

# Select Committee on the Long-Term Sustainability of the NHS

## Corrected oral evidence: The Long-Term Sustainability of the NHS

Tuesday 6 December 2016

11.05 am

[Watch the meeting](#)

Members present: Lord Patel (Chairman); Baroness Blackstone; Lord Bradley; Lord Kakkar; Lord Lipsey, Lord McColl of Dulwich; Baroness Redfern; Lord Ribeiro; Lord Scriven; Lord Turnberg; Lord Warner; Lord Willis of Knaresborough.

Evidence Session No. 27

Heard in Public

Questions 257 - 264

### Witnesses

I: Jim Mackey, Chief Executive, NHS Improvement; Professor Sir Mike Richards, Chief Inspector of Hospitals, CQC; Professor Terence Stephenson, Chair, GMC; and Jackie Smith, Chief Executive, NMC.

## Examination of witnesses

Jim Mackey, Professor Sir Mike Richards, Professor Terence Stephenson and Jackie Smith.

Q257 **The Chairman:** Good morning, lady and gentlemen. Thank you very much for coming to help us with this session. We are being broadcast. I do not know whether the BBC is carrying it live or not, but we are certainly on the parliamentary broadcast. If you would not mind, please introduce yourselves, from my left first and, if you want to make a short opening statement, feel free to do so. We will send you the transcript of the session subsequently. Feel free to correct it, but you are not allowed to change it. Can we start from the left first?

**Jim Mackey:** Good morning. I am Jim Mackey, chief executive of NHS Improvement.

**Professor Sir Mike Richards:** Good morning. I am Professor Sir Mike Richards. I am chief inspector of hospitals at the Care Quality Commission.

**Professor Terence Stephenson:** Good morning. I am Terence Stephenson. I am chair of the General Medical Council and I have been dean of a medical school, president of a royal college and I am still a practising doctor seeing emergencies every month.

**Jackie Smith:** Good morning. I am Jackie Smith. I am the chief executive of the Nursing and Midwifery Council. We are the largest regulator, regulating almost 700,000 nurses and midwives.

Q258 **The Chairman:** Thank you very much. I will kick off with the first question, which relates to the model of health and social care that we need. The whole of the inquiry for this Committee is looking longer-term, to 2025, 2030 and beyond. What actions should be prioritised now, do you think, to prepare a system to deliver a model of care that will be fit for purpose in terms of funding, manpower and training of the workforce?

**Jim Mackey:** From my point of view, the priority should be integration organised around the needs of the people we are looking after. In the bit that I heard of the previous session, there was some discussion about the multiple morbidity problem that we have now and that will get worse over the next few years. In that context, it should be a real focus on joined-up services that are not as compartmentalised or as siloed as they are now.

**Professor Sir Mike Richards:** I would go along with that completely. I think it is all about integration between health and social care and also integration within the health service between primary care, community health services and acute hospitals, working more effectively together to keep people in the right place at the right time.

**The Chairman:** How do we get there? Are there barriers to it?

**Professor Sir Mike Richards:** I think it is beginning to happen. After a long period when it has not happened, I sense that the new models of

care that people are talking about are beginning to take shape. We will have accountable care organisations which, effectively, cover all those bases. We see it probably the most closely in Northumbria, and Jim Mackey can talk about that in more detail, where you are seeing an acute trust already running community services and starting to manage aspects of primary care, a number of GP services and care homes—so it is beginning to happen and, with that, we will see efficiencies.

**Professor Terence Stephenson:** Perhaps I could say something about the medical workforce for 2030. My own professional life would indicate that it is fraught with difficulties trying to predict the kinds of doctors we might need in 2030. That would say to me that what we need is a group of doctors who are very flexible and adaptable. You have heard already that there will probably be more generalists and more people in primary care because we will have an older population with comorbidities. Over and above that, I think it would be rash to be training people today for a very fixed role in 2030. I think we need to train doctors in a flexible way, and the GMC is doing that with our flexibility review and our review of general professional competencies.

On training doctors, remember that most of the people working in the NHS in 2030 are already working there now. We are not starting to train them, they are there—people like me and people younger than me. We need to have the capacity to retrain and upskill them as health changes, which is very important. Finally, if you were Florence Nightingale walking around the NHS today, a third of our doctors were not trained in the United Kingdom and we need to maximise what we get from them in whatever kind of transition there is between now and the Brexit settlement. We need to make sure we maximise the use of the doctors we have and any who are coming to this country from abroad because, historically, we have been very dependent on overseas doctors.

**The Chairman:** So both your organisation and Jackie's organisation are regulators of professionals, doctors and nurses. We have had evidence asking that a change be brought about and states that we train our doctors for too long, that the profession does not want to address this issue, that you, the regulators, can bring about that change but are not willing to do that, that there ought to be more of a skill mix and that others, who are not doctors, can be trained to provide some of the care and bring about efficiency and productivity. What would be your comments on that?

**Jackie Smith:** Yes, we find ourselves in the same position as the GMC. In fact, we are embarking on a radical review of our pre-registration nursing standards at the moment because we cannot just think about the workforce for today, we have to think about it in 10, 20 and 30 years' time. We are very keen to raise the bar so that employers can find themselves with nurses and midwives who can deliver the complexity of care that we have heard about.

