HOUSE OF COMMONS

Health Committee

Oral evidence: Integrated care pioneers, HC 560

Tuesday 4 November 2014

Ordered by the House of Commons to be published on 4 November 2014.

Written evidence from witnesses:

Watch the meeting

Members present: Dr Sarah Wollaston (Chair), Rosie Cooper, Barbara Keeley, Mr Virendra Sharma, David Tredinnick, Valerie Vaz

Questions 292 - 369

Witnesses: **Rt Hon Norman Lamb MP**, Minister of State for Care and Support, Department of Health, **Clara Swinson**, Director of Social Care Policy, Department of Health, and **Ian Dodge**, NHS England, National Director, Commissioning Strategy, gave evidence.

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Q292 Chair: Welcome to the final session of our inquiry into the integrated care pioneers. Thank you very much for coming. Would you mind introducing yourselves and your roles to those who are following this debate elsewhere?

Clara Swinson: Good afternoon. I am Clara Swinson. I am Director of Social Care Policy at the Department of Health.

Norman Lamb: I am Norman Lamb, Minister of State for Care and Support.

Ian Dodge: I am Ian Dodge. As of 7 July, I am the National Director for Commissioning Strategy in NHS England.

Q293 Chair: Thank you. Could I start by asking what assessment you have made of the progress the pioneers have made in integrating health and social care in their local areas? Could you provide a general overview?

Norman Lamb: I will start by giving a general overview. Evaluation of the progress is a critical element of this. It is very much work in progress. There is national work going on. There will be a report from that next summer. Then there is local evaluation, which we are encouraging each of the pioneers to do in collaboration with their local universities and so on. From my point of view, the evidence that is available of the impact of integrated care globally is still quite embryonic, so we have to find the evidence of what interventions

work and which are not so successful. The pioneers give us an opportunity to do that, but it is far too early to reach firm conclusions.

You can see anecdotal evidence. I went to Greenwich last week; I know that you have been there. When you see their emergency admission rate compared with that for the rest of London—I don't know whether they showed you the graph; they probably show it to everybody who goes there—it is very impressive. If we could get the whole of London performing to that standard, we would both achieve a very significant impact on people's lives and relieve pressure on the hospitals, but that is anecdotal. Of course, it is difficult to know exactly what is causing that effect, but that is the purpose of what we are trying to do here.

Q294 Chair: You said that the national evaluation—the initial evaluation—will be published next year. When are you intending to publish that?

Norman Lamb: Perhaps Clara can help.

Clara Swinson: We have commissioned an evaluation that looks at how the pioneers have gone about their vision and how the national support has worked. That will report next June and be published after it has been peer reviewed. It is not a quantitative evaluation, but it is the early evaluation.

Chair: The evaluation of how they are actually getting on with the job.

Clara Swinson: Exactly.

Q295 Chair: At this very early stage, can you tell us how far ahead of the rest of the country the pioneers are already? In other words, were they already ahead of the game? Was that why most of them were picked, or was it a complete variety?

Clara Swinson: Yes. When they were picked, one of the criteria was how far ahead they were in their vision for integrated care and the quality of relationships locally, which meant that they had the vision and the practicality to deliver some of the changes. That does not mean that they are the only areas and that they are the top 14 in all areas, but it means that they had that vision. There was an application process, and that was one of the criteria to pick them.

Norman Lamb: It is also fair to say that there is quite a variation between them. Within the 14, there are some that are more advanced than others. You will be very familiar with Torbay; they have been doing it for years. Others are much more recent converts, in a way, to this way of working. There is a lot of variety and, indeed, quite a lot of diversity in the particular nature of the approach that they are taking. You will be aware of Cornwall, where there is very strong collaboration between GPs and volunteers. Each one is different. In a way, that is the strength of it.

Ian Dodge: Can I make three observations? First, looking at the pioneers collectively, they have unleashed an energy within the NHS around integration of care. That applies both to the process originally and—reflecting on the conversation you had with my boss Simon Stevens a week or so ago—to chapter 3 of the Forward View, which in part is building on

the principles, with a model of what the pioneer programme was about: how do we unlock new models of care? In many ways, the pioneer programme is a precursor of that. One has to consider that kind of macro-effect.

Secondly, in relation to individual pioneers, I have just set up a new national pioneer support group, which will meet for the first time next Thursday. We flagged in the Forward View that we want to create a different kind of national-local dialogue around providing better-quality support. At that first group meeting, I want to discuss with pioneer leaders whether we might, in advance of the first part of the evaluation, publish a "one year on" report that makes clearer the stories of each of the pioneers around what they have achieved in their first year, as well as what the future work programme will look like. Part of the responsibility of being a pioneer is to blaze a path. Associated with that is being transparent and clear so that other people can see what you are doing. That is what I will be proposing.

The third observation I would make relates to whether it has helped them to go further than they already were. I have been in conversations with the Minister and the pioneers where they have claimed that the badge of being a pioneer has helped to unlock change at a faster rate than would otherwise have been possible locally. We have more to do around the national support programme. Designing with the pioneers, I am keen for us both to improve the offer around the kind of Dyno-Rod function of unblocking barriers and to construct better support arrangements for them.

Q296 Chair: One of the issues around the pioneers was that they had an obligation to help to roll it out elsewhere—to spread the best practice. Are you clear that you are already seeing that process in train—that they are already influencing and moving on integration in other parts of the service?

Norman Lamb: I think that they are. We have a long way to go but, as Ian said—I came up with this idea, so I take responsibility for it—my whole approach was to unleash energy and, rather than have a top-down diktat, to say, "This is permission to develop your service as you want to do it and as you know how." Psychologically, if you give people the right to do it, the energy and the dynamism that you get as a result is wholly different from people complying with a national diktat. This is quite a change of mindset for the NHS.

On reading the Five Year Forward View—if that is the right terminology—I was thrilled to find that it had adopted the philosophy that we encourage dynamism at a local level; it was entirely consistent. The fascinating thing on a macro level, which Ian referred to, was that in the process of inviting applications 99 areas put themselves forward. I talked to several areas that put themselves forward, which did not ultimately get selected, but said to me, "We are going to do it anyway." That sense of dogged determination—and the sense that they had been given permission just to do it—was very encouraging.

On your particular point about the potential impact, payment systems are something I feel terribly strongly about. If you do not have the incentives right in the system, you get sub-optimal results. Payment by results has to change. The work that several of these areas are doing with Monitor to look at that and to design an approach based on a capitated model is incredibly exciting. We have not yet got to the point where that is disseminated widely,

but we are well on the way to that happening—and I think this is the mechanism by which it can happen. The exciting thing is that this is the national level working through problems with local areas—people on the ground who are having to grapple with problems—rather than a more divorced state of mind, which has perhaps been the traditional model.

Q297 Mr Sharma: You have indicated this partially, but I will still put my question to you. Why is it that, even before they were selected as pioneers, some areas were able to make very swift progress on integrating staff and creating multidisciplinary teams, yet there are other areas that have not even begun to move down that path?

Norman Lamb: It was fascinating last week at Greenwich. I do not know how many of you went there, but I am enormously impressed by what they have done. They described to us the integrated team that they have established, which is made up of professionals from a whole range of different organisations and different cultures. They were very honest in saying that to start with there was mutual suspicion. It took time to work through that and to get to the point where there was real trust. Working together—often literally in the same room—had that effect, but it requires really strong local leadership and will be stronger in some areas than in others. That is why you see a variation in the pace at which these things are happening. In some areas, there are leaders who just get it—who see the absolute value of breaking down these institutional barriers. That may not always be the case everywhere.

Ian Dodge: If we are going to make progress, it is terribly important that we look to understand the reasons why things have not happened in the past. I would entirely concur that some of this is about local leadership. Often it is about local leadership finding its way around structural barriers in the way in which the NHS has historically been organised. One thing that we are trying to do in the Forward View is to reflect on the silos that exist between different sectors of care: the GP practice, which is arguably a legacy of 1911, not just 1948; the district general hospital model, since 1962; and the separation from community services, as social care services. We have a set of almost legacy provider governance structures, ways of regulating those structures and ways of contracting for those services that reinforce those existing divisions. We have payment mechanisms that do the same thing. It is often quite difficult for people to navigate their way around organising services around individuals, rather than the interests of their institutions.

That is the agenda we need to tackle. It is difficult stuff. I remember observing to the Minister earlier this morning how in 1997, when I was working in the Department, there was a line in the new NHS White Paper that said, “By combining budgets at PCT level, we will integrate primary and community services.” Seventeen years on, we are some way away from that. The real challenge is how we design services around individuals, think about the role of technology, using the existing work force and infrastructure, and then try to unlock those new forms of provision that better serve patients and the taxpayer.

Q298 Mr Sharma: I will give you a further opportunity to explain more. The Staffordshire pioneer does not formally incorporate social care in its programme and Greenwich co-ordinated care does not have the participation of the local acute trust. Can

those projects genuinely be regarded as effective examples of integrated health and social care?

Norman Lamb: It is a fair challenge. In a way, the value of this programme is the diversity I talked about earlier. I do not begin to believe that all of the pioneers will emerge from this providing brilliant evidence that their model is precisely right. We should all expect that there will be varying degrees of success; hopefully we will learn lessons.

I have been clear in the past—and I remain of the view—that the capitated budget for populations is a model that I find very attractive, but that is absolutely not to say that we should not be willing to experiment with other approaches of joining up care around the needs of the individual patient. As far as possible, all of this has to be driven by the patient experience—or the person experience—and making sure that that improves. We know that often the experience of an individual patient is sub-optimal and that they fall through the gaps between different institutions. Let us see what emerges from this, and let us be prepared to learn the lessons.

