be to drive up patients experience from a safe to a high quality service. If fully implemented these recommendations have the potential to achieve this ambition.

4.4 Nurses have frequently told the RCN that they feel as though financial considerations are considered to be more important than the quality of healthcare services. Two to three years ago the effect of the NHS deficit cuts meant that the balance between finance and Quality shifted in the wrong direction. We believe that if the vision in this document is translated into reality then this is a golden opportunity to readdress this balance and place the commitment to quality at the very centre of the delivery of care

4.5 The Government's ambitious plans to strengthen the place of quality in the system also need to be matched with sufficient resources to turn this vision into a reality.

4.6 The RCN are committed to working with Government to establish clear and transparent definitions of quality. It is important to have widely recognised quality measures, for example patient satisfaction and feedback, complaints, standards of cleanliness, infection rates, food, drug errors, communication and dignity. Performance on these indicators should be linked to Payment by Results (PbR).

4.7 The overall theme is on regional implementation through SHAs and the end of top-down re-organisations. There will inevitably be some conflict between the commitment to establish national standards in order to end the 'postcode lottery' effect and the desire of SHA's and PCT to take advantage of the increased devolution of responsibilities. The implementation at a regional/local level is welcomed but this inherent conflict must be recognised and actively managed. The process must ensure that there is consistency in quality standards and local nurse-led initiatives are allowed to develop innovative approaches to care without excessive SHA control or over-reliance on SHA agreed procedures.

4.8 The RCN acknowledges that the establishment of NICE has been a successful initiative. It is important to have a body that assesses drugs using a transparent process based on cost and clinical success. The RCN accepts there have been problems with the speed of decisions and hopes additional funding committed to this area will help improve this situation.

4.9 The intention to include the CNO as a member of the National Quality Board is a very welcome development. We look forward seeing further detail and the terms of reference.

4.10 The RCN welcomes the establishment of the Care Quality Commission and have previously stated (in consultation responses) the desire to see an organisation that is properly resourced and empowered with the necessary regulatory powers to take strong enforcement action when needed. In particular the continued commitment to tackling HCAIs is supported and the RCN looks forward to working with Government to ensure there are robust systems in place together with the ability of nurses to raise infection control issues without fear of damaging relationships in their own workplace.

5. Partnership Working

5.1 There is an emphasis in the report on partnership working between health professionals and also between health professionals and the public/patients.

5.2 We welcome the acknowledgement of the important interface between health and social care as well as the piloting of new integrated care organisations.

5.3 More collaborative working in multi-disciplinary teams is a positive development and the levers contained within the report will contribute towards a greater integration across the full length of the care pathway.

6. Empowering Individual Patients/Personalised Care

6.1 Throughout the Report there is a focus on meeting and exceeding the expectations of patients

6.2 The RCN support the principle of patient empowerment and patient control. However there is a need to consider the practical considerations of extending personalised budgets into the NHS. Although direct budgets have been shown to successfully work with some patients with long term conditions caution should be exercised on the wider application across the health service which will require significant long term planning and a fundamental change of culture. There is the danger that those who are the most vulnerable in our society will find it difficult to commission and manage the services they need and we are concerned that there could be a risk of creep in terms of individual payments. The RCN look forward to working with Government to overcome these practical and logistical challenges presented by individual budgets.

6.3 The RCN is supportive of moves to bring care closer to home and nurses will play a critical role in delivering this. However polyclinics are not a "one size fits all solution" but rather the shape and configuration of local health services should be based on a needs of the communities that they serve and should not result in closure of services from rural communities

6.4 We regard the relationship between the nurse and the patient as being critical to the delivery of quality and dignified healthcare. We also believe that the professional and personal relationship, not just personalised services, is at the heart of delivering quality and dignified healthcare.

7. Partnership with NHS Staff

7.1 An additional theme running through the report is the Government working in partnership with NHS staff to take the service forward over the next 10 years.

7.2 The key aspect of the report is rightly focused on the role of multi-disciplinary teams but the RCN welcomes the enhanced role for the nursing workforce, the increased focus on training and the expansion of services that can be provided in nurse-led centres. We are pleased to note that the Government shares our vision of an NHS where nurse leaders are supported and empowered to effect meaningful change.

7.3 The RCN supports in particular the increased investment in nurse and midwife preceptorships as these offer invaluable protected time for nurses to learn from more senior colleagues within their team and their organisation as a whole.

7.4 Doubling investment in apprenticeships will allow greater support for clinical and non-clinical healthcare staff

7.5 The report recognises the key role nurses play in setting up their own clinics and services which have led to real benefits for patients, such as improving access. We welcome the intention to allow nurses, transferring from the NHS to set up their own not-for-profit companies, to keep NHS pension which removes significant barriers to nurses setting up own services. However, we are also concerned that a two-tier system doesn't develop if new employees are prevented from joining the NHS pension scheme.

7.6 The RCN welcomes nurses being given the statutory right to request they be allowed to set up a not-for-profit trust. We are concerned that such new organisations are supported to enable them to preserve their integrity and avoid takeover from large corporations. But this must go hand-in-hand with making sure that nurse-led enterprises are given support and appropriate training in areas, such as financial planning and governance to ensure they succeed. Otherwise these factors could act as further barriers to nurse-led initiatives.

7.7 The RCN do want to get into confrontations over territory but strongly welcome this opportunity to further enhance the professional skills of nurses. However, good progressive doctors recognise there are roles for nurses who do highly complex work.

7.8 Although there must be measures to produce incentives for success there must also be appropriate re-investment of resources to ensure the effective delivery of effective patient care.

7.9 The RCN has long called for a shift to an all graduate nursing profession, so we welcome the announcement on this key issue in the Review. We look forward to working with the government to make this a reality.

7.10 The RCN has been lobbying to improve the education and regulation of Healthcare Support Workers. We welcome the request to ask the Extending Regulation Working Group to consider extending regulation to this group. We look forward to working with them on issues over enforceability rights and responsibilities through the consultation process.

8. Continued Commitment to the NHS

8.1 Within this report and within additional statements to coincide with the 60th anniversary of the NHS the Government have made an overall commitment to taking the NHS forward over the next 10 years.

8.2 The RCN strongly welcomes the commitment to an NHS which is tax funded, universally provided and free at the point of need. However we believe that the report presents a significant opportunity to take forward the NHS model for the next 10 years and build on the achievements of the last 60 years.

9. Implementation Process

9.1 The Next Stage Review includes the commitment to a significant number of changes and new/expanded organisations to take these initiatives forward.

9.2 The RCN has repeatedly asked that proposed NHS reforms should be evidence based and tested. We are pleased to see that the Next Stage Review process has spent considerable time gathering the views of clinicians and members of the public before making recommendations.

9.3 An important next step will be to equip commissioners and providers with the resources to deliver the progress detailed in the report. The principles for managing change published in May 2008 should be incorporated clearly in the proposed October 2008 Operating Framework. Earlier commitments to ensure existing NHS services continue uninterrupted whilst models of care are relocated or reformed—so called double running—need to be restated clearly. The RCN would welcome the opportunity to contribute to an independent review of the reforms as suggested in Chapter 8 of the Next Stage Review report at a suitable stage in the process.

9.4 Both the main report and the summary provide very little information in terms of resources. The RCN acknowledge that it will be frontline staff that will in most cases be delivering the changes and therefore funding mechanisms need to be clear and transparent.

9.5 The RCN believes that three key principles should be used in the implementation process as follows:

- — independent evaluation of performance which is evidence based;
- — working together with health professionals and clinical leadership; and
- — demonstrable improvements for patient care.

9.6 We hope that publication of the final review reports will mark the beginning of a much-needed period of stability for the NHS, which will allow time for the service to embed the many changes and reforms that have been introduced in recent years. The nursing profession welcomes the move to a service that is professionally led, in partnership with Government and with patients.

Royal College of Nursing

July 2008

Memorandum by the Association of British Healthcare Industries (DZ 11)

NHS NEXT STAGE REVIEW FINAL REPORT: "HIGH QUALITY CARE FOR ALL"

1. Introduction

1.1 The Association of British Healthcare Industries (ABHI) is the lead industry association for the medical devices sector, representing around 200 hundred companies that supply around 80% of the medical technology products used by the NHS. The Association aims to ensure that best and most appropriate treatments are available to patients and clinicians in support of life-long health.

2. Executive Summary

2.1 ABHI believes changes to incorporate quality in the Payment by Results (PbR) system recommended in the NHS Next Stage Review (referred to hereafter as "the Review") will have a positive impact on the uptake of new technologies in the NHS.

2.2 ABHI welcomes the Review's recognition of the problem of slow adoption of new technologies in the NHS and supports in principle the simplification and recommended improvements to the National Institute for Health and Clinical Excellence. However, Health Technology Assessment must be appropriate for medical devices and differentiated from pharmaceuticals.

2.3 Measures to boost innovation are welcomed by ABHI, but in order to be successful there must be a recognition and resolution of the barriers to innovation in the NHS created by centralised procurement policies.

2.4 Personalised budgets for patients have the potential for increasing patient access to new technologies if adequate information is available. Further clarification on how patients would receive this information is needed.

3. Payment by Results

3.1 Under the proposed Commissioning for Quality and Innovation (CQUIN) scheme in the Review patients will have greater influence over NHS resources, with quality being reflected in the Payment by Results (PbR) mechanism.

3.2 The proposed introduction of Patient Reported Outcome Measures (PROMS) under the new CQUIN scheme has the potential to create a vital link between patients and the funding of hospitals, giving patients influence over the quality and safety of their treatment. ABHI believes that this new scheme could have a positive impact on the uptake of innovative technologies as payments to hospitals will be conditional on the quality of care as well as the volume.

3.3 Hospitals that in the past may not have prioritised quality of care, being content to use older and cheaper equipment, may in future have stronger incentives to seek out the latest and best quality medical devices. Provided that clinical coding and the tariff mechanisms (including systems for excluding innovative products where appropriate) can keep up, there should therefore be reward for innovative technologies. This could influence the way the NHS procures medical technology and is consistent with a more strategic approach to procurement encouraged by the Healthcare Industries Task Force (HITF) March 2007 report.[23]

4. Access to Technologies and NICE

4.1 ABHI welcomes the recognition of the historic problem of slow NHS uptake of innovative treatments in the Review (pg 55, para 38) and the proposals to address this through the elimination of outdated practices and championing best practice. ABHI also supports the simplification of the UK Health Technology Assessment (HTA) regime and subscribes to the principles contained in the Eucomed (the European medical technology industry association) HTA Position Paper (June 2008),[24] which defines the purpose of HTA thus: "Health technology assessment should be used to support patient access to innovative technologies by promoting the use of technologies that are clinically and cost effective. Conversely, HTA should be used as a mechanism to support disinvestment in current services and technologies which are cost ineffective, thus creating 'headroom' for new technologies when they become available." The Review seems to support this view, and also states that: "For new clinical technologies, we will simplify the way in which they pass from development into wider use by creating a single evaluation pathway (pg 44, para 51)."

[23] *Innovation for health: Making a difference*, Report of the Healthcare Industries Task Force Strategic Implementation Group, March 2007.

[24] Eucomed HTA Position Paper, June 2008.

4.2 Creation of a single evaluation pathway sounds straightforward, but ABHI would like to obtain more information about what this means in respect of existing evaluation bodies such as the Technology Adoption Hub in Manchester, the Centre for Evidence based Purchasing (currently within the NHS Purchasing and Supplies Agency) and the National Innovation Centre to name but a few. Also, whether it is intended to organise these activities differently for example under an expanded National Institute for Health and Clinical Excellence (NICE) as the Review seems to imply.

4.3 ABHI supports in principle the speeding up of the NICE appraisal process, and the enforcement of NICE guidance, provided there is a thorough and transparent process in place with adequate opportunities for stakeholder engagement. Of particular concern to the medical device industry is that devices should not be routinely assessed using the same evidence requirements as for pharmaceuticals, but in a manner appropriate to the particular technology. If the wrong assessment criteria are used it can result in the blocking of patient access to safe, cost effective and clinically beneficial new technologies. Medical device technology may in some cases have the potential to change patient pathways by affecting the way in which treatment is delivered, but cost-effectiveness data may be limited until such a new approach has been tested.

4.4 The NHS Evidence portal proposed in the Review may involve a distinction between what NICE and others actually evaluate and evidence from other sources. It is plainly impossible for the NHS and its agents to evaluate everything, but it would be beneficial to make it easier to access such evidence as is available and possibly to benchmark it.

4.5 The Review mentions the strengthening of horizon scanning for medicines. With different protection for intellectual property in the medical devices industry clarification is needed as to how this would work.

5. Innovation

5.1 The Review proposes that Strategic Health Authorities will have a legal duty to promote innovation, and given regional innovation funds to do this. Also that Health Innovation and Education Clusters will be formed to harness the creativity and skills of NHS staff, academics and industry.

5.2 ABHI has been arguing for a greater emphasis on innovation and partnership working between industry and the NHS for some time. This will benefit patients, the NHS, and boost R&D and the UK industry. The NHS will need to demonstrate an improved rate of adoption of new technologies given its poor track record.

5.3 The medical technology industry in the UK has had decreasing incentive to promote innovative technology. The top-down approach to procurement taken by the NHS historically has encouraged uptake of industrial supply chain models with a cost control focus by operational units very poorly equipped to understand their limitations. This has tended to reinforce the continued antipathy to innovative technology.

5.4 Larger medical device companies have informed ABHI that they will tend not to launch innovative products in the UK as the market would not bear the price. Where innovative products are less likely to be sold, R&D is less likely to be carried out. The access for small companies with new products for the NHS market is a slightly different issue, very much affected by the style of procurement.

5.5 Currently, local incentives to innovate are limited and easily drowned out by the strength of NHS-wide drivers and PbR has not to date had significant effect in stimulating innovation (with some exceptions in Practice-Based Commissioning).[25]

6. Personal Budgets/Direct Payments

6.1 The Review proposes a pilot programme in 2009 to explore the potential of patients with long term conditions being allocated healthcare budgets to spend on treatments of their choice as currently happens in social care.

6.2 This raises questions as to how patients will receive sufficient information in order to make an informed treatment choice. The treatment options could involve patients choosing between different medical technologies, or similar products made by different companies. Patients would therefore need to be provided with all the relevant information in order to make this decision.

6.3 If the pilots were successful and the practice rolled out to all eligible patients could this potentially lead to companies advertising their products directly to patients? With competing hospitals soon to be allowed to advertise to attract patients, there certainly seems to be a trend in this direction. The policy appears to connect with the changes proposed under PbR although further clarification is needed on how this will work in practice.

[25] See ABHI submission to the Next Stage Review on innovation.

7. Conclusion

7.1 Overall, this report looks like a step in the right direction, and adds to the mounting pile of evidence contained in reports from Wanless,[26] Cooksey,[27] and the Healthcare Industries Task Force[28] that there are systemic problems of adoption within the NHS which must be addressed.