**The Chairman:** The challenge is to you.

**Professor Terence Stephenson:** Let me take it in two parts. Over the last four or five years, I have been to 23 different countries to see how they train doctors. There is no country in the world that takes as long to train as us, but there is no country in the world that is so dependent on its trainees for delivering the service. In most countries, training is much more formalised and structured. We have to recognise that we have 55,000 trainees out of a workforce of 150,000 and that, for much of their time, their training is long because they are not being trained, they are just providing a service.

Lord Patel, you are an obstetrician and gynaecologist. There is nobody in the GMC today who could set out how you train an obstetrician. We are like a judge in a court; we are totally dependent on the experts telling us how long they think it takes to train and then we can make a judgment. Colleges have no monopoly. If anyone else were to come forward with an alternative training system—shorter, different, more flexible—we would look at that.

**The Chairman:** So, as a regulator, why do you not talk to institutions of higher education, the universities?

**Professor Terence Stephenson:** We would be very happy for anybody to bring forward any kind of training scheme. If the University of Dundee wanted to put forward how to train obstetricians and to do it in a shorter time, we would be very happy to look at that. No one has a monopoly on this. It is probably the start-up costs that deter people. We have a training system which has been running for decades. For anyone to break into that would take probably quite a big up-front investment and nobody yet has ever come forward with an alternative.

Q259 **Lord Kakkar:** I want to build on this discussion about what your organisations are doing on ensuring that regulation enables the workforce to adapt. What about your statutory regulatory responsibilities and the ability to provide flexibility for the workforce to adapt both in terms of addressing the sustainability of NHS care and social care? In particular, what do you consider are the greatest workforce threats to long-term sustainability and what solutions do your organisations have to address those particular pressures?

In terms of the current workforce resource and how you see it going forward, what are you doing to address what is available and what might be available and the gap with regard to perceived patient needs?

In terms of the future requirements, do you believe that there is a mechanism in place to ensure that there is the capacity to make sustainable change over the medium term to ensure that the skills are available for the longer term?

I should declare my interest as a recently retired member of the General Medical Council who sat on the review that looked at the change in training.

**Jackie Smith:** At the risk of repeating myself, the responsibility we have is to set the appropriate standards to deliver care, as I say, not for today

or tomorrow but for the next 10, 15 and 20 years, and we cannot do that in isolation. Regulators are famous in the past for working in isolation, but we need to understand what the demands are and we need to work with employers and providers across health and social care and universities to find the best way of delivering the standards required and to protect the public—because, at the end of the day, that is our job.

**Lord Kakkar:** Does that capacity currently exist to bring those different stakeholders together to have that type of discussion?

**Jackie Smith:** That is exactly what we have embarked on over the last 14 months; the radical review of the pre-registration standards for nursing has done just that. It will raise the bar and I fear it will scare some individuals at the same time, but that is the place we need to be in. We cannot just be saying, “This will work for now”; that is too short-term.

**Professor Terence Stephenson:** Probably the greatest threat to the workforce is, as Chris Whitty alluded to, that we continue to produce highly specialised clinicians, who are very highly trained but in a very narrow area, when the demographic is a population that is getting older, more obese and with multiple comorbidities. The Greenaway report, an independent report commissioned by the GMC, flagged up the idea of needing more generalists, both in primary and secondary care. And everything that has been said, including treating people closer to home, better social care and probably fewer larger elective centres – I agree with, because all the evidence is that the more you do of something the better you get. I think those are the threats.

In addressing the question of whether we have the capacity to change that, yes, I think we can work with the royal colleges to change the training to produce a cadre of generalists, and we are doing that. Second, there is a scope of practice where many, particularly trainee doctors, are spending a lot of time doing things that do not really need a doctor’s training. We may talk more about physician associates or other entrants to the workforce who would allow us to deploy the medical workforce to do what they are trained to do—to make diagnoses and embark people on the treatment pathway—whereas others might be able to help to deliver that in a more efficient way.

**Lord Kakkar:** Do you believe that the Shape of Training review, the Greenaway review, has been implemented sufficiently quickly and robustly to be able to help address the longer-term sustainability needs of the NHS by radically changing the approach to workforce development?

**Professor Terence Stephenson:** It definitely has not been implemented yet; there is no question about that. We are in discussion with the Academy of Medical Royal Colleges and, in response to the recent industrial dispute, we are conducting a flexibility review so that trainees who start in one discipline and change their minds can move to something else more easily.

On this idea of generic competencies, whatever kind of doctor you are, there is a whole set of skills that everybody needs. If you change your training pathway or medicine changes so we need different care or we do not need cardiac surgeons anymore—and the amount of cardiac surgery has gone down hugely—then you have a group of people who already have those generic competencies, which is quite important.

**Lord Kakkar:** Do you believe that your current statutory framework for providing regulation allows you to be sufficiently flexible to address the questions that we are discussing?

**Professor Terence Stephenson:** No, we absolutely do not. Our legislation, as we are a creature of statute, is the 1983 Medical Act, which is now over 30 years old. We have been pressing for some time. First, there was the Law Commission Bill, and there will be a consultation, I hope, soon by all four Governments on the future of regulation and the reform of it. We would very much like enabling legislation which allowed us to reform our practices, protect the public, improve professional standards, change training and change the way that we deal with fitness to practise issues. We think it is overly prescriptive overregulation, but we need primary legislation by government to change that; we cannot change it without primary legislation.