Q299 Barbara Keeley: It has been reported that the Department wants NHS and local authority joint commissioning to incorporate public health and even children's services. Will the second wave of pioneers be expected to experiment with that model of integration, where those extra services are drawn in?

Norman Lamb: It is interesting. In the first wave, the focus was more particularly on adult populations, especially older people. Torbay is an exception to that. They focus in particular on integrating mental health into primary care, something I very strongly support, but also on looking at mental well-being in schools and trying to work more upstream of problems developing with children's mental health. I am very keen to develop the model to encompass the areas that you have described. We are getting Jennifer Dixon involved. From the start, I did not want the whole programme to be dominated by Whitehall. I wanted to bring in external expertise to support this and to help with the selection. Jennifer led an international panel in identifying the best 14. She is meeting her panel members next week, I think, to work on the process for the second wave.

Q300 Barbara Keeley: The concern is that, as you incorporate more and more services, you start to lose the focus on the original aim of integrating health and social care. I was responsible as a councillor for integrating education and children's services. It is not easy, because the area of children's social services has its own culture. That is the focus of the questioning around that. Isn't there a risk that the more you bring other things in, the more you lose what you originally set out to do?

Norman Lamb: I very much did not see it at the start as narrowly looking at integrating health and social care. That is absolutely part of my ambition, but I often talk about the fragmented nature of the NHS itself. Ian made a point about how the payment systems often exacerbate fragmentation. There is the separation between primary and secondary care and between mental health and physical health. If you focus on the patient's experience and where care and support fall down and you try and improve that, that is the best approach to take. Whether it is cancer care or children's mental health services—whatever it might be—that is always the starting point for me.

Q301 David Tredinnick: Good afternoon. I want to start on the point you have just raised about the scope of integration. Given that we now have patient choice and personal budgets at the centre of the health service, how do you react to patients who ask for specific therapies that are not necessarily mainstream? Do you have a sympathetic view of that? Do you have any views on how you integrate into the system other types of medicine that are seen by some people as fringe—and by some as not?

Norman Lamb: First, I do not think there is anything incompatible between giving power to a patient and joining up care. In fact, for me the best integrator of care is the individual themselves. That is why I am very strongly supportive of Simon Stevens's integrated personalised commissioning, bringing together personal budgets and health and social care. The power of the patient to make decisions, in collaboration with the clinician, has to be central to this. You can go about all sorts of institutional integration, completely forget about the interests of the patient and achieve nothing in terms of advancing their interests. It has to be focused on their needs. It should be possible to have a discussion between the individual and the clinician in determining the right package.

Q302 David Tredinnick: Your chief medical officer, Dame Sally Davies, has written a book, "The Drugs Don't Work", which is largely about antimicrobial resistance—something the Science and Technology Committee, on which I also serve, has looked at in some depth. Isn't it a fact that patients now are very worried about the increasing use of antibiotics and resistance and are looking for other alternatives—and there are some out there in the landscape?

Norman Lamb: I would agree with that. When we look at personal budgets in local government, in social services, people have chosen to use the money in all sorts of ways. For me the bottom line is, is the outcome better? Has their health and well-being—their enjoyment of life—improved as a result of that initiative taking place?

Q303 Valerie Vaz: Can I start by apologising for the fact that I have to leave the meeting early? I do not normally do that, but I have another Select Committee to go to. Minister, you have been quoted as saying that these pioneers "have been selected to act as exemplars of the co-ordinated care, tailored to meet the need of each individual, that we, our family and friends want to experience." What if the family and friends do not experience that?

Norman Lamb: Do you mean if the experience fails to meet expectations?

Valerie Vaz: The pioneers are putting through a system. I will be more specific, but I was trying to ask you for your opinion. I am really pleased that you said that you want to take responsibility, because it is very rare that people do want to take responsibility. I am concerned that you want to take responsibility for something you have no control over. Clearly, what is happening in Staffordshire has been devolved down to individual pioneers; that is correct, isn't it? However, you will still take responsibility for that. Let me be a bit more specific on the point of whether there has been wide consultation with local people in the area. It has an impact on health generally, but particularly on Walsall. Local people are

concerned about this particular pioneer for cancer services. They have expressed opposition, have tried to get information and have been unable to do so.

Norman Lamb: First, let me make it very clear that I take absolute responsibility for this programme, the approach and the philosophy behind it—in other words, not dictating things from the centre but encouraging local diversity. We are encouraging local clinicians—critically, working collaboratively with local communities—to develop services in their way, without me or anyone else dictating to them.

The second point is that I fundamentally believe in transparency, as far as it is possible to achieve that. I am also conscious that sometimes lawyers—I speak as an ex-lawyer myself—take a rather restrictive view and act quite cautiously in terms of what it is possible to get into the public domain. I am not an expert in this area of law and in what specific processes have been pursued in Staffordshire. All I say is that I advocate the maximum possible transparency that is achievable within the law, because I think it is the best way of taking people with you.

There was a poll undertaken in that local area that showed a rather different picture to some of the protests. I completely understand people's anxieties about change, but as much as possible I want this to be driven by achieving the best possible cancer outcomes for people. I have tried to go to all of the pioneers. I finally got to Staffordshire last week, so I have had a fairly recent discussion with people there.

Q304 Valerie Vaz: By people, who do you mean?

Norman Lamb: The leaders of the proposition. I have tried to go to the clinical leaders wherever I have visited around the country to talk to them about what their proposition is and how they are going about achieving it. One of the people there was someone who had had cancer and had had an experience of the way the current system works. It was quite interesting to hear her account as an individual. She wanted to challenge the proposed method of treatment for her particular cancer. She was someone who had got cancer at a much younger age than many people with the sort of cancer she had. The proposed treatment did not seem appropriate for her, so she had researched alternatives on the internet and wanted a second opinion. She found a lot of resistance to that from the clinician and found that she was there on her own, while suffering from cancer, trying to fight a battle to get her voice heard. Eventually she got her second opinion and the right to go to the Christie hospital in Manchester, where she had to start all over again. There had to be new tests and all the rest, because there were no transfer of care records.

Q305 Valerie Vaz: Can I stop you there for a minute? I accept what you say, but this is just one piece of anecdotal evidence.

Norman Lamb: We do have to listen to these cases.

Q306 Valerie Vaz: Absolutely. We can all find examples of where a system is not working, but I am talking about the much bigger picture, where local people have not been involved and have not been consulted in the way that you say. I do not know what this poll is

and whether it has been published, but there have been meetings. There has been a paucity of evidence as to whether this new system will work, particularly because there is this new thing called the prime provider, which will be outsourced to Virgin Care or other stand-alone—

Norman Lamb: Or it could be an NHS provider.

Q307 Valerie Vaz: It could be, but it may not be. The local people are saying that you are taking a huge risk with an already distressed situation. Local health care in Staffordshire is hugely distressed. You said in your evidence just now that they may fail. While we can allow that to happen, we cannot really allow that to happen with public money in the NHS, particularly in a distressed area. I do not know what the poll is. It would be nice if you had actually talked to local people, which it does not appear you have, to get a general view of what is going on in the area. You say that you have, but we had a clinician give evidence in front of us that he was not consulted and was not happy with this system.

Norman Lamb: Let me repeat that I am keen that there should be the maximum possible engagement of people. That is the approach that I always favour. I absolutely favour attempts to take people with you on a journey, rather than just assume that you have people's support. You were one of the people who questioned Chris Ham on this at a previous session, which I glanced over. I think he made the point that there are risks in not doing anything. You came back to me and said that what I had said was anecdotal. I accept that, although I think that these individual stories are really important in understanding sometimes the failures—

Valerie Vaz: I could probably find you 10 others.

Norman Lamb: The point I was going to make was that, if you look at the overall picture, outcomes for those who have suffered cancer in that community are below the national average, and we are quite a long way below the European average. That is not something we should tolerate. I suppose that my plea to you and to others is, let us be open-minded about how we can achieve improved outcomes for people. I take the view that Macmillan is an organisation that is driven by trying to improve cancer outcomes. It is very heavily involved in this programme; I welcome that. While I totally agree with you that there should be maximum engagement, I also think that we should not assume that the local clinicians and Macmillan are seeking to do something malign here. They are driven by a desire to improve outcomes for people who suffer from cancer.

Q308 Valerie Vaz: Okay. I am not going to touch on the aspect of Macmillan, but you mentioned cancer care. There must be good practice in the rest of the country on cancer care. My point—and the point of local people—is, why take a risk with NHS money, which is public money, and go down a route that the majority of people do not want?

Norman Lamb: If we carry on as we are—

Valerie Vaz: Is there good practice in the rest of the country?

Norman Lamb: I am quite sure that there is, but we must also be prepared to learn. My understanding from what I was told was that what we are talking about here is a care integrator, someone who pools together all of the different providers—a bit like, in their

words, a travel agent does. The expectation is that exactly the same providers as now—the acute hospital and so forth—will provide the care. However, at present I am told—if people tell me this is not the case, I am very happy to hear that—that too often people fall through gaps when the individual patient gets referred across from one organisation to another. In a sense, this is the essence of everything that we are trying to do in joining up care. If there is a way of pulling together these existing providers in a way that provides a more seamless journey for that patient, surely that is something we should be willing to explore.

Q309 Valerie Vaz: Let us move on slightly. I will start with a concern that I have. One of the questions that came out of my questioning of the two people who were there and are running it was that some CCGs were involved and some were not. They dropped out of this particular pioneer, yet we were reassured that everyone who had cancer in the whole of the area would still be part of this new programme. That does not seem to me to be quite logical. CCGs can just opt out, but then the rest of the CCGs can foot the bill.

Norman Lamb: I am not clear on the answer to that question. It seems to me that CCGs are there to commission care for people in their area. If they are not part of it—

Q310 Valerie Vaz: That is the logic. That is what we could not get an answer on. My plea to you is, please could you look at this particular pioneer?

