

Health and Social Care Committee

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

Tuesday 30 April 2019

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[Watch the meeting](#)

Members present: Dr Sarah Wollaston (Chair); Diana Johnson; Andrew Selous; Derek Thomas; Dr Philippa Whitford; Dr Paul Williams.

Questions 188 - 246

Witnesses

I: David Hare, Chief Executive, Independent Healthcare Providers Network; Professor Sue Richards, Executive Committee member, Keep Our NHS Public; Andrew Taylor, former Director of Co-operation and Competition Panel for NHS-funded services; and Dr Graham Winyard, former Chief Medical Officer for NHS in England.

II: Dr Clare Gerada, Sara Gorton, Head of Health, UNISON; Dame Donna Kinnair, Acting Chief Executive and General Secretary, Royal College of Nursing; and Rob Harwood, Chair, BMA Consultants Committee.

Written evidence from witnesses:

- [Keep Our NHS Public](#)
- [UNISON](#)
- [Royal College of Nursing](#)

Examination of witnesses

Witnesses: David Hare, Professor Richards, Andrew Taylor and Dr Winyard.

Q188 Chair: Thank you very much for coming to this afternoon's Health and Social Care Committee. We are considering the legislative proposals and long-term plan. For those following from outside this room, will you all introduce yourselves and whom you are here representing?

David Hare: I am David Hare, chief executive of Independent Healthcare Providers Network, which is a membership association for the UK's independent health care sector.

Andrew Taylor: I am Andrew Taylor. I used to be head of the Co-operation and Competition Panel for NHS-funded services, a former regulator of competition in the NHS.

Professor Richards: I am Sue Richards. I am a member of the national executive and former co-chair of Keep Our NHS Public.

Dr Winyard: I am Graham Winyard, a former medical director of the NHS back in the '90s, and more recently I was a claimant in a judicial review against the Secretary of State about accountable care and was a witness in your inquiry into that.

Q189 Chair: Thank you for that.

You come to this with very different approaches. The Committee would like to start by giving each of you an opportunity to set out your key pluses and minuses of these proposals. If you kept it succinct, that would be really helpful because we will then explore some of the issues in greater detail through separate questioning. Make your pitch, if you like, about what you like and do not like about them, starting with Graham Winyard.

Dr Winyard: The NHS is in the worst organisational mess in its entire history. We cannot sort that out now, but I see these proposals as a pragmatic, sensible way to make what is a mess somewhat better.

I particularly welcome the proposal to enable the Secretary of State to set up a specific form of NHS trust to deliver integrated care where it is felt that is appropriately done through a single provider.

I strongly support the revocation of section 75 and the removal of arrangements between NHS commissioners and providers from the scope of the public contract regulations. The principle we ought to be going for there is that the decision about whether to go out to competitive tendering should be a matter for the NHS body that is going to do it, whether it is a commissioner or trust subcontracting. Things like best value tests should inform that decision and judgments about whether they are fulfilling their stewardship role adequately. I could see the CQC and NHS Improvement adding a recommendation that something should



HOUSE OF COMMONS

be tendered to their quiver of arrows to fire at the bodies they are inspecting, but whether or not to put services out to tender should be a matter for the NHS.

Professor Richards: Keep Our NHS Public was formed in 2005 against the marketisation processes surrounding the NHS under the then Labour Government. It grew massively as the Lansley Act was being discussed because it was turning the NHS into a market as a means of co-ordination.

We are obviously delighted that section 75 is being abolished as the core of that compulsory competitive tendering process, which was at the heart of the market, but we are alarmed that there are many other reasons to believe marketisation is still going on. One example, which is not much known about, is that NHS Improvement has driven non-foundation hospitals to give up their pathology labs to join bigger teaching hospitals in collaboration with private partners. There will be 29 pathology networks across the country. This has not been subject to consultation because it has not been thought to be a change in service. None the less, it is a major marketisation and financialisation of that service, which is critical to successful work in the acute sector.

There are many things like that which lead us to believe that there is a long, long way still to go before we can breathe a sigh of relief that we again have a full public service NHS. We watch with bated breath to see that.

I make one other point at the beginning. Looking back to the 2012 Act, one of the attractive things about it—I guess there were some—was that it was quite decentralist. It gave lots of commissioning power to many local bodies that were coterminous with local government and established health and wellbeing boards, lodged within the local system of accountability for driving that process.

Both in the STPs and now more so, we are seeing NHS England returning to the role it had in the bossy 2000s when central Government told local health bodies what to do, how to count things and so on. The phrase I remember from that time, which I think public servants felt, was, “We have hit the target but missed the point.” It took away much of the scope for judgment and intelligence at local level that meant the NHS could do its work. That is an ongoing process alongside section 75. We need to realise they are both part of the picture.

Andrew Taylor: Under what is being proposed for the NHS going forward there will still be a lot of patient choice in the system, if you are talking about patient choice having an ongoing role. There will still be a lot of private sector participation in the NHS. I do not think anyone has realistically talked about removing the private sector from the NHS, because of the reliance on it to deliver a significant amount of services. Inevitably, there will still be a degree of commissioner choice between



HOUSE OF COMMONS

different providers of services; we will still have autonomous NHS service provision.

All those things mean you have markets in the NHS, and where you have markets you need appropriate governance structures to make sure they end up delivering best value for taxpayers and the best possible outcomes for patients. The current rules provide a Government structure for those markets. In effect, the proposals deregulate NHS markets. They do not remove markets from the NHS; they just deregulate them and remove those governance structures. My concern is that ungoverned markets will no longer necessarily deliver the best outcomes for people, so these proposals have to be treated with a degree of caution.

David Hare: The detail in the proposals is relatively light at this stage. It is inevitably welcome to have to some extent a decluttering of the national architecture. Working within the health system, who is doing what and where is deeply confusing. To be honest, I do not think patients have a prayer.

Looking at the proposals, however, some areas would need strengthening. The definition of integration is to an extent slightly selective. One of our concerns is that what is going on at the moment in the integrated care systems is bringing commissioners and a lot of public providers together, but it is perhaps not as inclusive with local government, the independent sector, the voluntary sector, the social enterprise sector and so on. Therefore, there is a danger that where the proposals speak positively about not wanting to attack incumbency where there is quality provision, that should not be just for the NHS, the public sector; it should be for any incumbent provision that is delivering a fundamentally good service.

I would agree with Graham's point on the need to avoid a compulsory competitive tendering system. It would be crazy if we were tendering contracts that delivered good value. Yesterday, the *Financial Times* reported some numbers that we had pulled together about how much is actually competitively tendered within the NHS—around 2% by value over the past three years. Therefore, when we are looking at the need to streamline the system, we also need to base that slightly on facts—how many contracts are actually put out and what the effect of that is—and definitely avoid moving down a road of unresponsive monopoly provision.

Q190 **Chair:** You say you have seen evidence that it is 2%. Two per cent. of what?

David Hare: Of all contracts let by clinical commissioning groups. This does not include NHS England specialised commissioning services. These are contracts tendered by CCGs—how many of those are let by competitive tender as opposed to being rolled over with an incumbent provider.

Q191 **Chair:** If you could provide us with a link to that evidence, we will look at



it.

David Hare: I am happy to provide the Committee with that evidence.

Q192 **Dr Williams:** Andrew, you said that effectively it is removing regulatory control over the market. Do you think that a best value test, which is referenced but as yet undefined, could provide that regulatory control?

Andrew Taylor: I am not saying there will be no regulatory controls, because in a sense by removing the section 75 regulations—for example, the prohibition on anti-competitive behaviour—all you have left is the Competition Act prohibition on anti-competitive behaviour. Therefore, there will be CMA unfettered jurisdiction in this space, as opposed to joint jurisdiction by NHSI and CMA in relation to those matters. What we are talking about is removing some of the regulation, not all of it, and moving from what is perhaps a more specialist regime to a more generalist regime.