**The Chairman:** Do you think a single regulator of healthcare professionals might be the answer to developing a workforce that has the appropriate skills and works together?

**Jackie Smith:** I am particularly interested in what the PSA said about this recently in relation to regulation rethought—in fact, they talk about a single portal and a single register. I do not think the benefits have necessarily been sufficiently articulated. It is absolutely true that the public want to be able to access a solution when they want it and an apology when they want it. Those things are not provided by the regulators, but by where it happened, the point of care, and we, as regulators, would encourage that. I am not clear what a single regulator does in terms of the overall benefits to the public. I do not think that has been sufficiently articulated.

**Baroness Blackstone:** My question was mainly asked by Lord Kakkar, but can I just pick up on the issue of regulation? A single regulator is possibly a step too far, but there is a question about how many different regulators providers can cope with. I would be very interested to hear whether you think that at the moment providers are under too much pressure from a large number of different, external and quite interventionist regulatory systems?

**The Chairman:** The systems regulator might be able to answer that.

**Professor Sir Mike Richards:** Speaking first for the CQC, as you know, we brought in a new model of inspection and rating three years ago. We have now completed our first round of inspections of NHS trusts and foundation trusts, which includes ambulances, community health services

and mental health trusts—and I think we have learned a great deal from that. We have seen the variation of quality that there is within the NHS from outstanding trusts through to those that are inadequate, where we have been working with NHS Improvement on the special measures regime and are seeing considerable improvements in that area. We have a much clearer picture and we are moving towards working together on developing an approach to assessing the use of resources and efficiency. We will be working as one on that so that we can give a balanced picture of quality and use of resources for every organisation and acute trust in the country.

**Lord Warner:** We have had a lot of evidence on the issues that particularly Terence Stephenson raised about whether you can get a bigger bang for your buck from your existing workforce by pushing things down to associates or assistants—call them what you will. What are the things that we should be saying in our report to make that happen? There are lots of good ideas out there, but there does not seem to be a coherent game plan for making it happen, so any thoughts you have on that would be very helpful.

**Professor Terence Stephenson:** I think nine regulators is possibly too many and one is too few—and too big. We had a huge throwing of the cards up in the air in 2011 and I am not sure that we need that right now when we are in a state of stress and crisis. For sure, if we are going to bring in new people who will do the kinds of things that doctors currently do, they do need to be regulated—so that is a double-edged sword. Perhaps we can streamline some of the current regulations, but that would not, for me, be an argument for bringing in physician associates as an unregulated group. I think most of the public would expect people who, after all, will be asking you intimate questions, laying hands on you, examining you, possibly sticking things inside your body, which are invasive procedures, to be part of a body that is regulated.

**Lord Warner:** Could you take that on though in your role?

**Professor Terence Stephenson:** We would be agnostic. If we were approached by the four Governments to look at that, we would be very happy to look at it. We are not looking for business. I think all the regulators are agreed that it is a group of people who should be regulated. If they are to fulfil their maximum function, they have to be able to do the kinds of things I have talked about, to make a diagnosis and start treatment, and, if they are going to do that, they should surely be regulated.

**Jackie Smith:** Of course, the Secretary of State has asked the NMC to take on the role of regulating nursing associates.

**Lord Turnberg:** First, let me apologise to you, Lord Chairman, and to the witnesses for missing the beginning. I have to express my interest as a past president of the Royal College of Physicians.

We have been talking for a very long time about the development of

generalists. I remember the Royal College of Physicians way back talking about it and trying to develop a cadre of generalists. Does that necessarily mean a diminution in the number of specialists? Are we in danger of throwing the baby out with the bathwater, because people do need specialists? Is it that we need more or do we need to convert them?

**The Chairman:** Or does it matter if there is a diminution?

**Professor Sir Mike Richards:** Can I have a go at that, largely building on my previous work in the field of cancer? I think we need the right balance of specialists and generalists. Yes, we need more generalists, and I think we have seen that with acute medicine, for example, which has been a very valuable step forward. If you take surgery, and I realise that I am surrounded by surgeons, if you are going to have oesophageal surgery for cancer, you want it done by somebody who is highly specialist. Getting that balance right and being clear on what needs to be done by a specialist and what is best done by generalists is very important. At the same time, thinking about other skill-mix issues, when I was working in cancer, we pushed the idea of non-medical people doing endoscopy and becoming advanced practitioners, radiographers taking on extra roles and clinical nurse specialists taking on extra roles. It is not that we have not seen any of this happen, we have seen a lot of it happen, but it just needs to be pushed further.

**The Chairman:** Jim, you wanted to come in on the last question and this time, so cover both.

**Jim Mackey:** On the single recommendation, the key thing would be to allow local flexibility within a clear set of national guidelines and rules. Often, the innovations that Mike has just described are there in appetite, but it is very easy for somebody inadvertently to get in the way of that and the decision-making systems are very complex. In this next phase, we need to do things that encourage and enable local innovation. That is the first point.

Secondly, I agree with Terence on the regulation point. Physician associates are a good example where, if they are going to do the job, they need to be able to prescribe; if they are going to be really effective, they need to do that and, therefore, they need to be regulated. We need to allow them as much flexibility as possible to develop.