Norman Lamb: Absolutely.

Q311 Valerie Vaz: They are trying to tie up contracts for 10 years, which is a long time.

One of the questions that I asked—it had not come out of anywhere else—was, "Where did you get this idea from?" They said that they were helped by NHS England—the commissioning support unit—and that they were paying £250,000 for this advice. This is money coming from you, the Department of Health, down to the pioneers, who are then paying NHS England £250,000. Imagine if that £250,000 was available for the patient in the anecdotal evidence that you gave to have that alternative treatment, or perhaps for a Maggie's Centre nearby. Don't you think that is a waste of NHS money?

Norman Lamb: I come back to my main point, which is that we have cancer outcomes in this community worse than the national average. We ought all to be willing to look at ways of improving that. We are not talking about this sum of money, which we talk about over a 10-year period, somehow disappearing from the NHS. Every expectation, as I understand it, is that the acute hospitals concerned will continue to provide the care. This is about the pulling together of those different aspects of care that a care co-ordinator can potentially achieve. Given that we have poorer cancer survival rates in this country than in the rest of Europe, we ought to be willing to experiment with different ways of doing things to improve those outcomes for people, because at the moment people are dying unnecessarily. That is the bottom line. I do not find that acceptable. We ought to be willing to challenge it.

Q312 Valerie Vaz: We have to be careful about our statistics, because I do not think it is true of breast cancer particularly. I do not share your reassurance on this issue. I plead with you to look at this particular pioneer.

Ian Dodge: In the spirit of trying to be helpful, may I offer three comments back on your questions around Staffordshire? The first is in relation to the CSUs. The CSU spend is part of the overall administrative cost constraint on the commissioning system, which is combined NHS England and CCGs. Overall, the management spend in the NHS is about 3%, whereas in other countries it is significantly higher.

The money that is supporting this particular project is part of that overall constraint. This is for services that the CCG, rather than providing itself by way of employing people, has decided that it can better get from an expert organisation. One rationale for having the CSUs—and a limited number of CSUs, as opposed to the 220-odd CCGs—is that, where they need expertise, the CSUs can do that more efficiently than the CCGs and provide it themselves.

On the other CCGs, I recall reading the transcript of the evidence session. The reason why one of the CCGs—it may have been South East Staffordshire—said that it did not want to participate was because its patient flows were not directed at the same services. It was facing in a different direction.

Norman Lamb: So presumably it is not part of it.

Ian Dodge: Although it is part of the area, it has decided—

Q313 Valerie Vaz: You are not taking everybody with you, are you? You may say that it is okay to commission this, but the fact is that public money is coming out from the centre, going out to the pioneers and then going back to NHS England. Actually, it was Anglia commissioning support unit; this expertise was not procured from the local support unit.

Ian Dodge: In line with the mandate set by the Department to NHS England, CCGs have a choice of commissioning support, in order to try to make sure that they can get the best possible support.

I want to make a quick observation on best practice in cancer services. One of the models we alluded to in the Forward View is something Sir David Dalton will be opining on shortly in his review of hospital organisational forms. One of the options that he has been discussing—I have had the privilege of being part of the expert panel for that review—is to what extent there can be things like specialist franchises. We have examples in ophthalmology, with Moorfields having 20 outposts in other trusts. In cancer services, the Marsden is running a franchise at Kingston district general hospital. The Christie is similarly developing some options.

I am not at all close to what is happening in the process in Staffordshire, but one of the purposes that I imagine Andrew Donald and his CCG colleagues are thinking about is, “How do we tackle the clinical isolation that Robert Francis so graphically illustrated in his report on Mid Staffs? How do we, through an open process, try to engage expertise to

help with the prime provision model?" I imagine that it is precisely because of a desire to try to bring in additional outside expertise and help that they are running with this project.

Norman Lamb: I will add one final thing. I am very happy to look at the pointers and the concerns that you have raised with me and to report back.

Valerie Vaz: Thank you.

Q314 Barbara Keeley: It may be that when we report back on this you will see that a number of us were concerned. Minister, you make the point that there should be maximum possible engagement. We did have concerns about engagement on this pioneer. Healthwatch did not seem to be clear at all about its role; it seemed to be mixed up. Was it representing the general public, a lot of whom, as my colleague Valerie Vaz has said, are against this? This was recruiting of just a few champions and people with cancer, who clearly have one of the most important roles, but the vast bulk of people who live in the area are important, too. They and the local MPs have expressed a lot of concern about it.

There is a danger I want to touch on with you. You talk about consulting people and working collaboratively, but in this pioneer what they are doing is controversial and has a fair degree of opposition, which some of us here would not think is being well handled. That is a danger, as it puts a question mark in my mind about Healthwatch and Macmillan. I wanted to make that point about Macmillan, which you touched on.

It was not made clear to us that funding the work was an issue. My colleague has already raised the point about funding going to the CSU. That has drawn the charity Macmillan Cancer Support into controversy, because now it is funding this transformation work. It is putting a lot of money into this work. It gave us a figure of £867,000. I am not sure whether that is per year; I had heard a figure of £4 million over a period of five years.

A number of us felt, in the questions that we put, that there is a danger in that. You were drawing—through the controversy related to privatisation and the prime provider, whoever that may end up being—a very well known and well favoured charity into the front line of controversy, as the ones who fund this work. It is not being funded by you, who want the pioneers, but by this charity. That is drawing it into the line of fire. Do you think that was a reasonable thing to do? A number of us ended up feeling very unhappy and dissatisfied that a charity that a lot of us support has put itself into that situation. It is not very desirable that it has.

Norman Lamb: First, there is absolutely nothing that we have done to draw them into the line of fire, as it were. This is a judgment that Macmillan has made.

Q315 Barbara Keeley: Can I stop you before you get on to that line? The funding is not there unless it provides it. One of the first things that was said to us in our panel session—you can look back on that—was that the great thing about Macmillan is that it is putting up the funding for this. You are not putting up the funding for this. The funding is not just for the work and is not going to front-line patients—it is going on this transformational work. That is the issue. If you do not fund the work, somebody else is drawn into it. The somebody else in this case is Macmillan.

Norman Lamb: I think Macmillan decided that of its own volition right at the start of this. It put forward a proposal—an application—to become a pioneer. As I understand it—if this is wrong, we will obviously correct it—it was already working on developing this model before it applied to become a pioneer. Macmillan got involved in this entirely of its own volition. My plea to you is that Macmillan is motivated by improving the lot of people who suffer from cancer and achieving better outcomes for people. It is a worthy ambition and objective and one that means that I hold Macmillan in very high regard.

Q316 Barbara Keeley: Minister, it is not just your view; there are the views of the people who live there, which we have already heard about; you yourself talked about protests. There are the views of local MPs. There is a gathering view. A number of us on this Committee have concerns. I understand that you want to talk about the good that comes out of this. I am saying to you that there is damage coming out of this because, to me, it seems to be starting to damage the reputation of a charity that has previously been held in high regard.

As the Minister, you cannot walk away from the fact that that is happening. There are people worried about their careers and people worried about where the future of these NHS services is going in their area. It is not being well handled in terms of consultation and the collaborative working that you said you want to see. We have raised a number of concerns, which we may well report back on. If we are not going to agree, we may just as well leave it there; we have a lot of other questions for you. I wanted you to know—you probably do know, but we wanted to emphasise it to you—that we have a lot of concerns about it.

Norman Lamb: I want to stress again that it is through no pressure from us. It has acted of its own volition.

Barbara Keeley: You create the pressure if you do not fund the work, I am afraid.

Q317 Rosie Cooper: If I might come in there, it is clear that the chief executive is a non-executive on NHS England. There is a great suspicion that he has joined the establishment and the magic circle and that this is all behind closed doors somewhere else. Last month I spent five and a bit hours dispensing tea at a friend's house to raise £1,000 for Macmillan, a charity I used to believe in 100%, providing nurses and people who directly support cancer patients with services they would not get from the NHS. I tell you now that I would never do it again. I will do it for another cancer charity, but I will not do it in this regard because Macmillan is not raising funds openly and honestly for that purpose. People who are raising money think they are doing so for cancer nurses. That may cause it problems elsewhere.

I want to put to you something else that was said at that panel; you will have noted it in the minutes that you read. Dr Shapiro said that, as a non-executive director in the NHS, he is not allowed to work for the NHS. Very clearly—in a very blasé way—he then said that he did carry out this work, but that as a cover, in order to make it happen, Macmillan paid his wages for two days a week or something to that effect. Do you think that that duplicitous way of raising funds and paying this man's salary is in the spirit of the rules of a charitable concern and the Charity Commission? Indeed, are you not unhappy that a non-executive in a health authority body can circumvent the rules just because they think so? If that is the bar, I am really scared about how we operate.

Norman Lamb: I am very happy to write to the Committee in response to the concerns you raise. You have raised quite serious concerns about duplicity. I take those concerns seriously. I just do not feel able to—

Q318 Rosie Cooper: I have written to the TDA. I am not going to let this go. I passionately believed in Macmillan. I am really sad that their chief executive has now become part of the magic circle—part of the establishment—and that the money will go to support whatever latest idea somebody has in a cupboard somewhere. That is not why the money was raised. I will stop there, because this will play out over time.

Norman Lamb: May I make one final comment to you on this? Of course there are different views on how we achieve good results. In this room we are all motivated by trying to achieve better outcomes for people with cancer or with any other condition. Macmillan is as well. That is my judgment. You may take a different view, but I think it is absolutely—

Rosie Cooper: No, I agree.

Norman Lamb: The other point I would make, when you talk about its joining the magic circle, is that it is quite important for NHS England to have representation from the third sector on its board.

