House of Commons

Health Committee

Appointment of the Chair of the NHS Commissioning Board

Eleventh Report of Session 2010–12

HC 1562-I

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Report, together with formal minutes

Ordered by the House of Commons
to be printed 18 October 2011

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The Health Committee

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

Membership

Rt Hon Stephen Dorrell MP (*Conservative, Charnwood*) (Chair)[1]
Rosie Cooper MP (*Labour, West Lancashire*)
Yvonne Fovargue MP (*Labour, Makerfield*)
Andrew George MP (*Liberal Democrat, St Ives*)
Grahame M. Morris MP (*Labour, Easington*)
Dr Daniel Poulter MP (*Conservative, Central Suffolk and North Ipswich*)
Mr Virendra Sharma MP (*Labour, Ealing Southall*)
Chris Skidmore MP (*Conservative, Kingswood*)
David Tredinnick MP (*Conservative, Bosworth*)
Valerie Vaz MP (*Labour, Walsall South*)
Dr Sarah Wollaston MP (*Conservative, Totnes*)

Powers

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

Publications

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

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

Additional written evidence may be published on the internet only.

Committee staff

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

Contacts

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

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Recommendation on appointment

1. On 12 October 2011, the Secretary of State for Health informed the Health Committee that the Government proposed to appoint Professor Malcolm Grant as Chair of the NHS Commissioning Board and asked the Committee to hold a pre-appointment hearing to consider this proposal. **The Committee held the hearing on 18 October 2011 and we are pleased to endorse Professor Malcolm Grant's candidacy for the post.**

Appendix

Professor Grant's responses to Health Committee questions posed in advance of the hearing

1. The advertisement for the post of Chair said that it would be for two days a week in the first instance, and reducing to between four and six days a month "in due course". What do you regard as your principal role in that time?

The role of the Chair will vary over time during the initial stages of Board development. An early priority will be to support the recruitment of the Board's senior leadership and then the initial development of the Board's systems and culture. The early focus of the role will also include establishing key relationships, developing the Board of the organisation effectively and guiding the development of strategy and purpose.

2. The Government said in the White Paper

> "To support GP consortia in their commissioning decisions we will create a statutory NHS Commissioning Board. This will be a lean and expert organisation, free from day-to-day political interference, with a commissioning model that draws from best international practice." [paragraph 4.10]

What is your view of the optimum relationship between the NHS Commissioning Board and ministers? If the NHSCB is to be "free of political interference" is it also to be "free of political accountability"?

The NHS Commissioning Board will be an independent body operating at arm's length from government. Its accountability relationship with parliament and ministers is clear: the Board will be held to account for delivering the requirements set out in the mandate through its work with the commissioning and broader NHS system. A mature and open relationship will be needed between ministers and the Board with clear expectations about processes and behaviours. Ministers will remain accountable to parliament and the public for all aspects of the NHS, but will be at arm's length from detailed operational decision-making.

3. What is your view of the optimum relationship between the National Commissioning Board (NHSCB) and local Clinical Commissioning Groups (CCGs)? Should the NHSCB have a performance-management role with respect to CCG's? If not, how will the NHSCB be accountable? Is there a danger of accountability without power?

The key role for the Board will be to support clinical commissioning groups to be as successful as possible in commissioning high quality care for their patients. Supporting CCGs effectively will require the Board to use a range of levers including development, progress monitoring, performance assessment and intervention in the event of failure. The Board will need to use all of these levers effectively to support all CCGs to realise their potential and thereby ensure delivery of improved outcomes.

4. Do you anticipate that the new clinical commissioning groups will be looking to local partners such as the Health and Wellbeing Boards for discussion/feedback on their plans and priorities rather than upwards to the Commissioning Board?

Effective CCGs will need to do both. Delivering the national mandate will require CCGs to work closely with the Board, particularly on the delivery of national priorities for improvement, and CCGs will therefore be accountable to the Board. However, CCGs will also need to work closely with local partners to develop and contribute to local strategies for health improvement. Health and Wellbeing Boards offer an important forum for this joint working.

5. How will major service reconfigurations be dealt with under the new system? Do you anticipate that they will continue to be as sensitive even with plans being developed locally?

Effective service change will continue to require a clear local case for change, supported by commissioners, clinicians, patients and the public. The new system offers the potential to create clearer local consensus for service change through local Health and Wellbeing Boards. From a commissioning perspective, service changes will need support and leadership from CCGs, potentially working together in groups, and from the Board itself where specialised services are involved.