It is hard to comment on the best value test. I don't know what it is supposed to do. It could do anything, couldn't it? As far as I can understand it, it is a label without any description of what it is going to do, so I do not know.

Q193 **Dr Williams:** It is as yet undefined.

Andrew Taylor: Yes, exactly.

Q194 **Dr Williams:** May I ask a two-part question of all of you? The first part is about how the current legislative framework inhibits the NHS in working in the best possible way. The second part is: do the proposals from NHS England address that? Perhaps we can start with David.

David Hare: I spoke earlier about fragmentation. At a national level it can often be difficult as a provider. You look at the system and there are instructions coming down from NHS England on the one side of the ledger and instructions from NHS Improvement on the other side of the ledger. You have other national bodies as well. I will give you an example of how that challenges the private sector. Often, the private sector is used where there are capacity pressures, particularly over winter, to help with access challenges. On one side of the ledger you might have NHS England saying to CCGs that they need to commission additional capacity from the independent sector. On the other side of the ledger you might have NHS Improvement, saying, "For God's sake, don't do that because it will cause real balance sheet problems with trusts."

Therefore, having a bit more of a single version of the truth and management structure would be helpful. In recent years we have lacked a clear regional tier to help interpret some of the instructions from those national bodies and make them clear, concise and consistent at a local level. To an extent, we have lost some of the connective tissue in the system and I do not think the legislation hugely helped with that.



HOUSE OF COMMONS

The other point I make is that there is more we can do within the existing legislation to meet some of the ambitions set out in the long-term plan and legislative changes. There is more flexibility in the existing rules than perhaps some people acknowledge. In terms of the statistics I have cited, I would dispute that compulsory competitive tendering has been a feature of the market. I think commissioning can be done in a sophisticated manner to tender where needed to replace failing service provision and ensure that successful service provision is continuing, and that the default in any local system—we support this—is collaboration and working together. You should need that tendering only when you have a struggling part of the supply chain that is perhaps not delivering for patients. There is definitely some connective tissue to bring back together again within the system, but there is a danger of throwing the baby out with the bathwater.

Q195 **Dr Williams:** Sue, maybe I can give you the opportunity to respond to that and to my question.

Professor Richards: You may be surprised to hear that I want to agree with the last point. In sectors where there is a perfect market you expect to have low friction and low transaction costs. Everybody knows what they are doing and what they are buying, but health is not like that. Therefore, if you try to inject market forces, you build up transaction costs and spend money that should be spent on patient care. I think we have been doing that. One estimate of the cost of administration by the Centre for Health and the Public Interest is that over the past few years it has been 14% of the budget. It is hard to tell, but, if we look back to before all this started, the estimate was 4% or 5%, so there is a big cost to going into a transaction-based set of relationships.

What works best for health is when you build up trust and collaboration, and that is best done by not moving people around. If you are constantly chopping and changing you cannot expect trusts to develop that; it develops over a long time. Therefore, we need something that creates the opportunity for that to build up.

I see that happening. My local area, Islington, has a long history of various bits of the health service and the local authority working together. They have managed to sustain that during the difficult days of marketisation. I will not give names, but I see many very well-meaning and hard-working health commissioners trying to do the workarounds that sustain the integrity of the service and the relationships on which it depends rather than complying with putting it out to tender. It is true that in the past couple of years there has been a lot less pressure informally to do that from the top of the NHS, but before then it was very much all systems go and implementation of the Lansley Act to the full. Sense is beginning to prevail, but there is a long way to go.

Q196 **Dr Williams:** What I am hearing is that you think this is a step in the right direction.



HOUSE OF COMMONS

Professor Richards: I think it is. It is a very partial step and I am very aware that the best way of undermining local partnerships is to have a very strong hierarchical drive from the national level, because that cannot accommodate local difference and local variation.

Q197 **Dr Williams:** Will you send us the link to the data on the 14% transaction cost?

Professor Richards: I will.

Andrew Taylor: If what we are trying to do is encourage more co-operation between NHS bodies, but the tendering requirements and the prohibition on anti-competitive behaviour are somehow inhibiting that collaboration, there are two points to note. One relates to the prohibition on anti-competitive behaviour. For example, any co-operation that is in the interest of patients is allowable under that prohibition, so in that sense all people have to do is show that what they are doing is in the best interests of patients and that collaboration is not going to infringe any particular rule. In my experience, it is a useful discipline on people to make sure they show that what they are doing is in the interests of patients, as opposed to just making life easier for themselves. In relation to procurement, we see very few contracts being tendered.

Q198 **Dr Williams:** You are saying, "It ain't broke, so don't fix it."

Andrew Taylor: I am saying there are checks and balances introduced by the current system, and removing those rules to have nothing is not necessarily a great idea.

Q199 **Dr Williams:** In my local area the GPs and hospital partnered to open a local urgent care centre, the interface between primary and secondary care. The CCG felt that it had to put it out to tender.

Andrew Taylor: Is that a bad thing?

Q200 **Dr Williams:** It meant hundreds of hours of time were spent going through a competitive tender process; probably hundreds of thousands of pounds were spent on lawyers and management consultants to make sure the bid was won. There was a competitive tender process, and in the end the local GPs and hospital ended up running it. It made no difference to the outcome.

Andrew Taylor: There is truth in what you are saying in certain areas. For example, I thought that the tendering of the LCO contract in Manchester was particularly wasteful. It was a silly exercise when clearly only the NHS could provide that contract. I did not understand why there was a need for any kind of procurement process. What is more, I did not understand why they thought anyone would possibly challenge that decision.

If 98% of contracts are being rolled over or awarded without anyone challenging them, in a sense there is a point about people choosing what should and should not go out to tender and where and where there is not



HOUSE OF COMMONS

choice available. Maybe in that situation people made a poor choice about whether there was any feasible alternative.

Q201 **Dr Williams:** The lawyers told them to do it because the lawyers said it was the law.

Andrew Taylor: Maybe those people should be better advised. There are situations where there is craziness in the decisions people are making, the advice they are receiving or whatever they are doing, but the alternative of the best value test, as Graham sketched it out, is that, if we go to a statutory system that says, "These are the hoops you must jump through in deciding whether or not to tender," you could end up with more rather than less stuff being tendered. You will find that that will be the point of debate and challenge in the system as to whether people regard themselves as complying or not complying with the BVT.

At the moment, effectively people are making those decisions behind closed doors and maybe someone does or does not have a go, but what you are doing is introducing transparency and rules around that kind of decision making, and that will make it much more contentious and liable to challenge.

Q202 **Dr Williams:** That is very helpful.

Graham, what is not working well with the current system?

Dr Winyard: There is an elephant in the room that has not been talked about in other sessions and today. We have the worry about collusion between NHS commissioners and NHS providers. We have no mention of the inherent conflict of interest faced by for-profit private healthcare providers. The clue is in the title: they are there to make money from the NHS. They often do that by providing good-quality health services, which is fine, but they also often do it by very tightly specified contracts, which make integration de facto difficult, and careful case selection so that all the difficult cases are done by the NHS. If at the end of the day they cannot make money, they back off and you get out-of-hours care in Birmingham collapsing at a tiny number of weeks' notice.

Let us build all of this into our thinking. That is why I think the NHS should be able to say whenever it likes, "We do not want to do that."

David Hare: Graham generously acknowledges that there is good quality of care delivered by the private sector. There is no monopoly on good-quality provision either in the public or private sector. We need to develop a system that focuses on quality rather than any other measure.