From my point of view, a lot of this is possible now, but it is difficult. It is more possible when there is more supply, and we are too constrained from a supply point of view. There is some value in some work on the economics of a small excess of supply versus the shortage of supply we have now, and I think this system can be, in my view, demonstrably more productive if we could deal with that. The problem is that these are very long-term decisions and, if we make decisions now, it is a very long time before they feed through—but that should not mean we avoid them.

**Lord Lipsey:** Just on the supply question, I think we have experimented with that in Gordon Brown's Niagara of cash that hit the health service,



and we know that a lot of it went into doctors' wages—which, although important, did not obviate the shortage of supply. How will you obviate the shortage of supply without the money you are trying to use for that purpose being used for other purposes which are less obviously a priority for the public?

**Professor Terence Stephenson:** Maybe I can say two things about generalism that relate to that. First, we should not lose sight of the fact that 90% of the people seen in the UK by the NHS are seen in primary care. We already have a large cadre of generalists. Our problem is that they are dissatisfied with the work and the pressure on them, so we need to attend to making general practice a popular option.

The second thing is that I do not think it is an either/or. Of course we need specialists, so we would welcome the 1,500 new medical students who will be entering training, provided they are an additional number of doctors for the UK, which is below the OECD average of doctors per 1,000 people. If they substitute for the third of doctors who currently come from outside the UK, we will not have any more net doctors and then more generalists would mean fewer specialists—which I am certain is not what the UK population is looking for.

**Lord Bradley:** Innovation and flexibility, under devolution, is the direction of travel for long-term sustainability. To get to that point, you need short-term investment in innovation. Does that mean that you can be flexible around current control totals to enable, for example, Greater Manchester to invest and innovate going forward?

**Jim Mackey:** We would not rule that out, but we would need to see a business case for it. We are having conversations across the country with providers and STP areas, which are trying to demonstrate a case that, if there were some short-term investment or flexibility, they could get a longer return. That is difficult because there is no headroom at all anywhere in the system financially, so, to create flexibility for somebody, it actually means that somebody else has to work harder, financially, but we will try within those constraints. I have not yet seen a business case that shows that we get our money back on any of these transformations, so, if anybody has one and I could see it today, I would be very grateful for it.

Q260 **Lord Willis of Knaresborough:** Lord Chairman, a great deal of what I wanted to say has been answered before, so I will concentrate on two areas. First, all the panel, and indeed every panel we have talked to, has talked about greater integration between health and social care and more generalists as well as more specialists, which always seems to be the case from medics. In reality, the question which Sir Andrew Cash, the chief executive of Sheffield, who was a witness a couple of weeks ago, brought up with us made it quite clear that, without a significant change to the regulatory framework, we could not, in fact, deliver the sorts of ambitions that people have. Earlier, Professor Stephenson, you mentioned exactly that; that there needs to be new legislation to look at regulation that is fit for 2030 rather than 1930. What is your vision of

what that legislation should say? What should we be recommending in our report as to what the new framework for regulation should be about? We have systems regulators and professional regulators, a lot of them, and simply saying that it is something between nine and one is not a sufficient answer to go forward.

**Professor Terence Stephenson:** There are two broad strands that we would be looking for. One is that we want to, if you like, upstream. We get 10,000 complaints a year about doctors, of which about 7,000 we close very quickly. With the other 3,000, we put people through the mill and eventually 80 to 90 people are struck off. We are dealing with legislation that was not designed for 10,000 complaints a year. Lord Walton, who just died, one of my predecessors, told me that he heard every complaint personally—about 350 a year, one a day. We have legislation now dealing with 10,000 a year. The first thing would be to allow us to upstream because many of those could be dealt with locally and those doctors do not really need to be taken out of practice; it is a hammer to crack a nut.

The second thing, hinted at earlier, would be that if we had new legislation we could have a more similar common code where if a nurse, a midwife, a doctor and a dentist all did the same wrong thing, they all got the same sanction or the same kind of evidence was brought to bear. At the moment we are all operating under rather ad hoc legislation which has grown up higgledy-piggledy over decades. It must seem strange to the public that, if they see a health professional who is found to have done something wrong, there are all these different ways of dealing with them. That is why I would push for an ability for us to act with a more common set of rules and an ability for us to keep stuff locally that does not need to be reported to a national body.

**Jackie Smith:** I would very much agree with that. Actually, I would say that our legislation is probably 15th century: it is that out of date. Consequently, we are in the business of pleasing no one because the public have an expectation that we will deliver a resolution and we cannot because of the constraints of our legislation. I very much agree with what Terence said; we need to work together better. The public want consistency of decision-making across the regulators and they need to understand what we are doing. Because I hold a hearing and then Terence might do something later in a different way, the public are confused, so we need change to our legislation to make sense and to provide a better service.

**Lord Willis of Knaresborough:** I have to declare an interest as a consultant for the Nursing and Midwifery Council. So much of the evidence we hear about regulators is that they are part of the problem. How do we shift that to actually make regulators part of a solution to a modern healthcare system moving forward?

**Jackie Smith:** I would say first that we need to be honest about what we can do. We are fundamentally here to protect the public, but we are also here to set the right standards, and we need to work in partnership, not

in isolation, and be clear about what can be achieved. That is the first point.

