

# Health and Social Care Committee

## Oral evidence: NHS Long-term Plan: legislative proposals, HC 2000

Tuesday 2 April 2019

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Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Rosie Cooper; Andrew Selous; Derek Thomas; Dr Philippa Whitford; Dr Paul Williams.

Questions 1 - 97

### Witnesses

I: Professor Katherine Checkland, Professor of Health Policy and Primary Care, University of Manchester; Richard Murray, Chief Executive, The King's Fund; and Nigel Edwards, Chief Executive, Nuffield Trust.

II: Simon Stevens, Chief Executive, NHS England; Ian Dodge, National Director: Strategy and Innovation, NHS England; Ian Dalton, Chief Executive, NHS Improvement; and Ben Dyson, Executive Director of Strategy, NHS Improvement.

Written evidence from witnesses:

- [Nuffield Trust](#)

## Examination of witnesses

Witnesses: Professor Checkland, Richard Murray and Nigel Edwards.

**Q1 Chair:** Good afternoon, and welcome to our first session looking at the proposed changes to NHS legislation. We are very pleased to have you all here. Could you introduce yourselves and say who you are representing today?

**Richard Murray:** I am Richard Murray, chief executive of the King's Fund.

**Professor Checkland:** I am Kath Checkland, professor of health policy and primary care at the University of Manchester, and from the policy research unit in commissioning and the healthcare system, which is NIHR funded. I am also a GP.

**Nigel Edwards:** I am Nigel Evans, the chief executive of the Nuffield Trust.

**Q2 Chair:** As an opening question, what is in this for patients? How will they notice the difference? One of the points we wanted to stress in our report was that, unless this made a difference for patients, was it really worth doing? How can we explain it to patients? Would you like to start with that one, Nigel?

**Nigel Edwards:** I was sincerely hoping that that privilege would pass from me. It is quite tricky to identify an immediate link between the proposals, which are slightly disparate, and the impact on patients. There are a few more obvious places where there is a more direct impact. One of the hazards of creating integrated care providers is of creating monopolies where there is an incentive for the provider to retain patients within its organisation, because every patient you retain is a contribution to the overhead of your organisation, whereas patients may want choice, both for elective surgery and for providers of talking therapies, for example. There is a potential construction in which there is a diminution of patient choice, and not many checks and balances built into the system that, as I see it, would prevent patients from being steered away from choices.

**Q3 Chair:** We will look at that in more detail later. Professor Checkland?

**Professor Checkland:** I would turn it on its head. In an ideal world, patients will not notice any difference, in that the problems at the moment are behind the scenes. A lot of our research has found what we call workarounds in inefficiencies: managers and people behind the scenes are working like mad, running hard to stand still, to work around the issues in the legislation. There are inefficiencies, which I am sure we will come on to, particularly to do with things like procurement, challenges, and all those sorts of things.



It is more that it will make life easier. If managers are spending less time doing workarounds, they will have more time to focus on the stuff that matters, which is how services are delivered. It is more about taking away inefficiencies and things that prevent services from improving, rather than there being some big thing that will improve. It is more of a general sense that, at the moment, people are working incredibly hard just to get around the issues. I have some detailed examples of that.

**Q4 Chair:** In other words, the system is working in spite of the legislation rather than because of it, so it is about helping them to make the system work better.

**Professor Checkland:** Yes, and freeing up time and attention for the stuff that really matters.

**Q5 Chair:** That is how you see patients would predominantly benefit. How about you, Richard Murray?

**Richard Murray:** Very similar to Kath; it is about some of the behind the scenes hardwiring of the governance and committee structures in the NHS, much of which would be beyond the level of interest of most patients and members of the public. That does not mean that they are not important; they are the kinds of issues that eat up the time and effort of people working across the system. The proposals are enabling. They will enable the system to work better, but they will not make the system work better; you will still need to sort out issues around workforce and how teams work together, but they should make it easier for people in the service to do it.

**Q6 Chair:** It is enabling legislation, to get the barriers away. How effectively do you think it tackles those barriers?

**Richard Murray:** It is true, in the conversations and engagement that we have had with the service, that a lot of the issues in this are at the top of their mind. They may sound a bit uninteresting—double delegation, the ability to set up joint committees and joint appointments. They are not the kinds of things that you get people demonstrating in Whitehall for, but they are in the way of the work that people are doing at the moment, so I think they would definitely be welcomed.

However, do they set out a vision of what the health service is going to look like in five to 10 years' time? Do we know what the structure of an integrated care system would be? They are one step on the path towards a better integrated system, but that is not the last that you would hear. You have to recognise that there is still an awful lot that will need to be sorted out and come back again at a later stage for further legislation.

**Q7 Chair:** Thank you. Kath or Nigel, did you want to add anything?

**Professor Checkland:** Yes, I would agree. In some of our research, particularly when we looked at the interplay between competition and co-operation in local health economies, we found that procurement



## HOUSE OF COMMONS

regulations in particular have been a real problem. People have been doing what you might call defensive procurement, where they feel that they have to do it and are not sure whether they are going to be subject to legal challenge.

Of course, there have been legal challenges, which have produced real inefficiencies in the system. For example, there was one in Lancashire, which went to trial, and the procurement had to be run again, but the outcome was exactly the same at the end of it. That is a huge waste of everybody's time and effort. Those kinds of issues are important. The double delegation one sounds esoteric, but it is really important in terms of where different responsibilities sit in the system and the ability of organisations to work together meaningfully.

**Q8 Chair:** We are going to come back to the issue around procurement, which has been a hugely important area. Nigel, is there anything you want to add?

**Nigel Edwards:** I just have one point. As Richard says, a number of loose ends are left by this legislation that will need to be worked through, such as the exact role and status of the integrated care system, its relationship to the regional layer of NHS England and NHS Improvement, and how that relates to the CCG and its statutory responsibilities. Giving people duties is something that policymakers do when they are not quite sure what else to do, but the idea of giving people duties to try to reconcile their financial responsibilities and the responsibility to co-operate still leaves quite a lot of things that will need to be worked through.

**Chair:** This Committee is also interested in what is missing and should have been included, as well as what perhaps would lead to unintended consequences. If there are things that you want to write to us specifically about at the end of this, please do. We are going to come now to unintended consequences.

**Q9 Mr Bradshaw:** Nigel, you have mentioned one already, which is the possible diminution of patient choice. Could you elaborate on that a little bit?

**Nigel Edwards:** Other integrated care systems in other countries tend to have more competition between them, so people can choose different providers. The ones that we are setting up are geographically based, so patients are locked into that system. Where the hospital is part of the system, or particular providers, there is a choice for the patient about whether they might receive their treatment within that system, or might for various reasons want to go elsewhere, particularly in urban areas.

The difficulty is that every patient who leaves your system has to be paid for at full cost in another system, so there is quite an incentive to try to keep patients within the system. The upside of that is that you might want to focus on access and high-quality service for your patients, but



you might also want, and it might be simpler, to make sure that patients are not offered choices to go outside the system.

**Q10 Mr Bradshaw:** In practice, is that not already happening? My experience from correspondence from my constituents is that commissioners are already clamping down, and it is non-existent, for money and funding reasons.

**Nigel Edwards:** It almost certainly is already happening, and I have heard examples of that. That is perhaps a different thing from locking it in as an institutional feature of the system. It is the difference between a bug and a feature; we have turned it from being a problem in the current system to being something where there are some quite strong incentives. There may be an important role for the integrated care system, and possibly for the region, to set and oversee some market rules for how that operates and to ensure that the constitutional commitment about choices continues to be honoured. That will be an important driver of quality.

The model has a lot to be said for it—don't get me wrong—but one of the concerning things about it is that it lacks the sort of dynamism that leads to the improvement we see in other systems. It has neither the competitive pressure of markets nor some of the hierarchical methods that we have seen in other attempts to drive improvement.

**Q11 Mr Bradshaw:** Are you worried that that will have an impact on standards?

**Nigel Edwards:** The absence of choice is a problem for a number of reasons. One is that it is a spur, where it is available. There are a lot of things that the NHS does where choice cannot be very easily offered, but it is a spur to improvement for specialism procedures where it is an option. There is a principle that, where choice is available to patients, and to secondary care referrers and GPs, they should be able to exercise it.

**Q12 Mr Bradshaw:** Professor Checkland?

**Professor Checkland:** I would not go quite as far as Nigel. It is possible to overstate the extent to which competition improves quality. Certainly, there is some evidence—there is a paper that I can send to the Committee—that, particularly on elective surgery and hip replacements, patient-reported outcomes are no better in systems with competition than not.

As a GP, my lifelong experience is that, although some people want choice around the edges, most of my patients just want their local hospital to be good. They really do. In my area, choice tends to be geographical. The patients who live nearer Sheffield go to Sheffield, and the patients who live near Chesterfield go to Chesterfield, and that is all they care about—transport links.

**Q13 Mr Bradshaw:** Yet it remains a legal right in the NHS constitution.



**Professor Checkland:** Yes, it does.

Q14 **Mr Bradshaw:** Are there any other potential unforeseen consequences, apart from the impact on patient choice of the legislative proposals from NHSE?

**Richard Murray:** If you look at them in general, they are enabling; it all then depends on how you choose to use them. In the centre, the ALBs will take power to direct foundation trusts over their capital spending, but it all depends on what number they direct them to and how they do it. It gives power to the Secretary of State to move arm's length bodies around, but it does not say how he or she is going to do that. A lot of these things turn on how they will get used.

One of the difficulties is that, without a broader vision of the journey you are going on, it is not always easy to interpret what will be done with some of these things. You can think about some of the flexibilities in the tariff; many people are arguing for those and many areas are doing it anyway, whether or not they are waiting for the legislation. It all depends what you do with them. There are a lot of potential unintended consequences; it is not always easy to see where they are at the moment.

With choice and competition, we have to be honest. Choice and competition are fading away from the NHS anyway, and have been fading away for the last three to four years. We do not really have a competitive system; providers can run a couple of billion-pound deficits a year, but that is not much of a competitive force. Some of this is about recognising what has already gone on, but it goes back to removing the veil that choice and competition were the motive force behind quality in the NHS, which they clearly were not. What will it be? It is partly about recognising the fact that the world has moved on.

**Nigel Edwards:** One very substantial unintended consequence, which we can definitely predict, is that over the last few years providers have been asked to make very aggressive savings in return for payments from the STF, the transformation fund. The potential change in the capital regime means that commitments made to clinical staff in those hospitals, where they have been told, "One more push in efficiency and we will be able to spend the money that we will get through the STF on capital," may not be available if capital controls are then placed on those organisations. It is a transitional issue, but it is quite a significant one. About 80 foundation trusts are affected by that change, and we can send you a note that explains the implications.