Q319 Rosie Cooper: To use your words, Minister, "open and honest" and "fundamentally believe in transparency".

Norman Lamb: I do.

Rosie Cooper: Not you. I have not seen Macmillan go out there and say, "We are not really going to use this £1 million—or maybe £4 million—for nurses. We are actually going to use it to do this, this and this." Have you seen that, or am I seeing flying pigs? I have not seen it say that out there anywhere, yet Shapiro said very clearly at that meeting that this is the direction you have indicated today and the direction in which it would like to travel. The truth is that it has not consulted the people who are doing those coffee mornings and working out there to provide that money. They do not know what it is for. That is dishonest. That is not fundamentally open and transparent. That is my point.

Chair: On behalf of the Committee, I should stress that some very strong words have been used about Macmillan and they are an individually expressed view. I do not think that we should have on the record that that is a Committee view.

Rosie Cooper: I did not realise that I was speaking for the Committee. I speak for myself. I come here and speak for myself. I am very clear that I speak for myself and that the evidence will speak for itself. When I am finished with the Charity Commission and the TDA, the facts will speak for themselves.

Chair: Thank you for clarifying that, Rosie. We come on to David.

Q320 David Tredinnick: I want to ask you a question about finance in a minute, but while we are on patient choice, I wonder if you have had a chance to look at the Cancer Act 1939, which is very tight about claims that can be made about certain therapies in respect of cancer. Just to use one example, if an aromatherapist wanted to use lavender, which can be very good at reducing stress, they would not be able to make any claims that it was effective. I encourage you to go and look at that Act; it is from 1939 and is very out of date. If we are going to broaden choice, that is something that should be considered.

The second point I want to make—this relates specifically to cancer care—is that I am reliably informed that the food in some cancer hospitals is not suitable for people who have cancer. The basic problem is that there is too much dairy in the diet, I am reliably informed; I am not a physician, but that is what I have been told by people who are reliably informed. That is something you might want to look at.

Moving on, on financial risks, if a pioneer attempts to implement an ambitious programme that ultimately does not achieve its objectives, will the pioneer receive financial support so that they are not left exposed by the cost of experimentation and failure?

Norman Lamb: Ian may well be in a good position to talk about the view from NHS England—the emerging view, particularly based on the Five Year Forward View—but I think there is a legitimate issue about how we facilitate experimentation. The last thing we want is a system where people feel so constrained and risk-averse that nothing ever changes. You are then stuck with the same model of care, which may well be sub-optimal both in achieving good results for patients and in the way we use resources. We have to be able to encourage and facilitate experimentation. Ian may well have views on how NHS England seeks in the future to sometimes facilitate this issue of double running costs, as you try to change the model of care. I will hand over to Ian.

Ian Dodge: I will distinguish between two things—the risk, and how that risk is managed and shared within a locality. That gets to the heart of the question of the payment and financial flows within the system. One of the five supporting workstreams that have been established nationally, working with the pioneers, is looking at pricing mechanisms. Monitor is closely involved, with NHS England, in designing new models of paying for services. That work includes, as the Minister said, things like developing new capitated approaches. Linked to that, I believe it is also looking at things like alliance contracting and risk-sharing arrangements, so that there are robust mechanisms in place to support these new models. Potentially, some of those models may deal with financial risk more effectively than current models. If you think of the payment by results mechanism, which is payment by activity, there are significant risks within the current system for commissioners and, indeed, providers.

Being very frank, I think we have a lot more to do around designing those models. Doing that requires considerable technical expertise. It does not make sense for every part of the country individually to have to invest in understanding the mechanisms and how they might be changed and designed. That gets to the heart of what we articulate in the Forward View as a different kind of national-local dialogue. How can we avoid the over-rigidness of a single blueprint that we impose everywhere or, equally, the inefficiency of simply allowing a thousand flowers to bloom? Looking across the 14 pioneers and, potentially, some of those that may get through the second wave process or some of the new models work that we are articulating in chapter 3 of the Forward View, to what extent are there

some common patterns arising, where a number of different sites are trying to do similar things? If they are trying to do similar things, to what extent can we work with clusters of them to try to design, in essence, prototypes that can potentially be rolled out across the NHS more widely? That is the practical challenge that we need to try to address. We are just at the beginnings of that process.

Secondly, on your question around investment, this Committee has heard—and many observers of the NHS and historians will have observed—that, historically, things like changes in mental health services relied not only on technological change, such as the invention of new drugs, but also on some investment in those new models. There were double running costs associated with that. In the Forward View, we set out a view that, if we want to move beyond the current pace of change, we need to examine whether there is a need for some potentially significant additional investment in being able to unlock the new models of care. I think that in his evidence last week Simon said that we would be working with areas across the country to try to end up with a clearer view of that over the coming months.

Clara Swinson: As you know, the pioneer programme does not fund the services directly, but it should be aiming to give areas support if, as you say, they are taking a risk and thinking, "What is the new programme?" and are wondering how to evaluate that, what the metrics might be and whether they need leadership support. Hopefully, being part of the programme and the fact that they have been chosen should encourage them to think about different ways of doing things and, maybe, to take that risk, but also to get the support that they need if they are taking a bigger risk.

David Tredinnick: That is very helpful.

Q321 Mr Sharma: The leader of the Staffordshire pioneer told us that, even working collaboratively, CCGs are too small and too lacking in resource to undertake transformational work. Does that not indicate a fundamental flaw in national commissioning structures?

Norman Lamb: That is one view. Views are quite varied across the system. In some areas, CCGs may decide to move together or to collaborate in terms of commissioning. If I think about what is going on in Manchester, for example, a whole group of CCGs have come together to look at quite big transformational change across Manchester. We facilitated the establishment of a joint committee to undertake work of that sort. There are sometimes big changes covering a wider health economy than an individual CCG that may well require that collaborative work, but there are facilities within the system to allow that to happen.

Ian Dodge: There is some interesting survey work that suggests that GP practices in larger CCGs are less satisfied with the engagement with the CCG leadership. There are probably trade-offs between the benefits of affinity and the coherence and meaning of smaller CCGs, and the potential benefits of scale with larger CCGs. That is a first observation.

Secondly, clearly CCGs can, for the right type of services, look to collaborate with one another when they are commissioning services for a larger population. One thing that NHS England has recently set out is a desire on specialist services commissioning to involve CCGs more effectively across the footprint of the 10 specialist commissioning hubs—to

invite CCGs into that process as part of collaborative, collective arrangements. That is possible.

I touched earlier on the possibility of CCGs, where they require technical expertise, procuring that from commissioning support units. I spent last Friday talking to South East commissioning support unit and saw some of the fantastic work it has been doing—for example, around work force support and outcome-based commissioning.

The fourth and final observation is one you will be familiar with from your session last week. It is on the debate around structures. I worked in the Department of Health for 20 years, working for 10 different Secretaries of State during that period. I was involved in a number of restructurings—arguably far too many—of the superstructure. As the Forward View sets out, there is an argument that there is no perfect size for CCGs or the intermediate tier in the NHS, but there is potentially a wrong answer. That is for us to keep changing our mind as to what the right answer is, because it creates significant disruption.

Mr Sharma: Thank you.

Q322 Rosie Cooper: With the Chair's permission, I am going to go back to question 7, but if I might just come back here—if I do, that will probably reduce my contribution to the rest of this session—there are two big things. I hear what you are saying. You are saying, "Let people sort it out and reorganise it locally, and it will work itself out." This might sound a bit of a daft question, but what do you define as local leadership?

Norman Lamb: Critically, it is across the system and it should not be based on an individual institution. I was hearing a concern expressed recently that, in a particular area, the acute trust was focusing very much just on its own organisation and its own patients without recognising that we have to look across the whole system. One of the benefits of the reforms is the establishment of the health and wellbeing boards, which brings together the leaders from the different parts of the system, whether it is mental health, the NHS care services through the local authority and so on, and that, for the first time, also introduces an element of democratic accountability in the system.

Q323 Rosie Cooper: Great. You see, that, for me, in the most amazing way, produces a problem. For example, Southport and Ormskirk is considered to be part of the Mersey health economy.

Norman Lamb: Sure.

Rosie Cooper: The problem is that when Manchester and Neil Goodwin, as the chief exec there, wanted to promote lots of change in the '90s and early 2000s, there was major controversy. In the Mersey economy each of our organisations is suddenly getting appointed a chairman not from Mersey, not from Liverpool, but from Manchester or Cheshire. I locally now have in Southport and Ormskirk a chair who comes from Cheshire. Neil Goodwin, who was chief exec of the strategic health authority, took a huge pay-off, set up his own company and is now chair, still living in Cheshire, in Aintree. Alder Hey have David Henshaw, and I could go through the list. These people are going to be making health decisions for a population where they do not have a dog in the game. They are not going to receive the care

that is dished out here. Do you think this is a way of the establishment enforcing change on to an unsuspecting Mersey public?

Norman Lamb: First of all, I think back to the days of the primary care trust in my own county of Norfolk, and I had no idea who any of the board were. Several of them did not come from Norfolk and did not appear to have any great connection with the county. This is not a new issue. At least through the health and wellbeing boards, the elected local authority has representation on the board.

Q324 Rosie Cooper: They do not have any power. This is about power. The people who are going to make the decisions about the transformation of the economy—as you just put it before, unleashing the energy—are not even from Merseyside.

Norman Lamb: You also have the role of the overview and scrutiny committee and the local authority to challenge and to stop change in its tracks if they want to refer it up.

Q325 Rosie Cooper: Meanwhile, these people are meeting in cupboards and making those decisions. I leave that as a point. People need to know what their health services, their health organisations, are now. The idea of them being "locally" accountable is not necessarily true, and the people who are dishing out those positions of responsibility can come from 40 or 50 or more miles away and will not receive the care that they are agreeing to transform; or whatever it is they are going to do, they are going to do without having a dog in the game. That is, for me, outrageous.