The second, and I keep coming back to this, is that we need to think about the workforce in the future and how we are setting the right standards to deliver care in 10 or 20 years' time.

**The Chairman:** Are you doing that?

**Jackie Smith:** I believe we are. As I say, the review that we are doing now in relation to pre-registration nursing is radical.

**Lord Willis of Knaresborough:** What about Jim Mackey and Mike Richards?

**The Chairman:** Jim, you wanted to come in.

**Jim Mackey:** On the question about what should be in the legislation—

**Lord Willis of Knaresborough:** Do you agree that there should be legislation?

**Jim Mackey:** Possibly. I think we are all a bit fatigued with change and we have not recovered yet from the last changes. If there is a need, what I would like to see enshrined in the legislation is a duty on regulators to guarantee minimum overlap and minimum duplication and to collaborate on consistency, which people are trying to do, but to make sure it is a core commitment.

A fundamental principle is that we should look at regulation as a kind of safety net, but not a guarantee of success. The service runs by people taking control locally and making their own decisions. In this last period, that has all got a bit confused and there is far too much focus on the regulatory system and far too little focus on how people, such as Manchester and others, take more local control of their circumstance. I think the regulatory system needs to support that.

**Professor Sir Mike Richards:** I am not sure that legislation is what is needed at this instant from a systems regulator point of view—I cannot speak for the professional regulators. We are already working much more closely with NHS Improvement, NHS England and CCGs. I co-chair the National Quality Board with Sir Bruce Keogh and one of the things we are doing is looking at how we can best align all our requests for information on quality, or efficiency for that matter, so that trusts are only being asked once rather than multiple times in slightly different ways. We are also working, as the organisation representing the trusts, with NHS providers to say, "Tell us where we are not working well together so that we can understand that and put it right".

One of the specific objectives we have set out in our new strategy for the CQC is to have a shared view of quality. We base that around our current five key questions and we are adding in questions on the use of resources. What we are finding is that trusts are already using this model

for their own internal quality assurance and quality improvement. If you go to a trust such as Frimley Health, it is already using it for its own internal insurance—and it does it at a much more granular level than we would do. It will look at cardiology, respiratory medicine and gastroenterology, whereas we might just look at medicine combined. It is finding it very valuable and also using it when it is trying to drive up improvement—and other places such as Oxford are doing the same.

**Q261 Lord Warner:** The thing which keeps coming back to us from witness after witness, particularly those in the operational field, is a sense of conflicting demands being made on them by a group of people called “regulators”, and they do not always distinguish between whether they are professional or systems regulators. You guys and gal are actually in the frame, as far as I can see, for many of the operational people. What would you like us to say to help you get, if I may put it this way, a better press from the operational people—not from us, not from the politicians but from the people whom you are regulating?

**Jim Mackey:** I do not think there is much you can do. We need to help ourselves with that and, as Mike has described, we are doing an enormous amount of joint work to try to minimise the interactions with providers, and it is absolutely work in progress. One example would be that we have a bit of joint work about to kick off with a major provider to look at safety in ED, and we are doing that together rather than as separate interventions and separate support. We need to do much more of that. If you start saying positive things, unless it is borne out by experience, it will actually not do anything. Often, people use the word “regulator” when they just mean somebody else in the system. It is often the commissioning system where a lot of the interactions happen and then we can absolutely ask for similar things, so we have lots of work going on trying to simplify that. Simon Stevens and I are working, as part of the STP process, on whether there is a way of us devolving as much local responsibility for all that resource to STP leaders or devo leaders to make sense of it in the current context.

**Professor Sir Mike Richards:** You mentioned the negative press we may get, and we have all said that we need to work better together to reduce the burden. On the other side, we do survey the providers that we regulate. In adult social care, 93% are positive about the benefits and impacts of our inspections, in independent health it is 92% and in NHS trusts it is 86%. You may not hear about the good press that we also get.

**Lord Willis of Knaresborough:** They dare not say anything else.

**The Chairman:** Exactly.

**Professor Terence Stephenson:** I was preparing for my annual appraisal after midnight last night, so this is quite close to my heart. Almost all of what I am doing is not required by the GMC. The vast majority of it is mandatory training required by my employer and some of it is dictated by the royal colleges. So I think we have to reflect a huge societal change. I qualified as a doctor in 1983. Nobody was expecting

me at midnight to do online training on different colours of fire extinguishers. Now, it is mandatory training. Nobody was expecting me to do training on back lifting. You can argue whether that is right or wrong, but society has changed hugely. The burden of regulation across society and what we expect of people is vastly different. Just look at the change in the driving test.

**The Chairman:** The comments we have had suggest that sometimes, both for systems and professional regulators, the regulatory regime that you require us to follow is not proportionate.

**Professor Terence Stephenson:** There is a huge risk with that; that is what I am trying to say. It is a *cri de coeur*. Most of what I have to do is not mandated by the General Medical Council. What the General Medical Council asks for is actually quite modest, which I have to do. I have revalidated—along with 155,000 other doctors, so it is doable—but a huge amount of what I do is dictated by other people.

**The Chairman:** I will not invite comments around the table about revalidation.

**Baroness Blackstone:** One of the criticisms that is made of the systems regulators, in particular, is that they are too driven by processes and procedures rather than by outcomes. Is that a criticism that you think is valid and one of the areas that you want to work on to improve?