Q15 **Dr Whitford:** My question is around choice and clinical competition. Obviously, our system in Scotland is quite different. You talk about choice fading away, but was there ever any evidence that choice really became an active thing? As a clinician, my experience would be the same as yours, Kath. People want to know that their local hospital is good, and they are not going to travel an extra 60 miles for something that might



be good, if that kind of evidence is not there.

**Professor Checkland:** There is some evidence that there is a role for choice, particularly at the margins. My experience of the NHS goes back to the days when waiting lists were for one or two years, and that was a problem. Being able to say, "No, I want to make a choice to go somewhere different to avoid that," is obviously important.

My experience of its operation has always been that it is at the margins, and it is not the mainstay, particularly for non-elective care, where it has never operated. For a lot of elective care, the choices my patients make are based not on grounds of quality, but on how easily they can get to the hospital and whether they can park their car when they get there.

- Q16 **Dr Whitford:** That particularly opens up different inequalities between urban and rural. A big urban city may have three or four hospitals, but if you are in a rural area you are quite thankful to have one. Do you not think it is a problem to be creating the sort of inequality whereby, if patients live a long way from hospital B, it is not real choice?

**Professor Checkland:** That is kind of inevitable.

- Q17 **Dr Whitford:** You were talking about competition around the financial side, but the main discussion is around trying to improve clinical quality. If you are on the frontline in the clinic, if your chief exec gets a bonus because of something or other, or a bigger car, the team on the ground does not gain from that. Has any thought been given to clinical competition, in the sense of quality improvements, standards or audit, and actually having peer review? Clinicians, whether medical or nursing, are naturally very driven people, and they want to be able to look at their unit and say, "Actually, we're doing really well," or, "How come we're at the back of the queue? What do we need to change?" Financial competition seems a long way to get to quality.

**Professor Checkland:** That is not the kind of thing you can legislate for, and it is not what this legislation is for. You are absolutely right, but one of the arguments I would make—to go back to my original argument—is that one of the issues that makes it difficult for that kind of thing to happen is that all the managers are running around like mad trying to work around the legislative issues. If you can get rid of the blocks and difficulties, you will smooth things out, and there will be more energy to put into that kind of thing. As Richard said, there is nothing in this to make that happen, but that is the intention, and it is about how you then manage the system.

I would go back to the role of regional structures. Something that is missing is what used to be the strategic health authorities' regional statutory layer, which would have oversight of those kinds of quality issues. We now have seven regional directorates of NHSE/NHSI, but their role, remit and responsibility are not clear.

**Chair:** That is something that we are going to address with our second





## HOUSE OF COMMONS

panel—where the structures are in the middle. Thank you for raising that. Andrew has a quick supplementary, and then we are going to move on to ICSs.

**Q18 Andrew Selous:** Will any part of the new regime prevent patients from being referred to specialist hospitals, sometimes referred to as tertiary treatment centres? For example, the Royal National Orthopaedic Hospital at Stanmore has been the salvation of a number of my constituents, and I would hate to think that the ability to refer out of area to a specialist hospital would be lost. Can you reassure me that it will not?

**Professor Checkland:** As far as I am aware, there are provisions in the legislation. The main thing is around the pricing regime. Essentially, you have to have a regime whereby, if somebody goes to a specialist hospital like that, there is a mechanism to pay for it, which in my understanding is built into the regulations.

**Nigel Edwards:** Except that, in the 2012 Act, a substantial number of specialist services were given to NHS England to commission. The legislation allows for, and there is a policy intention for, devolution of significant amounts of that specialist commissioning to local bodies. It is not clear who.

My point about choice was not so much about competition but more about the incentive to reverse geographical flows, when that benefits the integrated provider itself. We have seen definite examples of that against patients' wishes, when they have been asked to go to less convenient hospitals because they were on the edge of catchment areas.

Specialist orthopaedics and some specialist services have traditionally been a bit at risk because, for local commissioners, there is a grey area about where the referral is made. The key question will be who holds the responsibility for commissioning those services. At the moment, many of them are held nationally or done regionally, but there will be an intention to devolve some of them. For things such as renal dialysis and chemotherapy, that would probably make sense, but it is something that will need to be watched, and there are some potential issues about that. At the moment, a very substantial amount of that commissioning is vested with NHS England—about £20 billion-worth—and the intention is probably to devolve a significant amount of that.

**Chair:** Rosie is going to ask about accountability.

**Q19 Rosie Cooper:** I have a brief point about the idea of patient choice. I accept absolutely that people want their local hospital to be great, but what if it isn't? If it isn't, you want better care and you need the ability to move off.

To move on to my part of the questions, if you are looking at this and trying to understand it, you would say that ICSs integrate horizontally, while ICPs integrate vertically. The last time I saw that was when I was working in industry; it was called matrix management, and it led to





## HOUSE OF COMMONS

paralysis. When something happened, you did not know whether you were looking up or sideways. It terrifies me that everybody thinks that this will magically work. It did not work and it had to be unpicked, at major cost.

I have had a lot to do with Liverpool health and accountability, and that has taught me an awful lot about accountability in the health service. I do not believe that it exists any more, virtually. How will the accountability of integrated care systems to taxpayers and local communities be maintained? The question says, how will it be maintained, but my real question is, when will it appear?

**Professor Checkland:** You are right. There is a real issue with the accountability of integrated care systems. It is not clear. They are not going to be statutory bodies; it is in the legislative proposals that they are not going to be statutory bodies, which means that it is unclear. That is one reason why I am quite keen on the idea of a higher level of regional statutory accountability that can, for example, oversee a number of ICSs in their area, in the way that strategic health authorities used to do. As the system stands at the moment, you are quite right that there is nothing. For example, the idea is that there is going to be a system control total or a budget for an ICS area, but, if there are disputes about that, there is no mechanism for how they will be resolved, as far as I can see.

**Rosie Cooper:** Paralysis.

**Professor Checkland:** That is why I think it should be the next level up. ICSs are quite local, and it is about having a level above that which could oversee more than one.

**Richard Murray:** There are some things that will reduce the degree of paralysis or slowness in the system. That is exactly what NHS England has tried to give you—a number of slightly operational steps, which make life a bit easier, as well as making the lives of people working in ICSs easier. Is this a fundamental piece of legislation that would set up an ICS under a clear form of governance and accountability? No, that would be a very different piece of legislation, and I suspect that we would struggle to define what it looked like at the moment.

There will be a bit of living with some of the tensions, which means that those messy accountabilities will remain the same. The accountabilities of foundation trusts and CCGs are being altered by this. There is some degree of flexibility around how they can delegate and work with others, but this kind of legislation is not quite as brave as I think you are looking for.

**Nigel Edwards:** There is an issue with ICSs, in that the shape of them is going to be based on the STP footprints. I live in west Hertfordshire. Hertfordshire was founded in 913, and public administration has perhaps moved on since then. It has been paired with west Essex, a place that I



would go to only if I was travelling through it to go to Stansted and which has no connection with Hertfordshire. It spans upper-tier local authorities, Cheshire, Mersey and Wirral, East Surrey and Sussex. There is quite a collection of odd geographies, where things have been lumped together—it seems to me an equivalent process to the Sykes–Picot agreement in 1918, which drew lines on the middle east—with no regard to the shape of the population or how people actually travel.

Not everywhere is like that; Dorset, for example, on the whole makes sense. But the actual geography will militate against that type of accountability, because it makes it quite difficult for upper-tier local authorities to participate in multiple geographies. In fact, the whole arrangement for local accountability remains quite weak, and this legislation does not seem to do anything to improve the current situation.

- Q20 **Rosie Cooper:** For my constituents, for example, it will be very weak indeed. I am a Lancashire MP, in a Lancashire STP, but actually the local hospital, Southport and Ormskirk, is in Cheshire and Mersey, so there are only local councils. Who has the coin to decide who is responsible today? To be frank, if you read “The patronising disposition of unaccountable power” by Bishop James Jones, and go to page 6, three paragraphs up, you will get the answer to what I am saying. Basically, what we are now looking at is that, for a patient, you get what you are given, and the patient has no voice. As we no longer have any complaints system in the health service, how do you think any accountability will be delivered?

**Nigel Edwards:** Cornwall has a model in which it intends to make the health and wellbeing board the overseeing body for the ICS. There are ways of building it in, but it will need to be intentionally built in; there is nothing in the rules of the system that mean you can do that. It will be more difficult in areas that do not map on to particular geographies very well.

- Q21 **Rosie Cooper:** So there is no real accountability.

**Professor Checkland:** But you could argue that the patient voice could be better in this system, if they ironed out those things. At the moment, there is a lack of clarity, particularly about rules and procurement, and those kinds of things. It is possible that if they get the regulations better, with the joint committees, for example, you would know more about who was responsible for what. One lack of clarity at the moment is that, for example, you can form a committee in common, but you cannot form a joint committee. What does that committee do and what are its responsibilities? It could be clearer in the new system.

**Chair:** That is something we are going to explore with the next panel.

**Rosie Cooper:** The bottom line is that if we cannot get accountability right, and we have had Mid Staffs, Liverpool community trust and all the other things that have happened—and that is with good structures—what on earth is going to happen in this loose-leaf, “guess where we are going



this week" arrangement?

- Q22 **Dr Whitford:** Professor Checkland, you were suggesting that ICSs are not going to be statutory and should therefore have a body above them. Would the push not be that we should be getting ICSs that are statutory? They should have a board in whatever way fits with the system, which is then able to be accountable to the local population, within the limits that Rosie talks about, rather than just saying that they are not going to be statutory and we will stick that in a board. I don't see how, when you were talking about when the money gets tight—

**Chair:** Should they be statutory bodies? That is the question.

**Richard Murray:** Ultimately, the answer to that question is yes. There is a real risk in trying to push NHS England and others to define what they look like at the moment. These are emerging around England; they look different and behave in a different way, and they are trying to establish their own internal governance. Yes, I think we will, ultimately, end up in a place where they need to be statutory, but beware of the risks of plumping for one model now. The problem with a lot of health legislation in the past is that it was invented in Whitehall and then cookie-cuttered all over the country in a model that has not worked. There is a tension—

- Q23 **Dr Whitford:** But surely, even if the model was different, they could still be statutory public bodies, in the sense of being answerable and not able to hide behind commercial sensitivity, or whatever else.

**Richard Murray:** Yes, and I suspect that is where we will end up. It is about whether or not you do it now.

**Nigel Edwards:** It means sorting out the role of the CCG, because there is significant overlap between some of the functions that you would want to see sit with an ICS and those that would sit with the ICP or the others—pardon me, I was forgetting my acronyms—so that the provider has some functions that would cross from the CCG to the provider, particularly the design of care pathways. There are some bigger functions, such as the overall strategy for the system and the needs assessments, where it might make more sense, in holding to account, for them to go up.

**Professor Checkland:** In holding to account for quality.

**Nigel Edwards:** There is an unanswered question about the CCGs' role in future, and it has to be answered before you can say confidently that we need some form of integrated care system.