The reality within the system is that the private sector does not get bailed out. In the public sector it is possible to make an additional balance sheet payment, provide a sustainability fund and other types of things that clearly are not available to the private sector. We need to ensure that where we are commissioning services the available budget is sufficient, the objectives are achievable and they work in partnership with other



HOUSE OF COMMONS

providers. That is what we need to crack because, whether you are a public or private provider, if the financial envelope to deliver the service is too little you will have failure either way. That is the thing to avoid rather than the public-private debate.

Q203 Dr Whitford: Andrew, I want to ask a supplementary. You say there is no need for any change because basically people are quite happy to sort out contracts, but what happened to the six clinical commissioning groups in Surrey that were sued not for breaking their contract but for wanting to bring a community contract back under the NHS? That will have sent a cold chill down the spines of all commissioning groups. Surely the idea that we do not need to deal with this and everyone has stopped doing it is not true. It is not like that is a long time ago.

Andrew Taylor: I am not sure that is what I am saying. I am saying that by removing these rules you will still have some other rules; you will still have, for example, CMA jurisdiction over anti-competitive behaviours in the NHS. By removing the section 75 rules you do not get rid of the rules on anti-competitive behaviour, for example.

Q204 Dr Whitford: But, surely, you get rid of this compulsion that clinical commissioning groups feel they are under by law to put things out to tender.

Andrew Taylor: It is a funny kind of compulsion when 98% of contracts do not go out to tender.

Q205 Dr Whitford: Obviously, we are waiting to see your—

Andrew Taylor: In a sense, I do not know whether it is 98%, 95% or 90%, but the vast majority of contracts do not go out to tender.

Professor Richards: May I just say in this company of MPs, as someone who has spent 30-odd years as a public administration academic, that we should have laws that are obeyed? If they are not obeyed, they should be changed. It degrades our whole system if we are constantly having to rely on workarounds and understandings. It is important that we have laws and we respect and obey them.

Chair: I think there was an acknowledgment that with a hung Parliament it is very difficult to have major change, so the purpose here was to see whether something can be agreed on a cross-party basis to make the system work better and acknowledge some of the existing problems, but also to reflect the reality of getting any major NHS legislation through this Parliament. That was the purpose.

Philippa, do you have a further question?

Dr Whitford: No. I was concerned by the implication that CCGs could just ignore this. That is not how they feel. They feel it is the law and there are lawyers, as Paul said, advising them to be careful.

Q206 Derek Thomas: Have you given some thought to the unintended



consequences of these changes to legislation? What could occur that might be a negative if these legislative changes go through?

Professor Richards: KONP would like to see introduced a version of the NHS Reinstatement Bill that brought in full public accountability at local, regional and national level, with the Secretary of State regaining the powers lost under the Lansley Act. There is an ancient book, "Exit, Voice, and Loyalty" by Albert Hirschman, which, much to my surprise, I heard mentioned on the radio this morning. It is a kind of set text. You can exit if you are in a market, but if you are in public service you make your voice heard. That is how you ensure that the public interest is served.

We need to refresh the public accountability that surrounds the NHS in order to recognise that that is what it is and that we cannot have market rules as the means of running it. In general, the point is that we need more people to be able to make their voice heard at various levels—at practice level, local authority level and above that nationally—so that everything is as transparent as it can be using public law rules about public bodies all the way through.

Andrew Taylor: I spoke about the best value test. Depending on how that is designed, the NHS could find itself in court a whole lot more with a whole lot more contracts going out to tender. We do not really know.

As for the patient choice space, at the moment NHS Improvement has a responsibility for overseeing any complaints that arise under those rules. Under these proposals, that responsibility would go. People who wanted to bring a complaint under those rules would then be forced into the courts. In my view, that is a less-good outcome than having a kind of NHS-specific dispute resolution regime.

Similarly, on anti-competitive behaviour, let us assume you cannot get rid of those rules because you will still have Competition Act and CMA jurisdiction. My view is that you are better having an NHS-specific regime running alongside that to deal with those issues more efficiently and at lower cost and so on.

The risk around some of these proposals is that you are not getting rid of all the rules but some of them. It is very difficult to get rid of all of them. By getting rid of some of them, what is left potentially forces you into the courts more and into a less NHS-specific enforcement and regulatory regime around them, which can be a deal messier.

David Hare: I entirely agree with that. There is real attractiveness and benefit in having an NHS-specific organisation looking at some of these issues. There will be times inevitably in the future when tenders are wrong; there will need to be fair treatment of all providers, and it is much better if we can try to resolve those within an NHS-specific regulatory regime rather than expose the NHS unnecessarily to the courts.



HOUSE OF COMMONS

There are two other unintended but foreseeable consequences at this stage around the provision. One is the danger of moving towards slightly unaccountable monopoly-type provision where everybody gets on swimmingly well but the service delivered to the patient is not good enough. As a patient you cannot move between systems, so you are in that system as a place. It is great if you are in one that is performing really well; it is pretty awful if you are in one that is performing terribly. What are the drivers for improvement going to be?

We need to be careful around changes to the NHS tariff and pricing. We could quickly move into price competition. I remember the debates around the 2012 Act. Ironically, it was probably independent sector members who lined up saying, "We do not want them to be able to compete on price." We do not think competition on price is the right direction of travel for those small services that are subject to patient choice. Where some of the proposals talk about softening the tariff rules around the margins, let us be careful we do not drift into price competition.

Q207 Derek Thomas: You mentioned a monopoly and the potential lack of scrutiny. Are we also entering into a situation where costs can keep rising and care might not be as good as it could be, but there is no real stress testing, pressure or scrutiny as a result of legislation? Do you see that as a potential problem?

David Hare: That is a danger. In reading the legislative proposals, that leapt out as a potential challenge. You move away from an architecture that secures value for a very deregulatory environment. If you have a system where you have blended the purchaser-provider split too closely and maybe have formed joint committees—proposals that I know are outlined by NHS England—and the commissioner and provider are very much in hock with each other, you end up in a place where in effect you are writing a cheque to a system that says, "Do your best." We need much more rigorous arrangements around that accountability to avoid that unresponsive monopoly environment.

Professor Richards: I think your take on this really depends on whether you think people train for very many years to join the NHS in order not to do well for the patient. We should start with the assumption that they do, and then provide support that enables them to continue to do that.

I am sure you will find from your next panel of witnesses that there is a huge problem with NHS morale at the moment. If it was flying high, we would have no need to fear vast wells of underperformance. We should assist NHS professionals and managers to do their best for the public. I believe that is what they want to do, and we should start from that assumption.

Dr Winyard: For the first 10 years of my career I worked in such a system in England. It was brilliant. It was not perfect, but there was very clear accountability and it was very simple. I did not see a lawyer or



HOUSE OF COMMONS

management consultant for the whole of that time. We did not need to. We made extensive changes and improvements; we rebalanced services and balanced the books, and everyone—the managers and doctors—was in it together. Our focus could be on providing the best services we could in Lewisham and North Southwark, I think it was.

We now seem to see hospitals and commissioning groups as being populated by rather dark and unimaginative people who are going to collude and not do the best for the patient. I do not think it is like that at all.

Q208 Derek Thomas: That is not my experience in Cornwall. I am the MP for the far end.

Within the NHS an enormous amount of innovation, new ideas and positive progress can be made. I think that has always been the case. Can you see anything in these changes that would stifle that, or do you see them as not impacting on the ability or encouragement of people to innovate?

Dr Winyard: I think it would liberate people because a huge proportion of senior management's time and effort at the moment is involved in all this contracting nonsense, legal disputes and whatever. You heard it from your other witnesses. If you do not have that, you can focus on what really matters—making services better. That is what we want people to do.

Q209 Andrew Selous: Everyone in this room will accept that clinicians join the NHS to do the best possible job. Having said that, we know from the Getting It Right First Time data analysis that there is huge variability in clinical outcomes. It is not always the fault of commissioners; it is perhaps the wrong metrics, the wrong leadership or insufficient clinical challenge of clinicians by clinicians.