7.2 Measures contained in the Review have the potential to address some of the historic problems the NHS has with providing access to new treatments and encouraging innovation. Of particular benefit will be the proposals to incorporate quality into the PbR system, enforcing uptake of NICE recommended technologies, improving and simplifying the HTA system, and providing incentives for innovation.

7.3 The main areas of concern for ABHI are ensuring that HTA requirements are appropriate for medical devices, and that medical devices are differentiated from pharmaceuticals. That any reform of the HTA system and NICE occurs in a manner which does not block access to innovative technologies, and that all reforms are implemented in a manner that boosts innovation and improves patient access to new and clinically effective technologies.

July 2008

Memorandum by the Assura Group (DZ 12)

NHS NEXT STAGE REVIEW

1. Introduction and Background to Assura Group

Assura welcomes the opportunity to submit to the Health Select Committee on the subject of the recently published final report of Lord Darzi's NHS Next Stage Review.

Assura partners with GPs and other healthcare professionals to deliver high quality medical care, innovative property solutions and consumer responsive pharmacy services. It is fully listed on the London Stock Exchange, has a strong balance sheet and substantial asset backing.

Assura and its three business divisions—Medical, Pharmacy and Property—work together to deliver solutions to meet local primary care needs. We believe that this strategy is what sets us apart from other healthcare providers through our:

- collaborative model of working with GPs;
- competitive advantage in the pharmacy market;
- business model built on a strong asset backed portfolio of property;
- synergies between the three divisions in delivering integrated care; and
- relationships and reputation with individuals from all levels of the NHS value chain and particularly within Primary Care Trusts (PCTs).

Assura aims to be one of the UK's largest health care provider organisations by 2010.

Assura is encouraged by the report's recognition of the importance and potential of primary and community care. Enabling local health economies to drive quality, to take advantage of the opportunity to provide more integrated care and to take control of and direct local resources will be vital in delivering Lord Darzi's vision for the NHS. We also believe the various measures to enhance patient empowerment, such as the new NHS Constitution, will enable the NHS to become a truly patient-centred service.

The implementation phase of this process will be vital in delivering real and lasting change to the NHS and Assura looks forward to working in partnership with the Government in delivering Lord Darzi's vision.

2. Summary

2.1 The overarching commitments to high quality-care and the delivery of choice in primary and community care settings are to be particularly welcomed.

2.2 Putting clinicians at the heart of the service is vital and Assura believes that this report will herald a new commitment to delivering this. Assura partners with GPs to form provider organisations (GPCos) to provide community-based medical services whilst being supported by Assura's supply of enablers such as informatics, IT, management, diagnostics and capital.

2.3 Assura welcomes initiatives to ensure transparency in the funding system and enhance competition. The proposed reforms to payment by results will ensure this reform lever is better able to drive competition and choice in local health economies.

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[26] *Securing Our Future Health: Taking a Long-Term View*, Derek Wanless, 2002.
[27] *A review of UK health research funding*, Sir David Cooksey, 2006.
[28] *Innovation for health: Making a difference*, 2007.

2.4 We fully support the further integration of new and innovative community-based services, whereby service providers collaborate with one another to offer a range of services operating from a single location or a federated model.

2.5 Enabling PCTs to become effective commissioners is essential to ensure Lord Darzi's vision is delivered on the ground, and so Assura welcomes the various initiatives in this area, including steps to develop and implement world class commissioning.

2.6 Assura is keen to see a strong role for integrated pharmacy services such as offering treatments for minor ailments in delivering Lord Darzi's vision.

3. Choice, Competition and Quality

3.1 Assura is encouraged by the report's focus on the extension of choice and the particular commitment to its extension for patients in primary and community care settings. We believe independent sector primary care organisations such as Assura have a key role to play in delivering this vision and in enabling GPs and other primary care service providers to deliver improved patient care in a setting close to home. We are pleased to see the patient's right to choice will be enshrined in legislation through the NHS Constitution.

3.2 The initiative to phase out minimum-income guarantees is welcome as this will lead to a level playing field for primary care providers, enabling better competition which will lead to improved services for patients as providers compete on quality and responsive services.

3.3 We welcome the focus on quality and the goal of embedding high-quality services for patients throughout the NHS. The 'Quality Accounts' initiative will be a useful tool in making information on local services available to patients, thus facilitating choice, and is right to include providers from the independent sector.

3.4 There is a focus on allowing much more decision-making to take place at local PCT level, with PCTs encouraged to champion quality in their local health economy. The proposed pilot to explore how this system can be further embedded should give greater flexibility to PCTs to work with primary healthcare teams to select quality indicators (from a national menu) that reflect local health improvement priorities. Assura will be interested to learn further details of this pilot process and would welcome the opportunity to contribute to the formation of the national quality indicators.

3.5 Assura notes that the Government intends to publish advice for PCTs on the range of organisational options and the implications for issues such as governance, patient choice, competition and employment. As part of this process it will be important to ensure that PCTs are supported in their ability to liaise with independent providers and work closely with SHA commercial leads to increase their knowledge and skills in this important area.

3.6 Assura welcomes the statement within Lord Darzi's report that responsive primary care services should be tailored to the needs of local health economies and the recognition that this might take the form of either co-located services in a one-stop-shop or a federation of GPs, both options which are supported by the Assura model and determined with local stakeholders.

3.7 The proposed reforms to the Quality and Outcomes Framework (QOF) to better enable high quality care and preventative health are to be welcomed. Assura believes that streamlining and developing the QOF system will better incentivise and reward the delivery of high quality care by GPs.

4. Integrating Care

4.1 Assura supports the aim of better integrating care—the Assura model is predicated on enabling a greater range of services to be delivered in primary care and community settings, including diagnostics and out-patient day care.

4.2 Assura is particularly encouraged by the Government's recognition that "the good primary and community care services of the future will not simply be more efficient and responsive versions of what we have now. They will have seized the opportunity to provide a much wider and more integrated range of services".[29] Independent sector organisations such as Assura have a vital role to play in enabling PCTs to do just this.

4.3 We note with interest that the Government intends to pilot new models of integrated care with the aim of transforming patient services. Assura has been developing models of integration for some time, working not just with GP partners but also other health professionals and local acute services to provide seamless care for patients. The latter is absolutely vital since improving primary care services must not come at the expense of destabilising the local health economy and it is in this area that Assura has significant experience.

[29] *NHS Next Stage Review: Our Vision for primary and community care*; p 50.

5. Commissioning

5.1 Enabling PCTs to become effective commissioners is essential in ensuring Lord Darzi's vision is delivered on the ground. The report quite rightly recognises that more support needs to be put in place to ensure Practice Based Commissioning (PBC) is able to live up to its potential in ensuring commissioning is tailored to the needs of local patients. It will be vitally important that PCTs work closely with their local clinical community to reform PBC and that any changes are done alongside GPs.

5.2 Aligned to this, Assura strongly welcomes proposals to give high-performing groups of Practice Based Commissioners greater freedoms. When held to account for how they discharge their responsibilities by PCTs, PBC groups can play a leading role in improving health outcomes for local people.

What does good commissioning look like?

- be clear about priorities and make sure all agree;
- be clear about the process of engagement;
- specify the outcomes needed and quality markers;
- transfer risk: activity, financial;
- transparent, sophisticated procurement;
- robust contracting and audit;
- principles and Rules of Co-operation and Competition; and
- let the providers innovate within a clear framework.

5.3 Assura is encouraged by the desire to embed the world class commissioning competences and deliver choice and competition on the ground. In particular, we welcomed the publication of the PCT procurement guide to support PCTs in the local procurement of health services. The guide recognised that the "Any Willing Provider" approach[30] should not be constrained except under "exceptional circumstances". This approach will enable choice and competition and deliver the best level of care for patients and will enable the removal of barriers to entry for independent providers which still exist in many local areas.

5.4 The creation of community foundation trusts is an interesting development and an area that will require focus over the coming years. Having been through challenging reconfiguration processes, PCTs should now be in a stronger position to lead the Darzi vision and where they can demonstrate delivering this effectively, Assura fully supports greater freedoms and more flexibility.

5.5 As the report recognises, GPs have the expertise and patient knowledge to provide and commission patient care and act as gatekeepers to other services which are increasingly being delivered in primary settings. However, GPs may lack the time and resources to cooperate with colleagues to form viable and effective commissioning and provider organisations. The Assura model was established to enable GP groups to become effective provider organisations and to maximise the opportunities offered by the new contract and Practice Based Commissioning framework. Working in partnership, we support GPs to deliver high quality out-patient day care, diagnostic services and minor procedures to their communities.

5.6 We achieve this by forming joint venture partnerships (GPCos) with GPs and locality groups where the GPs become 50% shareholders in a Limited Liability Partnership (LLP). All profits are split between Assura and the GPCo partners and any losses are fully underwritten by Assura. The company does not run GP practices, but we do offer start-up capital, ongoing financial and administrative support and expertise in understanding SHA and PCT priorities to enable groups of GPs to provide services effectively. Where they are required, Assura can also provide the new facilities to enable delivery of this range of new services.

5.7 Assura welcomes the Government's support for accreditation schemes, such as that being developed by the Royal College of General Practitioners. As well as supporting the focus on quality, Assura believes accreditation systems such as these will support the Government's intention to devolve increased responsibilities to those commissioning groups that are performing well.

5.8 In addition to accreditation schemes, the Government's commitment to showcasing and encouraging best practice is also to be welcomed and will help enable the delivery of Lord Darzi's vision for primary and community care services. As part of this process it will be important for the Government to showcase the full range of services being delivered in primary care to demonstrate the effectiveness of some of the reforms which are going on at the local level.

[30] The term "any willing provider" (AWP) describes a set of system rules whereby, for a prescribed range of services, any provider that meets criteria for entering a market, can compete for business within that market, without constraint by a commissioner or payer organisation. (From the DH PCT Procurement Guide, May 2008).

6. Pharmacy

6.1 Assura notes the lack of reference in the review to the role of pharmacies in delivering a range of enhanced services and enabling the delivery of more and better care in the community. The report does, however, make a specific reference to the provision of vascular health checks and other preventative services in pharmacy settings, which is to be welcomed.

6.2 It is important to note the contribution that each of the SHA Visions makes to the Next Stage Review process. Specifically for pharmacy, there are examples of innovative thinking such as South Central SHA's proposal to look at allowing prescribed drugs to be sent to people's homes or local pick-up points. This ties in well with a Repeat Medicines Management Service being trialled by Assura in Bristol and would, if replicated nationally, free up GPs to focus on their core job and give patients greater choice and control.

6.3 The wider vision for pharmacy as set out in the Pharmacy White Paper[31] has been welcomed by Assura and we were particularly encouraged by the clarity of the Government's view that modern clinical pharmacies are the pharmacies of the future and by the intent to enable and support the commissioning of services in the pharmacy sector, supporting the delivery of an integrated pharmacy model which is at the heart of the Assura's pharmacy approach.

6.4 Despite the lack of explicit references to the potential of pharmacy in delivering many of the initiatives set out in the report, it is vital that this potential is not overlooked in the implementation phase of Lord Darzi's vision. This should be acknowledged in the forthcoming consultation on various issues identified in the Pharmacy White Paper.

7. Payment by Results

7.1 Assura welcomes the various proposed reforms to the Payment by Results (PbR) system as set out in Lord Darzi's report. It is important to ensure this reform lever is enabled to work most effectively and Assura agrees the best way to do this is to ensure the system is tailored and responsive to local settings. Assura therefore particularly supports the proposed development of a framework to support local development of pricing for community-based services.

7.2 Given the overarching focus on ensuring the delivery of high quality care, Assura believes it is appropriate to strengthen the PbR system to reflect quality in the payment mechanism as well as increasing the control of individual patients.

7.3 Assura fully supports the Government's intention to move away from block contract funding. This development is vital to ensure the Government's aim of a transparent funding system is fully realised.

8. Regulation of Primary Care

8.1 Assura supports the Government's decision to extend regulation into primary care and believes that the registration of GPs and other primary care providers will serve to future-proof the system and represent an important step in improving patient care and safety.

8.2 Assura has put together a full submission to the Department of Health consultation The future regulation of health and adult social care in England: A consultation on the framework for the registration of health and adult social care providers. Assura supports the operation of a regulation system based on clearly defined criteria and looks forward to an ongoing dialogue with the Government and the Care Quality Commission on these issues.

9. Conclusion

9.1 The NHS Next Stage Review represents a tremendous framework out of which real and lasting change can develop. On primary and community care—a central part of this review—the signs are there that a robust market is being created with policy and rules to enable progress, applied in a fair and consistent way, with providers armed with the tools to achieve the implementation of the highest quality services.

9.2 GPs at the heart of this reform process is the central message to come from the review; a message which Assura fully supports both practically through our business model and more broadly as the way to ensure local decisions are taken that reflect the health needs of local people. This collaborative and non-predatory approach is the way to ensure true partnership between public, private and voluntary sectors and to ensure that at each stage of the patient journey the highest quality care possible is being delivered.

July 2008

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[31] Department of Health, *Pharmacy in England: building on strengths—delivering the future*, April 2008.

Memorandum by the British Geriatrics Society (DZ 13)

NHS NEXT STAGE REVIEW

The British Geriatrics Society

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,200 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, allied health professionals, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.

Geriatric Medicine

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.

The Society is delighted to be given the opportunity to present evidence.

1. The extent to which individual SHA Darzi reports are welcomed by geriatrician colleagues seems to be proportional to the degree of input of geriatricians to the care pathway groups.

2. There is support for the principles expressed in end of life pathways, mainly because these all seem to promote the principles of a good death as expressed by NCPC and others in an ageless way. However, the BGS would seek reassurance that older people will be strongly encouraged to discuss any advance care plans with a health care professional who has a rapport with the individual and where necessary, supported by a professional with relevant specialist knowledge. In particular Advance Decisions to Refuse Treatment should be discussed with a doctor. Professionals should avoid initiating discussions immediately after a move into a care home but these should be undertaken once individuals are more settled

3. Most reports do not appear to recognise the complexity of older people with long-term conditions, in that they have multiple long-term conditions rather than just one.

4. There is no apparent linkage of proposed changes in health care to transportation and so a presumption that everyone will be able to travel to 'polyclinics'.

5. Not all reports emphasise the wealth of literature on falls prevention and but most do mention this important area.

6. In West Midlands there is no mention of the diverse population and their various ethnic and cultural needs (service provision, language, care homes and rehabilitation services).

Professor Peter Crome MD PhD FRCP FFPM
President

July 2008

Memorandum by The Company Chemists' Association Ltd (DZ 14)

NHS NEXT STAGE REVIEW

Executive Summary

As the forum for large businesses engaged in community pharmacy service provision, the Company Chemists Association (CCA) welcomes the opportunity to respond to this Inquiry. Through the CCA, our nine member companies work together to help create an environment where community pharmacy can flourish, and where pharmacy contractors compete in a fair and equitable way. Our nine members—Boots, The Co-operative Pharmacy, LloydsPharmacy, Tesco, J Sainsbury, Wm Morrison Supermarkets, Asda Wal-Mart, Rowlands Pharmacy and Superdrug.—own over 50% of the pharmacies in the United Kingdom.