- Q24 **Andrew Selous:** Professor Checkland, as you are both a professor of primary care and a GP, I want to ask you about the accountability of GPs in the new world. My take at the moment is that it is quite difficult to have accountability of GP practices or, actually, to help them to come alongside when they are in difficulties. In the new world, I understand that some GPs work as part of hospitals in some parts of the country, in



some of the evolving ICPs that we have at the moment. Do you think that GP accountability and the ability to help GP practices in difficulty will be any better?

**Professor Checkland:** Yes, I do. One reason why we have been through a period when it has been difficult is that there have been issues—it gets quite technical—about how primary care services are commissioned and how contracts are managed. They used to be managed by PCTs. When we went to CCGs in 2012, that responsibility went to NHS England, which could not do it because it was too big and did not have the local knowledge required effectively to manage GP practices, so there was a gap in accountability for GP services for a while.

In 2015, they decided to delegate responsibility for commissioning primary care back to CCGs, which I think have done a very good job in working alongside GPs in trouble; they are trying hard to do that, but this is where the double delegation comes in. The responsibility is delegated to CCGs, but a couple of CCGs cannot then work together to support the GPs in their patch because of double delegation. The regulations would help, in that they clarify the role of CCGs in managing their local GPs.

Where it gets slightly more complicated—it is not related to the proposed legislation, because it will not be legislative—is with the creation of new primary care networks. GPs across a patch will be encouraged to work together and support one another, bringing together some contractual things. We are in the very early stages of that, and I certainly would not want to legislate for it at the moment, because we do not know what it is going to look like or how it is going to work. The double delegation question means that CCGs' responsibilities for commissioning primary care will be much clearer, and they will be able to do a better job of supporting GP practices together across a network.

Q25 **Dr Williams:** Is this the end of the purchaser-provider split?

**Nigel Edwards:** It is a recasting of elements of it. Commissioning is an odd term that is not really used outside the UK; it is a collection of different activities. England has been unusual in the extent to which the commissioner, or the payer, as it would be called in other systems, has taken on detailed responsibility for matters that would normally be left to providers in other systems, such as the design of detailed care pathways. In fact, a friend of mine who is a professor of comparative health policy from the States thinks that commissioning has to some extent been a continuation of top-down management, while pretending to have some form of quasi-market mechanism.

Strategic commissioning, or strategic purchasing, which is a phrase that is used across the rest of Europe, involves understanding the standards and the shape of the provider system—for example, which of your five hospitals will be the hyper-acute stroke unit. The strategic assessment of needs and priorities, as well as the balance of resources between different bits of the system, is still a function that you absolutely need. If



you do not have a body separate from providers to hold them to account, the lesson we learned from the NHS in the 1980s is that there is a danger of a self-congratulatory closed monopoly, in which you mark your own homework. Some elements of that remain, but the detailed design of care in the system that is starting to emerge would pass back to frontline clinicians and the managers who work with them. I do not know whether you would agree with that analysis.

**Professor Checkland:** Yes.

**Richard Murray:** To be clear, some of this allows CCGs and trusts to make joint appointments and form joint committees. It does not make them do it, so you could be here in two years' time and find that they have decided not to, and the structures had carried on as they are now. I do not think that will happen, because these are the kinds of flexibilities that people trying to create a more integrated system have asked for.

It is interesting how difficult it has become to answer that question, when you look at the variety across what is going on in different parts of England, and what happens in acute care, mental health or community services. We have a very complex system running out there. I think we have always exaggerated the power of commissioners. I suspect that most providers are rather more frightened of NHS Improvement than they are of their local commissioner.

Q26 **Dr Williams:** Are these proposals just catching up so that the legislation matches the configuration of services today, or should the legislation be forward looking, and should we be legislating for how we want things to be in five or 10 years' time?

**Professor Checkland:** I think they are catching up, largely in very sensible ways. Certainly from our research, they seem to arise out of real problems that people have to work around all the time, so I think they are catching up. I agree with Richard. It would be very easy to legislate, but you could argue that the Health and Social Care Act 2012 tried to design a clockwork system, and now we are having to wind some of that back. It is sensible to take an incremental approach. Let's see how ICSs and primary care networks work out, and then see what legislation is needed. That is a much more cautious approach.

Q27 **Derek Thomas:** I hear what you are saying, but given that we are catching up, and it has finally been accepted that legislative change is needed, is there any other legislation we should do now, while there is this window of opportunity? Obviously, this kind of restructuring and legislation is resisted, in that people do not want to take it on.

**Professor Checkland:** I would clarify the role of the regional directorates of NHSE/NHSI, and, personally, I would reinvent the strategic health authority function.

**Nigel Edwards:** We have a slightly different legal system from some other countries in Europe where I have worked, but, as a general rule,



## HOUSE OF COMMONS

where we have done better than them is in permissive legislation that allows secondary legislation or decisions by Secretaries of State that are subject to scrutiny but do not require you to come back and change the statute book every time you want to change an aspect of organisational structure. I am not entirely sure that legislation is the best way to do organisational design. Broad powers and principles, and scrutiny for secondary legislation decisions, might be a more flexible way. The Lansley Bill, if I may call it that, definitely felt like a piece of eastern European legislation in its specificity, rather than the more permissive British style of giving powers and a certain amount of latitude for Secretaries of State to act.

**Richard Murray:** It is unusual, or an argument needs to be made, as to why the CQC is not mentioned here, because it is one of the things that comes out from local services. It may be great to have a common view from NHS England and NHS Improvement, but the CQC is then forced to regulate institution by institution and GP practice by GP practice. There are powers that enable the CQC not to do that, but, in the spirit of tidying up and letting the legislation catch up with some of the changes, I think it is slightly odd not to mention it.

At the risk of opening a door I cannot close, a lot of the integration we would want to see is with local authorities, and these proposals are very light on the role of local authorities. That may be because we do not know yet, but there is a risk of going down a path of increasingly close integration in the NHS that leaves local authorities on the outside. I should have said at the start that most of the things we have been speaking about come up when we speak with people at local level in the NHS, but there are quite a few that do not, such as controls on foundation trusts' capital spending and the ability to direct trusts to merge. There are a few additional ones that have come up more from frustrations at the centre.

Q28 **Derek Thomas:** Thank you, Richard. Nigel, you kindly mentioned Cornwall. I am a Cornish MP. You are right; if we cannot get it right, I do not know who else can, because we have the geography—the one clinical commissioning group, the one trust and the one local authority. From what I see, and we meet quite regularly, we understand the role that the local authority can take in integrating health and social care. The Green Paper coming up might help that further, or it may not. You are right. If we do not get that bit right, we will fight the battle of social care and health care for the next 40 years.

**Nigel Edwards:** There is a risk with this set of reforms, as there has been with others, that what looks like the sheep of decentralisation is in fact the wolf of centralisation. A powerful regional tier facing a non-statutory ICS with uncertain powers, with a whole set of direction abilities, and the natural tendency for people in regions—if I may be allowed another first world war analogy—to sit in their chateaux a long way from the front, with maps drawn on the wrong scale, is not





## HOUSE OF COMMONS

necessarily the best way to run a health system. That is something to be watched for.

Q29 **Chair:** Can I clarify something? Professor Checkland, we have heard from you that you would like to have this look more like an SHA-type structure than an NHS south of England-type role. In what way would you specifically like to see the legislation tweaked so that it could deliver that?

**Professor Checkland:** I am not a legal expert, so I do not know what you would need. I have looked at the websites and read as much as I can about the regional directorates of NHS England, and at the moment I do not know what their roles or responsibilities are, or the limits of their powers. I do not know how much they will be able to make their own decisions and how much they will be directed by NHS England. It is very unclear at the moment. You would need to know what those seven directorates were going to do before you could understand what you would need to do.

One of our research projects was to look across areas of what used to be covered by NHS England local area teams before they were all merged. We were looking across a big geographical footprint. People kept saying to us that there was nobody to hold the ring. When you have a very local dispute, where people are disputing what to do or where the money should go, there was nobody to hold the ring and to look strategically across the area. I take the point about ICSs, but they are not huge areas. Something might be happening in one ICS and something else in another, and we need to make sure that we have one overarching thing—the holding-the-ring function.

Q30 **Chair:** SHAs used to have the final power to make changes and decisions.

**Professor Checkland:** They did, and they could hold the ring between competing organisations.

Q31 **Chair:** That is what you would like to make sure that the new structures can do. Would that be fair?

**Professor Checkland:** Yes, but first I would like to know what the new regional directorates of NHS England are going to do, because that is the thing that is not clear at the moment.

Q32 **Chair:** Richard and Nigel, do you agree that that is not clear and that it needs to be?

**Nigel Edwards:** I have a slight anxiety. I take the point about holding the ring, but the question is on whose behalf. The risk is that these organisations hold it on behalf of the centre and the centre's objectives, rather than of the needs of the local population. Other regionally run NHS systems have more political input and legitimacy at local level. Not to use the word pejoratively, these are bureaucrats with a mandate set from





## HOUSE OF COMMONS

above, and that has some risks associated with it. It is not universally a bad thing, but there are some worries.

**Professor Checkland:** That is one of the reasons why I would like to see them having statutory roles because, at the moment, as I understand it, they are outposts of NHS England and outposts of the centre, and that worries me, too.

Q33 **Andrew Selous:** Perhaps you could go a bit further on the local authority point, particularly on the integration of health and social care, which is what we are trying to move forwards. We are of course waiting for the social care Green Paper. At the moment, I am hearing that disputes and co-operation could be arbitrated at a reasonably local level, with the CCG being reasonably local. Where will local authorities be left when we have much bigger geographical structures, particularly the smaller local authorities in larger areas? How is that balance going to work in integrating social care with health?

**Professor Checkland:** I don't think we know. Part of the problem is that we are waiting for the Green Paper and the funding, because the big problem for local authorities is the funding. That is the thing that causes a lot of issues in local systems.

**Nigel Edwards:** There are some practical issues. If you are a very large authority, you may have your footprint across more than one ICS, so it is a matter of how many relationships you can sustain, which I think is an issue. There has been a concern—I do not know whether you are hearing it from the LGA and elsewhere—about the extent to which the agenda has shifted to one that is really about health, and local authorities feeling that they have been to some extent excluded. The ideal would be for these systems, if they are really taking a full population health view, to think about the other policy levers that local government employs. In the Scandinavian example, there are some very good examples of local government working on managing health, in that particular case, with much better results. I agree with Kath that it is very uncertain and variable in different parts of the country.

**Professor Checkland:** It is incredibly variable in different parts of the country. The long-term plan says very little about local authorities and how the NHS will work with them, and that is a shame. Certainly, in some areas it works very well.

Q34 **Andrew Selous:** But this is absolutely critical, isn't it? I do not think that we are talking about a takeover of social care by the NHS, are we? I think you agree that that is not the plan, so unless local authorities are equal partners at the table and fully involved, we will have problems. Would you agree?