The question I want to pose, which David and others briefly referred to just now, is: how do you see the new environment making sure that patients are not left with a substandard service? Where are the challenges going to be within the system? We have heard the phrase "airless room" used in earlier hearings. We perhaps get some of your concerns about the previous environment's over-reliance on endless competitive tendering, but how are we going to make sure there is sufficient challenge so that services do not slip and it is always the same group of people delivering the service—you just have to take it and lump it? How do we deal with that in the new environment?

David Hare: One of our concerns with the detail of the legislative proposals presented is that you are stripping away some elements of accountability but are not necessarily introducing clear new elements of accountability.

We believe very strongly that retaining some degree of commissioner-provider split will be essential. You can have close collaboration within



HOUSE OF COMMONS

those systems. Frankly, that should be the default setting, but you ultimately need a commissioner who is able to hold the providers to account within that system.

You might want the commissioners to be rather bigger than they are at the moment. I am sure the Committee will have followed a number of CCG mergers that are beginning to create a somewhat larger CCG footprint.

Anyone operating in that system needs to know that, if they fail to deliver as a provider, they will be challenged and can be removed. New providers and entrants can come into the market.

Sue's point is absolutely right. People who go into healthcare want to do absolutely the right thing, but we also have to have a framework of accountability for provision that is not good enough, because the healthcare system is there ultimately for patients, not the provider.

I do have some concerns about the legislation. It needs more detail and firming up. Certainly, there will have to be considerably more detail on scrutiny of the best value test before we can say with confidence that that airless room you describe has been remedied.

Q210 Andrew Selous: Sue, how do we ensure high standards, absolutely accepting that that is what clinicians want to provide?

Professor Richards: I was very struck by watching the evidence you heard last week from Jon Rouse from Greater Manchester, who was a representative of new devolved structures, and, by the way, people like him at senior levels in those structures, whether they be local government, health or other public bodies, occupy the Greater Manchester space and work together. They will take responsibility for that; they will not be interested in covering up; they will be doing their best to ensure every bit of the system is working well.

In aid of that, you need full transparency and representative bodies able to question and to bring things to light—capacity that is probably not there at the moment. I speak as the mother of one junior doctor and the mother-in-law of another. I hear about quite a lot of covering up and bullying in the system informally. We have to put a stop to that. It has to be okay to speak up and speak out, and for that to be seen as a contribution to getting things better.

Q211 Andrew Selous: To be fair to the Secretary of State, he mentioned a couple of days ago that he wanted to go further down that route, did he not?

Dr Winyard: Specifically in answer to your question, it is done by building on and liberating the commitment and enthusiasm of managers. I speak as the father of an NHS manager. I think they all go into it because they want to make health services better. Then we sit them in a highly regulated, highly inspected environment, where they are judged by



HOUSE OF COMMONS

all these different bodies—often, as David said, coming at the same question from different angles. If we could simplify the system and they knew where they were, a huge amount of energy and commitment could then focus on making things better. I do not think people instinctively want to be in airless rooms; they want to get out and improve things.

Q212 Diana Johnson: I would like to ask about patient choice. Andrew, you have already spoken about NHSI overseeing complaints and the courts getting involved if NHSI cannot deal with that in the future. My question is for David and Andrew. Do you think any alternative appeal body could be used other than the courts to deal with issues where patients believe they have been denied choice?

Andrew Taylor: There is nothing stopping the Government putting forward proposals to give that responsibility to some other agency or establish a new small agency to deal with it. I am not sure it is worth establishing a new small agency just for the purposes of this, because you do not get a lot of complaints about patient choice; you get some, but you would not want to establish a new bureaucracy around it.

You could go down the path of giving it to someone else in the system. In my view, under the current architecture, it is not obvious to whom you would give it. You could go down that path; you would want to make sure that it was sensibly designed and had a range of responsibilities that justified its existence.

David Hare: It is important that somewhere in the system feet are held to the fire on patient choice. Up until 2015, NHS England ran a survey on patients' recollections of choice when they are going in for an outpatient appointment. I think it showed that about 48% of patients knew they were entitled to a choice. Exactly the same question was put recently by IHPN and it had gone up to 49%, so the public's awareness of their right to choose has not really changed fundamentally.

The public repeatedly say they want to be able to choose. By the way, that is not inconsistent with wanting a good local hospital. You can want both those things. You can want investment in your local hospital. For example, there is huge variations in RTT performance. The best performing trust in the land is dealing with nearly 99% of patients within 18 weeks; the worst is about 75%. If I am in the latter area, I want investment in my local hospital to improve it but I also want to be able to make a choice if my access is not good enough.

We do need to push choice harder. That can be an operational decision as well as a legal one. You could declutter some of the architecture around choice. You just need to ensure that it is properly performance-managed and the public are aware they have a choice. We provide them with the information required. We measure that and enable people to make decisions that are right for them. In my view, we move away from that kind of system at our peril.



HOUSE OF COMMONS

Q213 **Diana Johnson:** Do you have any idea what could be used in dealing with patient choice appeals?

David Hare: My preference would be for one of the national bodies to have part of its remit very clearly carved out to look at whether patient choice is being administered—if people have concerns and it is not being done properly—so it is not necessarily on the same side. It is not the referee on the same side as the team making the decision. It can look at that independently and say, “Are patients in this locality or system getting the choice they need?”

Professor Richards: This seems to be a slightly beside-the-point discussion. One of the big issues at the moment, following NHS England’s decisions about procedures of limited clinical effectiveness, is that a whole range of interventions and treatments is being taken off the NHS’s agenda. This includes highly effective treatments for cataracts and hip and knees, which are being misleadingly called “clinically less effective”. What they are doing is rationing them, and that seems to me to be the big issue that the public are most alarmed about at the moment rather than patient choice.

Q214 **Dr Whitford:** David, you gave the example of one area having a short waiting time and another having a long waiting time. As someone who has worked on the frontline for over 30 years, the problem is that if the people waiting in one area all move to another area those figures will reverse. If those areas are 300 miles apart, only somebody with a lot of money will be able to do that.

You said there are not a lot of complaints about choice. We heard in our session last week that, other than waiting times, there is not a huge amount of that and patients want their local hospital to provide the service. When you talk about removing financial competition as a driver of quality, would not clinical quality be a better thing to look at? The GIRFT stuff is very new; clinicians have not been able to compare themselves with someone else.

David Hare: I would be delighted if we had a system where clinical quality was the principal driver of activity. That would be very good for patients. We are a long way away from that. I think patients make choices based on a whole series of reasons.

Q215 **Dr Whitford:** But why not focus on quality improvement? In Scotland we started that in 2000—we have been doing it for nearly 20 years. Why not look at using GIRFT and other data to drive up quality? As Sue said, people do not become doctors to be rubbish. If you show them they are the worst in the country, they will talk to their teams and do something about it. I cannot see any evidence that financial or contract competition has improved quality for patients, which surely is what we are meant to be doing.

David Hare: I think the GIRFT programme has been fantastic and it applies in the independent sector as well as within the NHS. Its



HOUSE OF COMMONS

methodology is excellent because it holds a mirror up to an organisation when it goes in. You see the data for yourself and improve. It is absolutely fantastic, and hopefully that will raise all boats. That is what we need to get into.

However, as a patient I still hold to the view that, if you are looking at information, whether it be about waiting time or quality, you want to be able to make the right choice for you, so in my view we have to hold both those things true at the same time—go gangbusters after quality improvement across the board using methodologies like GIRFT, but also say to the public, “Let’s make sure that constitutional right is made good on and you are able to use your choices to inform decision making around quality that operates around the system.”