The CCA has read with interest the NHS Next Stage Review report[32] and the primary and community care strategy.[33] The CCA believes that the Department of Health's (DH) direction of travel is the right one, and that a health service where commissioners collaborate with providers to improve quality and focus on

[32] Department of Health. *High quality care for all. NHS next stage review final report*. July 2008.
[33] Department of Health. *NHS next stage review. Our vision for primary and community care.* July 2008.

health and well being, whilst driving a primary care market where providers compete fairly and equitably to provide a choice for patients will increase innovation and ensure that different health care consumers' needs are met; as long as a number of caveats are addressed in practice. They are summarised below:

- development of commissioning competence amongst PCTs, including widespread adoption of social marketing techniques at local level;
- redesign of practice based commissioning;
- equalisation of the NHS internal market to mitigate against continued dominance by legacy providers; and
- clarification of how competition law applies in the NHS.

1. PCT Commissioning

1.1 It is our members' experience that dealing with PCT commissioners is currently a huge challenge. They have undergone significant structural reform and in many cases this has impeded their ability to bed down primary care commissioning and translate it into meaningful management processes. We are hopeful that the Department of Health's commitment in the NHS Next Stage Review to get PCT commissioners quickly up to speed is delivered through the world class commissioning programme. To ensure this happens, we would propose that the Health Select Committee calls for stringent monitoring of PCT performance against these competencies by strategic health authorities. As part of this monitoring, the CCA would like to see PCTs undertaking 360 degree appraisals with their external stakeholders, including patients, local authorities, social care and local NHS providers with whom they contract (including community pharmacy owners). They should also put in place feedback mechanisms with these stakeholders to outline what the PCT has done to remedy their concerns—if they express any. This would represent a more qualitative measure of stakeholder satisfaction with the PCT as a commissioning partner.

1.2 In addition, we believe that for the NHS to become more patient focused, NHS commissioners—and indeed providers—need to base their service development on healthcare consumers' real preferences. Social marketing employs the techniques of marketing used in the commercial sector. The fundamental building block of all marketing is robust market research. This is alluded to in the primary care strategy with its reference to the need for primary care providers to "seek out ever more sophisticated ways of understanding their customers". In order to commission effectively, PCTs must understand how people actually use services; and how they would use them if they were remodelled in the future. Professionals' opinions of patients' preferences are not a good proxy in this regard. For instance, we are aware that Which? have recently undertaken consumer research that suggests that the majority of patients are happy to trade convenient access to a GP for continuity of care.

2. Practice Based Commissioning

2.1 We are also aware that practice based commissioning has failed to deliver any significant patient benefits,[34] despite costing the NHS at least £94 million to date. Whilst we welcome commitments to reinvigorate PBC in the NHS Next Stage Review, we think, given its failure to deliver after three years, reform needs to go further; with a radical overhaul of the current model. First of all, PBC needs to be re-named. Especially in light of the increasing focus on prevention, health and well being heralded in this Review, the scope of clinician-led commissioning clearly goes far beyond the realm of general practice. Practice based commissioning is a misleading name and casts too narrow a reference point.

2.2 We believe that a wide range of health and social care professionals need to be engaged in the commissioning process; and that their decision making should be underpinned and informed by market research that helps commissioners to understand patient's preferences for service design and builds on feedback from their experience of using existing services. Given that medicines are a key part of treatment of most conditions, community pharmacy is an important part of this commissioning team. Because they are a key stakeholder in ensuring a quality, integrated service where specialist knowledge supports generalists in primary care to triage patients, secondary care is also a key partner. Depending on the disease state under consideration, other professional groups should also be included as appropriate. For instance, opticians and podiatrists will have a key contribution to make to diabetes care; community nurses and care workers will be important in services for older people.

3. Levelling the Provider Playing Field

3.1 Historically, the NHS is risk averse when it comes to working with new providers. This is unsurprising, given the imperative to ensure continuity of service for the public. However, the Department of Health has signalled clearly that PCTs are tasked with stimulating innovation and choice by creating markets in primary and community care. Community pharmacy contractors already compete fiercely with each other to provide services to patients. This drives innovation and customer service development within

[34] Audit Commission and Healthcare Commission. *Is the treatment working?* June 2008.

the pharmacy sector. Our members are keen to compete in the wider primary care market for a wide range of clinical services, but their experience of commissioning to date suggests that current commissioning and procurement processes favour legacy providers, and effectively gated out new market entrants.

3.2 The Pharmacy White Paper[35] paints a picture of community pharmacy services in the future that are focused around pharmacies as healthy living centres. The CCA would ask the Health Select Committee to ensure that commitments to redesign the Quality and Outcomes Framework to refocus on health and well being are dovetailed from the start with similar developments in the pharmacy contract so that pharmacists and GPs complement and support each others work with local communities to refocus the public on taking personal responsibility for their health. Experience from the implementation of the first iterations of the GMS and pharmacy contracts teaches us that unless there are incentives for collaboration, the introduction of new services are viewed as a competitive threat or infringement of traditional spheres of practice, and act as a deterrent to collaboration. We do not want this to happen, and would encourage the Health Select Committee to scrutinise carefully how contractual arrangements to incentivise pharmacy and GP engagement in health and well being are dovetailed to ensure maximum impact at local level.

3.3 Further more, we believe that the missing link in the agenda to improve quality and assure of patient safety is new thinking on how providers can be incentivised to collaborate within an environment where commissioners require tough competition between providers for patients in pursuit of choice and innovation. The CCA believes that the key to success will be creating the right incentives and instilling a shared business ethic amongst all providers so that focusing on the best interests of the patient drives provider success—however that is measured. The CCA is considering how we can contribute to this thinking currently, and would be keen to be involved in policy discussions on this issue.

4. Competition Law and the NHS

4.1 The emerging NHS market is fraught with market development challenges. It is dominated by monopoly providers; and we understand that at least one key provider group in primary care, general practitioners, are exempt from competition law. Our members, as major players in the UK retail pharmacy market, are acutely aware of the restrictions placed on them in terms of collaboration through competition law.

The introduction of GP federations signalled by the Royal College of GPs in its recent publication;[36] and the development of integrated care organisations may inadvertently create monopolies or consolidate dominant providers within PCT geographical boundaries.

We believe that the Department of Health must urgently review and clarify how competition law is to be applied within the NHS. Whatever the outcome of this review, it must ensure a level playing field between all providers, regardless of their organisational model. We believe that any provider exemptions from the rigours of competition law must be independently scrutinised and justified by the Department of Health, given its commitment to a transparent, competitive market within the NHS. We believe the continuation of the current inequitable application of competition law between providers is unsustainable.

July 2008

Memorandum by Diabetes UK (DZ 15)

THE NHS NEXT STAGE REVIEW

1. Introduction

1.1 Diabetes UK welcomes this inquiry by the Health Select Committee and the recognition of the impact that the Darzi Review will have on the configuration and provision of NHS services in England.

1.2 Diabetes UK welcomed the extensive opportunities for stakeholder involvement in the development of the NHS Next Stage Review and was delighted to contribute through the national stakeholder forums, regional working groups and other events and meetings.

1.3 Diabetes UK is committed to working both regionally and nationally to help implement the recommendations in the Darzi Review in order to ensure the delivery of better care for people with diabetes.

1.4 We have concentrated our remarks to the issues where we feel we can most effectively contribute to the debate. We would be delighted to supply additional information, or clarification on any of the points raised in our evidence.

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[35] Department of Health. *Pharmacy in England. Building on strengths—delivering the future*. April 2008.
[36] Royal College of General Practitioners. *GP federations—the solution to improving care for patients*. July 2008.

1.5 Diabetes UK is the largest charity in the UK working for people with diabetes, funding research, campaigning and helping people live with the condition. We have over 170,000 members and represent the interests of people with diabetes, their carers, family and friends, by lobbying the government for better standards of care and the best quality of life.

1.6 2.3 million people in the UK have been diagnosed with diabetes and it is estimated that more than 500,000 people have the condition but are not aware of it. Evidence suggests that 4 million people will be living with diabetes in the UK by 2025.

2. Summary of Key Points

2.1 Diabetes UK welcomes moves to improve the health of the population through prevention and screening but believes it is vital that screening programmes are targeted to those at most risk and are linked to increased education and public awareness.

2.2 Diabetes UK believes it is vital that people with diabetes and other long-term conditions are involved in treatment decisions and agree their care in partnership with their healthcare professional team.

2.3 Diabetes UK welcomes the announcement that the use of personal healthcare budgets will be piloted for people with long-tem conditions prior to wider roll out but it is still unclear how this will work in practice. We recommend that personal budgets for people with diabetes should focus on non-clinical services.

2.4 Access to services that are integrated across primary and secondary care and focused on the individual's needs leads to improved outcomes for people with diabetes.

2.5 Diabetes UK supports the general principle of the models such as polyclinics as a way to integrate local care in a "one-stop shop", but recommends further piloting as this may not be the best way to structure services in every PCT area.

3. Vascular Screening

3.1 Meeting the health needs of the population, particularly through prevention and screening is something that Diabetes UK welcomes. The recent Government commitment in Putting Prevention First meets our long standing calls to establish proactive and systematic programmes to ensure early identification of more than half a million people with Type 2 diabetes who remain undiagnosed.

3.2 Increased public education about the risk factors for diabetes and how this links to vascular disease is needed alongside communication of the continuum of risk. It will be necessary to develop better ways of communicating risk to help people understand their level of risk, what it means and how to take appropriate action.

3.3 Presence of a risk factor for diabetes (obesity, large waist circumference, family history, Asian/ African origin etc) improves the performance of all screening tests. Over 80% of people with Type 2 diabetes are overweight at diagnosis and the more overweight a person is, the greater the risk of diabetes. Therefore, targeted case finding of high risk groups should be encouraged.

3.4 Delivery needs to reach those living in deprived communities, who are 2.5 times more likely to have diabetes as well as those from Black, Asian and Minority Ethnic communities who are at increased risk of developing diabetes at a younger age. The programme must ensure it does not increase health inequalities by ensuring that services are provided in a variety of settings, including pharmacies and other local outreach services. Flexibility is required with regard to the proposed age range of 40-74 and the age for those from higher risk diverse communities will need to be lowered (ie 25 years for South Asian/African Caribbean men).

4. Personal Budgets

4.1 Diabetes UK supports the decision that personal health budgets must be piloted prior to wider roll out, particularly whilst the evaluation of the social care model pilot has not yet been published. A detailed assessment of the impact of health based personal budgets on care experience and outcomes is needed. We would advocate that where personal budgets are implemented for people with complex long term conditions, they are used for the commissioning of non-clinical services such as education, weight management and health promotion. The current literature and the NHS review have identified that individual budgets are likely to work best when conditions are stable and predictable. The complexity of diabetes means that people may experience unplanned healthcare events such as developing a complication which will incur additional healthcare costs, it is therefore unclear how the use of personal budgets for people with diabetes will work in practice. Calculating the allocation of individual healthcare budgets for people with diabetes will be difficult, however work is ongoing within the Year of Care pilots to identify packages and costs for diabetes care.

4.2 Should individual budgets be piloted within diabetes care, or an element of diabetes care, it should be done within the context and structure of the Year of Care approach. Diabetes UK has a desire and willingness to contribute to the development and piloting of personal budgets for people with long term conditions.

4.3 It is also imperative that personal health budgets do not impact negatively on the access to and outcomes of care, ensuring that they do not increase health inequalities. People with diabetes must be assured access to the clinical care, treatments and support to self-manage that they are entitled to. The budgets, types of treatment or management that are made available should have an associated cost. All services must be regulated to ensure that standards and competencies are attained.

4.4 The choice "not to choose" should also be recognised and that, where personal budgets are described as voluntary, consistency of services providing high quality, effective care should remain available to those not wishing to use a personal budget.

5. Empowering, Collaborating and Forming Partnership with Patients

5.1 The involvement of people with long-term conditions in planning their own care and choosing how to manage their own condition is a critical step towards improving patient related outcomes, and personalised care.

5.2 Less than half (47%) of those surveyed by the Healthcare Commission reported having an agreed plan to manage their diabetes. Findings also suggest that older persons and those from the most deprived communities had fewer opportunities to discuss their goals and ideas compared to younger aged groups.[37]

5.3 Diabetes UK's *Year of Care* describes the on-going care a person with a long-term condition should expect to receive in a year, including support for self-management, which can be costed and commissioned, putting patients in the driving seat of their care and supporting them to self-manage effectively. The Year of Care programme tests the feasibility of, and provides practical solutions for delivering personalised diabetes care as part of mainstream care using the mechanisms and opportunities provided by the Health Reform agenda and World Class Commissioning.

5.4 The Year of Care programme is rolling out care planning to stimulate a wider range of more flexible service provision, tailored to the needs of individuals with long-term conditions. It is also exploring how to get the right services and support in place for individuals, capturing individual priorities and goals from care planning discussions to feed back into commissioning at a population level.

5.5 The delivery of high quality and supportive care needs to be supported by training programmes to enable professionals to work in partnership with people with long term conditions. This training must be based in a consistent and quality assured curricula.

5.6 If personal budgets were to be put into practice then they would need to be implemented within this context to ensure that all people with diabetes are informed of the care they should expect and how to access it.

6. Integrated Care

6.1 Integrated diabetes care aims to ensure that the individual's experience of interacting with a range of professionals, based on clinical need, is both seamless and focused on individual's needs. Any model of care for diabetes services must not compromise continuity or consistency of care, and the focus must be on delivering well planned and integrated services that ensure timely access to appropriate treatment, diagnostics and advice.

6.2 The greatest consideration in planning is accessibility to and availability of services, and the need to ensure that existing services are not fragmented. It is imperative that any restructuring of local services, and in particular the integration of secondary and primary care services, be planned and developed in line with the key issues identified in Our Health, Our Care, Our Say, and latterly the 11 competencies of World Class Commissioning, which will be central to achieving the vision set out in Lord Darzi's review. The needs of people with long-term conditions, and particularly diabetes, will be to ensure that their local services are provided in a seamless, accessible and effective manner, via which option is recognised as best suited to the needs of the local population.

6.3 If services are being reorganised they need to be subject to proper consultation; an integrated approach to planning and delivering care is likely to produce the best results for people with diabetes. Effective commissioning is vital if organisations are to work in partnership across the whole system of care. Managed diabetes networks, which include people with diabetes, are an effective means to engage with all stakeholders to review and develop services.

[37] National Centre for Social research. The National Survey of People with Diabetes. Substantive report. Prepared for the Healthcare Commission. September 2007.