**Professor Checkland:** Yes.

**Richard Murray:** You face the risk that the NHS will move forward, leaving out probably not only local government but the voluntary and



## HOUSE OF COMMONS

community sector as well, and become a very inward-looking group. The legislative proposals are slightly odd, because they are a long list, but at the front you do not have a preamble saying what it is all supposed to look like.

What is the role intended for local authorities, particularly in the period when the system is learning and growing? You are getting a lot of variety across the country, and many areas are moving forward, and many of their views are what you hear. But this cannot be the end point, because it would leave you with parts of the country where it has proved much more difficult to get local authorities on board, either because the NHS has not been easy to work with, or, sometimes, because of issues with the local authorities themselves. You will be left with them. This does not make things happen; it allows good things to happen, but it will not stop bad ones happening.

Q35 **Chair:** That is something we can take up with our next panel, who are waiting.

**Professor Checkland:** Health and wellbeing boards are a missed opportunity, because they could do a lot of this, but they are being sidelined by the ICS process to some extent.

**Chair:** Thank you all very much for coming. If you have any further thoughts about what should be in the legislation, please write to us.

### Examination of witnesses

Witnesses: Simon Stevens, Ian Dodge, Ian Dalton and Ben Dyson.

Q36 **Chair:** Welcome to our second panel on NHS legislative changes. I welcome back Simon Stevens and Ian Dalton, both very well known to this Committee. For those who are unfamiliar with you, can you all introduce yourselves and who you represent?

**Ian Dodge:** I am Ian Dodge, national director for strategy and innovation, NHS England.

**Chair:** Thank you. It might help if you were slightly nearer the microphone, because otherwise people find it difficult to hear.

**Simon Stevens:** I am Simon Stevens, from NHS England.

**Ian Dalton:** I am Ian Dalton, from NHS Improvement.

**Ben Dyson:** I am Ben Dyson, from NHS Improvement.

Q37 **Andrew Selous:** Thank you. Don Redding, the director of policy at National Voices, told us that patients “want to feel that their care is co-ordinated, that the professionals and services they meet join up around them, that they are known where they go, that they do not have to explain themselves every single time, and, therefore, that their records are available and visible.” Will that be the experience of patients in the



new environment we are creating?

**Simon Stevens:** As you know, that is the central thrust of the service redesign that the long-term plan sets out. Today, we are particularly talking about possible legislative adjustments. Our point there is that, if they were done right, they could speed us on the way towards bringing about the kind of joined-up services that Don Redding described and that we all want to see. That is the basis on which we have begun this engagement with the NHS to come forward with recommendations to yourselves.

Q38 **Andrew Selous:** How much involvement has there been with local health and care communities in designing the legislation? How have you consulted and talked to people about getting the legislative changes right?

**Simon Stevens:** In shaping the long-term plan, we had a very inclusive process with 200 separate events and 2,500 responses to the engagement, from patient organisations and others, representing 85,000 members of the public, garnering responses on behalf of 3.5 million people. There was a big engagement process in the construction of the long-term plan.

We are now in the engagement phase on the detail of the legislative recommendations contained in the long-term plan. When we have had a chance to take account of the comments, recommendations and feedback from patients groups and others, we will produce a final set of recommendations for you. You have seen the engagement document that we put out, with more detail than was in the long-term plan. We are now in that phase of wide discussion. The new NHS Assembly that has been created and has its first meeting in the last week of this month, on 25 April, will also have the chance to debate these questions, with a wide cross-section of frontline staff, patients groups and clinical leaders.

Q39 **Andrew Selous:** These plans will work only if we successfully integrate health and social care, and perhaps have some risk and budget-sharing across the board to achieve that. At the moment, health and wellbeing boards are the place where local authorities and local health communities meet to discuss and mediate these issues, but we have just heard from the panellists in the previous session that there is a worry that health and wellbeing boards will be superseded in the new, larger geographic areas.

Who will hold the ring and mediate when there are disputes between local authorities and health authorities in this world? How are we going to get that integration, which is absolutely critical? I do not think you are proposing to take over and run social care, so how are we going to get integration working really well?

**Simon Stevens:** Some of this is obviously using the flexibilities that the local NHS and local authorities already have. As we have discussed before, in some cases that means pooled budgets. The better care fund is one such mechanism, and, despite the well-documented flaws in the BCF,



## HOUSE OF COMMONS

which others have spoken about, the fact is that, across the NHS as a whole, local CCGs are choosing to pool with their local authorities on a voluntary basis more than the nationally minimum specified amount. Budget pooling is happening, but it needs to be a partnership of equals, where the local NHS and the local authority can look at the whites of each other's eyes and come together on a voluntary basis to get that done.

We are proposing nothing that directly affects the statutory architecture for social care. We recognise that that is a matter for the Government, and the long-awaited and much-speculated-on social care Green Paper will, presumably, lay out proposals on that side of the equation.

**Q40 Andrew Selous:** What is the future for clinical commissioning groups in this new world? We have them coming together in wider geographic areas, but how do you see their function going forward? Will they be increasingly merged with NHS England?

**Simon Stevens:** No. What we are suggesting is that CCGs would be coterminous with the areas covered by the integrated care systems and the integrated provision. Maybe I can take a step back. There is, essentially, a big design choice that Parliament will face if it chooses to legislate on the NHS basis. One option would be to start with a completely blank sheet of paper and have a redo of the totality of 30 years of legislation. That would almost certainly mean legislation that was more expansive, thicker and harder to transact through Parliament than the 2012 legislation I have here, with the 2006 amendments. That is the double phone directory option.

The alternative proposition, which is the one we are recommending, at least as the next potential step, is a more targeted and precise set of changes to deal with some of the current frictional consequences of the way the legislation works, seen through the lens of advancing integrated services and implementing the long-term plan. We have not been asked by the Committee, given your excellent work last summer, or by the Government, to propose a total package of legislation about everything that might possibly change about anything to do with the health sector. That is not what this is; it is a targeted set—precision surgery to deal with some of the issues that we think will make the biggest difference. The consequence is that we build on the accountability architecture that sits for trusts and CCGs, but we enable greater joint working and deal with some of the regulatory barriers that we think stand in the way of that.

**Q41 Andrew Selous:** We will come to accountability later. Finally from me, leading on to the legislation, what are the main barriers to the integration that we are all looking to see, which you have identified that legislation needs to deal with, and move out of the way?

**Simon Stevens:** It is a combination of the ability of local care provision to join up primary care, community health services and acute services. Some of the changes that we have previously discussed around



## HOUSE OF COMMONS

integrated contracts to enable GPs to join on the provider side gave rise to a question about whether we could ensure that there was a public entity, a public statutory body, that could hold those contracts. We propose that there would be such an option, to take away the concerns that that type of integration would lead to privatisation, which is not what we are advocating at all. This would deal with that concern. We have integrated care provision through a publicly accountable NHS body.

Secondly, we have the ability for different parts of the health service locally to work together more closely, including CCGs and NHS bodies.

Thirdly, we have the ability, from the patients' point of view, to overcome some of the fragmentation that currently exists between some of the services that NHS England nationally, by law, is required to commission, versus those commissioned locally. To give a practical example, if a woman is having a baby, some of the maternity services that she would get on the NHS are the responsibility of the local CCG to fund and commission, and some of them are part of our NHS England so-called section 7A public health responsibilities. That is not changing the boundary with what the local authority does; it is joining up the care pathways, from the patients' point of view.

Then there is a series of changes around some of the transactional costs and fragmentation of the system linked to procurement, competition and the national regulatory superstructure, which we also recommend should be looked at.

**Ian Dalton:** In addition, it makes it easier for providers of healthcare to work together, particularly in relation to providers coming together formally through merger.

Q42 **Andrew Selous:** On the provider point, could you give us some reassurance on the issue of specialist hospitals and tertiary referral centres? From the previous panel, there was just a little bit of worry and concern about the money that NHS England gets centrally to run, for instance, the Royal National Orthopaedic Hospital at Stanmore and other specialist hospitals around the country. Where will that end up? Is there any danger that patients will not be able to be referred to a tertiary treatment centre or specialist hospital when they need it, outside their area?

**Simon Stevens:** None whatever. There are two reasons why that is not the case. The first is that we are, under our recommendations, still going to have national specialised commissioning responsibilities and budgets, and the second is that we are explicitly proposing not only to protect but to enhance patient choice where that is an option for patients. The case of orthopaedic surgery would be a very good example of where patients would want to see that choice intact, which can absolutely be secured through the legislation while, nevertheless, dealing with some of the problems that we think arise under the current procurement rules.



**Andrew Selous:** Excellent.

Q43 **Chair:** Is that specialist commissioning going to remain unaltered, or are there some aspects of it that may go to a more local level?

**Simon Stevens:** We are not proposing that there should be some across-the-board shift in who does specialist commissioning. We are proposing that there should be flexibility for a particular service to join up the specialist and the local commissioning. To give one example, we have seen in the case of neurology services a rather complicated interaction between what is commissioned by CCGs and what is national specialist commissioning. At the moment, the only choice available to us is to make a shift, lock, stock and barrel, one way or the other, with every CCG having to do one thing, or no CCG doing it, on the recommendation of the national advisory group that the Secretary of State then has to determine.

We think there would be an advantage in some more flexibility there, of the sort that we have been able to engineer as a workaround to some extent on mental health services, say, where we have given local mental health providers the ability to work with their patients and clinicians to provide services more locally, using some of the money that would otherwise have flown for patients going hundreds of miles away to tertiary services, and to reinvest that locally. That is the kind of targeted flexibility that we think it would be advisable to allow.

**Andrew Selous:** That makes sense.

Q44 **Rosie Cooper:** Prisons?

**Simon Stevens:** The question being whether we are proposing a change in the direct commissioning responsibilities for prison health? I do not think that is integral, but it is something we could look at. Obviously, we have discussed on a number of occasions the situation not just in Liverpool prison but more widely, and we think there is a circle to be squared between the local flexibility you need to respond to the particular circumstances of a prison and the aftercare of offenders when they leave, versus the need to drive proper standards throughout the prison estate, which is what our national team, with Kate Davies, has been doing, as you know.

Q45 **Dr Williams:** I welcome the published proposals, and equally welcome the 10-year plan. You talked a lot about engagement in the 10-year plan, but, when I talk to people about the published proposals, there is very little knowledge or understanding about them in Parliament, the health profession or the wider general public; I appreciate that there is quite a lot of competition for space at the moment. Andrew asked you this, but what are you doing to engage more widely with the public?

**Simon Stevens:** The answer is a lot, but maybe Ian as the person leading this work will want to respond.





## HOUSE OF COMMONS

**Ian Dodge:** We have a number of events with different national organisations. I was at a roundtable yesterday convened by the RCN, with all the royal colleges, and I had a session last week with local government. We have a long list of different national organisations; we also have some public events taking place.