Q216 **Dr Whitford:** Do you not see that that widens health inequalities because it is much more likely to be the middle-class patient who comes in, makes a noise, uses data and demands to go somewhere else, whereas someone from a more deprived, poorer background is told to lump it? If quality is the thing, the quality of the local hospital is driven up, and lots of parts of the country do not have another hospital 5 miles down the road.

David Hare: We have looked at this. It is very interesting. The desire of those in the lower socioeconomic groups to have choice is stronger and further up. I think that is due partly to the fact that they do not have the choice or ability to pay privately; they have to act within the NHS system, so empowering them and enabling them to make a decision about where they get their NHS-funded care is absolutely critical.

Q217 **Dr Whitford:** You think that at that end of the scale they can easily absorb their accommodation and travel, or whatever, if that really good hospital is a couple of hundred miles away?

David Hare: People have demonstrated that they are willing to travel. A couple of hundred miles away is probably an exception. In many areas there will be a multitude of different operators within a reasonably accessible distance from which they can choose, and that ensures they are getting the best care they obviously desire.

Q218 **Dr Whitford:** Maybe not in Scotland. We are a very big place. I do not know whether anyone else has comments on the reality of choice.

Dr Winyard: I think 38 Degrees have given us an important patient population perspective on this. I think it has sent you its data. It encouraged responses to NHS England’s consultation from 173,000 people, 97% of whom thought that local services ought to be provided by the NHS.

Q219 **Chair:** It often depends on how you ask the question.



HOUSE OF COMMONS

Dr Winyard: There was overwhelming support for what is being proposed, but within the detail was: when is the use of the private sector a good idea?

Chair: Indeed, but if you ask people whether they would like choice, it is very important that you balance sometimes how you ask the question. I accept that it is always helpful to have feedback from as many sources as possible.

I thank all of you very much for coming today and sharing your thoughts.

Examination of witnesses

Witnesses: Dr Gerada, Sara Gorton, Dame Donna Kinnair and Rob Harwood.

Q220 **Chair:** I thank the second panel very much. I am sorry to have kept you waiting. Will you introduce yourselves and tell us who you are representing today for those following from outside, starting with Sara Gorton?

Sara Gorton: I am Sara Gorton, head of health for UNISON, representing UNISON. Although I chair the NHS trade unions, much of the content represents the consensus view of the TUC-affiliated NHS trade unions.

Dr Gerada: I am Dr Clare Gerada, a general practitioner. I am here representing myself, but since you invited me I have become the co-chair of the NHS Assembly, so I will be bringing into my evidence the views of the NHS Assembly.

Q221 **Chair:** We anticipated that that would be the case, so we are very pleased to have you here.

Dame Donna Kinnear: I am Donna Kinnear, chief exec of the Royal College of Nursing, so I will be providing the nursing perspective. As a former health commissioner myself for a lot of things prior to the 2012 Act, I will be talking about some of the collaboration that existed previously to improve services.

Rob Harwood: I am Rob Harwood. I am also a doctor. I am a consultant anaesthetist by trade. I am here representing the BMA and I chair the consultants committee of that body.

Q222 **Chair:** Thank you very much. Each member of the previous channel made very brief opening remarks about the things they would most like us to focus on. I ask you to keep that as brief as possible, because we have a lot of detailed questioning to go through. May we start with you, Sara?

Sara Gorton: Doing exactly what you asked the other panellists to do, we are broadly supportive. In the plus column there are four key areas for us: the priorities around reducing the role of the Competition and Markets Authority; very strong support for revoking section 75 of the Act;



HOUSE OF COMMONS

removing the duty on Monitor/NHSI to enforce competition in the system; and making it clear that for integrated care providers contracts are either given to statutory bodies or a statutory body format is developed for use of those contracts.

In the minus column is lack of detail around the best value criteria that have been suggested and already touched on. There are some concerns for us about the very ambitious scope of increasing personal budgets and the speed of that.

Overall, it is a pragmatic set of suggestions. We do not see this as limiting the ambition for a future overhaul on a more comprehensive basis, so it is a pragmatic set of steps in the right direction.

Dr Gerada: On a personal level, I am absolutely delighted with the proposed changes. The Assembly also absolutely favours them. When we come to evidence I will say where there are some concerns.

Having listened to and read the evidence you have already heard, we must not forget primary care because it has been slightly left out. I used Ctrl+Find to discover the number of times GPs and primary care have been mentioned in the evidence you have heard. It is referred to quite rarely, usually with respect to the beginning of the NHS in 1947 and the errors that Bevan might or might not have made when he set it up.

I would like to take us back to ground level, as the previous speakers said, to make sure we do not forget what it is we are trying to deliver in the alphabet soup we seem to have come back to. I myself, let alone patients and staff out there, find it difficult to keep track of the acronyms.

Dame Donna Kinneer: From our perspective, we broadly welcome the intention of these proposals and think that a lot can be achieved. There was a lot of collaboration prior to 2012 and there was grit in the system as well. There was accountability on commissioners to drive up service improvement. That has always existed and the role of the commissioner is to look across the country and see where services are better and improve them.

That was how we delivered changes to breast services and a number of changes in Lambeth and Southwark, where I worked as a commissioner. There were lots and lots of improvements, because the people who deliver improvement best are clinicians working together. When you get clinicians working on an outcome that is about improvement, based on a proper needs assessment, you will get a driving up of quality, and it is usually quality that we are commissioning for.

On the minus side, what are the best value criteria? We need to understand that because it can mean a whole range of things to a whole range of people.



HOUSE OF COMMONS

Flexibility in the payment system is about reflecting local factors. That is a good thing, because we need some of that.

On the other side, the best benefits of integration are not just about health integration. Some best outcomes arise when health and social care integrate to alleviate some of the system problems we can see. Therefore, is it just health services that this Act is going to cover? I came from a system where we managed to alleviate a lot of the negative impact by having integration between health and social care. I think you will pick up the rest of it.

Rob Harwood: I am afraid I am going to be rather dull and agree with most of my predecessors on this. One of the greatest opportunities that we see is the reduction in competition and, therefore, wastefulness within the system, allowing more of the money diverted to the NHS to be spent on actual patient care. We think that is a real opportunity.

We very much welcome the removal of the section 75 obligations. We think that is a sensible thing to do, and to us integrated care seems eminently sensible. It is a no-brainer to work across primary and secondary care to deliver effective, seamless care for every patient we come into contact with. That ought to be part and parcel of everyone's healthcare system.

Like my colleagues, we have anxieties about the lack of detail around some of the legislative requirements that are not specified to date, particularly that around the best value test. What we are clear about in that respect is that it must be a best value test, and value encompasses a lot of variables. It must not be a least cost test. There has always been that concern from the marketisation of the health service to date.

Q223 **Andrew Selous:** I want to pick up some of the points made in the opening statements. How much involvement do you think healthcare professions and staff have had in these proposals? Clare, I was particularly taken with your point about GPs, the frontline of the NHS, and the whole care profession as well. Have they been intimately involved, or have they been too busy to take much notice? What is your experience of that?

Dr Gerada: You have to understand that the landscape for primary care and general practice is very confusing. We have GPs involved in clinical commissioning groups and federations, and now they are involved in primary care networks. We also have GPs trying to run their own practices and work together without any formal structure. We also have a landscape where, certainly in London, it is now predominantly a peripatetic workforce; outside London it is slightly less.

When you ask whether GPs have been involved, yes, of course some have. For senior-level GPs you tend to get the same ones taking leadership across the different parts of the system, but, if you look at ground level and a GP in a consulting room, they will know what is



HOUSE OF COMMONS

happening because they have rapidly to form PCNs by July, but, as to what is going on with the legislative changes and all the other regulatory changes, you will be hard-pushed to find GPs, beyond those who are already involved, who know what is going on.