6.4 Diabetes UK agrees with the general principle of polyclinics as described in *A Framework for Action*, recognising that in certain circumstances they may provide cohesive local services in those communities where identified needs have been established. However, we would urge prudence in the national rollout and a need to run structured pilot schemes to provide evidence of the model's effectiveness.

6.5 The model of Diabetes Centres provides another viable option to enabling people to have access to the complete range of diabetes care as a "one-stop shop". This provides a means of ensuring that people with diabetes have access to high quality care and support from a team of clinicians and diabetes specialist health professionals.

6.6 The development of primary care based diabetes services, for example those implemented through practice based commissioning, also seek to ensure locally based services that provide the full range of care and support previously offered by hospital based services, whilst maintaining access to a comprehensive range of hospital based specialist clinical services.

Douglas Smallwood
Chief Executive

July 2008

Memorandum by NHS North West (DZ 16)

IMPLEMENTING THE NHS NEXT STAGE REVIEW: DELIVERING HEALTHIER HORIZONS IN THE NORTH WEST REGION

1. Introduction to the Author

1.1 Mike Farrar was appointed as Chief Executive of NHS North West, the new Strategic Health Authority for the north west of England in May 2006. Previous to this, he had been Chief Executive of West Yorkshire SHA and of South Yorkshire SHA before that. Other previous posts include Chief Executive of Tees Health Authority and Head of Primary Care at the Department of Health.

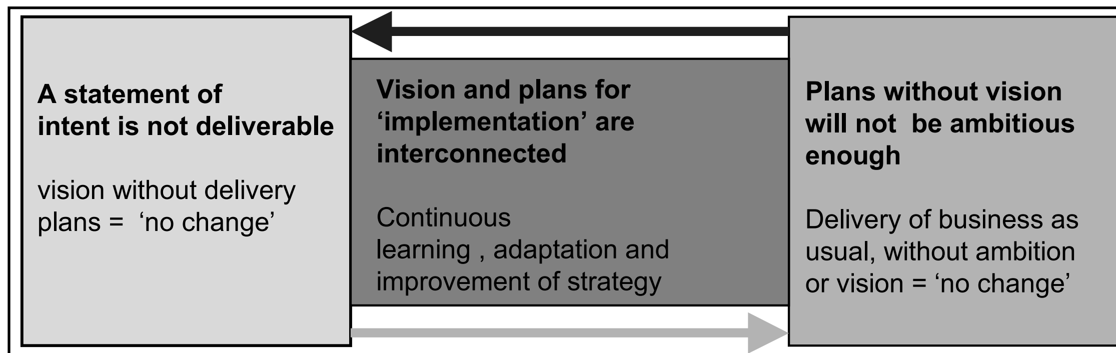
2. Purpose of this Memorandum

2.1 This memorandum has been prepared for submission as written evidence to the Health Committee session that explores how Strategic Health Authorities (SHAs) intend to implement the visions for health and healthcare they published in Spring 2008. This account refers particularly to the implementation of Healthier Horizons the long term vision for health and healthcare in the North West of England published in May. The next steps in the implementation of that vision are identified, along with an account of how the work of NHS North West (NHS NW) fed into the national Our NHS Our Future review.

2.2 From September 2007 to July 2008 the NHS in the North West was part of a once-in-a-generation review of its services. Launched in September 2007 by Lord Ara Darzi, Our NHS Our Future aimed to put clinicians, patients and the public at the heart of the NHS; to improve patient care and safety; to ensure care is more accessible and convenient; and to establish a vision for the future of the NHS to coincide with its 60th anniversary in July 2008. NHS North West saw this as an opportunity to establish an ambitious, but deliverable vision for improving the quality of care in the region and to close the health gulf which exists between the people of the North West and other parts of the country.

2.3 Before outlining the main elements of that vision, and the next steps for implementing it in the North West region, it is worth making some general statements about NHS NW's approach to the Our NHS Our Future review. Firstly, NHS NW considers vision, strategy and planning for the effective implementation of those proposals as inextricably linked. This organisation recognises that ambitious vision without appropriate delivery mechanisms is unlikely to result in improvement and change on the scale described in Our NHS Our Future review. On the other hand, it is important that the NHS in the North West does not deliver 'business as usual' without ambition for change on behalf of the people using health services. A delicate balance between ambition and implementation has to be struck, and the structure and emphasis of Healthier Horizons reflects this balance—the implementation implications are considered alongside the long term vision for change throughout the document, and an exhaustive account of the next steps for implementation is given in chapter 3 *Delivering our vision*, and chapter 4 *How will you know we are succeeding?*.

Figure 1



2.4 From the outset, the review was designed as a participative "listening" process to create a long term vision for the NHS that was owned, and steered by existing NHS stakeholder groups. At the outset of the Our NHS Our Future review, Lord Darzi challenged the process "to help local patients, staff and the public in making the changes they need and want for their local NHS". In recognition that improvement solutions already "lie within" the system, the Our NHS Our Future review sought to engage people already working in, with and served by the NHS. At a regional and national level, this participative process involved a wide and diverse range of stakeholders—different types of clinicians; staff; patients and members of the public; partner organisations from Local Government; third and private sector organisations. But there was much more to this process than simply "listening" to people's ideas. It was important that those who took part were enabled to lead and create change themselves, and that change was driven by a strong local NHS. NHS North West took seriously the task of sustaining this multi-dimensional engagement, and viewed this engagement as critically important in enabling and sustaining long term change.

2.5 Finally for this introductory section, NHS North West recognised at the outset of the Our NHS Our Future review that the vision and accompanying delivery mechanisms should enable regionally what the NHS aspires to and drives locally. The North West is not a homogenous region in terms of its geography, infrastructure, communities, mobility or geography. One regional "plan" that prescribes too closely how change will be effected would not deliver long-term, sustainable change and improvement in health and healthcare. The importance of local leadership of change is reiterated in "Leading Local Change", the Our NHS Our Future interim report published in May 2008—one of the five "principles of change" outlined therein is that "all change will be locally led". In line with recent Department of Health policy, and in line with our own corporate experience of effecting change and improvement from the regional tier, Healthier Horizons determinedly enables local NHS commissioning organisations to own, and sustain change.

3. The Key Elements of the Healthier Horizons Vision for Health and Healthcare in the North West

3.1 In summary, Healthier Horizons for the North West calls for NHS hospitals and healthcare centres to improve the quality of care they provide and to listen and be accountable to the patients and public they serve. But the report also calls on the NHS in our region, its stakeholders and members of the public to shift their focus much more towards the promotion of health and the prevention of illness.

3.2 The NHS has made considerable progress towards a healthier future for the people of the North West. Healthier Horizons highlights some of the achievements of the NHS and NHS staff in the region. But people do not always receive high quality health services in the North West. NHS services in the future must deliver world-class quality services time after time; and engage the public and patients more effectively so that decisions are made with and not for them.

3.3 Healthier Horizons describes the intractable health problems among our population and of the need for an effective approach to tackling the source of sickness and ill health in our region. The "10 compelling reasons for change" includes the fact that the North West has the lowest life-expectancy for men and women and the highest rate of infant mortality; people in our region do not always get the latest treatment and technologies; only two of our hospitals received an excellent rating from the Healthcare Commission for quality of services and use of resources. After listening to NHS staff, our partners, and the public NHS NW is convinced of the need to shift the focus in this region to truly become a 'health' service, as well as a being a service to help us when we become ill.

4. The Implementation of the Healthier Horizons Vision

4.1 In recognition that vision without robust plans for delivery will not achieve sustainable change, implementation is a constant theme running through the Healthier Horizons report. Alongside the creation of an ambitious and compelling vision for improvement, it was important that stakeholders and the project

team also considered how those changes would be enabled. The NHS can not achieve these long term changes in isolation, and partnerships with Local Authorities in particular will be of critical importance. The detail of these plans is provided in section 3 of the report, entitled *Delivering our vision", but a summary of these next steps in implementation follows.*

Primary Care Trusts as local leaders of the NHS

4.2 If the Department of Health's vision of World Class Commissioning is realised, then Primary Care Trusts (PCTs) will be the future local leaders of the NHS. PCTs in the North West spend approximately £11 billion per year and are required through their strategic plans to secure services that are valued by the public. It is for this reason that PCT leadership capability will be critical to delivering the Healthier Horizons vision of long term change. Therefore, NHS North West have invested heavily in supporting PCT development of their 3–5 year Strategic Plans, which are due in October 2008. These plans will provide detailed proposals for improving local health and healthcare, including setting out specific changes to the configuration and expansion of local services. NHS North West is also prioritising support to the PCTs as they prepare for the first round of World Class Commissioning assurance, during which they will be assessed in terms of their competences, outcomes and governance. NHS NW is also ensuring that the themes of Healthier Horizons are sufficiently reflected in the Strategic Plans, with a particular emphasis on PCTs taking forward the recommendations of the Clinical Pathway Groups.

North West Leadership Academy

4.3 The development of the NHS North West Leadership Academy, actively hosted by Blackpool, Fylde and Fylde NHS Foundation Trust, is a clear indication of our intent to foster world class, local leadership in the NHS. Building on current leadership initiatives across the North West, it will open up a wide variety of leadership opportunities by a) improving support for people already in senior NHS roles b) achieving a more diverse leadership community by attracting more recruits from outside the NHS c) developing clinicians in leadership roles c) providing leadership development programmes for non executive directors and NHS Trust Boards d) promoting strategic alliances such as links across the public sector, business community, academia and the independent sector.

Quality

4.4 The NHS in the North West has made great strides in improving services and getting the essentials of safety, quality and governance right. But Healthier Horizons proposes that local NHS organisations need to go further, and adopt world class best practice faster. There is already a significant regional initiative underway to enable local NHS organisations to do this. Advancing Quality is the first example in the NHS of a systematic approach to rewarding providers for shifting their emphasis from quantity of provision, to quality. The programme is a clinically led, evidence based approach to improving the reliability of care processes for coronary artery bypass graft, acute myordial infraction, congestive heart failure, hip and knee replacement and community acquired pneumonia. Where this programme has been implemented in the United States, the average improvement of clinical and process indicators was 50.72% over four years. In addition, the cost of providing care fell as the quality of care improved. 16 local NHS organisations have participated in the Advancing Quality pilot, and this approach is projected to result in the prevention of 150 deaths per year in the five clinical areas. The first year of data collection is due to go live in October 2008. In December 2009, Trust performance against the process indicators will be made available publicly as a means of driving improvement, and enabling patients to exercise more informed choices.

Enabling and engaging patients and the public

4.5 A commitment to enabling the public to take more control over their own health and engaging them to take a more active role in NHS decision-making is a critical theme in the North West's long term vision. In Healthier Horizons, this enablement and engagement of the public is described as a 'new relationship' between the NHS and those who use it. NHS NW has a number of programmes planned to enable this to happen locally. The Our Life programme will provide an insight into influences on people's health choices; campaign to increase awareness of health issues; galvanise the public to demand change and to make changes themselves. In addition to Our Life, the NHS in the North West region is developing population risk based assessment so that prevention services are tailored to individual needs. NHS NW plans to establish a citizens "Touchstones Panel" whereby citizens will be able to check NHS progress in realising the Healthier Horizons vision. The SHA is also developing the first NHS tailored Customer Care programme, which will bring a new set of skills and perspectives into the NHS on a local basis—making service improvements where customer feedback tells us it is needed.

Increased transparency and accountability

4.6 Increased transparency and accountability is a significant theme running throughout the North West vision. NHS NW knows from listening to patients and the public that they will expect to see and feel clear benefits and improvements in their health services. In turn, this will in theory drive local NHS systems to be increasingly 'self-improving' to meet the needs and aspirations of a more demanding, better informed public. Healthier Horizons outlines proposals for 10 "Touchstone Tests", indicators which everyone can use to tell if their services are getting better. The tests include indicators such as "I will be more involved in decisions made by the NHS", "I will be receiving better customer care and an improved patient experience", and "My family will have a better opportunity to live a longer and healthier life". NHS NW will be held to account for NHS progress against these tests via a Citizens Touchstone Panel, and through providing regular Touchstones progress updates on the NHS NW website.

Innovation

4.7 Building on earlier work already undertaken in the North West—some of which prompted the growth of Clinical Assessment Treatment and Support (CATS) services in Manchester and community access MRI and CT—NHS NW has commissioned a region wide technology audit. The aim of the audit is to establish a broader baseline, determine priority areas for future action as well as stimulate the growth and development of clinical pathway reform. In addition, NHS NW has been involved in the double-award winning cardiac telemedicine service that has proved the potential to avoid the immediate hospital referral of patients with non-acute chest pain symptoms. A six month pilot of Broomwell's service demonstrated a reduction of nearly 20% in referrals to A&E. This cardiac monitoring service is now currently in use across 150 surgeries in the region, and NHS NW is supporting increased uptake.

Clinicians as leaders of change and improvement

4.8 The involvement of clinicians in the development of high quality services is a mainstream part of NHS North West strategy now strongly reiterated in both Healthier Horizons and in the national Our NHS Our Future review. Clinical leadership has been a vital part of delivering Advancing Quality and to the success of the North West Clinical Leaders Network. In addition, NHS NW plans to ensure sustained clinical engagement in two ways: firstly, by ensuring that the SHA itself has a "clinical heartbeat" and that clinical leadership is a core element of all NHS business in the North West. Secondly, NHS NW will continue to support the development of the PCT Strategic Plans as a key planning mechanism for change and improvement in the next three to five years and will ensure that the Strategic Plans produced by PCTs in the North West region reflect both the CPG recommendations and the involvement of local clinicians.

October 2008

Memorandum by NHS Yorkshire and the Humber (DZ 17)

IMPLEMENTATION OF HEALTHY AMBITIONS

1. Executive Summary

Healthy Ambitions was published on 14 May 2008. In July it was adopted by the board of the Yorkshire and the Humber Strategic Health Authority (SHA) as its vision for the developing services and improving health over the next decade.

The SHA's approach to delivery includes the following elements:

- a clear model for delivery underpinned by key principles and a focussed development programme for key senior leaders across Y&H;
- a programme of dissemination and involvement to ensure a high degree of awareness of the content of Healthy Ambitions and to enable individuals to understand and own their role in delivery. Senior leaders of the NHS organisations across Y&H are fully involved in designing and taking forward delivery;
- clarity about who will do what—with clearly defined levels of delivery to support local and regional action—and with confirm and challenge built into delivery arrangements at each level;
- a robust delivery infrastructure;
- a dedicated budget to support delivery to which all of the region's PCTs have committed resources;
- an approach to innovation and improvement activity designed to support the delivery of the changes outlined in Healthy Ambitions; and
- clear timescales.

2. Margaret Edwards

Margaret is a former Director General of Access at the Department of Health and an experienced NHS manager. At the Department of Health she sat on the national NHS Board and had national responsibility for policy and service delivery across primary and secondary health care. Prior to joining the Department of Health Margaret was Chief Executive at Heatherwood and Wexham Park Hospitals Trust. Prior to this she worked in Surrey, Devon and Norfolk. Margaret is a graduate of the top management programme INSEAD and also holds an economics degree and an MBA. She is a qualified Chartered Secretary and has a diploma in the Philosophy of Medicine.