Norman Lamb: I understand your concern, but all I would say is that there is more democratic accountability now than there ever has been in the past. That is the truth of it.

Q326 Rosie Cooper: As a former chair, I do not necessarily believe it. I was living in the city, being part of the city, and meeting the patients who use it—I was a councillor at the time—and my constituents held me accountable. Being a former chief executive coming in, using my knowledge and whatever to make sure I clean up on services, is not real accountability. That is being accountable to A.N. Other. That is not real.

Anyway, I will leave that as it is and just say this to you. Going back to where we were before—and I will shorten the question—shifts in care usually are achieved by double running during transition. Organisations need help to enable them to get the space to achieve it. Is there any pot where that funding will be available to enable pioneers in this case to develop new forms of care, and, if not, where does the money come from? Do you have more Macmillans up your sleeve?

Norman Lamb: The first point I would make is that if I look at, say, Greenwich, the change they have achieved so far in the very low level of emergency admissions compared with the rest of London has been achieved through very smart collaborative working locally without any additional resource. So, to an extent, if they can do it, then other areas of the country can do it as well and we should absolutely be encouraging areas to follow the lead of places like Greenwich. But then I go back to what Ian has just said in response to David Tredinnick—that, in the Forward View, the idea of being able to provide some

investment in testing new models of care is absolutely part of the vision that NHS England is developing and is a recognition, in other words, of the problem that you describe. Their objective—I do not know whether you have had a chance to look at the Forward View—is to look at how you could potentially provide that additional support.

Rosie Cooper: Okay.

Norman Lamb: This has been an intractable problem for years and years, has it not? And in a way the fear of failure has stopped innovation in the NHS and has resulted in blockages to change. The fact that NHS England is recognising that and looking at ways of facilitating that sort of change is very welcome.

Q327 Rosie Cooper: There has to be a halfway house.

Norman Lamb: Sure, absolutely. That is what I think they are looking at.

Ian Dodge: If I may briefly say this, there is not any additional funding for these areas outwith what is in their main allocations. There are clearly some costs of people developing new services and potentially thinking about infrastructure in a different way, so some of this is not just around revenue—this may be about capital. We allude to Watford, and there are a number of places across the country that are thinking about integrated health and care campuses. I was in Whitstable in Dr Jon Richards's practice a few months ago and he is thinking—I do not know if this is part of the Kent pioneer—of potentially, next to the Estuary View practice, developing a campus with a residential care home, a care home, a debate around the community hospital and also sheltered accommodation. Some of these potentially visionary models will end up requiring investment. What I do not think we have, speaking candidly, is a clear articulation both of what some of those standard models would be—the prototypes—and what the numbers look like in terms of the cost of investment and the outcomes arising from it. That is what we want to try and do. Part of the Forward View is to think about how we begin to structure some of the experimentation and provide some method so that we are able then to move faster and replicate.

Q328 Rosie Cooper: So you need more money from somewhere. Do you have any more Macmillans lined up? Are there any other organisations that you know of that are providing money to do what the average member of the public would think was necessary, such as the Department of Health, NHS England, or however they structure it? Do you have any other organisations that are putting money in like Macmillan right now?

Ian Dodge: I am not aware. I will need to check with colleagues around other potential partner funding. There is certainly a potential to unlock and use the balance sheets, for example, of foundation trusts more effectively to support service change. I know that some of the pioneers have been thinking about trying to unlock investment from other sources—for example, through innovative social impact bonds. So I suspect there will be a variety of different potential funding.

Norman Lamb: It is important that I should mention Age UK working with the pioneer in Cornwall, and I totally welcome that. It is a fantastic collaboration. I cannot honestly tell

you what degree of investment they have made in their time involved in that, but the impression I get from the early results of the pilot in Newquay, now extended to Penwith, appears to be encouraging. If local areas can work collaboratively with organisations like Age UK, that seems to me to be an entirely good thing.

Q329 Rosie Cooper: Could you write to the Committee and say if and where that is happening and what the outside organisation is involved in, what it is providing and what its aim is? I am not against this. What I am against is not being up front, open and transparent and continuing to raise money, if you like, on the one hand, while, on the other, perhaps even having a major strategic change in direction and not being clear with the public. That is absolutely wrong.

Norman Lamb: I totally agree with you. I genuinely believe in transparency and I think, if organisations are going to get involved in this sort of thing, they should be completely open with the public who may be giving them money about what their ambitions are. It is a great ambition, and it is fantastic that these organisations are looking not just at supporting current models of care but experimenting with how it can be improved, and that should be totally welcomed. But there should be complete transparency about it.

Ian Dodge: I mentioned in my introductory comments that at the first meeting of the pioneer support group that I am chairing next week I will be exploring the idea of a “one year on” report where potentially we set out what each of the pioneers is doing. Just connecting that thought with your question, I will take away and raise with the group the point about whether or not we might include the very clear list of who the partner organisations are for each of the pioneers so that that can then be transparent.

Q330 Rosie Cooper: That is great in your report, but will you still write to us?

Norman Lamb: Yes, I am very happy to do it.

Rosie Cooper: Thank you.

Q331 Chair: Before we move on to the subject of double running, we also heard from Simon Stevens in the Five Year Forward View about land sales being part of the contributor to the double running set-up costs for some of these projects. How long are you estimating that it will take for those land sales to take place? When could we see money being released from these kinds of projects? Certainly most people’s experience of trying to sell property is that it takes a long time.

Norman Lamb: For me there are two areas: there are the land sales and the balance sheets. It is deeply frustrating to me that there is a very substantial resource locked up in these ways. I have not discussed this at any length with Simon Stevens, although I have had an initial discussion with him about it, but one—

Q332 Chair: Is this from PropCo, which is owned obviously by the Department of Health and not by NHS England?

Norman Lamb: Absolutely. It is not just PropCo. There are foundation trusts around the country, and indeed NHS trusts, that own land and buildings that are either unused or under-used.

Q333 Chair: The trouble is that, unless you are working closely together, it is all very well for NHS England to think they are going to have this money to spend, but they do not own the property. Other bodies own it.

Norman Lamb: No, but there are mechanisms you can use to unlock the money; this is work in progress at the moment. I hope that we can provide more information collaboratively in the reasonably near future. There is much more we can do to unlock the potential of this money to provide the investment and the transformation that we are talking about. When you think about digitalisation of the system, linking up the entire local health economy, and you think about quite a lot of foundation trusts that have good balance sheets, it would be good to find a way of unlocking that and encouraging or providing the incentive for them to do that. There are already incentives in place, but we need to go further than that.

Q334 Chair: Yes, because it might not be in one organisation's interests to hand over the money from a sale.

Norman Lamb: Absolutely.

Q335 Chair: There is an assumption that it will be there, but who would have the say-so? The other area which was touched on briefly was social impact bonds. We heard about that in Worcester when we visited the Worcester pioneer. In your initial one-year-on appraisal, will you be setting out whether that is yielding any money so that other parts of the service could start to look into that at an early stage?

Norman Lamb: My impression is that it is too early to reach any conclusions yet, but I do not know whether Clara has anything to add.

Clara Swinson: I think that is right. The evaluation will look at the way they have gone about it and what potential benefits they will be getting, but it will be too soon to see whether that has actually recouped money.

Q336 Chair: Are there other parts of the system already using social impact bonds?

Norman Lamb: There is a fantastic organisation in Sandwell in the west midlands called Friends and Neighbours, facilitated by an organisation called DEReC, believe it or not; I can't remember what it stands for, but it is not run by a bloke called Derek. That is an incredibly exciting project. DEReC is involved with Sandwell, Leeds and, I think, Belfast. It is a social impact bond facilitating community action organisations, developing networks of volunteers combating loneliness and so forth. The potential for that is enormous, but I do not have any evidence to give you yet about outcome. It is very, very early days in their process.

Q337 Chair: There are a variety of mechanisms for having some double running money coming in from land sales, possibly social impact bonds and possibly releasing money from balance sheets. But, in addition to that, are you making a specific case to the Chancellor—do you have a view in your own mind—about how much we need to fund these double running costs? It is an issue that we have also raised in our CAMHS inquiry that is being published tomorrow.

Norman Lamb: I have expressed the view that the system needs more money—I think I saw you on "Newsnight" saying very similar things to what I have said—and it needs it in 2015-16, in my view.

Q338 Chair: Yes, but have you made an appraisal specifically in terms of double running, because it is sometimes easier to get, if you like, neat pots of money to cover things like that? What I have not been able to see is any assessment from the Department clearly articulated about an estimate of what these double running costs would be in order to make this transformational change that everyone talks about.

Ian Dodge: May I come in, Chair? On that specific question, I think this would be informed guesswork at the moment. There needs to be more—

Chair: That is better than nothing.

Ian Dodge: There needs to be considerably more work around what the costs associated with the roll-out of the different models would be, which is quite hard to do at the moment in advance of having got that information and known what the particular sites are across the country. It will be some months before there is a clear view. Simon said at the session last week that he was aiming to have a clearer view of what investment funding might look like at some stage in the first part of next year; I can't remember his exact phrase. We have more work to do around that, being frank.

The second observation I want to make is around these other mechanisms that he alluded to. I do not think it is the assumption of the six organisations that are the co-signatories to the Forward View—the sextet—that we are not banking on NHS trust balance sheets or land sales necessarily delivering, but what we are pointing out is the fact that, if we are smart around unlocking their energy and their resources, then potentially there may be more than one way of funding this rather than just making an assumption that it is the taxpayer who stumps up the capital.

Chair: Thank you.