We have had a large number of responses already to our engagement process, and there are additional national organisations trying to get not just staff engagement—the unions have been very closely involved—but wider public engagement. For example, 38 Degrees, the campaign group, developed their own questionnaire, which they launched last week, and I understand that within 48 hours they already had 53,000 responses to the questions. I think we will get a very rich, wide and high volume number of responses by the 25 April deadline.

**Dr Williams:** You could have a revoke section 75 petition.

Q46 **Chair:** Can I pick up on something that Nigel Edwards from the Nuffield Trust suggested in the last session? He thought it would be best to have broad powers to introduce further changes via secondary legislation rather than having to keep coming back for primary legislation. Would you like to comment on that?

**Simon Stevens:** There is merit in what Nigel is saying, but, ultimately, of course, this will be a choice for Government and Parliament. We think that probably the desirable flexibility in the national working of the NHS has been somewhat hamstrung by the very prescriptive description of the division of labour between different national bodies, so some flexibility will be helpful. That is probably a better way of doing it than trying to answer on the face of the Bill every final detail.

Q47 **Chair:** Because otherwise we are going to have to keep coming back and talking about this again later, it would be helpful to have your specific thoughts on the legislation.

**Simon Stevens:** We have a particular set of recommendations in our engagement document around how that might work, particularly relative to the national bodies, although, to be clear, there are aspects that we are certainly not suggesting should be changed through those flexible powers. We are not proposing any change in the division of labour between NHS England and NHS Improvement versus the Care Quality Commission, for example. We are not proposing that that would change.

Q48 **Chair:** Yes, but there were some very specific recommendations. I think he was referring to further down the structures, and to making tweaks in future, and whether you needed greater flexibility to make changes in future, but we can return to that.

Can I come to the issue of patient choice and competition? We were wondering how patient choice, which includes the right to choose a private provider, if necessary, will work if these legislative changes are made. One of the concerns would be that we did not want to move to the



## HOUSE OF COMMONS

completely airless room of having a single, monolithic choice for patients. Could you talk us through how that is going to work?

**Simon Stevens:** Absolutely, Chair, we certainly do not want to be in airless rooms. As I said a moment ago, we are completely clear that the rights to patient choice need to be maintained and, potentially, extended. Existing legal rights to patient choice are not primarily set out in section 75 of the 2012 Act—the section 75 piece that we would recommend revoking. Instead, they are set out in separate standing rules and regulations from 2012 as well as section 13 of the National Health Service Act 2006. Our recommendation would be that those standing rules must contain provisions for commissioners to require patient choice, and there may be other elements of the new package that could further indicate that.

Q49 **Chair:** The concern was more that, if you have an ICS that is both the commissioner and the provider, the tendency will be for them to want to direct everybody to within their own organisation. Could that end up making it more difficult, ultimately, for people to move outside that organisation? We accept that, for most patients, the priority is to have a very good local provider. Will it make it much more difficult for people who want to travel outside that system to be able to do so?

**Simon Stevens:** No, there is no intrinsic reason why that should be the case at all, and there are a couple of safeguards on that. One, obviously, would be having in statute the right of patient choice; the second would be the recognition that, in the real world, the joined-up services that people are talking about mostly relate particularly to ongoing care for long-term conditions, rather than to a one-off elective procedure.

Thirdly, we are recommending that, whatever is done around the move towards population-based payments for integrated care systems, we would still retain a mechanism whereby, if a patient chose to be looked after somewhere else, the money would follow the patient, to coin a phrase, and we would use the version of the national tariff to take out the frictional barrier to that occurring.

Q50 **Chair:** How would that be enforced? Even within the current system, as MPS we have all come across people who have been told that they cannot travel elsewhere to have treatment, even if that is their definite preference.

**Simon Stevens:** The question of how it is enforced and how people see that opportunity is obviously a live one, but it is not a question that this statutory change per se makes either more intense or not.

Q51 **Chair:** You do not think that will change it at all.

**Simon Stevens:** In fact, across the NHS, as well as the existing choices that people have at point of referral, during the course of the coming year we are going to remind people, if they have been waiting for six



## HOUSE OF COMMONS

months, which is the minority of people getting planned care, that at that point too they have other choices, should they wish to exercise them.

**Ian Dodge:** I do not think it is primarily just a question of legal rights; it will be about the operational arrangements for things such as choice at six months. There was a previous policy some years ago of offering choice to patients who were also waiting for a number of years, which I do not think was terribly successful, partly because of the way it was operationalised and how patients were actually contacted. We are very mindful of that, and, irrespective of any wider changes around creating ICSs and all the legislation, the actual experience of people being offered choice will be more about whether we can identify the patients and make sure that they get direct communication, rather than relying on the provider with whom they are currently waiting.

**Chair:** We will come on to a different aspect.

Q52 **Derek Thomas:** Where does procurement fit into this, and getting best value? Is there an understanding of how procurement will go forward? I am from Cornwall, so we have seen all sorts of changes where things go outside and back into the NHS, along with various ways of navigating away from the private sector. It would be interesting to see how you see that being formalised and moved forward.

**Simon Stevens:** We think that commissioners should be able to exercise discretion over when to run a formal procurement process but that there need to be safeguards to ensure that taxpayers' interests, as well as patients' interests, are safeguarded. One potential mechanism for doing that is through a statutory best value test, but there may be other ways of doing it as well. That is one of the elements we are in detailed discussion about as part of the engagement exercise.

What we have seen through experience, however, is that, with the way the rules are currently structured, we often end up having to run quite administratively expensive procurements for very small services that are a fragment or sliver of the patient pathway. In fact, I shamelessly quoted an example from Dr Williams's constituency for extended access GP hours for whatever it was—an hour and a half a week—as a case in point.

**Dr Williams:** No, a day.

**Simon Stevens:** The gentleman sitting next to you can give you that instance.

At the other end of the telescope, as it were, for things like big swathes of our specialised commissioning we are required to run an OJEU process. For example, in August last year, we had to put an OJEU out for £29 billion-worth of specialised services across the English NHS, with an annual value of £7.25 billion. As it happens, all the bids we received were from incumbent—current—providers. Nevertheless, we had to incur the expense of so doing. Be it 90 minutes of GP time in Dr Williams's



## HOUSE OF COMMONS

constituency or £29 billion of heart transplant services and other specialist care, we think that injecting some discretion into the service as to when to do that, not reverting to a closed shop, would be the right answer.

**Q53 Derek Thomas:** That sounds helpful, and I think we would welcome that in Cornwall, with our experience. Do you see disadvantages moving forward? Will it take away opportunities to make things more efficient, for example?

**Simon Stevens:** That is why I say that we must ensure that there is a set of objective tests that commissioners are required to apply, be it a best value-type test or something else. There will be circumstances where that will be the right thing to do, but it is right that the NHS should be able to determine when those circumstances are.

**Ian Dalton:** What we are not saying is that this is an end to any use of procurement. What we are saying is that the experience of procurement, particularly in community services, has become almost an expected part of the way business is done. Any contract currently over £615,278 is, by and large, tendered; that is clearly a lot of contracts. You will find that there is often in the community sector a continual change of contracts, with staff ending up wearing different badges every couple of years. It is right to have a look at that, as we look to integrate community services with other bits of the health service, and bring people together for the long term. We need to do that.

The safeguard I would highlight is where procurement is decided on as the appropriate way forward—there will still be examples of that—when obviously the standing rules will require it to be undertaken in a fair and appropriate way that is blind to the organisations bidding. We want to inject a degree of common sense and an opportunity for people to form a view on best value, and for providers to be able to work with commissioners to plan services together, rather than having to do it separately and then have to compete in a contractual approach.

**Q54 Derek Thomas:** To go back to the Cornwall example again, we have had two fairly high-profile examples where companies or organisations have under-priced to secure services and have had to hand back contracts because they could not deliver. Would this effectively rule out that problem?

**Ian Dalton:** What it will offer is that, from the point at which a commissioner and a group of providers decide the model of care they want in order to deliver the long-term plan, they can plan it together, rather than its having to be planned by commissioners and then put to the market for a competitive process, as is the norm now, almost without discretion. That not only potentially reduces transaction costs and provides more stability for people to work together across the medium term, but enables people, without fear of challenge, to define how they should work together for the interests of patients. We feel that best value



## HOUSE OF COMMONS

test is important, but there are safeguards; we are not looking to create monopolies.

Q55 **Chair:** Are you going to put in more detail about the best value test?

**Ian Dalton:** We are currently engaging on that. They are inevitably proposals that NHS England and NHS Improvement jointly put together; they are a response to problems that we have seen in the NHS, of which this is one. It is fair to say that, as we work through the engagement, we will have to be much more explicit on that.

Q56 **Chair:** One of the criticisms was that people could not see much to judge what the best value test would be. But that is something that we will see more detail on.

**Ian Dalton:** We have set out in the engagement document some of the core principles, which need fleshing out after the engagement.

Q57 **Dr Williams:** There will be joint committees between providers and commissioners. If a commissioner wants to put a service out to tender, and they judge that it is in patients' interests to go through a procurement, will commissioners be able to make that decision by themselves, or will it be the joint committee? Of course, the providers may well be on the joint committee, which may make it difficult; there may be a real conflict. How would that work?

**Simon Stevens:** That is a great question, and the answer is that the commissioners will have to decide that, and will need to decide it independent of any conflict of interest on behalf of incumbent providers. We are completely clear about that.

One of the lessons from previous best value regimes is that you can aid the objectivity of decision making by being clear prospectively as to the sorts of measures that would lead you to believe that a procurement process might generate improvement, compared with the status quo, if you see what I mean. It does not have to be entirely a local judgment; there can be a degree of objectivity about how well a service is performing. However, the changes that we are looking to introduce and implement are to guide the hand of the commissioning decision.

Q58 **Dr Whitford:** Can you confirm that section 75, which created that compulsion to tender, is going? Therefore, what we saw in Surrey, where the CCGs wanted to bring services in the next contract back in-house, would not apply. They would not be able to be sued by A N Other private provider for not putting it out to tender. Section 75 would be revoked or repealed, or whatever.

**Simon Stevens:** We are proposing to remove section 75. There are various consequential elements of other parts of the procurement law that we operate under that also have to be factored in. But to answer your specific question, yes, we think section 75 would go.

**Dr Whitford:** That's great.



## HOUSE OF COMMONS

**Q59 Rosie Cooper:** It goes without saying that what patients and the system need is greater accountability and stronger local leadership, but, when you look at intended or unintended consequences, choice and competition were introduced to drive efficiency. I know of some organisations where therapists see two or three patients a day and think that is hard work. If competition is to be reduced, how will you measure or drive efficiency in future?

**Simon Stevens:** Our touchstone is going to be implementation of the service improvements for patients in the long-term plan. That decomposes into a series of improvements that we want to see; we want to see joined-up care, particularly for older people, and we want improvements in cancer, mental health, cardiovascular services and so forth. Ultimately, it has to be judged through the lens of patient experience. The measures that we set out in the long-term plan are how we will, ultimately, answer the question you have described.