3. Information—Implementation of Healthy Ambitions

(a) *Healthy Ambitions*

Healthy Ambitions was published on 14 May 2008. In July it was adopted by the board of the SHA as its vision for developing services and improving health over the next decade.

(b) *What will delivery mean?*

It will mean better, safer and fairer care, easier access to services, support and information, fewer trips to hospitals, more treatment available nearer to patients and more prevention.

Putting Healthy Ambitions into action means the NHS will:

- Help people to stay healthy and prevent illness.
- Make sure local services are up to the highest clinical standards which will result in better outcomes for patients.
- Provide clear information for patients on where to get treatment and how to manage conditions.
- Reduce trips to hospital and offer more care out of hospitals.
- Make the most of new technology to treat patients faster and better.
- Make sure we spend money well and make the very best use of our resources.

Examples of what the changes will mean over the next ten years:

- A better system with fewer journeys for patients, carers and families.
- Healthier lifestyles—with a halt in the rise in obesity.
- Rising breastfeeding rates—with reduced variation across the region.
- Halving the number of children admitted to hospital with asthma.
- Mental health services available without waiting.
- Half the number of preventable admissions from diabetes.
- Experienced staff making decisions at the front door of every hospital and beyond for acute care.
- Saving 600 premature deaths every year with better stroke care.
- Double the number of people dying at home rather than hospital.

(c) *Model for delivery*

Our model for delivering Healthy Ambitions is based on the model developed by the Institute for Healthcare Improvement.

Their model, developed from an analysis of high performing and high transforming health systems from around the world, emphasizes that the three key ingredients necessary for any major change.

These are:

- will—you need to create shared purpose about your objectives;
- ideas—you need to be specific about what you want to change and test out how you can make those changes; and
- execution—you need project plans, with timescales and milestones, measurements and clear accountability.

(d) *Principles for delivery*

In light of the model mentioned above, we have confirmed five principles for implementation which in essence support the creation and maintenance of "will"—a clear shared purpose and "execution"—throughout this programme of change:

— clarity of purpose: we aim to keep the objectives of the report—improving health and health care—at the forefront of all discussions;
— co-production: we aim to co-design implementation programmes as much as possible with the NHS, local authorities and key stakeholders;
— subsidiarity: we aim to ensure that where details of implementation can be determined locally, they should be;
— clinical ownership and leadership: we aim to build and sustain clinical engagement and leadership through all elements of implementation; and
— system alignment: we aim to incorporate implementation into mainstream processes, and align our objectives to the goals of Healthy Ambitions.

(e) *Involvement for delivery*

Implementation begins with the engagement of all players in the system.

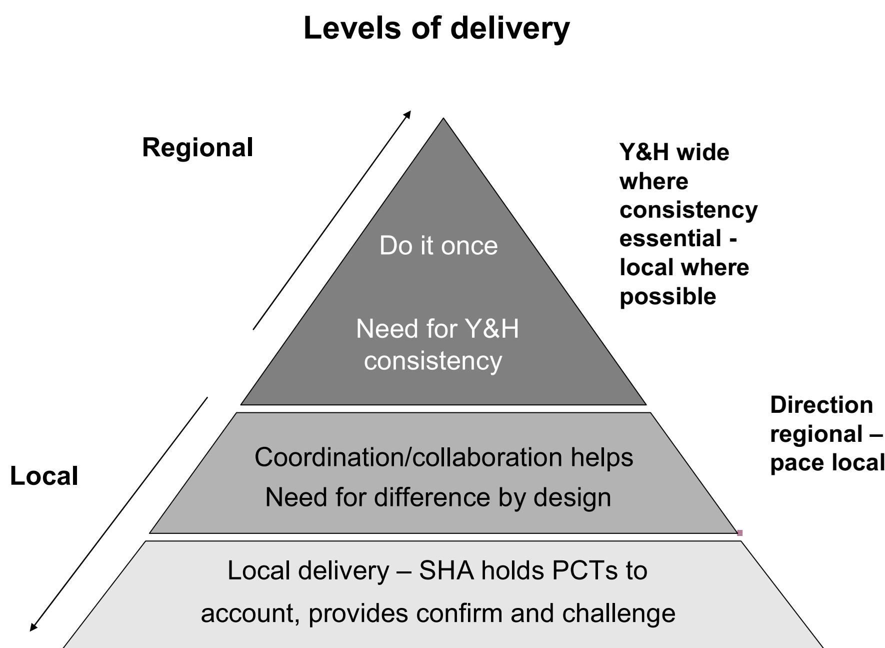
The SHA has offered to provide clinical leaders or members from the clinical pathway groups to attend meetings of staff from across the region. We have already participated in a wide range of events ranging from the BMA Regional Council meeting to an all-day event with senior clinicians and managers at Leeds Teaching Hospitals Trust.

Other key events include:

— a wide range of local events throughout the region, where discussion of Healthy Ambitions forms part of the wider agenda;
— Local Government Yorkshire and the Humber will hold a high level workshop for local authority CEs and SHA officers later this year. The relevant LA director networks are deciding in their September meeting how they wish to play into emerging regional programmes—as well as local processes;
— the SHA's Director of Patient Care and Partnerships and the Director of Workforce and Education are meeting the university deans of health/medicine to discuss the implications for them. Some of our higher education partners are already rethinking their research and education programmes to align along the clinical pathway groups; and
— a clinical summit is being held in October for senior clinicians from across all NHS organizations in Y&H and from all professions to ensure that they are fully aware of Healthy Ambitions and to explore the role that they can play in its delivery.

(f) *Levels of delivery*

Delivery is taking place at three levels. These levels of delivery have been discussed and agreed with all CEs of NHS organisations in Y&H.



For each clinical pathway group, the lead Primary Care Trust (PCT) chief executive, in consultation with the clinical leads and other stakeholders as necessary, has produced a hierarchy of what needs to be delivered at each level, and has outlined the mechanisms (new or existing) for ensuring it happens. This will be refined in discussion with the leadership community and other stakeholders.

An example from the staying healthy pathway is shown below as an illustration.

PCTs Delivering on Healthy Ambitions

Our PCTs have worked collaboratively to develop timelines for the key deliverables set out in healthy ambitions…

…they have also assigned responsibility for delivery against the specific recommendations

For example, staying healthy

Overall	Timing
Initial baseline gap analysis completed by all PCTs setting out where work is already underway across all 3 key risk areas	complete
Contribution of region wide social marketing programme (based on NSR review)	Scoping Summer 2008
Workforce analysis to assess potential gaps in delivering recommendations with ensuing workforce plan based on findings. To be undertaken by PHWAG	November 2008
Confirmation of core role of DsPH network and reporting routes for 'Staying Healthy'	September 2008
Alignment of work of new posts to support delivery of NHS Review be confirmed (Paul)	September 2008

Recommendations	Local delivery	YH wide coordination and collaboration	YH wide implementation
The NHS in Y&H should improve screening and identification of people with alcohol use problems.		Regional Alcohol Group	
PCTs should commission the systematic use of brief interventions on alcohol to 'industrialise' their use across NHS services.		Regional Alcohol Group	
PCTs should commission a range of tiered services to cope with people who present with different levels of dependency and ensure simple referral routes are accessible from screening points.		Regional Alcohol Group	Tier 4 (high level) Poss SCG
PCTs should commission alcohol services separately from drugs misuse services.		Regional Alcohol Group	
NHS should work with other organizations to reduce the accessibility of alcohol, including an increase in its price.		Regional Alcohol Group	
Every PCT should commission localized weight management services for their local population. To meet life expectancy targets these should focus on adults at mid-life.		Promoting Healthy Lifestyles Board Obesity leads Group	

(i) Local delivery

Most recommendations are for action at a local level to ensure that they can be taken forward in the context of local circumstances, needs and priorities.

The key vehicle for local delivery in the first instance will be the strategic plans being developed by PCTs as part of the world class commissioning agenda.

In developing these plans, the SHA chief executive has required all PCTs to:

— prioritise recommendations from the Yorkshire and Humber Next Stage Review—as set out in Healthy Ambitions;

— explain the ways in which these priority recommendations have been identified and will be delivered locally—with clear evidence that these are aligned with financial, activity and workforce plans and with Local Area Agreements;

— demonstrate use of Next Stage Review resources—for example, the evidence base available from the SHA's website;

— provide clarity about the impact that plans will have on improving outcomes across the eight pathways—this will be the subject of peer review by means of the Yorkshire and Humber Clinical Reference Panel;

— demonstrate that local clinical leadership is in place and aligned with the pathways; and

— include a succinct and compelling narrative about the tangible difference each PCT will make to their local population over the period of the plan.

PCTs will submit initial drafts at the end of September for some early feedback, before their final draft is submitted at the end of October for assessment as part of the national assurance process for world class commissioning

(ii) Regional delivery

All recommendations which fall to delivery through a sub-regional or regional process will be subject to rigorous challenge.

We will hold confirm and challenge meetings during October and November to ensure that the regional programmes of work are clearly defined, mechanisms for delivery are robust, and that individual accountability is clear.

(g) *Infrastructure for delivery*

(h) *Resources and risks for delivery*

The PCT chief executives have agreed to create a Healthy Ambitions Investment Fund to support and facilitate cross-community work in 2008/09.

We hold the budget at the SHA, reporting to the 14 PCT chief executives. The key areas planned for investment are:

- clinical engagement;
- clinical leadership programme;
- events costs;
- pump priming for regional service reviews;
- social marketing; and
- health intelligence.

In addition to this investment, the resourcing of the implementation infrastructure within the SHA will come from within existing budgets.

Locally PCTs will be setting out their investment plans as part of their strategic plans in the autumn.

Our current risk assessment is that we are well on track to design the implementation programme in line with our five principles. We will carry out a full risk assessment of the risks to delivery on completion of the published delivery programme. We will publish the delivery programme early in 2009.

(i) *How Healthy Ambitions fed into the national next stage review*

Throughout the review process in Y&H there was regular dialogue with the Next Stage Review team at DH and with review leads from across the ten SHAs

This included:

- weekly telephone conferences;

— regular meetings between clinical leads from across the country and with Lord Darzi both collectively and on an individual pathway basis;
— the international clinical summit organised by the Department of Health attended by a number of clinicians and staff from Yorkshire and the Humber;
— participation by Lord Darzi in key events during the regional review process including the "Invitation to Influence" event organised by the SHA at which over 500 stakeholders had the chance to give their views on the emerging findings from the review ad to question Lord Darzi; and
— submission of draft versions of Healthy Ambitions to the DH to enable the review team to take account of the findings in preparing the final report from Lord Darzi—"High Quality Care for All".

Margaret Edwards
Chief Executive

October 2008

Memorandum by NHS South West (DZ 18)

IMPLEMENTING THE DRAFT STRATEGIC FRAMEWORK FOR IMPROVING HEALTH IN THE SOUTH WEST 2008–09 TO 2010–11

1. Introduction

1.1 This report briefly sets out the next steps in implementing The Draft Strategic Framework for Improving Health in the South West 2008–09 to 2010–11. The report has been requested by the Health Select Committee in preparation for their meeting on 16 October 2008.

1.2 A separate document, Improving Health: Ambitions for the South West, has been made available to the Health Select Committee and sets out a summary of the proposed ambitions for improving health and health care in the South West.

1.3 In common with all regions in England, the approach in NHS South West to the NHS Next Stage Review included the following clinical pathway groups:

— staying healthy;
— maternity and newborn care;
— children and young people;
— mental health;
— long-term conditions;
— planned care;
— acute care; and
— end of life care.

1.4 In addition to the eight clinical pathway groups, the approach in NHS South West was extended to include the following further clinical pathway groups and system-wide topics:

— services for people with a learning disability including an easy-read version of Improving Health: Ambitions for the South West;
— improving dental health services;
— reducing waiting;
— patient safety;
— workforce for the future;
— integrating health and social care; and
— managing the health care system.

2. Ambitions for the South West

2.1 The Draft Strategic Framework for Improving Health in the South West 2008–09 to 2010–11 has been developed to set a clear direction to improve health and health care in the South West.

2.2 The proposals in the document represent an ambitious programme of change designed to ensure that services in the South West are the best the NHS can offer: a world class service, leading to world class standards of health.

2.3 Listening carefully to what matters to the public, patients, carers and staff in the South West has highlighted the strong case for change. Leading clinicians and representatives of patient groups, staff organisations, voluntary groups and local authorities have worked together to consider the way forward. Progress has been discussed at regular meetings with Chairs of Overview and Scrutiny Committees and leads of Patient and Public Involvement groups.

2.4 The vision for health and health care in the South West is for services of consistently high quality and safety, with people enabled to live healthy lives, supported by a highly skilled and committed workforce.

2.5 The proposed ambitions for the future harness the latest evidence, best working practice, innovation and new technologies to identify specific improvements for patients and their carers. The ambitions are designed to:

- improve health by raising life expectancy to the best in Europe, tackling the rising trend in childhood obesity and strengthening the focus on prevention;
- improve access by ending unwanted waiting with a maximum wait of eight weeks for planned care, two hours for accident and emergency care and four weeks for mental health assessments;
- improve quality by implementing the National Cancer Reform Strategy two years ahead of the timetable, achieving the quality markers in the National Stroke Strategy within three years and establishing improved heart attack services available around the clock;
- improve safety by driving down health acquired infection to the best in England and implementing the Framework for Patient Safety in NHS South West;
- improve local services by moving half of all outpatient appointments to local settings closer to home, supporting people with long-term conditions to retain their independence and reducing by one third the days they need to spend in hospital;
- promote innovation by rapidly expanding the use of telemedicine in local settings and assistive technology in the home; and
- ensure a fit-for-purpose workforce and strong managerial and clinical leadership as well as maximising the benefits of technology.

2.6 A three-month period of engagement on the proposals has taken place until 31 August 2008 and the final document, taking account of comments received, will be presented to the South West Strategic Health Authority for approval on 20 November 2008. During this time, Primary Care Trusts have been engaging local people and key stakeholders to build on the work to date and to update their strategic plans for 2008/09 to 2010/11 for each local health community.

3. Implementation Approach

3.1 The delivery programmes in the South West will be designed to:

- improve population health;
- improve the quality and safety of care;
- promote innovation;
- integrate health and social care delivery;
- build the capability of people, technology and facilities; and
- improve productivity and taxpayer value.

3.2 The principles that will be used during implementation are that:

- the focus of implementation will be at local level in each health community, with regional and national action enabling local delivery;
- NHS South West will seek to contribute to national policy development for key implementation initiatives;
- NHS South West will continue to encourage all clinicians to be actively involved in delivering the programme of change for their services; and
- the NHS is a system. In line with the NHS Next Stage Review and the NHS Constitution, all parts of the system will be expected to use their combined efforts in alignment to drive up the quality of care for patients.