Q339 David Tredinnick: I would like to ask a few questions about the reforms of the payment system, some of which we have touched on already, if I may. Your written evidence refers to capitated budgets being a "fundamental building block" of new ways to reimburse providers in integrated care. Do you think it is possible to deliver fully integrated health and social care within the current mix of activity-based payments and block contracts, please? That is my opening question.

Norman Lamb: It is rather akin to an answer that Ian gave earlier about joining up teams. It is not just getting the culture right of bringing different groups of workers together, but it is making sure that the regulatory system is aligned to trying to work more collaboratively, and that the payment systems are aligned and work with the grain of trying to join things up. At the moment, my view is that the payment systems are not aligned with that and there is an urgent need to review the system of payment for activity. Everything that I have read suggests that it produces sub-optimal results in terms of patient outcomes.

Q340 David Tredinnick: We will link this to patient choice in a moment, but are there any examples of where capitated budgets are being regularly used to fund care for the high-risk and high-use patient groups targeted by integration projects?

Norman Lamb: There are examples in the United States of integrated care organisations which in effect have a capitated budget and are working with those groups along with other groups. Valencia is another example of that, and there are emerging examples in the UK. I think Salford is developing the idea of a capitated budget and a sort of alliance contract for frail elderly people. That is my understanding. But we are in the very early days. From recollection, the east London pioneer and the north-west London pioneer are working closely with Monitor and NHS England in developing alternatives to the payment-for-activity model.

Ian Dodge: May I add to that? I would say that on payment systems the key thing is to have a "horses for courses" approach. So, on occasion, block contracts over multiple years can be a good thing. What Sally Davies did around research funding some years ago, which was contestable block grants, was the right thing for research. There will be occasions when payment for activity may make sense. I am conscious of an experiment in the west midlands some years ago where smoking cessation services were deliberately trying to get greater throughput, and they ended up adjusting it for deprivation because they were trying to target people whom they had struggled to reach. For some elective activity it will continue to make sense to have some kind of fee-for-service activity. We already have, in the UK system, a long tradition of capitated funding for general practice. If you think most of the—*[Interruption.]*

Chair: I am very sorry to interrupt you, Mr Dodge, but we have a Division, so is it possible to expand further on the capitated systems for general practice when we return after the vote? Thank you.

Sitting suspended for a Division in the House

On resuming—

Chair: Apologies. We had two votes. I beg your pardon for keeping you waiting a long time.

Q341 David Tredinnick: We have a lovely old tradition here where, if you are on your feet in the Chamber, there is an interruption and you have forgotten where you are, you can say, "I am not quite sure…" so a colleague will get up and say, "My honourable Friend was talking about this," and you say, "Yes, thank you so much." That is a good way of doing it, so I am going to do the same for you. We were talking about reforming payment systems and you were in full flow. You were talking about activity-based payments and block grants. Perhaps you would like to start all over again.

Ian Dodge: In response to your question on capitated payments, I was offering some wider observations around payment systems overall and suggesting that the key thing is that we have a "horses for courses" approach around the right payment mechanism for the right thing you are trying to buy. I observed that block grants are not necessarily a bad thing, citing the example of Dame Sally Davies's work when she was the director general for research and development in the Department and the work that she launched under the banner of "Better Research for Better Health", where she constructed a new system of contestable block grants for research, which led to major and significant reform.

Referring to trying to drive increases in throughput, in activity, I cited the example of some pioneering work that West Midlands strategic health authority did some years ago where they developed a currency for smoking cessation services that was adjusted not just for quit rates but for deprivation, and that seemed like an interesting model. Within the UK health system, we have a long tradition of capitated payments based around the registered list in general practice through the global sum in GMS and EMS. So I think we have a foundation on which we can build.

In relation to delivering more integrated care for the frail elderly and for people with long-term conditions, there is certainly a case that expanded capitated payments will intuitively make a lot of sense. The average sum is something like £120 or £130 in general practice per patient. One of the interesting questions is: can we construct models that are for a wider range of services than just the narrow range of things delivered currently through GMS based around, potentially, the registered list? Those are exactly the kinds of things that some of the pioneers are interested in, and the Minister alluded to North West London, who I suspect are further ahead on this, perhaps with the Waltham Forest, East London and City pioneer as well. We have said in relation to the multi-specialty community provider model and the primary and acute care systems model that we will be looking to develop new models of capitated payment. I imagine that that will form a core part of the forthcoming long-term pricings strategy agenda work which Monitor are developing with NHS England.

So there is a lot of potential and a potential that we plan to capitalise on through expanded capitated payments. That said, I do not think it is necessarily a precondition for people being able to join up care. We have good examples of local leadership designing what is the right thing for patients. The challenge is that, if we want to accelerate that work, we need to make sure that provider governance systems, regulatory structures, commissioning systems, and payment and contracting mechanisms all support rather than hinder that desire to get the right care models.

David Tredinnick: Thank you.

Clara Swinson: To look at your question from another point of view, what can be done for the national funding flows and what should be done to make those models more

appropriate? There is also what can be done at the individual level. The integrated personalised commissioning and personal budgets that can bring together the funding for the individual is another way of looking at the same question about funding flows.

Q342 David Tredinnick: I want to ask a supplementary question to try and look at the practical aspects of patient choice and the narrow range you have spoken about in connection with availability of funds. You have mentioned Dame Sally Davies a couple of times. She was in fact in front of the Science and Technology Committee this morning at 8.30 talking about Ebola, and last week Simon Stevens was presenting to us on the Forward View. The Science and Technology Committee is extremely concerned about antibiotic abuse, which is packaged up as antimicrobial resistance. We had a report last week that doctors are now prescribing 24% more antibiotics for colds. Dame Sally has written a book, "The Drugs Don't Work", that majored on that.

I raised the Cancer Act, which is out of date, and I want to raise another old Act—the 1950 Faculty of Homeopathy Act, which regulates homeopathic doctors. They are regulated as part of the health service by Act of Parliament in 1950. They have been relentlessly under attack in the last couple of years, but that whole attack seems to be fading away, not least because the Professional Standards Authority have just agreed to oversee the 1,000 or more people in the Society of Homeopaths who are non-doctor homeopaths. They are qualified—

Chair: Is this really to do with pioneers, though? Can we jump to the question about pioneers?

David Tredinnick: Not everybody is in favour of homeopathic medicine, Chair; we know that. With Dame Sally herself—thinking of Halloween—it is like a cross to Dracula: she does not like it at all. But there are people out there who will use homeopathic medicine to avoid using antibiotics. The problem is—and we have heard this under the old medical system—that the funds do not necessarily flow to those qualified doctors to prescribe that. The Science and Technology Committee has had this problem—and Dame Sally is noted as saying—that there are no new antibiotics on line and there is nothing down the road because there is no money in it, or we are desperately trying to get Government incentives to do it. But my point is this, Chair, and then I will finish, and I know this—

Chair: No, it is just a question of, "Can we have a question?"

David Tredinnick: I have not really had a chance to explore this, so I would be grateful. What I am saying to you is that we have the Cancer Act 1939, which I referred to, and we have these people who are already providing a medical service which is available throughout the world, and could provide alternatives and stop people taking antibiotics if there is a greater range of funding there. I am just appealing to you, Minister, to look particularly at this ancient art, which is part of our health service, and now we have another layer of Government regulation that has come to bear on that. I do think that it is ludicrous to be advocating that we need to be just looking at the potential of new treatments when you have old treatments there, which may not appeal to everybody but they are there and they are regulated by law.

Norman Lamb: You appeal for me to look at it and I will do so, absolutely.

Q343 David Tredinnick: Will you do that?

Norman Lamb: Yes, absolutely.

Chair: Thank you.

Q344 David Tredinnick: Is that it? Mr Dodge looks like he might say something.

Ian Dodge: NHS England and its partners are certainly committed to choice, not just of provider but of treatment, and, as my colleague Clara alluded to, as part of the work on personal budgets and the integrated personalised commissioning programme, our ambition is that the type of services that patients receive is determined by patients themselves rather than just by professionals. Obviously, they will want to do that bearing in mind the evidence that they see around what does and does not work.

David Tredinnick: Thank you.

Q345 Barbara Keeley: I have a couple of questions around IT and data. Risk stratification is fundamental to making integrated care work, yet your evidence cites the example of Southend, who have so far, we understand, been stifled in their efforts to access the data to do this. Does the fact that pioneers have to make section 251 applications to the Confidentiality Advisory Group demonstrate that some sort of change in the law is required to accelerate the process of integrating care? That is just the data aspects.

Norman Lamb: The first thing I would say is that the pioneer programme can be very useful at testing and exploring these issues. When we talk about removing barriers to good joined-up integrated care, this is clearly one of them. One is having to negotiate one's way through, on the one hand, the absolute importance of privacy and of respecting people's confidential data, but also, on the other, recognise that risk stratification, for example, is essential to maximising the opportunities for population-based, joined-up care. They have made their application to the CAG. Is that the right terminology?

Part of the problem is that this is the first one, so inevitably it is really important that we get this right. We are working collaboratively with Southend to do this. The objective is that they meet again in December to reconsider the application. If it emerges in December with that approved—and they are independent, so I cannot pre-judge the outcome of that—then we will have a model that can be used and replicated elsewhere, obviously with adaptations to suit the local area. This is a learning process and we are not there yet, but I totally agree with you that it is essential that we crack this in order to facilitate effective joined-up care.

Q346 Barbara Keeley: Do you think there is more that commissioners can do to access the information required to accurately target—and we talked about Southend and this application—not only those patients who are the greatest users of care now but patients who will be so in the future? There is another data aspect there, is there not?