Having said that, to be fair to NHS England, it is doing a lot of hard work to try to engage GPs, but, as you know, general practice is in a bit of a bad way at the moment. The last thing many GPs want to do is go to yet another meeting. By way of example, my own practice is a multi-site practice. We are now connected to nine, soon to be 10, PCNs. That means we have to furnish a member of staff at senior level nine times a week to engage in the process that is going on, notwithstanding that we also have to engage in the process that is going on around federations, CCGs and the new integrated care organisations.

The worry I have, if you really want my different view, which I have not heard, is that, unless we engage care staff and GPs through facilitation—at the moment, there is no support around the legal and governance frameworks, even on the issue about PCNs being accountable for VAT and holding NHS pensions—what we will have, sadly, is what we had prior to the 2012 Act, paradoxically, where I started by saying that there are lots and lots of organisations and acronyms and one is trying to make sense of all of this. Having said all that, this is the right direction of travel, so I do not want to detract from that.

Q224 Andrew Selous: That is very helpful. Donna, you represent care staff—nurses who work in the care professions. Have they been involved in and properly consulted on these changes?

Dame Donna Kinnair: The shortages in nursing staff alone—40,000 staff—mean that there is not a huge number of people who can leave the frontline to be consulted on some of these legislative changes. Our organisation has tried to put the information out there. We have held groups so that we can have the conversation with people. To be fair to NHS England, perhaps it has consulted doctors more than nurses, but we are trying our best to get the information out to them.

What you see is the impact on nursing staff when some of these tenders are happening, and the VAT impact. That is when people really notice it. It is not so much that people are going to have a big interest in what the bigger structure is—the issue is the implications that doing all this moving around of the deckchairs will have for themselves.

Q225 Andrew Selous: That is helpful. I will bring in Sara and Rob now. These changes are being brought in to try to get rid of barriers to integrated, place-based care. Is your overall take that the suggestions are sensible ways of bringing those barriers down? Do you think that what NHS England has proposed is sensible, in terms of the barriers that your organisations have identified? We will start with you, Sara.



Sara Gorton: We are a UK-wide organisation. The other countries take different approaches towards the way in which different bits of the health service and health and care work together. It is very different across all four UK countries. We have been able to learn from those approaches.

To summarise our position, we are broadly supportive of the proposals, on the basis that they do not make integration more difficult. There are more barriers to integration than just the legislative barriers. I did some work through the Social Partnership Forum in the NHS in 2017-18. It is wise to remember that there is often a massive gap between policies being released in Whitehall and their being realised on the ward or behind a reception desk.

Eighteen months on from the five year forward view and STPs supposedly being up and running, together with others from the Social Partnership Forum, I did a series of visits to those who were seen to be on the front foot in bringing together organisations from health and social care. The level of cultural change that is required even to get different bits of the NHS working together across a footprint is quite shocking. There are exceptions. I know that London and Manchester have done lots of work on this and have changed the situation, in many ways, but in lots of places the conversations around getting all the different providers in one room to discuss care around a patient-centred approach required a cultural change that was way below a set of legislative changes.

Yes, we are supportive. We know that the current competition rules are a big barrier to integration. Other panellists you have heard from have talked about the example of Dudley. The examples that were used there of considering not just the direct costs, but the opportunity costs of having to work within a contractual framework, when the time and resources could have been spent on actually setting up collaborative approaches, have been well referenced.

We found that support for the changes from our membership is about removing the barriers to our workforce discussing integration without fear. One of the big barriers is engaging staff in progressive conversations without their constantly worrying about what Donna referred to—the impact that this is going to have on their service—and the potential of being moved to a situation where they are outside direct employment. We are very supportive, as this would have a liberating effect on conversations about how to do better integration across health and social care, without fear and barriers.

Q226 **Andrew Selous:** Rob, what is your view?

Rob Harwood: We think of integration as being a very positive thing. We think that it makes sense and offers an opportunity to waste a lot less money that is given to the NHS for patient care and actually to spend it on patient care. We think that all of those are potentially positive things. Of course, as always with these proposals, the devil is in the detail about



HOUSE OF COMMONS

how that is done. Some of the details are hinted at in the documentation to date, but it is not completely clear exactly how it will play out.

I go back to the previous question that you asked, about representation and whether we were consulted in the process. For the original long-term plan process, there was some consultation with our members, largely from private care. The people whom I represent from secondary care were not invited to participate, although we tried to make sure that that point was heard. We were not involved regarding the legislative changes, although we have been involved in them subsequent to their being announced.

We are broadly supportive. We think that there is much to be done, and much clarity that we would welcome. We think that integration is sensible, as I have said. We also think that it offers an opportunity not only for a less wasteful approach to healthcare delivery, but to do something else for groups of people the health service definitely needs to focus on now—its employees.

It is massively destabilising to employees to have different potential employers coming to the market, to have their employment base switch and to be TUPE-ed over from one employer to another. We need to keep hold of and to retain those staff.

I am sure that my colleagues will tell you about the number of nursing staff that we need. That is absolutely clear across GPs. It is clear across consultants and other doctors, too. We need to make sure that those staff are offered stability, to make them want to invest their careers and working lives with us in the NHS.

Q227 Andrew Selous: That is great. Donna, do you want to come in briefly on this?

Dame Donna Kinnair: Added to that, the consequence of some of these TUPEs is quite often a downsizing of staff, once we have TUPE-ed staff across. One of the big oversights in the 2012 Act was that no accountability was given to anyone for workforce. We are very clear that one of the things that we need to invoke is an explicit accountability to the Secretary of State for workforce. There is no delivery of the long-term plan without adequate numbers of nurses. We cannot go on thinking that we can just use the same number of staff, move them around and deliver a safe, quality NHS. We are really clear that, in the same way as we needed primary legislation to do these changes, we also need it around workforce.

Andrew Selous: I think we would all agree with you on that.

Q228 Diana Johnson: What will be the effects of these legislative changes on patient choice?

Dr Gerada: Some of us may remember that, way back when, the Future Forum did a consultation on patient choice. At the time, I was the chair of



HOUSE OF COMMONS

the Royal College of GPs. Because I was a bit of a nerd, I analysed all the responses. There were about 800 responses, predominantly from members of the public. I put them all into categories—pro-choice or against choice. Nobody is really against choice, but there were those who predominantly wanted choice and felt that it was their right. Out of the approximately 600 responses, 17 wanted choice. I still have the document; I would be very happy to send it to you. As you have heard right across the evidence, which I have listened to, the other responses wanted good local services.

They want choice at the margins, of course. For example, I have had patients who have had double mastectomies who have analysed and researched and want to go to the place that they think is best and that does the right plastic surgery and so on. I have had patients who want choice because they might want their hip replacement to be done nearer to their daughter, rather than in London, so that they can have rehab, or parents of children with complex facial deformities who are willing to wait. Of course people want choice, but we know that choice causes anxiety. If you have the choice of more than four—this happens with toothpaste, as well as the choice of providers—rather than get reassurance, you get increased anxiety. Again, there is a great deal of evidence around this. There are whole textbooks written about it.

Choice is important, but, as you have heard from the evidence to date, I do not think that it should be the overriding concern. What should be the overriding concern is safe, local services that deliver good-quality care to their patients, based on need, not want.

Dr Whitford, you mentioned the middle class walking. Yes, of course that is what will happen. Yet again, we will have a postcode lottery of people looking on their smartphones for where there is the shortest waiting time.

Of course, choice happens with me as the provider. As a GP, I have a much better sense, based on the patient, of where I think that they may be better. When I first started in general practice, if I knew that it was three years for a hip replacement, I would scattergun and send a referral to every single hospital in London. It is probably not good to do that. Yes, there should be choice, but it should not be the overriding concern. It is at the margins. What we want is good local providers.