3.3 This means that the approach to implementation of the ambitions for the South West will include:

- strategic and operational plans at local level for each health community, building on the extensive engagement to date of patients, public, staff and Local Authority partners;
- work in partnership with the Department of Health to develop new systems for improving quality; and
- strong leadership of implementation with a particular focus on clinical leadership of change in local services.

3.4 The implementation programme will take full advantage of the extensive range of opportunities arising from the national work on the NHS Next Stage Review as set out in:

— *High Quality Care For All* (June 2008);
— *Our vision for primary and community care* (June 2008); and
— *A High Quality Workforce (June 2008)*.

4. Implementation Action

Improvements in health and health care

4.1 The ambitions for improvement in health and health care services will be taken forward for each of the major clinical pathways:

— staying healthy;
— maternity and newborn care;
— children and young people;
— mental health;
— learning disability;
— long-term conditions;
— planned care;
— acute care; and
— end of life care.

4.2 The work on dental health services is included in both the staying healthy and planned care clinical pathways. For each of the clinical pathways an annual review process and work programme will be established, supported by a policy lead from the South West Strategic Health Authority. The clinical leaders associated with each pathway will be asked to assist in annual reviews to monitor progress, assess barriers to implementation and identify the priorities for action for each NHS organisation.

4.3 It is expected that the implications for care delivery will include:

— significant shifts of care for patients closer to their homes by developing primary care and community services;
— improved access to specialist care in centres of excellence in line with national quality standards;
— more coordinated care by integrating health and social care;
— service changes that are strongly supported by the best clinical evidence and improve quality of care for patients; and
— applying the principles of the six sites of care (home, primary care, local hospital, major acute hospital, elective centre, specialist centre) to all urban, shire county and rural areas, with local adaptation.

4.4 Significant shifts to bring care for patients closer to their homes are already underway including the development of:

— asistive technology to monitor patients in their own home;
— local outpatient and diagnostic services; and
— integrated care in community hospital developments such as pharmacy, healthy living and local authority services.

4.5 The following major service improvement programmes will require region-wide action:

— tobacco control programme;
— childhood obesity programme;
— review of imaging services;
— National Cancer Reform Strategy;
— review programme for paediatric surgery;
— review of stroke services;
— review programme for primary angioplasty; and
— review programme for level 1 trauma services.

4.6 The local actions to take forward the improvements in health and health care in each health community are to be included in updated strategic plans for the period 2008–09 to 2010–11 and operational plans for 2009–10. Each Primary Care Trust is taking into account the ambitions for the South West in developing their strategic plans.

4.7 Action is already underway in 2008/09 to take forward the ambitions for the South West including:

- establishment of the South West Regional Office for Tobacco Control and the commencement of local media coverage to support 'smoke-free south west' as part of a public information campaign;
- completion of the review of stroke services;
- completion of the review of imaging services;
- reduced waiting times beyond the national requirement of 18 weeks from referral to treatment;
- improved ambulance turnaround times at acute hospitals as part of the action to achieve faster ambulance response times;
- progress towards a maximum wait of two hours for urgent care; and
- improved patient safety through the patient safety campaign to reduce hospital mortality, reduce infections in hospital and improve the quality of incident reporting and learning.

Enabling strategies

4.8 The key enabling strategies to support delivery of the ambitions for each clinical pathway include:

- developing world class commissioning;
- developing strong providers of care;
- developing people including education and skills and planning the workforce for the future;
- promoting clinical engagement in the delivery of improved care;
- developing clinical and managerial leadership;
- improving clinical quality, safety and the user experience;
- improving clinical value and productivity;
- developing primary and community services;
- integrating care delivery;
- using technology to deliver improvement;
- investing in improved facilities;
- promoting research and innovation;
- creating incentives for improvement; and
- working with partner organisations.

4.9 NHS South West will work with the Department of Health to take forward the new opportunities arising from the NHS Next Stage Review such as integrated care organisations, piloting individual health budgets and quality measurement and reporting.

4.10 During implementation, NHS South West will encourage all the clinical and managerial leaders who have been involved in shaping the direction for the future to be part of the programme of change.

5. Implementation programme

5.1 The key steps in the phasing of the implementation programme include:

- publication of The Draft Strategic Framework for Improving Health in the South West 2008–09 to 2010–11;
- revision following the period of engagement and comment;
- preparation of by each Primary Care Trust of a Strategic Framework for Improving Health in 2008–09 to 2010–11 for their local population; and
- agreement of Operational Plans 2009–10 based on The Operating Framework for the NHS in England 2009–10 and taking forward the ambitions for NHS South West.

6. Conclusion

6.1 The implementation of The Draft Strategic Framework for Improving Health in the South West 2008–09 to 2010–11 represents an ambitious programme of change. The hallmarks of successful implementation will include:

- use of the latest evidence, best working practice, innovation and new technologies;
- a relentless focus on what matters to patients, the public and staff;
- behaviours driven by a vision of the future, not limited by the past and present;
- ambition;
- the engagement of clinicians and the public to secure change; and
- strong clinical and managerial leadership.

6.2 The delivery of the changes is expected to significantly improve health and the patient experience in the South West.

October 2008

Memorandum by the Department of Health (DZ 19)

TOWARDS WORLD CLASS COMMISSIONING—"ADDING LIFE TO YEARS, AND YEARS TO LIFE"

Introduction

This note for the House of Commons Health Committee provides an update on the progress being made towards world class commissioning. The note covers the following:

- the case for better commissioning;
- the aims of the world class commissioning programme; and
- practical measures in place to achieve the aims:
  - vision for world class commissioning,
  - organisational competencies for world class commissioning,
  - commissioning assurance system, and
  - support and development Milestones for implementation.

Background

Lord Darzi's recent review of the NHS and his report *High Quality Care for All* builds on earlier healthcare reforms but sets a new challenge around the quality of care, information and choice for patients and the public. Improving commissioning is at the heart of delivering this important agenda.

The world class commissioning programme will be an underlying delivery vehicle for improving PCT's commissioning capability. World class commissioning will drive improvements in health outcomes and reduce health inequalities—adding life to years and years to life.

The Commonwealth Fund paper *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Healthcare* (May 2007) claimed that the UK had one of the most progressive and high performing health systems in the world, scoring highly in quality, efficiency and equity. The very nature of our NHS—comprehensive, universal and free—means that we have the preconditions for world class commissioning. Furthermore, in the tax funded environment of our NHS—covering all the population and not just those who can afford to pay—we have a strong basis for population health improvements, as well as improving the health of individuals.

Commissioners and insurers globally recognise that by coupling these excellent preconditions with the rich information that is available, we can better exploit the way that we commission, to move from diagnosis and treatment to prevention and promotion. The NHS has real potential to develop world class commissioning—investing NHS funds to secure maximum improvements in health and well-being outcomes from the resources available.

The Case for Better Commissioning

Primary Care Trusts are responsible for a commissioning budget of £70 billion per year. NHS commissioners spend on average £200 million per day.

The Fitness for Purpose diagnostic programme which took place in 2006 identified significant commissioning weaknesses and a range of development needs for PCTs.

A subsequent Prime Minister's Delivery Unit report in 2007 identified slow progress and set out a range of focused actions to be taken by the Department of Health and NHS to ensure that commissioning is rapidly strengthened.

Context: fitness for Purpose - description and baseline results

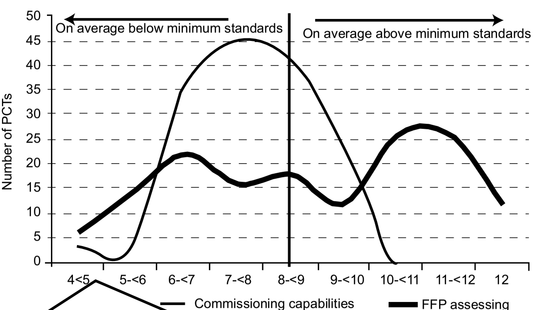
FfP showed significant areas of weakness in both the overall assessment of PCT capability and specifically their commissioning capability.

FfP evaluates both PCTs' short-term risks and their process and capability developments needs. It consists of two components:

1. Assessment
   - Assesses the short-term risk of a PCT's failure to meet its objectives.
   - Evaluates main drivers of performance (finance, strategy, governance, external relations, emergency planning).
   - Ratings from red (high risk) - green (low risk).
2. Diagnostics
   - Diagnostics process and capability development needs of PCTs to act effectively a scommissioners of health services.
   - Evaluates functional performance (strategic planning, care pathway management, provider management, monitoring).
   - Ratings from 1 (red - needs significant improvement) - 3 (green - good to best practice).
   - After completing FfP, PCTs were required to create and implement a Development Plan to address capability gaps (Operating Framework 06/07).

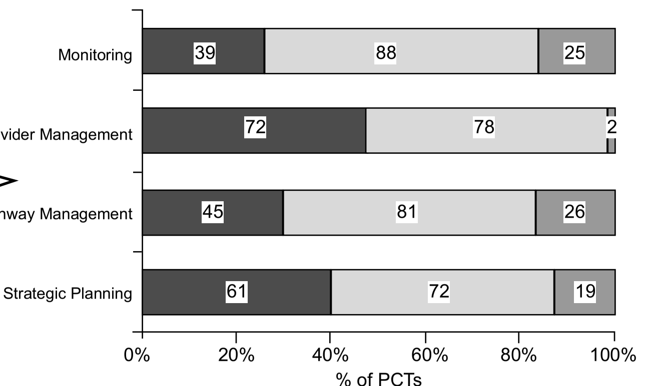
- 39% of PCTs meet minimum standards in the 4 areas of the commissioning diagnostic.
- 13% do not meet minimum standards in any area.
- 29% of PCTs display best practice one or more of the commissioning areas.
- No PCT was found to display best practice in all areas.

PCT performance on Fitness for Purpose areas and Commissioning capabilities (152 PCTs)



There was found to be a wide dispersion of organisational capability with respect to short term risks. Commissioning skills were found to be lacking across the board

PCT Commissioning capabilities scores (152 PCTs)



Aims of the World Class Commissioning Programme

The world class commissioning programme is designed to raise ambitions for a new form of commissioning that has not yet been developed or implemented in a comprehensive way anywhere in the world. World class commissioning is about delivering better health and well-being for the population. It is about driving up the quality of care for patients and providing personalised services which are fit for everyone's needs.

Primary Care Trusts are responsible for a commissioning budget of £70 billion per year. The WCC programme will strengthen the onus and responsibility on local commissioners to commission services that deliver improved health outcomes for their patients and population, whilst driving down health inequalities.

Primary Care Trusts (PCTs) will take forward this core commissioning role, in partnership with local government, practice based commissioners and others. PCTs supported by Strategic Health Authorities (SHAs), will lead the NHS in turning the world class commissioning vision into a reality, adding life to years and years to life.

What are the practical measures being using to achieve world class commissioning?

The world class commissioning programme includes four main strands:

(i) A vision for world class commissioning setting out how the programme raises ambitions and strengthens PCTs as commissioners on behalf of their patients and populations.

(ii) Organisational competencies that a world class commissioning organisation will need to demonstrate.

(iii) A commissioning assurance system to hold commissioners to account and to reward performance and development.

(iv) Support and development tools and resources to help commissioners achieve world class commissioning.

Vision for world class commissioning

World class commissioning is not an end in itself, so in order for commissioners to be successful, they will need to develop a local vision, one which is articulated and owned by the local NHS with a strong mandate from local people and other partners (such as local authorities). PCTs will state what their vision is for world class commissioning in terms of better services and better health outcomes. Our aspirations for the programme are that it will deliver better health and wellbeing, better care and better value for NHS resources.

Better health and wellbeing for all. This means people living healthier and longer lives and health inequalities being dramatically reduced. Commissioners will need to focus on the immediate and longer term to identify current needs and anticipate future trends. They will respond with commissioned services that meet the needs of the local population, as well as promoting good health and well being.

Better care for all. Services will be evidence-based and of the best quality. People will have choice and control over the services that they use, so they become more personalised. Commissioners will need to fully engage with clinicians to gain best evidence and practice, on what high quality care looks like and how to deliver it. The development of NHS Evidence will greatly assist commissioners with access to the most clinically and cost effective diagnostics, treatments and procedures.

Better value. Investment decisions will be made in an informed and considered way, ensuring that improvements are delivered within available resources. PCTs will work with others to optimise effective care, set strategic priorities and make investment decisions, focused on the achievement of key clinical, health and community outcomes.

Further information on the vision for world class commissioning can be found at http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Vision/index.htm

Organisational competencies for world class commissioning

Commissioning competencies are the knowledge, skills, behaviours and characteristics that underpin effective commissioning. When put into practice they become capabilities. World class commissioners will secure effective strategic capacity and capability to turn competence into excellence, transforming people's health and well being outcomes at the local level, while reducing health inqualities and promoting inclusion.

Commissioning competencies are the platform for a commissioning organisation's development programme. They assist boards, executive teams and clinical teams in working together, building and shaping organisations, so that PCTs are clearly recognised and respected by local people and partners as leaders in the development of local health services.

World class commissioners will possess the following competencies:

- locally lead the NHS;
- work with community partners;
- engage with public and patients;
- collaborate with clinicians;
- manage knowledge and assess needs;
- prioritise investment;

— stimulate the market;
— promote improvement and innovation;
— secure procurement skills;
— manage the local health system; and
— make sound financial investments.

Further information on the world class commissioning competencies can be found at http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Competencies/index.htm

Commissioning assurance system

The commissioning assurance system is the key vehicle for improving commissioning capacity and capability. It holds commissioners to account, rewards performance, and ensures local health outcomes are improving. Assurance is a powerful and rigorous process with a strong focus on improvement. It will review the PCT's status and current direction of travel, and development needs, in addition to focusing on organisational health issues.

The commissioning assurance system is an integral part of the annual planning cycle for PCTs, which has at its core, the production of five year strategic plans setting out how the PCT will prioritise and deliver improvements in health outcomes for their populations. Strategic plans will be underpinned by five year financial plans, five year organisational development plans and annual operating plans. We have provided PCTs with extensive Data Packs to support strategic planning.

There is one national approach to assurance which applies to all PCTs. A rigorous calibration process will be undertaken to ensure that this nationally consistent methodology enables reliable comparison of performance across all PCTs.

There are three elements of commissioning assurance: outcomes, competencies and governance.

(i) Outcomes reflect the overall improvement in the health and well being of the population.
(ii) Competencies reflect improvements in the PCT's skills and behaviours as commissioners.
(iii) Governance reflects the underlying grip that the Board and the organisation have on their core business.

These three elements will be assessed using a combination of approaches including self assessment and certification, feedback from partners, evidence gathering and review of data.

Ultimately, the assurance system which is as rigorous as Monitor's assessment of foundation trust hospitals, drives the systems and processes of PCTs, but more importantly will ensure the delivery of better health outcomes for patients and the public through a strengthened commissioning system led by PCTs and involving all relevant partners.