Norman Lamb: Again, I completely agree with you. In a sense, if you look at the pyramid, the people at the very top—who are the very expensive current users of care, who almost inevitably will, in many areas, be getting a poor experience of care because it is not sufficiently joined up—are the top, immediate priority. But it is stopping the flow up to the top of the pyramid, as you indicate, that is so important. I was really interested in visiting the Islington pioneer where one of the things that they are doing is looking at that group of people who are at risk of becoming diabetic—not the ones who are already diabetic. There is a whole cohort of people who may well be obese or overweight, and if you can stop that drift into diabetes then the impact you have on those people's lives and the saving you achieve to the system is enormous. So, yes, that is another example of using information to improve care. While we have to respect people's confidentiality, we have to find a mechanism to join up care so that we can share information both across providers but also between commissioner and provider in order to undertake this sort of exercise.

Ian Dodge: I agree with the Minister's comments. Of the five support workstreams, my understanding is that the informatics network group is probably the most advanced. It is led by the chief information officer of Leeds council and is looking specifically at this information governance piece. Obviously, it is disappointing that we have not made faster progress in sorting out the information and governance issues, whether that is through any changes to the rules that you alluded to or whether it is through things like the section 251 arrangements. We need to come up with practical solutions. We need to come up with them in such a way that other people, as the Minister said, can then, in a far simpler and easier way, have the model and the process set out, which they can then copy so that that can be done quickly. There are a number of other significant workstreams within that information and informatics group, including things like access to the NHS number in social care; how we make sure that the platforms work effectively; the PSN and the N3 and local government and the NHS; things like secure e-mail; having integrated electronic health records or aligned electronic health records. My desire is that, in each of these workstreams, we can start to construct clear and transparent work programmes with deliverables and make progress on these kinds of issues over the course of the next six months and year.

Norman Lamb: One of the great benefits, incidentally, is that the pioneers start to collaborate between each other, not just between them and us, but there are networks of pioneers who are all working together on the informatics, led by Leeds, but with others taking an active role in them.

Chair: Thank you. David, that brings us on to question 13 on the integrated care pioneers.

Q347 David Tredinnick: Thank you very much. I was just looking through some of the notes here. The University of York has called into question the whole notion of reducing costs and emergency admissions through better integration of health and social care. I do not know whether you have seen their report, but why do you believe that these are viable ambitions for the pioneers to achieve?

Norman Lamb: I have seen it—it is a while since I saw it, so I hope my memory is accurate—but, first of all, they are pretty clear that it can achieve improvements in care. Let us start by focusing on the most important thing, and that is that if we can improve a patient's experience by joining up care more effectively, even if it was to achieve no cost saving, then surely it is something that is worth doing. Beyond that, they also highlighted the fact that there are examples out there of interventions joining up care that do appear to achieve cost savings.

I come back to my starting point with all of this that the evidence base, globally, is still embryonic, and we need, therefore, to build up the evidence base. It is fair to say that virtually every leading health care country across the world is heading in this direction, recognising that the care of people with long-term conditions, which is the big challenge of our age, is not well served by episodic care and payment systems that pay for those episodes without looking at the whole experience of that patient and without focusing sufficiently on preventing deterioration. There is a growing consensus around this, but the evidence of the interventions that are most effective is still very embryonic and that is why the sort of experimentation that this programme allows is so important.

Q348 David Tredinnick: Fine. Do you believe that patient experience is important? Before there were double blind placebo controlled trials and all the science stuff came into play, the one thing that we really had was observation. The only reason cholera was discovered was because someone took a pump handle off a water pump in Soho and then established that the people who had been using that pump were catching cholera.

Chair: It was the other way round. It was after the—

David Tredinnick: I defer to the doctor.

Chair: They did the epidemiology and then they took the pump off.

David Tredinnick: Anyway, I am sure we are agreed that cholera was identified through that episode. Is that right?

Chair: Yes, but we will argue about that.

David Tredinnick: Anyway, patient experience does seem to be an extremely important part of this.

Norman Lamb: I totally agree.

Q349 David Tredinnick: I sometimes wonder if the health service, and certainly those who take very fixed positions, against any innovation tend to pooh-pooh patients' experience. In my view they do.

Norman Lamb: Incidentally, there were pilots in the last decade on integrated care, and the evaluation at the end of those pilots recognised that the patients' experience and their own views were not sufficiently central. That is why the work of National Voices is so important in this—that we concentrate completely on the individual patient.

I was very struck in Greenwich last week by how, when an individual is referred to the joined-up integrated team, they start by asking the question, "What is most important to you?" They gave a wonderful example of a man who was schizophrenic, who was a very heavy user of ambulance services and A and E departments. When they asked him the question, "What is most important to you?"—this was after years of the GP getting nowhere in identifying the solution and the GP in the end referred him across; a GP, incidentally, who is one of the inspiring leaders of all of this—the first three things he came up with had nothing to do with health care. It was damp in his house, his gambling problem and concerns about the behaviour of a relative. But the team was able to address those issues because they moved beyond the narrow confines of health. So everything has to be focused on the individual, on the person.

Q350 David Tredinnick: I wanted to ask you about Greenwich, which I know quite well because I stood for election there many years ago. Is there not going to be a firestorm of new thinking going through the health service if we really pursue this route of patient choice? We are patently going back to antibiotics. A lot of people are terrified of them. We are going to be looking for different solutions because they are worried about using them up before they have something really serious. We are going to have to have this spread of new thinking and it is going to be patient-driven. There will be great challenges there for health professionals.

Norman Lamb: It is a challenge for all of us, but your Chair was talking very eloquently—

David Tredinnick: I have to be very careful of the Chair; she is a doctor.

Norman Lamb: But she was talking very eloquently about the financial pressures on the system and the challenge we face. It is an existential challenge to the health and care system, whoever is in power—that is the truth of it—because of the rising cost across the developed world. So we have to think afresh.

Q351 David Tredinnick: Thank you. If we go back to Greenwich, they have claimed that their programme has achieved £900,000 in savings but could not provide us with any detail. On what basis can you be confident that these pioneers will deliver care more cheaply if they are not really able to provide hard numbers?

Norman Lamb: I come back to the fact that, again, we are building the evidence here and not all of them will succeed, I am quite sure. I am pretty confident that, through the work they are doing, all of them will demonstrate better care and a more personalised approach, but in terms of cost savings it is inevitably going to be variable. If you look at the emergency admissions, that data in itself is fascinating. You could, of course, be spending more money on the preventive work that stops those admissions from happening, so you have to make sure that you understand what the investment is and what the saving is. But the impact that they are having on people's lives must be dramatic because they are saving crises from occurring.

Q352 David Tredinnick: Running on from that, one of the problems of the new system, if it is successful, is that it creates new demand. Therefore, if you try and meet a previously unmet need, you are going to increase demand, and does that not compromise efforts to reduce the overall costs? I will help you with the answer. Is it not ever the case in the health service that, as you improve treatments, people live to a longer age and then you create a whole lot of new demand?

Norman Lamb: I do not think it is necessarily the case.

Q353 David Tredinnick: The answer is yes, is it not?

Norman Lamb: I give you the example of Cornwall and the work of the volunteers working alongside GPs in combating loneliness. The objective of that is to reduce dependency. I fundamentally believe that the wider community has a critical part to play in finding solutions to these problems; the state cannot provide happiness on its own. It has to be down to people. The incredible power of this experiment in Cornwall is that, if it reduces dependency, then it is reducing demand on both the social care system and the health care system, so I do not take it as read that it inevitably leads to more demand.

Q354 David Tredinnick: Finally, is your confidence in the patient and this new paradigm of getting away from disease-specific treatments to holistic patient-centred treatments partly driven by the success of the personalised budget trials in the health service, which have reduced costs and improved outcomes for patients?

Norman Lamb: It is most of all driven by what I believe in. Giving power to individuals to determine what their priorities are must be the right thing to do, but you then look at the evidence from personal budgets and it does seem quite powerful that people's experience of the system seems to improve. If that has happened in social care, then there must be scope for it to at least be explored within a mix of health and social care.

Ian Dodge: May I add one comment on the demand point? Certainly NHS England is mindful of the risk that if you introduce new services—potentially things like better access— then there is a risk of creating additional demand. The real challenge is how we look in the round at the resource utilisation for the individual. In an ideal world, we would have integrated systems to be able to assess the outcomes for individuals across all health and care services, and indeed the costs, because the real question here is, "What are the aggregate costs across health and local government services for individuals?" Having block contracts for community providers, NHS and social care systems that do not talk to each other—in terms of the IT—makes that really difficult. So there is a big practical question before we can fully answer the question and be able to make sure that what we are doing is reducing cost and understanding what that looks like at the level of the individual. That will be one of the first elements we will undoubtedly look at in the development of the integrated personalised commissioning programme: how do we construct joined-up budgets for individuals across the NHS and local government?

Norman Lamb: In some areas increasing use of services is something that we should absolutely welcome. Your own report, coming out soon, looks at children's mental health and the fact that access is so poor to children's mental health services as a percentage of

total prevalence. We should directly address that, say it is not acceptable and find ways of improving it.

Q355 David Tredinnick: Within that report, which we released earlier on today, there are big questions about where the money is coming from for that and whether the size of the budget allocated to mental health is the right size—whether the segment of cake allocated to mental health should be prized open a little.

Norman Lamb: I will tell you; it goes back to an earlier question you asked about payment systems. I am absolutely clear that if you have one payment system in physical health of payment for activity and a block contract in mental health, combined also with a whole series of access standards in physical health and nothing in mental health, this absolutely determines where the money goes and mental health loses out. I have no doubt at all about that, and that is why I am so determined that we change that so that we achieve equality between the two systems.