Q229 **Diana Johnson:** But with these changes—

Dr Gerada: These changes will allow exactly the same thing. They will not affect choice. To a certain extent, they will affect competition, but they will not affect choice. I heard one of the people who gave evidence to you say, "This is not the major issue. The major issue is getting good nurses in place and getting joined-up care." Mr Selous, you asked about an elderly patient and what happens to them. It is about getting our patients, especially those with complex needs—who are now 80% of our patients—not having to repeat their stories and not having a service that



HOUSE OF COMMONS

disappears because it has been commissioned for only five years and there is then a different provider.

Rob Harwood: I will come to the issue of choice, if I may. In a metropolitan area, you can have a lot of choice. If you live in a different part of the country, those choices are much less available to people. As you have just heard from Clare, that is what makes the requirement for good, effective, timely local services the principal thing that people want. Earlier you spoke about people having to travel 200 miles to another unit. What you have an absolute requirement for is a hospital near you that delivers those services and does them well.

Let us also remember that choice does not exist only because we mandated it into the system. Before patient choice existed, it still existed in reality. The patient would go along to their GP and say, "Actually, I know someone who had that operation in that hospital. Could I go there?" Of course, all that it took at that stage, until we were so focused on the money, was for the GP to be in touch with that unit on their behalf. That was still a thing that a GP needed to do, but it was a way of ensuring that you could select the provider that you had chosen to have. It was a way of using your choice to benefit the outcome that you wanted.

Sara Gorton: The previous panel suggested that removing the requirement for competition would mean that there was nothing patients could fall back on to challenge lack of choice. I would just point to existing bodies that can already be accessed for those purposes. We have democratically elected bodies within local authorities. The health overview and scrutiny committees, the health and wellbeing boards and, of course, the health ombudsman could all be looked at as bodies where people could address concerns around choice or lack thereof.

Dame Donna Kinnair: Some of the choices are about understanding what is happening. The issue is the time that clinicians can give to those patients to help them to understand that. It is not so much about running from Dorset to Manchester, because nobody truly wants that. What they truly want is to be able to access safe care and to know what is going to happen. Again, that is a call on a clinician's time. Clare, I am sure, and I, as a frontline nurse, would say that most of the time, when we are talking about choice, it is about what the operation involves and what it means for me, in my particular circumstances. That is the choice. We often refer to it as if it is a difference between King's and Guy's. To people, it is about their individual circumstances and what going somewhere to have an operation, or whatever it is, there means for them in their particular circumstances.

Chair: Do you have a follow-up to that, Philippa?

Q230 **Dr Whitford:** In the last session, we touched on using quality improvement and data—actual clinical data, rather than financial data or the small number of patients who move around—to drive up a service, on



HOUSE OF COMMONS

the basis that, when they see their performance, generally clinicians want to drive it up.

Rob Harwood: I think that that is absolutely right. You also have to look for drivers of good outcomes. The Royal College of Surgeons has worked with cardiac surgeons for 20-odd years to look at their outcome results. They are scrutinised minutely on those outcomes and for the kind of patient case load they are exercised in. Of course it is true that commissioners will maintain part of their duty of scrutiny, but there are other mechanisms, many of which are clinical mechanisms. In orthopaedics, there are joint registries that look at outcomes. Orthopaedic surgeons are answerable for those outcomes. They are scrutinised and criticised.

Q231 **Dr Whitford:** It is just about trying to get that on a bigger scale and across more specialties—and, indeed, generalisms.

Dame Donna Kinnair: We have that. We have HQIP. We have joint registries. There was no commissioner who was out there—certainly when I was a commissioner—who did not look at those outcomes. I know that we have Getting It Right First Time. One of the things that the system needs to do is to focus on what it is doing well. We get the joint registries and the cardiac improvements, and then we suddenly bring along something new. Everybody then has to learn that new methodology, as opposed to using some of the things that we already have to drive up the quality in the system. There is no magic wand that comes along. It is all about looking at our data and what the best does, and making those comparisons.

Q232 **Dr Whitford:** Is that data then published? Is it available and publishable?

Dame Donna Kinnair: It is absolutely there. HQIP does this all the time.

Q233 **Dr Whitford:** So patients could look at it.

Dame Donna Kinnair: They absolutely could.

Q234 **Dr Whitford:** I was surprised that last week we heard that very many people moved because of perceived quality. It was just about waiting times.

Dame Donna Kinnair: Yes.

Dr Gerada: You are focusing on how these changes will improve integration. There are very few metrics for integration. The metrics that we are currently doing are, "Is your cardiac surgery safe? What is the outcome? What is the longevity? What is the complication rate?"

In my previous life, I was head of transformation for NHS London primary care. I think that it is important to try to look at some metrics around the standards for integration. It is very, very difficult. On the whole, they are very soft metrics. Whereas you can have some quite good standards



around primary care delivery, where patients want accessible care, care co-ordination and proactive care to stay fit and healthy, in integrated care it is very difficult. We use the term “integrated care” so often, but sometimes we need to step back and say, “From the patient’s perspective”—I think that that is your question—“what do they want?” I think that what they want is to tell their story as few times as possible, to have handover or continuous care from hospital to the community and to have care that is delivered at home. We need to be careful about saying, “All the measures exist.” Saying that, of course, we do have measures for choice.

Q235 Dr Williams: I am going to ask about the best value test, which is what will replace mandatory competitive tendering. We know that local authorities use a best value test that looks at economic, environmental and social value. We have heard a strong suggestion that clinical quality should be within the best value test. Rob, in your opening comments, you said that it should not be a least cost test. What elements should make up the best value test?

Sara Gorton: We have members working in local authorities. One of the first things that I would say is that potential confusion could arise out of the use of that terminology. There are some points that I will make about the concept and the learning from how it was applied in local authorities, but your direct question was about what should be in a value test. We would be much more comfortable with terminology around public value, rather than best value, in particular.

In terms of what goes into any such test, we would see it as an opportunity to reflect both the direct and the indirect consequences of a procurement process for the wider system, with patient care being absolutely paramount in a decision. In particular, we would want to see a strong link to the impact of the quality of non-clinical care. We know that too often services like catering and cleaning, in particular, have a very direct consequence for patient care, but are not taken into account at a wider or contractual stage. The impact of removing those services from direct provision can often have unintended consequences, so we would like to see that considered.

We would also like to see a test extended to include employment standards. We would want to be involved in the further work on that. There is already some suggestion in evidence that has been submitted to you about using a value test to reflect the triple aims, and the need to reduce health inequalities as part of that.

I go back to the local authority learning from us. We think that it is very difficult to assess exactly what the impact of best value was in that sector, because of how it became conflated over time with people’s perceptions of cost-cutting. Just as the use of language around accountable care organisations set off all sorts of arguments that were not germane to the proposals for accountable care organisations, we



HOUSE OF COMMONS

would strongly recommend looking at the use of other terminology and moving away from “best value”.

Q236 **Dr Williams:** You think that we should use “public value”.

Sara Gorton: Yes.

Q237 **Dr Williams:** Can you explain a bit more what the difference between using the term “best value” and using “public value” would mean to you?

Sara Gorton: Our members will associate best value with a very specific set of changes that were made in local authorities to what had been the compulsory competitive tendering regime. That was softened by best value, which was introduced with the intention of allowing progressive tendering and contractual relations that did not just take lowest cost as a measure. However, the subsequent financial challenges across the sector mean that, for many staff working in that environment, best value is still associated with broad cost-cutting. Our strong recommendation would be that you should dissociate from that.

Q238 **Dr Williams:** So semantics are really important here.

Sara Gorton: Indeed.