Further information on the world class commissioning assurance system can be found at: http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Assurance/index.htm

Support and development

Strategic Health Authorities will take responsibility for support and development of PCTs to achieve world class commissioning, and where appropriate will create programmes to meet local needs. Development will therefore be self managed by PCTs or directed by SHAs.

Although the majority of support and development available to PCTs will be managed at a local level, there are some areas that would benefit from a nationally consistent approach. The Department of Health has for example, commissioned a national PCT board development framework for world class commissioning.

PCTs have been provided with a number of supportive resources including guidance and templates for strategic, financial, and organisational development planning, a Commissioning Assurance Handbook and SHA-specific bench-marking data packs to support strategic planning.

The NHS Institute of Innovation and Improvement is supporting the development of commissioning by developing a number of products that focus on the competencies. They also provide ongoing support to the NHS and are key in accelerating PCT achievement towards world class.

FESC (Framework for Providing External Support to Commissioners) provides a tool to support commissioners to become world class. Under the support and development framework there is a range of resources available for commissioners to choose from. It enables PCTs to procure additional commissioning support where a gap has been identified in their commissioning functions.

Further information on support and development for world class commissioning can be found at: http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Supportanddevelopment/index.htm

Milestones for implementation

There are a number of drivers behind the development of the world class commissioning programme. The findings from the Department's review of PCT's Fitness for Purpose exercise in 2006 identified significant weakness in commissioning capability. Furthermore, in 2007 a Prime Ministers Delivery Unit report endorsed the Fitness for Purpose findings and recommended the key actions necessary to improve commissioning.

In July 2007, the World class commissioning programme began as a co-production with the NHS and local government. In December 2007, the world class commissioning Vision and Competencies were published following extension consultation with local commissioners.

The Commissioning Assurance system for world class commissioning was launched in June 2008, following extensive co-design and testing with the NHS and local government. The system is currently in operation with the following timescales:

— *October 2008*—PCTs will all have produced first drafts of their five year strategic plans setting out the priorities for delivering improved health outcomes for their populations.

— *November/December/January 2008–09*—PCTs will be challenged on all aspects of commissioning including health outcomes, competences and governance, as part of a "panel day". This will be followed up with a report and recommendations for ongoing development.

— *March 2009*—all PCTs will have been through the first year of the commissioning assurance system, and will have received feedback on their performance, recommendations for their development and their ratings for 2008–09.

WCC team

October 2008

Supplementary memorandum by the Department of Health (DZ 19A)

EQUITABLE ACCESS IN PRIMARY CARE: LOCAL PROCUREMENTS OF GP-LED HEALTH CENTRES

BACKGROUND

1. The NHS Next Stage Review Interim report, *Our NHS, our future* (October 2007) gave a commitment "to invest new resources to enable Primary Care Trusts (PCTs) to develop 150 GP-led health centres, situated in easily accessible locations and offering a range of services to all members of the local population . . . including pre-bookable appointments, walk-in services and other services."[38]

2. Following the 2007 Comprehensive Spending Review (CSR), the Secretary of State for Health announced on 10 October a £250 million access fund to enable every PCT to provide a GP-led health centre—open 12 hours a day, seven days a week—and to help tackle inequalities by establishing over 100 extra GP surgeries in areas with the fewest GPs and greatest health needs. This £250 million sum reflects the additional annual investment for these new services by 2010–11.

3. With the new GP health centres, one in every PCT area, patients will be able to remain registered with their own GP but may also use the services provided by the health centre if they wish. This will mean people can see a GP for a routine consultation if they are away from home or at times that their local GP practice is not open, either by booking ahead or just turning up. These services will be in addition to, not instead of, existing GPs.

4. Every PCT has been asked to undertake an open and transparent procurement to identify providers for these new services, to ensure they consider the full range of innovative service models from all potential providers including existing GPs, social enterprises, and independent, third sector and secondary care providers.

5. As part of the NHS Operating Framework for 2008–09, we asked PCTs to complete their procurements for these new services by 31 March 2009.[39]

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[38] *Our NHS, our future, the NHS Next Stage Review Interim report* (October 2007), p 25.
[39] *The NHS In England. The Operating Framework for 2008–09* (December 2007), p 14.

6. Each PCT is managing the procurement process locally. At an event for commissioners and providers on 13 December 2007, DH set out the principles, core criteria and timescales, and launched the PCT Procurement Framework, which provides tools to support PCTs and SHAs in undertaking local procurements.

7. The Department has provided additional guidance on the pages of its website dedicated to the procurements of health centres and GP practices, which has recorded approximately 180,000 hits, and has undertaken around 80 workshops to support PCTs in their procurements.

Current Progress

8. The majority of PCTs are expecting to sign contracts for the new services by December 2008, ahead of the timetable set out in the Operating Framework. A small number of PCTs, mostly in London (where the local NHS needs to ensure that the new services fit with their wider plans for improving health services, following the Healthcare for London consultation), expect to sign contracts later in 2009.

9. PCTs have already agreed providers for at least 10 GP-led health centres. We expect around 21 centres to be open to the public by March 2009, with the great majority of the remaining centres opening during the rest of 2009.

Guidance on Services and Staffing

10. DH has avoided a prescriptive national approach; it is for SHAs and PCTs to design the service on the basis of local health needs assessments. However, the Department has set a small number of core requirements that PCTs should include in their specifications to ensure consistency across the country. The centres should be:

— in an easily accessible location;

— open 8am-8pm, seven days a week;

— offer bookable GP appointments and walk-in services;

— provide services for both registered and non-registered patients; and

— maximising opportunities to integrate and co-locate with other community based services.

11. We have kept the requirements to a minimum to allow PCTs to develop services which best meet locally identified need and to encourage innovation.

12. The only requirement on staffing is that health centres must have at their core the provision of GP services and staffing to enable patients to see a GP from 8am to 8pm, seven days a week.

13. The precise mix of pre-bookable and walk-in appointments will be determined by providers to reflect local needs and is likely to vary depending on the clinical design of the service in question.

14. As part of regional visits in January and February 2008, the Department discussed with PCTs and SHAs its working assumptions on staff numbers, and these were subsequently published on the DH website in Procurement Frequently Asked Questions. The working assumptions were that a health centre would have a minimum of three GPs, nine nurses, one healthcare assistant and associated administrative and support staff and locum cover. Ultimately, however, it will be for providers to determine the precise staffing levels subject to any requirements set out in local contracts and these will vary depending on the services required.

15. Further guidance is given in the draft Invitation To Tender: Requirements documentation. This sets out that all clinical staff working in health centres must meet NHS standards and requirements and that providers must ensure that their staff are suitably qualified and trained and demonstrate that all their workforce strategies, policies and practices comply with UK employment legislation and all NHS guidance and codes of recruitment.

16. One of the key requirements in the model contract for these services is that all doctors have to be vocationally trained. We have also recommended that PCTs include Membership of the Royal College of General Practitioners (MRCGP) as a requirement, but this will be down to local discretion.

November 2008

Supplementary memorandum by the Department of Health (DZ 19B)

High Quality Care for All included a commitment to make a proportion of a provider's income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN)

payment framework. More detail on how the framework applies, and suggestions for how local organisations can use it to improve quality of care, are given in the guidance on the CQUIN framework published last week alongside the Operating Framework.[40]

The CQUIN framework guidance and the Operating Framework set out that in 2009–10, commissioners will need to make available 0.5% of contract income to all providers on NHS standard contracts. This will be linked to locally agreed goals for quality improvement and innovation. This is about making quality and innovation integral to what PCTs pay for, rather than assuming that more money is always needed to drive them.

The comments reported in some media stories at the time of the publication of High Quality Care for All seem to have been based on the suggestion that the CQUIN framework may apply to a larger proportion of income. Whilst the proportion may increase in future years, the decision to set the proportion of income at 0.5% in year one was intended to recognise that using the CQUIN framework will be a developmental journey. It is important to allow organisations a chance to get used to developing local schemes and agreeing the right indicators. Therefore we are setting a reasonably modest proportion of money in year one, and suggesting that organisations may link this to data collection on quality.

It is likely that the proportion of provider's income will increase over time, as use of the framework moves beyond data collection to reflect measured improvements in quality of care and innovation. Any future increases will take into account the wider financial context.

15 December 2008

Memorandum by Professor Alan Maynard (DZ 20)

INCENTIVISING QUALITY IMPROVEMENTS IN THE NHS: A TIME FOR CAUTION

Alan Maynard is a Professor of Health Economics at the University of York who has been involved in NHS management for over 25 years. Since 1997 he has been Chair of the York Hospitals NHS Foundation Trust which is an acute facility with 700 beds and an annual budget of £210 million. He was Founding Director of the Centre for Health Economics at the University of York, teaches in the Hull-York Medical School and the Department of Health Sciences at York and has worked as a consultant for the World Bank, WHO and other international agencies in over 20 countries.

THE NATURE OF THE QUALITY CHALLENGE

For 60 years the "traditional "way of reacting to periodic crises in the NHS has been to use two policies. One policy to mitigate complaints about service delivery is to increase spending. The other policy has been to "redisorganise" the structures of the NHS. Neither of these policies have been systematically evaluated in terms of delivering a more efficient and equitable service for patients.

These evidence free macro "solutions" to ill defined problems have been accompanied occasionally with a policy focus on the micro characteristics of service delivery. This focus has repeatedly replayed the themes of waste associated with significant clinical practice variations and an absence of measurement and management of patient outcomes but done little to remedy these problems.

The issue of clinical practice variation has an international research and policy literature going back over 30 years. The Wilson administration in 1976 argued that the mitigation of large variations in length of stay for routine elective procedures and the failure to develop evidence based day surgery led to unnecessary spending of circa £40 million.[41]

Around the same time Professor Jack Wennberg, a clinician at the Dartmouth Medical School in the USA was analysing clinical practice variations in the Federal Medicare Programme. He noted that:

> "the amount and cost of hospital treatment in a community have more to do with the number of physicians there, their medical specialities and the procedures they prefer than the health of residents".[42]

His subsequent research over three decades has shown large wasteful variations in the use of health care in the US Medicare system but little attempt to remedy these failures to deliver health care efficiently.

It is remarkable that this work on variations has been largely ignored by the medical profession and policy makers worldwide. Currently in the NHS the Institute for Innovation and Improvement (NHS-III) is re-emphasising these problems (as did its predecessor the NHS Modernisation Agency) and advocating change to save resources and improve patient care. Darzi proposes to transmogrify the NHS-III into a new quality forum with similar goals

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[40] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443
[41] Department of Health and Social Security, Priorities in Health and Personal Social Services: a consultative document, HMSO London 1976.
[42] J Wennberg and A Gittelsohn, Small area variation in health care delivery, Science, 182, 1102–1108, 1973.

In the US, Wennberg's colleague, Elliot Fisher, has analysed Medicare clinical practice variations and concluded recently that:

"Residents in high spending regions received 60% more care but did not have lower mortality rates, better functional status or higher satisfaction".[43]

He went on to argue that there were potential savings of 30% if high Medicare spenders reduced their expenditure and delivered the safe practice of conservative treatment regions.

The transatlantic frustration with variation and an absence of outcome measurement is now being translated into enthusiasm amongst policy makers in the UK and the USA for using financial incentives to produce change in hospital and doctor behaviour. Can the use of financial incentives reduce inefficiency and improve quality?

What is Quality?

"Quality" is one of the most abused words in health care policy and practice. Any discussion of it should distinguish between process quality and outcome quality. This distinction is epitomised by the old joke that "the operation was a success but the patient died" ie the surgical process was good but the patient outcome was not!

Following the Darzi report and the announcement of a desire for "world class commissioning", there is a focus on methods to reinforce the power of PCTs to enhance the delivery of good quality care to patients. If commissioning in the NHS is to prove its worth it has to mitigate the waste inherent in clinical practice variation and the failure to measure outcomes so as to determine whether procedures improve the health of the patient.

The current policy consensus is that given medical leadership, spending more on the NHS and "redisoraganising" its structures in an evidence free way have failed, policy should now take a Walpolean view and regard all decision makers, be they doctors or non clinical managers, as having a price which when paid would improve their delivery of clinical practice and patient care.

How should Incentives be Designed and Should they be Targeted at Processes of Care and/or Outcomes?

Incentivising quality improvement

An example of the use of incentives to improve processes of care is the development of CQUIN ie commissioning for quality and innovation. CQUIN builds on the US incentive scheme for hospitals marketed by Premier. After some piloting in the North West this is being rolled out by the local SHA and will probably go national in the English NHS from April 2009.

Its purpose is to reward good process performers and to penalise poorly performing hospitals. As with the National Service Frameworks (NSFs), process standards are set for the delivery of some high profile patient services in order to reduce clinical practice variations and deliver high quality care processes. These standards are based on the evidence as interpreted by national experts.

Premier focuses on five clinical areas: acute myocardial infarction, AMI (or heart attacks), heart failure, pneumonia, coronary artery bypass graft, (CABG) and hip and knee replacements. For each area patient pathways and standards of care are set and performance related to these targets.

The crucial difference between NSFs and the emerging CQUIN programme is that the PbR revenues paid for these conditions is affected by performance. In the US-Premier scheme those hospitals in the top ten percent of performers annually get an uplift of 2% in their PbR income. Those in the second best 10% get 1% uplift. The hospitals in the worst 10% of performers lose 2% of the tariff and the second worst 10% lose 1% of their tariff.

These incentives are small but seemingly significant enough to affect behaviour. In the US it is argued that average adherence to process standards in Premier hospitals has improved. Some even dare to hope that these incentives reduce variation in practice and save money. The notion that improving process quality saves money is very attractive to policy makers in Whitehall. CQUIN is all about encouraging SHAs to roll out these incentives in their local areas to benefit hopefully both patients and taxpayers.

The use of these process standards is attractive but the cost of their implementation is unclear. They require greater sophistication in IT and systems management and this will challenge some trusts which are still failing to cope with PbR coding as demonstrated by the August report from the Audit Commission.[44]

Another nice issue is whether Premier incentives focus attention on a narrow range of services and performance elsewhere declines. To guard against this, it is necessary to monitor performance in non-incentivised areas of care and this inevitably adds considerably to the costs of management and evaluation.

[43] ES Fisher, Is more always better? New England Journal of Medicine, 349, 1665–7, 2003.
[44] Audit Commission, Developing the PbR Data Assurance Framework, 2007-8, London August, 2008.

CQUIN will be supplemented by fixing PbR tariffs in relation to best practice ie what is called "normative pricing". Currently PbR tariffs are usually set in relation to the average national cost of providing the service. Normative pricing might involve setting tariffs in relation to the average cost of those who are good performers eg the lowest cost quartile. This aggressive approach to pricing services would exert significant downward pressure on costs.