The mechanisms that have been in place in the NHS in recent times were designed to answer a set of challenges facing the NHS in the early 2000s. In particular, those challenges were how you convert significant extra investment by taxpayers into a lot more routine operations to cut long waits for planned care from more than 18 months to, for most people, way less than 18 weeks. The mix of reimbursement, independent sector capacity and so forth, along with competition, helped to achieve those goals.

The issues facing the NHS now are not solely, or principally, those; they are about how we move to a more integrated service, particularly for people with multiple health problems, and, for that challenge, the previous mechanisms are not well suited. I see no reason to think that the efficiencies we want to continue to get from the NHS cannot be achieved through a new set of mechanisms.

Of course, as you know, it is worth remembering that, for the last year, ending 2017, the Office for National Statistics, which produces productivity data for the NHS, showed that NHS productivity has been going up by 3%, three times faster than the rest of the economy. The NHS has a very impressive track record on productivity improvement. Very little of that 3% was driven by competition at the margin for where to go and get your routine surgery.

**Q60 Rosie Cooper:** Simon, you know that, when I sit and listen to you, you nearly always take me with you, with your vision and the way you set it out. But I have to say—

**Simon Stevens:** I knew there was a but, Chair; there always is with Rosie. That is the terrible problem.

**Q61 Rosie Cooper:** Absolutely. I really have to worry because accountability is so fragmented already. You mentioned Liverpool, and I am always going to mention Liverpool. In LCH, all the KPIs were financial and the





## HOUSE OF COMMONS

quality was not there. Because quality disappeared, it was not measured and it was almost a race to the bottom, and we arrived at the bottom.

There is a suggestion that there could be a local variation in tariff. How do you measure it, control it and stop the race to the bottom, if quality is not the first thing you look at? I look at the treatment Virgin Care is delivering, for example, in West Lancashire. They would say that they are meeting the specifications, but they do that by making it impossible to make appointments and/or by striking off good extra care that people used to provide, which now is just lost. It is about quality.

**Simon Stevens:** Exactly. The first thing to say is that community health services have for the most part not been reimbursed on a tariff basis; they have been reimbursed on often fairly opaque block contracts that may have been subject to the type of procurements that you described. That has been in the context of a squeeze on community health services spending. One important commitment in the LTP—in fact unique in the 71-year history of the national health service—is that primary medical care and community health service spending will grow faster than the overall NHS budget. We have never had that kind of commitment to community health services. The resourcing will grow at a faster rate.

Our take is that viewing community health services, vital as they are, as detached from what is happening in general practice on the one hand and from what is happening to acute and hospital services on the other, and then just trying to run procurements for the community health services sliver, is to completely miss the point. From the perspective of the community nurse working alongside the GP practices in their new primary care network, or of the specialist community health services linked with the musculoskeletal care that the orthopaedic department at the local hospital will provide, we need far more integration between both community health and primary care and community health and specialist care. Doing carve-outs of the sort you describe is precisely what we will be getting away from as we implement the long-term plan.

Q62 **Rosie Cooper:** You are sure that price competition can be and will be prevented.

**Simon Stevens:** In community health services, because it has been hard to measure what has been going on in the services, when there have been procurements it has been hard to specify quality-related outcomes. That has given rise to some of the issues you talk about.

Q63 **Rosie Cooper:** What about generally?

**Simon Stevens:** Generally, obviously, we are trying to move away from a system where part of the health service pays for activity on a tariff-based system. We are trying to move away from paying for each click of the turnstile and, instead, to pay for quality—often a pathway or a journey, a joined-up service that a person will get, linked to measurable quality, seen from the eyes of the patients themselves, as well as some of the objective measures.



**Ian Dalton:** Rosie, you raised the important question of accountability, and I am sure we will return to that discussion. One of the things that flows through this is that the accountabilities of someone running a provider, providing community services, are unaffected by any of these changes. This is not a top-down reorganisation of the NHS; this is saying that, just as with CCGs, provider responsibilities to offer high-quality care within available resources remain absolutely the responsibility of the chief executive and the board. Those responsibilities continue.

It is fair to say that, in community services, tendering has become the norm, often on a cyclical and fairly regular basis. I note from Lord Carter's report into community and mental health services that he identified that one community trust had, I think, 6,000 different KPIs from its various purchasers, and was trying to manage all of them at the same time. We have got into a situation where potential fragmentation through continued re-tendering is something that, in the world of integrated care we are setting out in the long-term plan, we need to revisit.

**Rosie Cooper:** Good.

Q64 **Dr Whitford:** Obviously there is concern, if competition is reduced, about what will drive efficiency. We have often heard the former Secretary of State and the current Secretary of State say that, if services and the care delivered are of better quality, they tend to be inherently more efficient. Would it not make sense to have more QPIs—quality performance indicators—that are actually used by the frontline, in essence, to peer review the pathway that you are trying to create and the service they deliver? That is what it is all about.

**Ian Dalton:** There is no question but that two things are simultaneously true and underpin our aspirations for the long-term plan. One is that quality of care needs to continue to improve and the second is that the efficiency with which that care is provided needs to continue to improve. In the evidence from some of the professionally led work that we are doing on getting it right first time, we continue to identify the importance of driving the simultaneous improvement of quality and efficiency by exactly that—getting it right first time.

Clinical variation exists across every western healthcare system, but we still have significant opportunities for improvement. Regardless of the structural and legislative changes that we have been asked to comment on, we make it very clear in the long-term plan that providers working with fellow providers and commissioners absolutely need to keep driving the quality and efficiency agenda. Whether it is the reduction in inappropriate outpatient services that are inconvenient to patients and take up resources, and can be provided in a different way, or whether it is addressing the length of stay variations that we know are not always in the interests of patients, there are many opportunities; variations in community services have been identified. We have a lot to go at, and it



## HOUSE OF COMMONS

fits very much with the proposals that we are putting here that both quality and efficiency continue to be drivers to deliver the LTP.

- Q65 **Dr Whitford:** I totally welcome getting it right first time. There has been a long period of years with almost no clinical audit, or quality outcome audit, which is why the patient is there in the first place. Would you see a need to expand the clinical outcome side? It does not matter that they only stayed a couple of days if the operation did not work at all.

**Ben Dyson:** One of the things that has struck me about the getting it right first time programme over the last year is that, although it began by looking at particular surgical specialties, and deliberately started with that focus, increasingly it started to move beyond that. One of the things it started to do was to look at the quality of care for people with long-term health conditions, not just from the perspective of what goes on in the acute hospital but what happens in community services, and even going further back into understanding how far you could put resources into preventing some of those conditions from arising in the first place.

That, for me, goes to the heart of the changes we are trying to reinforce and support through these legislative proposals; it helps everybody with a stake in health and care for a local community to come together and take a single collective look at how they are using their resources, right from how you use those resources to prevent long-term health conditions arising in the first place to how you treat them better once they arise. I agree that quality indicators that cross traditional sectoral boundaries will be at the heart of that.

- Q66 **Dr Whitford:** That can create the clinical competition that the frontline, which is actually looking after the patients, is using, rather than the managers behind them. Will there be a strong peer review system using whatever quality data you are collecting?

**Ben Dyson:** One of the principles, as you probably know, at the heart of the getting it right first time programme, is that it is based on clinical leaders leading change, getting doctors, nurses, allied health professionals and others to understand better both the quality and the efficiency of the services they are providing. That is all clinically led. Increasingly, that process is looking across traditional sectoral boundaries, not just going into a particular ward or operating unit, but bringing together, say, everybody who is interested in respiratory services.

- Q67 **Dr Whitford:** And will there be enough funding and audit support going in to maintain that, as opposed to clinicians keeping a ledger themselves?

**Ian Dodge:** Primary care is a good example. If you take the long-term planning goal around upping cancer survival rates through getting to 75% stage 1, stage 2 diagnosis, it would be through a mixture of actions, including by the new primary care networks you touched on briefly in the last session. In the new five-year GP contract deal that NHS England has done with the BMA, we have included the fact that there will be a service



## HOUSE OF COMMONS

specification, and there will be a focus on how an average 50,000 population primary care network will see between 270 and 280 new cancers a year.

How do they up the number that are seen at stage 1 and stage 2? It would be through a mixture of things, including engaging with their local community, as well as an auditing review of their own clinical practice and the consistency of that across the constituent practices. NHS England is working with the BMA as part of the reform of the QOF—the quality outcomes framework. We are developing new quality improvement modules, and one of those modules will specifically focus on how we can help provide benchmarking data, insight and peer support across and within primary care networks to help primary care get better at identification in relation to cancer.

**Q68 Andrew Selous:** Can you say a little bit more about getting it right first time as far as general practice is concerned? We have had the pilot and we now have the roll-out. How will GIRFT help spread best practice, and specifically what will it do to help GP practices that are struggling at the moment? There are exemplar GP practices like Larwood House in Worksop or Thistlemoor in Peterborough, which are outstanding, but under the same contract and the same budgets, other GP practices are struggling. This is a massive issue for our constituents, so we need some urgency and focus on spreading best practice. Is there going to be a real roll-out, with some help for the GP practices that need it?

**Ian Dodge:** It is a combination of how the GIRFT team expands its work and then connects. This is part of the join-up of NHSE and NHSI with the work we are doing with the BMA as part of the reform of the GP contract. If you take the Cambridgeshire and Peterborough STP—I was at Thistlemoor a couple of weeks ago—they are looking at forming possibly 20 to 25 networks from 94 GP practices going down to 92. There is massive energy, and I was struck when talking to the CCG leader and the LMC leader at their last meeting that they had 220 GPs engaging on how they can get involved in networks and the additional support that is going to be coming directly through the contract and as part of the new national support programme for primary care networks, which is directly addressing the challenge that you pose.

**Q69 Andrew Selous:** I am not hearing quite enough specifically on how struggling GP practices are going to be helped quickly. The need is urgent in some parts of the country. How is a struggling GP practice going to be helped in fairly short order as a result of the GIRFT GP roll-out?

**Ian Dodge:** Specifically, we have NHS England programmes around struggling practices.

**Q70 Andrew Selous:** You have the GP retention scheme and the GP resilience scheme. In my experience, there is not great take-up or even interest from some practices that are struggling.



## HOUSE OF COMMONS

**Ian Dodge:** As part of the wider network development, we have additional funding coming in as part of the deal this year for 2019-20, including for additional staff. We have a big expansion of the clinical pharmacists scheme; there is to be additional funding for an extra pharmacist per primary care network, an additional social prescriber. There are a number of ways we are trying directly to help and support some of the capacity gaps. That is based on what we think is achievable in 2019-20 as part of a longer-term trajectory.

Q71 **Chair:** I am conscious that we are getting away from what we were going to focus on today. Could you write to us?