**Jim Mackey:** I think that has been fair in the past. It is probably a work in progress, I would say, certainly from an NHS point of view, as we are in transition from a regulatory system that was created at a point in time and the world has changed and we are trying to adapt and be flexible for now and for the future. There will, over time, be more outcomes, focused and orientated. Frankly, a lot of clinical practice is absent of outcome measures, so we need the profession to help with that. There is really strong evidence that the CQC has moved a long way from the first inspections and is much more outcome-focused. I do not think any of us are happy that we are there yet, but we have started and we are trying.

**Professor Sir Mike Richards:** I am very happy to move in the direction of outcomes, particularly when people can measure them and provide them to us. For example, with all the national clinical audits, we are working with them, they do give outcome measures, and we are working with the leaders of those audits to say, "Tell us which are the five key questions in your 80-question audit which matter most and we will then incorporate those into our inspection programme"—so we are doing that.

When we look at processes, those are processes which an organisation such as NICE has said are closely linked to outcomes. I think there are times when we will have to look at processes because they are the best proxy and, at least, they are going on right now, whereas, sometimes in outcomes, you have to wait a year or even five years to know what the outcome really was.

**Q262 Lord McColl of Dulwich:** Staying with the regulation business, could the burden of regulation be reduced without damage to service consistency and patient safety? In particular, we have heard quite a lot of criticism of the CQC in general practice, where it seems to be much more interested in ticking boxes than in listening to outcomes and the views of the patients in the general practice that serves them.

**Professor Sir Mike Richards:** As you know, I am not the chief inspector for primary medical services, but we take the views of patients into account there. The GP patient survey is a very important element of the inspection programme.

The other thing I would say—and this is not only for general practice but for hospitals as well—is that we are now in a very different position from where we were three years ago. We are either completing our first round, or have completed it, and we have a much better picture of quality, which I think will allow us to be much more targeted in how we inspect in the future. Coming back to hospitals, if we have been to a hospital that is outstanding, it could be Northumbria, Frimley Health or whatever, do we need the same intensity of inspection at a hospital that we know is outstanding as in one that we know is really struggling? We will be developing a completely new approach to looking at our previous experience with their inspection, any new data that has come in from national data sets, our local relationship with that trust, knowing what is going on there, any concerns that have been raised by staff or patients, and we will take all that into account and say, “This is the specific service that we need to go into” and not necessarily do a comprehensive inspection.

**Professor Terence Stephenson:** I would agree with Lord McColl’s premise that the regulation burden can be reduced without impairing patient safety. That is why we need legislation. Modern regulation should be targeted, proportionate, data-driven and intelligent. It should not be a blunderbuss. Whether it is the way we inspect medical schools or the way we deal with complaints, we should be focusing our attention on where we need to and not labouring under very old legislation where one amendment can take two years.

**Jim Mackey:** I would agree with all of that.

**The Chairman:** I do not know if you have been following our evidence sessions. If you have, you have probably read or heard some of the comments we have had, particularly from well-recognised foundation trusts, about the bureaucracy that systems regulation imposes and the conflicting requirements that both of you ask for independently rather than working together, which not only produces more cost for them but disrupts their working.

**Jim Mackey:** I recognise that. It is not much more than a year since I was out there doing that, and I completely recognise that. It is not a new thing. I was thinking earlier on about one of the questions. It would be over 10 years ago when we got to a Thursday morning and we had seven

regulatory interventions that week—and that was before a lot of this architecture was built, so it has always probably been a bit of an issue in health.

As Mike has described, between our two organisations we are seriously rationalising our work to share intelligence, support and intervention and to manage the noise as much as possible and simplify that. It is a work in progress. We have started now, between NHS England and NHSI in an STP context, working on how we do that. There are lots of points of entry into providers.

A lot of the people you have heard evidence from are high performers. On the proportionate point, we should not have a lot to do with the high performers; we should be allowing them to get on with things. We also have a large number of organisations that, frankly, need our support and we need to help prop them up and get them into a more stable position. So I would agree strongly with the proportionality point and that we all have a duty to stand back occasionally and minimise duplication. One of the things we say within NHSI, which is a new organisation, is that often the right thing to do is nothing. If we are dealing with a provider and there is a lot of noise going on, probably what we should do is talk to the people who are generating the noise and allow them to get on with what they need to do. That is a very hard judgment to make when an organisation is in trouble.

**Lord McColl of Dulwich:** Could we do something about the CQC inspection of general practice because it really is a shambles—and that is the view of one of the Ministers?

**The Chairman:** You wanted to come in first on the last question.

**Professor Sir Mike Richards:** I was going to add on the high performers that, in a number of instances, we have found individual services where they have taken their eye off the ball and they have acknowledged that afterwards and where the spotlight that we have been able to shine by doing a comprehensive inspection has led to improvement. I am quite sure that those high performers, because they have good leadership, will put those things right—so we need to pay particular attention to the ones that are struggling.

Coming back to Lord McColl's point, even among general practitioners, going back to the question of whether we get good or bad press, 57% of them say that it has been beneficial and had a good impact, so it is not all that you may hear. What we will do at the end of our first round is look at the whole process of how we do general practice inspection. We have set out our new strategy overall for the CQC, which includes having a more targeted and tailored approach. As you will know, a large proportion of GP practices have come out as good or outstanding, so we will consider what we need to do with the reinspection of those, and we will be reconsulting on that in the spring.