An alternative approach to normative pricing would be to delineate evidence based "best" process conditions for some types of care and identify the cost of providing this pattern of care. For instance a best practice guideline for stroke might include CT-Scanning within 24 hours, starting rehabilitation within 24 hours, and using thrombolytics promptly where appropriate. Those good practice units following these standards would then be costed with the average cost being the basis of the PbR tariff for the whole of the NHS.

The standard set and the associated tariff will it is hoped, incentivise hospitals to provide what is seen as best practice care. In stroke these standards are already well articulated in the Royal College of Physicians national stroke surveys. Other areas might include fractured neck of femur, cataract removal and cholesystectomy. Again such incentives will have significant implications for data collection and its analysis to inform local and national performance management.

These measures will complement the incentives introduced into primary care by the GP Quality outcomes framework. The GP-QOF highlights a fundamental problem about incentives ie on what basis to set the performance target. Ideally targets would be set on the basis of evidence of clinical and cost effectiveness. However for the majority of medical interventions the clinical evidence base is absent. The GP-QOF was criticised for being incompletely based on evidence.[45] Recently Government has decided that QOF targets should be reviewed and informed by NI(H)CE.[46]

The financial consequences of the GP-QOF were poorly planned and very costly to the taxpayer. It was a classic example of "light touch" regulation with self reporting of GP achievements and minimal PCT scrutiny. However this policing issue associated with incentive systems and the issue of cost more generally are not the only issue that has to be confronted when incentivising process quality.

Premier, CQUIN, the GP-QOF and process quality tariff setting all must be linked to the measurement and management of patient outcomes. Given the "tradition" of policy making in silos, this is a real policy problem with the development of quality incentives.

There are Departmental initiatives to extend the publication of mortality rates for hospitals and consultants. There is also an ambitious programme to develop patient reported outcome measures (PROMs).

From April 2009 hospitals will have to measure patients physical and psychological ell being before and after hernia repairs, hip and knee replacements and varicose vein repairs using EQ5D (www.euroqol.org) and specific quality of life measures. Over the next three years PROMs will be extended to other procedures. The Government intend to publish comparative data on the Health Choices website to inform patient choice of clinician and hospital.

The investment in PROMs has not been costed and will involve no just collection of data from all patients before and after a procedure but also the achievement of high response rates to ensure statistical significance in the results. The results of the trial of these methods by the London School of Hygiene and Tropical Medicine indicate that for some procedures (eg hernia repairs and cataract removals) a large minority of patients are no better or indeed worse off.

Similar work by the insurer, the British United Provident Association (BUPA) also shows a sizeable minority getting no improvement in visual acuity after the removal of cataracts. Whether these outcomes are indicative of poor clinical practice and/or inappropriate patient selection is unclear. Suffice it to emphasise that the management costs and consequences of such results will be considerable.

The challenge for the NHS is linking this investment in PROMs to the process quality measures in CQUIN and the PbR tariff. Comprehensive performance management ideally combines both process and outcome measure.

It is the intention of policy makers to enable PCTs to pay below tariff if process and outcome performance for procedures is inadequate. The interpretation of these data by commissioners and providers could be divisive and if to be efficient will need careful collaboration and the application of sophisticated analytical skills by managers, clinical and non-clinical. Such skills are scarce.

Incentivising PROMs by including it in the GP-QOF might be a nice way of reinforcing "Choose and Book" as an alternative to allowing PCTs to pay below tariff if PROMs performance is poor. This option is being considered by NHS Employers who with the BMA determine the GP-QOF. Again it will need careful management.

[45] R Fleetcroft and R Cookson, Do the incentive payments in the new NHS contract for primary care reflect likely population gains? Journal of Health Services Research and Policy, 11,1, 2006.

[46] Department of Health, Developing the Quality and Outcomes Framework: proposals for a new, independent process. October 2008.

Overview

Incentives such as these are powerful. They have the potential to improve care if well managed. But there is little evidence from other countries about their costs and benefit. The upfront opportunity costs of these investments may be considerable in a world where zero growth in NHS funding may be optimistic beyond 2010 and the next election. The need for careful piloting and systematic evaluation to inform policy is great so as to avoid blunders that endanger patient welfare.

The use of these incentive mechanisms will require a very different quality of management expertise. Instead of NHS managers playing the role of the little Dutch boy putting their fingers in the dike to prevent disaster, they will require knowledge of economics and statistics as well as having corporate capacity to track and manage comparative cost, activity and outcome data in real time ie the reconstruction of the dike!. The "leadership" and workforce" elements of the Darzi reforms, both of which are working in their silos, will be greatly taxed to meet these requirements efficiently.

Getting away from unfocused and optimistic funding of the NHS with occasional "redisorganisations" of structures is welcome, but incentivising both process and outcome quality will be testing for all in the NHS. In conjunction with investment in the measurement and management of comparative patient level costing and clinical activity data, incentivising process and outcome quality, hopefully in conjunction with each other will provide an exciting journey for policy makers, managers, clinicians and patients!

November 2008

Further memorandum by Professor Alan Maynard (DZ 20A)

THE NEXT STAGE REVIEW: REFORMING THE WORKFORCE

Introduction

After the publication of the *Next Stage Review* (the Darzi Report) in June 2008, two further documents emerged. The first was *The High Quality Workforce* which was published at the same time as the main Darzi review. The second was published on 3 July 2008 and was called *The NHS Next Stage Review: our vision of primary and community care*. The focus of this note is the first of these two supplementary documents whose focus was the workforce.

The quality of care delivered to patients in the NHS is determined by the skills and motivation of the workforce. This workforce is over one million and is made up of many skill groups from doctors and nurses to physicists, pharmacists and porters. This workforce is a key determinant of the operating costs of hospital trusts and Primary Care Trusts (PCTs). Typically about 35% per cent of a hospital costs is taken up by nurses pay. The large pay increases for GPs and consultants in 2004 with the poor linking of increased remuneration to productivity imposed high costs on providers and PCTs for minimal improvements in work practices.

It has been traditional for workforce management at the national level to be dominated by concerns about the medical workforce, defined uniquely as doctors. Since the Second World War there has been a series of reports seeking to forecast the demand and supply of doctors (eg the Goodenough report, 1944, the Willink report, 1957 and so on regularly about once a decade). These forecasts have been often erroneous in their assumptions and conclusions.

More recently the issue of doctors' training has been a matter of contention when graduating doctors failed to find training slots for the development of their careers. The Modernising Medical Careers (MMC) crisis led to the Tooke report and subsequently to the proposed merger of the GMC and PMETb in 2010.

This is a product of several policy problems. Not only is it about the design of career progression it is also concerned with the regulation of the profession, in particular ensuring patient safety and avoiding problems such as those produced by Shipman in primary care and Wishart, Neale and Ledward in hospital care. For instance the regulatory process provides some control of the production of consultants and GPs but provides no system of re-validation over their career and inadequate control of hospital doctor groups such as staff grades and locums. These problems have been recognised for over a decade but reform comes slowly despite the pleas for urgent change as set out for instance in the Kennedy Inquiry into deaths of children after heart surgery in Bristol.

Next Stage Review: the Workforce

The objective of the main Darzi report is to improve the quality of patient care. The Blair-Brown reforms focused mainly on improving the quantity of care provided so as to reduce waiting times for elective care and improve access to core areas of care covered by National Service Frameworks. Gradually it was realised by Whitehall officials that the old joke might have some pertinence: "the operation was a success but the

patient died" ie process and activity was good but the outcome for the patient was poor! As a consequence the policy focus is moving towards ensuring that increased activity in the NHS makes patients better ie improves their outcomes.

To improve the quality of care for patients there has to be an increased focus on the training and education not just of doctors but the entire workforce. Increasingly it is typical for care to be delivered by teams of professionals. For instance in primary care, particularly following the introduction of the Quality Outcomes Framework (QOF), there is ever more dependency in primary care on the work of the practice nurse. In hospitals routine screening for colon cancer is and will be done increasingly by nurse endoscopists in collaboration with physicians.

The issue of team work is nicely recognised by the Darzi-workforce report. It sets out a series of roles for doctors (paragraph 27) which merits more careful discussion. Clearly doctors should offer timely and accurate diagnoses, ensure patient safety, help patients negotiate care pathways and contribute to managing (not necessarily leading?) the clinical team but how many doctors contribute to "health care research, development and innovation" and what percentage of the profession contribute to the training of future professionals? If the contention that a good doctor is also involved in research as a necessary part of improving her practice, there is a nice issue of the extent to which this happens and evidence of the gain offered to patient care by such generalisation rather specialisation of doctors' practices.

The Darzi-workforce document focuses on the improved training of doctors to take management roles. The report emphasises the need for lifetime training pathways with management training starting in medical schools and continuing throughout the career. Given the intent to pursue improved quality with quantitative analysis of comparative cost, activities and outcomes at the practitioner level this is a wise move for managers of hospitals and primary care management systems.

However given the data free nature of much of the current primary care system, the role of medical practitioners in quantitative management is less clear. Furthermore it highlights the problem of developing "World Class Commissioning" in PCTs. Just what impact will this have and when?

To tackle these problems the Darzi-workforce paper proposes the creation of a "Centre of Excellence" to plan not just the workforce for medical practitioners but for all skill groups. It has commissioned the Kings Fund to consult on the design of this Centre and make proposals about how it might be constructed and managed. These proposals, if accepted by Government, will then go out to competitive tender.

This is fraught with difficulties. Workforce planning nationally and internationally has traditionally been focused on medical practitioners and has usually been wrong! A principle challenge for the future is the substitution of doctors with other skill groups. GPs and consultants are very expensive to hire whereas nurses can work to protocol and seemingly deliver services such as anaesthesia and endoscopy equally as effectively. In primary care some argue that GPs could manage patient lists twice as long as now by handing over more tasks to nurses.[47] Nurse prescribers now number over 10,000 and can write scrips for the whole formulary. They currently act as both complements and substitutes for doctors but with their wages being a third of the average GP, economic forces may lead to them acting as substitutes more often.

Incorporating these issues into planning is difficult especially as sometimes nurse up-skilling is seen as a complement rather than a substitute for doctors' inputs. Switching the emphasis to economy and substitution may prove difficult unless managed and incentivised carefully.

In addition to the Centre for Excellence in workforce planning, Darzi also proposes the creation of a Leadership Council to identify and train "high flyers" and create the managers of the future. David Nicholson anticipates that an increasing number of future managers will be clinicians and he said to the Select Committee that he expects at least one medically qualified person to be on all short lists for NHS Chief Executive posts within two years.

Such sentiments are laudable but clinician-managers and other managers lack appropriate business-analytical skills. Furthermore this policy is ironic as during the Blair years it was proposed to create a NHS University to meet these problems. This was abandoned expensively. Will these proposals thrive where the NHS University failed? The need is obvious but the policy drive has failed in the past!

The Skill Gaps in Management

The essence of the problem in both primary and secondary care is that a considerable amount of evidence of clinical and cost effectiveness (eg in the data bases of the Cochrane Collaboration www.cochrane.org) as well as routine administrative data t has been available and underused for decades.

For instance Hospital Activity Statistics (HES) record for each patient using a NHS hospital should be used for routine business planning and performance management but generally is not. HES can be used to address issues such as:

(i) the identity of the referring GP, which makes possible the routine analysis of variations in the referral patterns of practices;

[47] Max Blythe, Almost a Legend, Royal Society of Medicine, 2008.

(ii) the postcode of the patient, which facilitates analysis of social characteristics of the patient by using geographical information systems (GIS) eg whether they come from middle class or deprived areas;

(iii) the description of what is done to the patient in hospital. From this it is possible to identify the procedures used by clinicians and the length of stay in hospital. It facilitates eg comparison of trends in length of stay as well as benchmarking of comparative performance; and

(iv) the identity of outcomes such as mortality (which when linked to ORCS data can give 30 day survival rates ie inpatient death and short term survival after discharge), complications and readmissions. This facilitates, for instance, the linking of attempts to reduce length of stay to their effects on readmission rates as well as complications and mortality.

These data for acute hospitals have been available since 1989 but why are they not used?

In primary care the supply of data is less with no national information on consultation rates for instance. However there is national data on prescribing and from the GP-QOF (also there is hospital referral data in HES)

Again these data are underutilised, or often ignored by NHS managers and their clinicians. Why?

One reason is top down targets for waiting times, NSFs and other politically sensitive issues dominate management. The managers generally have neither the skills, the motivation nor the time to tackle the problems of clinical practice variations which if benchmarked and performance controlled vigorously would free resources to enable their organisation to meet national targets. Instead of this micro management of performance, managers demand and gullible politicians allocate more resources to hit national targets and draw a veil over the inefficiency of NHS organisations as manifested by inefficient clinical practice variations identified decades ago.[48]

The NHS is not unique in this respect eg the US Medicare system is equally careless in its use of society's scarce resources preferring to spend more rather than challenge medical practice variations and spend more wisely.[49]

Overview

If the Darzi reforms are to improve the quality of patient care, a sharp focus on improving the workforce mix and its quality is essential.

To free up resources for new services generated for instance by the requirement to implement NICE technology appraisal proposals, the skill mix of the workforce will change perhaps radically as nurses take over tasks previously dominated by expensive doctors. Planning these changes will be a major challenge for any "Centre of Excellence" established by Government as internationally this has proved a most difficult task.

Establishing mechanisms of revalidations for doctors is yet to emerge. The revalidation of consultants and GPs is absent. In primary care and hospital care appraisal exists but could be improved. The absence of recertification mechanisms for staff grades and locums in hospitals cannot be tolerated much longer in these days of focus on patient safety.

The need for analytical "business" skills in the management of the NHS is recognised in the investments being made not only in improving the quality of HES activity data (as part of PbR) but also in developing service line costing and patient reported outcome measurement (PROMs). These investments will offer, for instance, the potential to analyse the comparative performance of individual consultants in real time. The implications of the application of these data for the management of Boards of Directors and managers are profound. The risk is that without the skilled workforce the NHS will once again collect but not use these vital sources of information to improve patient care.

Recommendations

1. Focus investment in education and training on the development of analytical skills around economics and statistics. Avoid vague statements about "leadership" and emphasise the skills needed to lead from the front.

2. Performance manage through appraisal and payment systems the use of comparative cost, activity and outcome data throughout NHS organisations by Boards, Corporate teams and Clinical Directors.

3. Re-validate not only consultants and GPs but also all members of senior executive teams every five years.

[48] Department of Health and Social Security, Priorities in Health and personal Social Services in England: a consultative document. HMSO, London.

[49] Elliot S Fisher, Medical care: is more always better? New England Journal of Medicine, 2003, 349.17, 1665–67.

4. Invest in improved training of Non Executive Directors and make their appointment contingent on possession of appropriate analytical skill sets.

5. Identify and apply incentives that will maintain the focus of the Service on the systematic analysis of routine administrative data and the use of the evidence base eg all applicants for Chief Executive posts to have a masters degree in quantitative health service research methods within five years.

6. Ensure that when financial hard times emerge in 2010, training and education budgets are not the first to be cut!

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