**Ian Dalton:** I was going to suggest exactly that. GIRFT started in the surgical specialties; it is rolling through medicine; it is engaging with mental health; it is starting to talk about community and it is in the early stages of primary care. It is an intensely powerful improvement methodology, which has quality absolutely at its heart. On behalf of NHS Improvement, outside the Committee, maybe I could drop you a line explaining what our thinking is on how we get from here to where we need to get to.

**Chair:** Thank you Ian, we appreciate that. Can we now look at integrated care systems?

Q72 **Dr Whitford:** The Committee's report recommended piloting and evaluation before those systems were rolled out. Can I start with you, Ian? What evaluation is being carried out of the ones that are already growing or is planned for those that are going to emerge?

**Ian Dalton:** Evaluation of?

Q73 **Dr Whitford:** Evaluation of ICSs and ICPs. There is another huge change before you do another huge change as happened in 2012. How will you work out that it works before it goes right across England?

**Simon Stevens:** While Ian is gathering his thoughts, we are not proposing a change like 2012. That is the point; 2012 was focusing a lot on the administrative superstructure of the national health service. What we are proposing is changing the way care is delivered for patients. This is not about that. This is about what is happening to patients in primary care community health services, and that is the test, therefore, of whether the integrated care systems are delivering.

How are we evaluating that? We are evaluating it by the work that has begun with the first ICSs across the country, learning from their experience. A second group will be joining them looking at how their data and improvement trajectories compare with the rest of the NHS and building in their advice to us in the recommendations we are making to you on legislative change.

Q74 **Dr Whitford:** With respect, ICSs are structures; they may not be as high up as what changed in 2012, but they are organisational structures.



**Simon Stevens:** They are not new statutory entities.

Q75 **Dr Whitford:** We are going to come to that.

**Simon Stevens:** That will obviously be for you to decide. If you take a parsimonious approach, the statutory entities will be trusts and CCGs, whereas, as you recall, the transition under the 2012 Act was to blow up all the primary care trusts, replace them with CCGs, change the Government's model, alter the national architecture and create a load of new national bodies. That is not what we are suggesting.

Q76 **Dr Whitford:** Not national bodies, but do we not need to have ICSs that are statutory? We heard in the first panel about the difficulty of its being a very informal co-operative thing that will be brilliant when the sun is shining, but the moment the money runs out or the rain is coming down, who faces the hit? All of that co-operation could disappear. Do they not need a statutory structure?

**Simon Stevens:** We do not think they need to, but that will be a judgment when you look at the scope of legislation and the extent to which you do or do not want to throw all the cards up in the air of the local NHS in England. That will be the judgment call.

**Ian Dodge:** Bearing in mind Simon's earlier comment about ICSs typically being coterminous with CCGs, one of the challenges around the idea of ICSs having a statutory basis is how on earth it fits with CCGs. What we do not want to do is to create two parallel statutory structures with a large degree of overlap between their functions, and the additional costs associated with that, which is one of the reasons why we have not proposed ICSs as statutory thus far.

The other point I would make is a point that Richard Murray made in the earlier session. As part of our laser-like focus on specific problems, this set of proposals is very much about enabling, creating new specific flexibilities in particular areas. Where you have an ICS where the FTs have wanted to form a decision-making committee with the CCG, they cannot, because the current FT legislation bars them from doing it, even with another FT. We have remarkably more flexibility for the NHS to join forces with local government through things like the section 75 pooled budget arrangements. In many regards, there is more flexibility legislatively there between the NHS and local government, and we are simply trying to create that additional flexibility within the NHS.

**Simon Stevens:** To clarify, that is section 75 of the 2006 Act, not the 2012 Act. The section 75s sometimes get conflated.

Q77 **Dr Whitford:** The power within their geography—whatever size their geography is—will be significant. We come back to Rosie's point about the issue of accountability. If they are not statutory, if we cannot FOI them, if we cannot see where money was spent and if we cannot say, "This body made this decision," is there not a danger that, when things do not go so well, everyone is going to blame everybody else?





## HOUSE OF COMMONS

**Ian Dalton:** As Simon said, there is a choice. We could have proposed a major top-down reorganisation of the entire national health service.

Q78 **Dr Whitford:** I am only talking about ICSs.

**Simon Stevens:** But it would be zapping all the CCGs as a consequence.

**Ian Dalton:** If we had looked at creating a new single statutory entity called an integrated care system, taking away the responsibilities and accountabilities that sit with provider chief executives and their boards to offer quality to their patients, and taking away the legal responsibility that Parliament has put in the hands of CCGs to spend public money to best effect, that would be a major programme of legislative change. History tells us that often takes years to bed down.

Our view is that the service—I think I speak for all of us—has not been knocking at our door saying, “We want a major top-down national reorganisation of the entire national health service.” What the system has been saying to us is that they want the opportunity to come together, to take collective responsibility as statutory entities coming together to look after the needs of patients that now stretch beyond the boundaries of individual organisations, while retaining the benefits, and there are real benefits from this, of, for instance, provider chief executives and their boards being absolutely accountable and responsible for the quality of care that the patients being served by that organisation receive. Speaking as an ex-hospital chief executive, I think that responsibility is very important.

There are choices, but allowing people to come together as accountable organisations, working together for the benefit of patients but avoiding a major top-down process of reform, with all the concomitant costs, disruption and uncertainty that would potentially get in the way of the long-term plan’s implementation, would be our judgment as to the balance.

Q79 **Dr Whitford:** You talked earlier of the need, in essence, for pathways.

**Ian Dalton:** Very much so.

Q80 **Dr Whitford:** Simon talked about a community care, primary care hospital. The ICS is trying to bring all those together, but there is not going to be a responsible board that is publishing its minutes, or that members of the public can attend to see what the decisions for their county are, and therefore what is going to be available. If it is good for a trust, is it not also good to have exactly those measures available in an ICS?

**Simon Stevens:** To clarify your point about transparency and accountability, the proceedings of the ICS as a committee comprising other statutory bodies would have their own FOI and transparency arrangements. The ICS would have those as well.



## HOUSE OF COMMONS

Q81 **Dr Whitford:** You do not particularly support them being a statutory body. We wondered why we are not waiting for legislation. There is nothing that excludes a private company from the contract.

**Simon Stevens:** There is, because the parties to the ICS are themselves covered by FOI—

**Chair:** Order. We have to suspend the sitting.

*The Committee suspended for a Division in the House.*

*On resuming.*

**Dr Whitford:** To go back to ICPs and building ICSs, the ICP contract is being made available before the legislation is there. Do you think that is a good idea? We have been told by the Secretary of State that no outside private providers will take them over, but they are not excluded from the contract, so would it not have been more reassuring to those in the public who are concerned about this to have got the legislation through before putting the contracts out?

**Chair:** It might be helpful for those following from outside if you would briefly explain the difference between an ICS and an ICP.

**Dr Whitford:** You might be better at that, Chair, than me, seeing as I am a visitor from far-flung corners.

**Chair:** No. I am inviting our panel because there are an awful lot of acronyms.

**Dr Whitford:** Spaghetti soup, yes.

Q82 **Chair:** It would be helpful if you could briefly clarify the difference between ICP and ICS.

**Simon Stevens:** When the national health service was set up in 1948, it—

**Chair:** Gosh, we're going right back.

**Dr Whitford:** So you don't want any dinner.

Q83 **Simon Stevens:** It hardwired the difference between hospital and community health services on the one hand, and GP services on the other. GPs were independent contractors, based on what had happened in 1911 when the panel doctors were established following the 1909 royal commission minority report. From that day forward, from 1948 until quite recently, the way general practice has been funded and operated has been organisationally, contractually and legally different from community health services and hospital services. In many ways, that has been an enormous strength, and general practice has been one of the foundational assets of the NHS, but increasingly people can see the benefit of GPs working alongside community health services and potentially in hospitals as well. An integrated care provider is an NHS body, publicly accountable, of which GPs can voluntarily choose to



## HOUSE OF COMMONS

become a part, so that primary care services are properly connected with community health services, and potentially hospital services as well. That is what an integrated care provider is. In order for the money to flow to fund that integrated care provider, we need an integrated care contract. That is what docks on to the integrated care provider.

We do not have integrated care providers right now because the hands of the Secretary of State and of Monitor are tied in terms of creating new public organisations to do that. We are recommending that it should be possible to create those new public bodies. In the meantime, without in any way commenting on the speed at which Parliament is currently transacting business, it may be that there will be a wait before any recommended new legislation could come into effect. That is why, with the consent of GPs and NHS bodies, we are bringing forward the ability to test this model, and, as you know, the first place likely to test it is Dudley, which will be a public NHS trust doing it with GPs with the new contract. In order to put to one side the concerns that it might subsequently, in other places, end up being privately held, we think we should create the integrated provider option.

Q84 **Dr Whitford:** And they would be statutory.

**Simon Stevens:** A public body, like an NHS trust.

Q85 **Dr Whitford:** But the integrated systems, for a whole area—

**Simon Stevens:** It is a collective noun for the public NHS bodies and CCGs in an area, working together on behalf of the population.

Q84 **Dr Whitford:** But you do not feel that they need to be answerable to the population in the way, say, our health boards are, where they have public meetings and everything is FOI-able, challengeable and so on. They will have a mixture.

**Simon Stevens:** CCGs could become the ICSs, but that would mean a big change to the governance architecture of CCGs, which have the ability for GPs to elect on to the governing board and so forth. All the business that is transacted by those accountable statutory bodies working together in an ICS is publicly open and FOI-able.

Q85 **Dr Whitford:** As individual bits. Do you not think that, as it moves more towards pathways and integration, which is the point, it will be very difficult for the public to find out about a pathway if they can only get little bits of it, by writing to the individual bodies, as opposed to writing to the board and asking what the breast cancer pathway is looking like and how it is performing?

**Simon Stevens:** They can write to the board of the CCG and get such information as we make available. I think we are one of the most transparent health services in the world in terms of the data that is available.



## HOUSE OF COMMONS

Ultimately, this is a trade-off question and it will be a question that Parliament will have to confront. Do you want to abolish several hundred clinical commissioning groups with all the disruption that goes with that, or do you want to enable evolutionary improvement in the way the NHS says it will deal with the particular problems that people are facing? You do not have to answer the question for all time. It may well be that, collectively, the Government and Parliament feel that there is an opportunity to make some of these changes in a piece of well-targeted legislation in the nearer future, while reserving the position a few years down the line as to what ultimately might be further changes.

**Q86 Dr Whitford:** Ian, you said that there was a lot of overlap between what an ICS and a CCG might do. Do you foresee that they will evolve into a single statutory body, whatever it is called?

**Ian Dodge:** We made it clear in the long-term plan that we saw CCGs evolving. This is happening already across the country through shared management teams, and increasingly mergers, so that they become coterminous. If you end up with a CCG covering each ICS area, at one level it is acting a bit like a health authority or a health board, the difference being that with the ICS we are trying to make sure that it is properly docked into and connected to the local providers, so that it feels like a shared endeavour across commissioners and providers planning the improvement of health services in their patch.