**Lord Scriven:** I have been listening very carefully. A lot of the discussion

in this session has been about small steps and what we are doing now to change. Can I take us forward to 2030? There is a lot of evidence coming to us which is talking about a more devolved system of health and social care: much more integration, much more generalist in terms of staff. Going forward to that system, what is the role of regulation and how would regulation change to sustain that very different model from what we are talking about today? Can you give us your views about that? It is quite important, not just in terms of numbers but in terms of what the role is, how it would work and how it would be different, because I think it will be a very different system and I have not heard that come out from what you have said.

**Professor Sir Mike Richards:** First, I think we will still need regulation. As Jim was saying, it is absolutely vital in ensuring that patients are getting safe services, so we need to adapt as the health and social care services are changed, and we are doing that. We are working very closely with those who are developing new models of care.

**Lord Scriven:** It is not a criticism. I want you to crystal ball-gaze a bit into what is needed.

**Professor Sir Mike Richards:** To crystal ball-gaze, we will still be needed, we will need to be lighter on our feet and we will need to target those places where the problems are greatest, but we will adapt so that we can inspect and regulate new models of care. With those new models of care, we are saying, "Please tell us what you are planning so that we can plan the regulation with you". For example, I am meeting with 13 of the acute care vanguards on Thursday of this week to discuss that very issue.

**The Chairman:** Is there not an issue where you inspect and Jim improves? Should part of the inspection regime not be to help to improve the delivery of service?

**Professor Sir Mike Richards:** Absolutely.

**The Chairman:** So why do you not do it together?

**Professor Sir Mike Richards:** We inspect and rate and we therefore shine a spotlight on what is working very well and what is working less well. It is very important that we do not also do the improving or are not overseeing that—otherwise, we would be marking our own homework. There is a real danger then that we would say, "Oh yes, it is all better" because we all want it to be so. So I think the separation of inspection from improvement is a very valuable one.

Q263 **Lord Warner:** We have heard a lot of concern expressed about unwarranted levels of variation in the quality of services, safety and, indeed, productivity. You are also moving to a system now, increasingly, and the STPs take you down this route, where you are talking about what is happening in a health economy rather than just what is happening in a particular institution. Following up on the Chairman's question, how do



you need to change, given that there will be health economies which often determine the performance of some of the entities within them? How will the systems regulators in particular change in that world and concentrate more on productivity and performance?

**Professor Sir Mike Richards:** Of course, one of the points is that the level of unwarranted variation is something we have helped to point out by shining that spotlight, so that is an important point. At present we do not regulate the commissioning side; that is the responsibility of NHS England. As we move to accountable care organisations, that changes because, in effect, a lot of the current commissioning tasks will be performed by the accountable care organisations. What is vital to us is to know who is accountable and what they are accountable for. David Behan, my chief executive, has a slide picture of a coroner's court. Who is the person who gets called to the coroner's court when something goes wrong—who is the controlling mind, if you like? As long as we can be clear about that, we can then design the regulation around it—but it will change as the balance between commissioning and provision changes.

**Lord Scriven:** I think where Lord Warner was going was that healthcare in the future might be around a health economy rather than individual organisations. What does that mean in terms of your regulation? A lot of the evidence we have heard is about this move, basically. Therefore, the role of regulation in holding to account a very different type of beast has to change. We are trying to get your thinking on where you fit in there and how you can help improve the sustainability of the NHS and social care moving forward in that new model.

**Professor Terence Stephenson:** Our view, as a professional regulator, would be that the devolution that you describe, and that localisation, needs to be matched by the regulator. We now have an employer liaison service, and we are out on the pitch, we have a regional liaison service and we have offices in London, Manchester, Edinburgh, Belfast and Cardiff. Moving away from the idea of the regulator just sitting in an ivory tower in London and waiting for stuff to come to it to being out on the pitch, talking to people and helping stop problems getting escalated to a national central regulator, we should continue that march forward to match that devolution in terms of regulation.

**Lord Warner:** Chairman, can I follow up Mike Richards' answer, which I thought was a very good answer? What it actually poses is an issue for this Committee about the 2012 Act because, if you are going to create new bodies to run health economies, call them what you will, and you can adapt the regulators to regulate accordingly, you then are posed with this problem of who is in charge. What you have is a very rigid system of legislation now which has made, and we can be kind, an interesting approach to who is in charge. But does it inevitably follow from where we are heading for the regulator that, if you do not change the accountability to clarify it, you have a problem with regulation?

**Jim Mackey:** I think there is still a lot more we can do. A lot of what Mike has described with the development of acute care organisations or

systems is slightly constrained by the law, but those organisations and how we work with them can change and adapt a very long way from where we are now. We apply a similar thing to David Behan with a kind of “Who goes to jail?” test, so we can help with the design. We will be doing this with STP processes, governance mechanisms and accountability mechanisms to make sure that it is clear and legal that the right people are in charge and you can actually point to somebody who is in charge and who the controlling mind is. So we can go a long way further than we are now without changing the law.