6. In its second report on commissioning in April this year, the Committee said that "Although it endorses the need for clear national accountability of commissioners to the Commissioning Board, it agrees with the Government that NHS structures should aim to reinforce responsible devolution of authority". How will the board under your Chairmanship set out to achieve both of these aims?

The Board needs to strike the right balance between support and guiding CCGs on the delivery of the national mandate, and creating enough local freedom for the benefits of clinical commissioning to be realised. This will require a mature and open two-way relationship which recognises that some CCGs will need more support from the Board than others.

7. How do you see the role of clinical senates, which will be based within the Board? Will they be top down in providing advice or will they be used when required by commissioners?

Development of clinical senates is at an early stage. It is anticipated that their key role will be in supporting CCGs, particularly on commissioning decisions which affect a wider geographical area than covered by individual CCGs. This may include advising on issues such as service change and reconfiguration.

8. What do you think is the best way of reconciling the fact that the optimum size of commissioning unit for the purposes of GP engagement is significantly smaller than the optimum size for the purposes of driving system change?

There is no ideal population size for commissioning all the different types of healthcare. As a result, CCGs are likely to need to join together to commission services where a larger population size is needed. Clinical senates and networks will also play a role in supporting commissioning across larger areas. The most specialised services will

be commissioned by the Board itself, reflecting the need for a flexible commissioning system.

9. Do you think NHSCB will need to establish a formal intermediate tier between itself and the CCG's?

It is too early to be definitive about the detailed design of the Board. While there will be no additional statutory tier between the Board at national level and CCGs at local level, inevitably the Board will need to carry out many of its functions across distinct geographical areas. Current transitional proposals are for the initial sub-national footprint of the Board to reflect the 4 SHA clusters and 50 PCT clusters which are operating at present.

Formal Minutes

Tuesday 18 October 2011

Mr Stephen Dorrell, in the Chair

[Evening sitting]

Rosie Cooper	Dr Daniel Poulter
Andrew George	Mr Virendra Sharma
Grahame M Morris	Dr Sarah Wollaston

Draft Report (*Appointment of the Chair of the NHS Commissioning Board*), proposed by the Chair, brought up and read.

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

Amendment proposed, in Line 4, after "2011" to leave out the words "and we are pleased to" and insert the following:

"We acknowledge Professor Grant's distinguished academic career and that he has been a distinguished Provost of University College London. Nevertheless, we do not endorse Professor Grant's candidacy for the post for the following reasons:

1. Professor Grant demonstrated a lack of experience of NHS structures and processes

2. Professor Grant did not demonstrate to the Committee a robust understanding of the issues affecting the NHS

3. Professor Grant acknowledged to the Committee that the Department of Health assisted in the preparation of answers to the written questions posed by the Committee

4. Professor Grant did not demonstrate to the Committee a clear understanding of how the NHS Commissioning Board would intervene in the case of commissioner failure

5. Professor Grant was not robust in terms of the advocacy role of the Chair of the NHS Commissioning Board

6. Professor Grant was unclear about the means by which the NHS Commissioning Board would seek service reconfiguration locally

7. Professor Grant demonstrated an assumption that his appointment was already confirmed

8. Professor Grant made a reference to the Health and Social Care Bill he is required to implement as being unintelligible

9. Professor Grant did not persuade the Committee that he would provide an effective counterbalance to the executive members of the NHS Commissioning Board."—*(Grahame M Morris.)*.

Question put, That the Amendment be made.

The Committee divided.

Ayes, 3	Noes, 3
Rosie Cooper	Andrew George
Grahame M Morris	Dr Daniel Poulter
Mr Virendra Sharma	Dr Sarah Wollaston

Whereupon the Chair declared himself with the Noes.

Question put, That the Report be the Eleventh Report of the Committee to the House.

The Committee divided.

Ayes, 3	Noes, 3
Andrew George	Rosie Cooper
Dr Daniel Poulter	Grahame M Morris
Dr Sarah Wollaston	Mr Virendra Sharma

Whereupon the Chair declared himself with the Ayes.

Resolved, That the Report be the Eleventh Report of the Committee to the House.

A Paper was appended to the Report.

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

[Adjourned till Wednesday 19 October at 4.30 pm

Witness

Tuesday 18 October 2011

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