Is now the right moment to mention one brief thing in relation to the ICP? I think this Committee heard from Paul Maubach, chief executive of Dudley, about his particular set of proposals. If we had had the legislation we are discussing today, Dudley would not have needed to go out to a full public procurement because of the changes to section 75 in the first instance. If you listen to David Hare and NHS Partners, representing the private sector, they have gone on record saying that they would never expect the private sector to hold any of the ICP contracts.

It would have been quicker and easier for Dudley to have constructed a statutory vehicle to hold that contract. As it is, they are having to explore an as-of-yet untested provision within the FT legislation to possibly do a de-merger, which is incredibly complicated and slow. We are trying to not stop the momentum in Dudley for what they want to try to do there, and to bank on the idea that there will be legislation. At the same time, hopefully, you can see how this set of provisions would have made their life an awful lot easier.

**Q87 Chair:** Do either of you have any further points you want to make on ICSs and ICPs? No.

Can I come to the point about centralisation and autonomy? Some people have argued that this will be a very centralising measure. Is that something that concerns you at all, Ian?

**Ian Dalton:** I don't think it is a centralising measure. It is fundamentally keeping the accountabilities for running the local NHS local. In relation to



## HOUSE OF COMMONS

the foundation trust regime, it is fair to say that it does not alter the statutory and legal basis for NHS trusts or NHS foundation trusts. They remain accountable for the things they are accountable for now.

In a couple of areas we are proposing, and engaging with the service on, some potential changes—a very limited set of circumstances to try to help a potentially quite unusual situation, where to improve clinical quality and sustainability a number of organisations might want to come together and the local NHS thinks that is right, but one particular organisation, for whatever reason, decides that is not what they want to do. We think there is a debate to be had about whether that organisation should be able, in that potentially rare situation, to stand away from where the NHS wants to go.

**Q88 Chair:** We heard from our previous panel about the role that strategic health authorities used to play, and they were wondering about where the new regional structures would fit in. Would they play a similar role to that—holding the ring?

**Ian Dalton:** I used to run several strategic health authorities, so that is an interesting question. The regions will be, effectively, NHS England and NHS Improvement in their interface with the local NHS. Increasingly, the local NHS will come together in integrated care systems and that relationship will be important, but I do not see this as a centralising move. There are a couple of specific examples where, for the good of the system as a whole, some changes to the regime are necessary. Fundamentally, this leaves the accountabilities for hospital boards absolutely where they should be, and they are rightly about improving the quality of care within the available resources.

**Q89 Chair:** They are not going to be overruled by the central NHS.

**Ian Dalton:** No, I do not see that. Ben, do you want to reply to that?

**Ben Dyson:** We worked very closely with the emerging integrated care systems. As you probably know, 14 areas of the country are part of our integrated care system programme, and we worked very closely with them in developing these proposals. These are places in the country where commissioners and NHS providers already come together to take shared responsibility for how they use their resources to improve quality of care. They very much supported this set of changes as a way of enabling them to collaborate better and integrate care better.

**Ian Dalton:** To be really clear, without rehearsing the statutory basis or otherwise of ICSs, an integrated care system is a partnership entered into by clinical commissioning groups and NHS providers that retain their statutory responsibilities. It is a voluntary coming together to improve the quality of care within available resources for the local population.

**Q90 Chair:** If foundation trusts can be directed over mergers and acquisitions, and if they do not have any flexibility about their capital expenditure because that would be subject to approval, what remains of the model?



## HOUSE OF COMMONS

**Ian Dalton:** We need to take a step back if we can. We are not getting rid of the responsibilities and accountabilities of NHS trusts or NHS foundation trusts. We are not suggesting in the documentation a generally applicable power to direct organisation A to join with organisation B. What we are looking at is potentially quite an unusual circumstance, where there are real clinical benefits to be gained from a merger.

It is inevitable, I think, that over the next five years we will see more organisations coming together to drive up quality and standardise the high quality of care across a larger base to support clinical services. As a last resort, if one entity decides for reasons that do not support patient care to stand aside, we need a potential reserve power to direct. We are not, however, looking to force an organisation to acquire another organisation, because we think that has to be a willing acquisition. This is a limited and targeted, potentially infrequently to be encountered in the real world situation, rather than a general direction of organisations to come together in some sort of top-down plan.

In relation to capital, we have an inequity at the moment between NHS trusts and NHS foundation trusts. NHS trusts have a capital resource limit attached to them. NHS foundation trusts do not. The Department of Health has a capital resource limit, and I have talked to this Committee before about the importance of getting sufficient capital out into the NHS to improve clinical services, deal with backlog maintenance and build new facilities; we have some significant issues that we have talked about several times and, as you know, I feel very strongly about that.

In a world where the global sum is constrained and will remain so for reasons of parliamentary accountability for the Department, it is difficult to justify a decision that NHS trust capital spending is in some way constrained when NHS foundation trust patients are in some way advantaged. This is looking to create an equivalence, so that we can manage capital resources where they are needed for the best purposes. I think it is quite targeted; I do not accept it as a major extension to centralisation or a diminishing of accountability. I firmly hold that accountability of providers to offer high-quality care within available resources is very important.

Q91 **Chair:** Thank you. Ben, did you want to come in on that?

**Ben Dyson:** The key principle on which the current foundation trust model is predicated is that if an organisation is found capable and well governed, such that it can make good day-to-day, month-to-month decisions about how it runs patient services, it should not have another organisation second-guessing those decisions. What the current legislation says is that, essentially, for as long as an organisation or foundation trust provides high-quality care and is a good steward of public resources, it should not have either us or any other organisation second-guessing it in that way. That remains under these proposals.





Under the current legislation, however, where there are failings in quality of care or there is poor, inefficient use of public resources, Monitor or NHS Improvement can intervene. Those powers of intervention do not extend to being able to require an organisation to explore mergers as an option. We think that is a weakness in the current legislation. None of that alters the basic fact that, if you are providing good services, you should continue to be allowed to do that.

**Chair:** Thank you. Can we come on to patient involvement?

Q92 **Derek Thomas:** Patient involvement is quite a big issue in Cornwall, and elsewhere. How will patient involvement be factored into the new arrangements for integrated care? How will patients and public be involved in ICS governance and operation? For example, is there a role for health and wellbeing boards in the process?

**Ian Dodge:** I think it is through a combination of measures. First, we do not propose any adjustments to the Healthwatch arrangements; they continue as is. Secondly, we have heard from local government; as I mentioned earlier, I was at a roundtable with LGA leaders last week. We will wait to see their considered response, but they were not suggesting particular changes to the legislation relating to health and wellbeing boards. They remain intact and will have a critical role, potentially more important as CCGs become more coterminous with ICSs. Thirdly, CCGs have very clear statutory duties around patient and public engagement, which was one of the changes in the 2012 Act. It was considerably stronger compared with the predecessor arrangements.

The fourth thing to emphasise, which goes beyond just citizen and patient engagement, is how we move beyond that. We started the Committee session by quoting Don Redding, who has been a huge champion of what we are now calling our NHS comprehensive model of personalised care: beyond patient choice, how do we drive shared decision making, social prescribing, personalised care and support planning? The south-west of England is ahead of most parts of the country in exactly that agenda. We have clear, big ambitions set out both in the long-term plan itself and in the board paper we set out at the end of January on embedding that across the country.

Q93 **Derek Thomas:** There is a concern in Cornwall that there has been a drift towards an ICS—drift might be the wrong word. The STP process was doing its thing and that went quiet, and then there was a drift to the ICS arrangement. There has been a reaction to that, because under STP there was lots of public engagement, and there has not appeared to be since then. People are nervous about where we are heading and whether there is a real opportunity for the public to engage. They engage well at primary care level but not so much above. Do you think that is the nature of the beast we are in until we get it all sorted out?

**Simon Stevens:** The relevant consideration is that between spring and autumn, across Cornwall, there is going to be a big public dialogue about



## HOUSE OF COMMONS

how to bring about the improvements that the long-term plan sets out for Cornwall. That will be a very practical and concrete set of conversations about the services that matter most to people in Cornwall. The ICS is a construct that, hopefully, will enable a deeper partnership between Curnow county council, the acute trust, the community mental health provider and the CCG. A relatively small number of statutory bodies covering Cornwall that work together intensively could produce some very significant improvements in patient experience.

**Q94 Derek Thomas:** That is certainly what we are hoping for. You are fairly relaxed that, as we go forward with all this in place, the public will know and understand how they can engage and how they can be part of the ongoing journey, because it is not going to be job done and now it's sorted. You are nodding Ian. Do you want to come in?

**Ian Dalton:** Merely to say, similarly to Simon, that there is a process that will engage a lot of discussion. The fact that organisations are coming together to talk about how their long-term plans and ambitions will be translated into clinical improvement for the people of Cornwall is one example of a process that will play out across the whole of the country over a period of months. That will be a really important conversation, and I am sure that local people and their representatives will rightly want to get involved. It is a really good debate to have.

**Q95 Chair:** One final question from me. Given that Brexit is not exactly—that it is still very uncertain what the outcome will be, do you expect that the changes you are proposing to competition and procurement arrangements will be challenged, and are you taking legal advice?

**Simon Stevens:** Challenged by whom, Chair?

**Q96 Chair:** Will they be incompatible with European law and procurement competition?

**Simon Stevens:** We are thinking about how to ensure that the recommendations would be future-proof in at least three scenarios. One would be a continuation of our current regulatory alignment through whatever vehicle. The second would be something akin to the withdrawal agreement, with a transition period and then moving to something different. The third would be an abrupt break.

The precise route that is used needs to be in a position to work on whichever of those scenarios we end up in. Given the likely timetable for Parliament legislating, and without creating a hostage to fortune, I would think it quite likely that Parliament will, by that stage, have answered the question for us all as to what is happening in our future relationship with the European Union. We will know that by the time we need to bring forward draft legislation.

**Q97 Chair:** Doubtless, we will come back to that. Are there any points you want to put on the record that you have not been asked about today?



## HOUSE OF COMMONS

**Simon Stevens:** The only thing is to thank the Committee. In a sense, this is your baby. You kicked it off with your report last summer, and your recommendations in May about the importance of a public provider vehicle for integrated care, but backing the idea of testing the model in the meantime and sorting out some of the challenges around procurement law and other things for which you had evidence from the NHS, patient groups and others. To some extent, we are acting on the mandate you gave us and will continue to do so, and we will bring forward a final set of recommendations for your consideration later this year.

**Chair:** Thank you. It certainly was our intention to make the system simpler in whatever way we could, and to help you to do that without a major legislative upheaval that certainly would not get through Parliament. That was the purpose, so thank you very much for your engagement with it. We look forward to seeing how it progresses. Thank you for coming today.

**Simon Stevens:** Thank you very much.