When we have done that, we will hit upon where the law needs to change—but we are not at that point yet and we can still do a lot more by collaborating, being flexible and helping people navigate what is possible within the law and what is not.

**Jackie Smith:** Can I make three points? We need the flexibility of our legislation to remove the most dangerous practitioners quickly and we need to continue to challenge ourselves about the right standards and outcomes, but then I think we need to be much more data-savvy. All the regulators have masses of data—we are rich with data—but I do not think we are very smart at saying to ourselves, “How best can we use it?”—and we will have to do that. We should have done it years ago.

**Lord Willis of Knaresborough:** How do you pull all this together? It is very interesting listening to your step-by-steps and Jackie Smith’s very interesting point about the use of data and different organisations using data, which has come up in a lot of our evidence. Who is going to do this? It comes back to Lord Warner’s constant question throughout our inquiry, which is so interesting, about who is going to be in charge. I do not want them in the coroner’s court, but I want to know who is going to lead this revolution because at the moment we do not know.

**Lord Warner:** It is not the Permanent Secretary at the Department of Health.

**Lord Willis of Knaresborough:** Do not start that.

**Jim Mackey:** My view is that the last thing the NHS needs now is a big nationally led reorganisation. We are all too busy.

**Lord Willis of Knaresborough:** You are avoiding the issue.

**Jim Mackey:** No, I am not. I will try to answer your question. We are at the point with the STP process, whether this works or not, where some of the STPs are coming to us and saying, “Sort this out, rationalise it. Help us get from where we are now”. Manchester has pushed it, Sheffield is pushing it, and Frimley is. Simon and I, David Behan and others are encouraging that process where they set out what they think they need and want from us and we will have a conversation about it. The arm’s-length body chief execs had a session yesterday to briefly agree that, in principle, what we should do is try to get to the point where we support and agree rather than find obstacles and we need some examples where

we can challenge ourselves on it. That will mean, I think, that we agree, which we do now, shared posts, shared intelligence, shared intervention and support, and we all have a duty to massively rationalise our overhead. We are spending a lot of public money when we do this and, when money is tight, we need to maximise the amount of money free and available for public use.

**The Chairman:** You keep saying, which we have heard before, that we do not need any further major reorganisation. On the other hand, we do get reorganisation. Manchester is an example with devolution; the STPs are a major reorganisation without legislation. If you are going to make the health service sustainable in the long term, and we are talking about 2030 onwards, there has to be some reorganisation, surely. The primary care model may not be appropriate.

**Jim Mackey:** I think that is all happening and people are out there and doing it. Our job, as regulators, is to try to find a way of facilitating and supporting that in a safe way rather than being obstacles to it. I have lived through lots of NHS reorganisations. The last one was very painful, very long and very expensive and I do not think that any of the people you have seen have said, "We want to do that again". I do not know anybody who wants to do that again. Everybody wants to get the best value and the best use out of what we have now. When we have done that, there might be a point when something very material requires a change in the law.

**Lord Willis of Knaresborough:** We really need to press you on this. If you take Manchester as an example, you have a group of organisations coming together under one umbrella. Do they create their own governance structure and then present it to somebody so that there is somebody in charge of it? Is that the model you are talking about?

**Jim Mackey:** Yes. They are in the process of developing and agreeing a kind of subsidiarity agreement where they agree that some decisions are made as a collective and each board agrees that and cedes control of that decision-making to the collective body. The institutions still exist. Mike Deegan, for example, who is the chief exec of Central Manchester, is still the accounting officer for the Central Manchester Foundation Trust. If something goes terribly wrong, he is accountable, but he does it within a framework of that broader decision-making. People are doing that now and it is starting to work, but it is still early days.

**The Chairman:** What is the governance mechanism of STPs?

**Jim Mackey:** That is an interesting point. It is very early days.

**The Chairman:** You mean there is none?

**Jim Mackey:** No, it is a development and planning process currently. A small number of them will want to move to a process where it becomes more of a governance mechanism, and it will be similar to the Manchester model, I think, for some. Most of them will see it as a joint planning and

development exercise, a strategic forum, rather than a governance entity, a structural change—but there are 44 and there is huge variation among them.

**The Chairman:** Here is your chance now, Lady Blackstone.

Q264 **Baroness Blackstone:** What is your single key suggestion for change that the Committee ought to recommend to promote the sustainability of the NHS—just one single change?

**The Chairman:** Looking ahead to 2030 onwards.

**Professor Sir Mike Richards:** We have all said that we want integration and efficiency. To get that, I think we need to put greater emphasis on leadership. We need to build the cadre of leaders, both clinical and non-clinical. Where we see good leadership and things are happening already, we need to put people working alongside those very good leaders so that they can learn from them.

**Professor Terence Stephenson:** We are an independent regulator answerable to Parliament, not to the Government. We need Parliament to give us legislation fit for 2030, not fit for 1983.

**Jackie Smith:** I will say the same thing as Terence. If we are going to be agile, flexible and current, we need change to our legislation immediately.

**Jim Mackey:** Support integration and do only the things in a regulatory system that need to be done in a regulatory system and allow as much local flexibility as humanly possible.

**The Chairman:** Thank you very much, all of you. We appreciate very much your coming today and giving us evidence. It has been most interesting. You will get a transcript, as I said, and you can correct it for accuracy but not correct its content. Thank you very much.