Q356 Chair: Before we come on to the issue of valuation, can I take you back to a comment you made earlier, Minister, about the service user with schizophrenia and the things he identified that were important to him not being the things that the system had identified? Of course the things that he had identified are the things that are provided very often by voluntary sector partners. Within the current pilots and in your assessment of the 10 future pilots, how much of that is going to bring in a valuation of how we lever in money to the voluntary sector? Indeed, it was something that Simon Stevens referred to in his Five Year Forward View. How important do you think that is as a whole?

Norman Lamb: It is crucially important. It varies from one pioneer to another. There are some that are really interesting and have strong collaborations between the statutory and voluntary sector, so the Cornwall one is an obvious example, but Greenwich is very strong on that as well. But there are many others too. So it does vary across the piece. It is going to be crucially important that we evaluate and assess the value of this and its potential for achieving more.

Q357 Chair: Do you intend to include that in the future as well?

Norman Lamb: I do, yes.

Q358 Rosie Cooper: Can I jump in? I wrote down—I was going to leave it—"damp in the flat or house", "gambling problem", "difficulty with a relative", and I can guess how important those three things are. But the climate in which the health professional is trying to resolve it is one of reducing money in local government or housing associations, or wherever, and not enough investment in mental health or gambling services. While it sounds absolutely brill—I am not jesting in that I absolutely think "Fix those things and you will help to fix his general well-being"—and when you are doing it for one or two people, I am sure you will get your successes. If you do that on a grand scale, it is going to become really hard to deliver

those successes, and yet that investment is going into that and coming out of the health service in itself. It is really difficult.

Norman Lamb: I am not so sure. I take the challenge; I accept the challenge. But when I talked right at the start of the pioneer programme to the people in Greenwich they recognised that there were a lot of things that the voluntary sector could do better than they could, and so they embraced it from the very start. If you talk to Sam Everington, an inspiring GP from Bow in the east end of London, he identifies the vast array of community organisations within that borough, which is quite an impoverished borough, and yet there is an incredible wealth of voluntary sector activity. Embracing that and recognising that they can reach the parts that others can't, often is not actually that costly. The small investment acts as a catalyst to unleash enormous power. I am not convinced that it is that complicated, and these people, these areas, are demonstrating that it can work. We can learn lessons from that.

Q359 Chair: Can I move on now to the issue of evaluation? One of the challenges facing an evaluation of integration is that there is not a clear definition—there are very many different models—and also the challenge of finding suitable controls to compare them with. How are you going about those kinds of issues of identifying valid controls that you can compare? It is not just longitudinal but it is directly comparing them. Is that something that is important in the evaluation?

Clara Swinson: On many of the challenges you have set out you are completely right. As I have said, the first step of the evaluation will be very much to look at the process and the model of what we are doing here, which is allowing local areas to come up with their own plans, their process evaluation. There is support for the local area so that they can evaluate what they are doing; that helps with metrics and so on, and in fact encourages them to put it through a more robust process. We are also looking at longer-term evaluation of integration, which would not just be the pioneers but also some of the other integration models and the Better Care Fund. The invitation to tender, which we have worked on, does need some clever people in a room to think about how to deal with exactly those issues of control, to make sure we have some baseline data for this year, but then to come back with some ways of being able to evaluate areas. The Better Care Fund will help us in some ways with this because the metrics there are the same across the country; so there will be more comparability. But for the pioneers themselves—because it is a bottom-up approach—it will mean that there will be limited comparability between those areas and, indeed, the controls. To give another Greenwich example, as you know, in their approach for the joint emergency teams, because they had rolled that out gradually within the borough, they have been able to see the difference that it has made each quarter. It is not a pure control because, of course, you cannot necessarily look at the interventions in the other geographical areas and think, "Can you attribute all of that effect to the change?", but it does allow them to make an assessment of how much difference the new model has made.

Q360 Chair: Thank you. Can I ask whether you agree with Chris Ham when he said that you can identify many benefits from integration even if they do not show up in the formal evaluation? Would you agree?

Clara Swinson: I think that is true. Partly it might be that we do not have the right measurements and metrics to reflect some of the things that are the outcome for the individual, so how to measure the "I" statements—what National Voices have said—and whether those individuals feel that the outcome has improved. There is not something comparable on there. There are some measures in the adult social care outcomes framework and some of the other outcomes frameworks that do ask for a self-assessed metric around how people feel that the care has been joined up, and some of those can be used. But Mr Ham is right that, whether or not we have the right metrics and models to make a direct assessment of how these new ways of working is improving year on year, it is limited.

Chair: Thank you. David, I think we are coming on to question 18 next.

Q361 David Tredinnick: I want to deal with the emphasis on evaluation. Much of the emphasis appears to be on removing system barriers to integration—and I think you have explained that throughout this presentation. At what point will that emphasis shift from measuring the success of the pioneers in making structural changes to determining whether they have delivered improved patient outcomes, please?

Norman Lamb: Ian may well have some views on this now he is in charge of the whole project, as it were, but certainly from my point of view the objective has to be the latter. The only purpose of removing barriers is to achieve a better result for patients. That has to be ultimately what we focus everything on, so that is what, ultimately, we have to be able to evaluate.

Clara Swinson: The focus for the pioneer areas is already on what changes they are making in their local areas for patients and users, and that should absolutely be the focus from the start. In terms of the evaluation, what we are not doing from the earlier evaluation is being able to compare those outcomes. Because of some of the difficulties that your Chair mentioned, that is what is coming in at the second phase of the evaluation, but, absolutely, pioneers should be doing what they are doing because of the outcomes for patients.

Ian Dodge: Going back to the earlier observation of the desire to introduce some greater method, structure and rigour into how we run local experiments and secure national learning, there is something around the real-time evaluation of assessment of what are the common elements across the different pioneer sites, to what extent we can discern and articulate those patterns, and how well different pioneers have gone about constructing and putting in place the new models. There is something around the learning from that as well as the learning from the outcomes—the costs involved.

Q362 David Tredinnick: So it is two elements, then: you have the outcomes of the new models and the outcomes of the models—

Ian Dodge: Absolutely. I would emphasise that, in order for us to have replicable findings elsewhere, we need to have an articulation of the models and how well people have gone about implementing them.

Q363 David Tredinnick: So you evaluate the models themselves.

Ian Dodge: Certainly, as we look to construct the new models set out in the Forward View—the multi-specialty, community providers, the primary and acute systems and so on, and we have talked about building up that real-time evaluation capability—if we are then going to spread learning, it is essential that we do that. An observation I would make from 20 years in health policy is the extent to which we have had lots and lots of pilots in the NHS and we have quite often then rushed to say, "Success. Let's spread them across the country," without first of all defining what it is that we are spreading. In most walks of life innovation has three parts: it has the invention of something; it then has the subsequent adoption, and then the spread—and that process takes many years. It is really important that we are clear about what it is we are actually inventing that can be adopted and then spread.

Q364 Barbara Keeley: I understand we only have a couple of minutes, so, to be quick, there clearly will be short-term and long-term national evaluations, and you have talked about evaluation at a local level. But, quickly, who ultimately will be responsible for determining what has been successful and what should be implemented elsewhere? It follows on from your last point, Mr Dodge.

Ian Dodge: The Department of Health is leading on the national evaluation—both the first and second phases of these pioneers. NHS England is working very closely with the Department to make sure that we can then, with the pioneers, make sure there is a robust and independent process, that we can make sure that the evaluation does the job and that we can look to spread that. The six organisations responsible for the Forward View will certainly say it is our job. It is a job of the national bodies to try and add value to local systems—however they are defined—and accelerate change. It has been very difficult historically for that to be realised. The challenge we articulate of getting a better national local dialogue is a difficult but essential one, and I would say that is a test of the efficacy of organisations like NHS England. If we can't make progress in this area, then I think we will be failing taxpayers and patients.

Chair: That is fairly challenging.

Q365 Rosie Cooper: Thank you very much. How will local commissioners strike the right balance between experimenting with radical new care models and implementing what is measurable risk and implementing the basic features of integrated care such as risk stratification, case management and case co-ordination? What we are saying is: what is the right balance between those two things?

Norman Lamb: Traditionally, the NHS has not got the balance right. It has been too risk averse culturally. We have not seen sufficient innovation, and in many ways you see more innovation in local government on the social care side than you do within the NHS. But, ultimately, the local commissioners have to try and strike that right balance on behalf of their local communities.

Q366 Rosie Cooper: So the CCGs would—
Norman Lamb: Yes, but informed by the health and wellbeing board and the strategic needs assessment that they undertake for that local community.

Q367 Rosie Cooper: How would that be evaluated?
Norman Lamb: As I say, we want to achieve an effective evaluation of all of this work, particularly developing these new models of care that Ian has talked about within the Forward View. Then, if we build the evidence base, you stand a better chance of disseminating it effectively across the system. If you get good evidence from these experimental areas about systems that work better than the current, there is not that much risk involved in trying to replicate that elsewhere. You experiment, learn, evaluate and disseminate. That is the sort of process.

Q368 Rosie Cooper: But that risk taker could be a visionary or a fool. Who decides?
Norman Lamb: Going back again to what Ian was saying earlier, they are looking at how they can help to support experimentation; I do not think they have reached a conclusion yet. The Forward View raises the question about how you can support experimentation, looking at potential new models, working collaboratively. It is not a thousand flowers blooming, but it is more about identifying some likely winners that should be given a test bed to really develop. One of the great failings of imposing a single model from the centre is that it completely lacks evaluation and using evidence because it is just doing the same thing everywhere. This approach is to build the evidence base in localities, with the local area working collaboratively with the national. If you build the evidence and it demonstrates that it can work, then you disseminate and reduce risk for everyone else.

Q369 Rosie Cooper: We are back to the end of Simon Stevens's evidence last week, which was, "It is horses for courses," and I was wondering what race we were in. There you go.
Norman Lamb: Fair comment.

Chair: On that note, thank you very much for coming.