Dr Gerada: I absolutely agree with everything that has been said, but I would slightly turn it on its head. From what you have just said, Sara, you would have to take into account an enormous number of financial and other metrics. I do not think that anybody can put those together and come up with a best value test. I would turn the whole thing around and say, “If the service does not go to the local provider, what impact will it have, either on the service or on the local community?”

I will give you two examples. This has so many unintended consequences that you will not know about if you go through it. Addiction services in the NHS, for example, are now being decimated—and with that, training of the next generation of addiction doctors and nurses, service delivery and research and development. What we have now is a lack of service provision. The best value test at the time may have been, “Yes, send it to this or that provider,” but what we have is the consequence of that.

Another example, on which I know you have had evidence from the Royal College of GPs, is sexual health services. Again, it has been a complete and total disaster.

I think that your best value test has to be, “What are the consequences of not offering to the local provider?” If it is a new service, you need to come up with a best value test, with commissioners and providers coming together to say, “What is this service, and how does it look?”

Q239 **Dr Williams:** Surely the commissioners need some type of teeth in this relationship. They need to be able to say, “We would give it to the local provider, but we need the local provider to show that it is meeting all these criteria.”



HOUSE OF COMMONS

Dame Donna Kinnair: As a previous commissioner, I would say that needs assessment is hugely important. The public health work that used to determine the needs for NHS services meant that we had some understanding of what local populations need. Those are the criteria by which you commission. Of course you take economics into it, but you need population health. What is your local population health? What are people suffering from most?

Then there is something about workforce issues. As Sara said earlier, you cannot just say, "Okay, we will give it to the cheapest provider," and then decimate the skillset and ability of doctors to deliver addiction services, or sexual health doctors who have specialist expert knowledge. That has happened as a consequence of some of the actions we have taken.

We know how to do proper needs assessment for our population's health. We have known that for a very long time. But there is something about, "What is the impact on workforce, and recruitment and retention? What is our contract with our local population? What is our health overview and scrutiny committee telling us the local population need?"

Then there is something about how we deliver that high-quality care—because it has to be of high quality. Care and quality of provision are also important. I am not saying that economics are not, but some of the drivers that we have had are the economics minus the rest of this stuff.

Rob Harwood: May I come in on that point? You started by asking, "What is a best value test?" We think that you have set yourselves a fairly difficult task there. It is clear what it is not. It is not all about money. It must be about quality. It must be about the patient experience. It must offer something that, if you were a patient, you would want out of the service. That has to be centrally important. It is also all sorts of other things. It is the social contract with the local area—retaining the stable employment that makes it an attractive option for people to be there, and retaining the money in the local economy from having those people around. It is about offering services that people want to be able to access locally.

We think that it is a difficult task. I take on board the point that how you title it is important for people. Clearly, it is, because it has to be something that enables people to have faith in the intention behind a particular process. However, one thing we would be very keen to participate in is an effective consultation mechanism to derive something that we will later call a best value test or something else.

Q240 **Dr Williams:** There is a certain simplicity about just putting something out to the market—of course, with the detail of a specification that you write. We heard from the previous panel that this could introduce all kinds of complexities that might well be open to legal challenge. Do you agree with that?



Rob Harwood: You could make it anything that you choose to make it. In creating a structure, you could definitely bring down unintended consequences upon yourself. The devil is in the detail of what the process actually involves. It could do that, but does it have to? The answer is, "Of course it doesn't." It could be something that is seen, and welcomed, as a way of developing services that have a realistic chance of working in the best patient interest—and the best public interest, too. That is part of what we feel a proper consultative process, to derive such a test, would represent.

Sara Gorton: If it works in the way Clare described, where the default assumption is that the provision will be statutory, your best value test tells you what to do if you are working outside that sector. A clear policy statement from the DHSC or NHS England would cover the approach. I am not sure that I agree at all with your previous panel about the level of risk.

Dr Gerada: It is not just about that service. It takes a long time to build up relationships between different providers in a complex, moving area—especially in areas such as inner London, where you have massive turnover of individuals. While you may change one service in good faith, that can destabilise the whole intricate jigsaw of existing services. First, do no harm—that is what I would say. As I said, the first option should be the local provider, with the networks—and there should have to be good reason why the contract does not go to them.

Q241 **Dr Williams:** But commissioners want to be able to innovate, to change and to improve.

Dame Donna Kinnair: We have always done that. We have always specified what improvements we would require from any contract. I do not see how I could agree with the previous panel; otherwise health services would have stayed still. Actually, prior to 2012, they did not. Prior to 2012, we had the NHS plan on whatever, and we all fought to improve services.

I am not quite sure what they meant by that. I know that, as a commissioner, I specified improvements year on year. When I made that specification, the performance checking then meant that we were looking for that. Whether you are commissioning local services or any other services, you will specify that and performance-manage to ensure that it is delivered.

Dr Gerada: Maybe we should get rid of the word "commissioning" altogether. I am serious. Maybe we should see how the NHS would work if we abolished that name completely and started calling it "planning", "population needs assessment" or "quality improvement". We have got hooked on the term "commissioning". I know that previous evidence—I think that it was from Nigel Edwards—has talked about the complexity of this word, which does not exist in other countries. Maybe we should just



HOUSE OF COMMONS

do an experiment. Let us use Ctrl+F to find “commissioning”, replace it with “planning” and see where we get to.

Q242 **Dr Williams:** The final word will be from you, Rob. You wanted to say something.

Rob Harwood: We diminish the role of commissioners if we expect that they will be entirely gullible and will go along with what the providers care to serve up. That does them a great disservice. They will expect to hold providers to account in whatever arrangement there is between us. I am not accepting Clare’s comments about whether that is a great term for them, but to equate that competitive tension between them as being the only way to make sure that patient interests are best served and best value is delivered is overly simplistic.

That is not the case at all, because in that competitive environment, as you heard from the previous panel, all those transaction costs are embodied in that competitive model, and the more competition you have, the more transaction costs you have. Let us keep it in mind that transaction costs mean money used in other parts of the system that has no direct benefit to patient care. It is not about patient care delivery; it is about everything else.

Q243 **Chair:** As a final group of questions, do you think decision making will be made at the right level? We have heard some evidence that it is moving it up to a different level and we will lose local decision making. Do you have any views about this, or is it good to be able to plan things over larger populations and do the planning, as Clare says?

Sara Gorton: I would come at this from the angle of the trade unions and our ability to work in partnership to influence decisions made about service provision, and whether enough staff are available to work in the services providing them. There has been a stripping-out of layers of accountability since 2012 that we think needs looking at. We would question whether this narrow set of changes is the right place to look at all the detail of that. The changes certainly would not make it worse. Will it automatically recreate the accountable structures that we want? I am not sure. It is a work in progress.

The bigger cultural change is around creating vehicles through which the bits of the NHS that need to work better together for the benefit of patients can do that, and there is discussion to be had around the aegis that those structures have over workforce; how they conduct workforce planning in a much more intelligent and responsive way; how they do sensible things like looking at pooling budgets for certain elements of provision.

Apprenticeships are one of the areas where that has gone very badly wrong. There is no ability for the current system to look at pooling apprenticeship levy across a wider health economy at the moment.



HOUSE OF COMMONS

In general, I would say, yes, the changes do not make the ability to work at a system-wide level more difficult. It is the culture that is needed to start those conversations and agree which bits of the structure are going to be responsible for what.

The one distinct area where I would point to some direct benefit from these changes, with a slight sting in its tail, is for the staff of the arm's length bodies. About 5,000 staff are at the moment working in a fictional organisation. The changes that would give clarity to the status of NHS England and NHS Improvement, and their merged selves, would be received well within the workforce, with some caveats about speed and expectations of cost-cutting that you would expect from us.

Rob Harwood: In general, we are supportive of local decision making, but we are aware that not every single decision is necessarily best made locally. It depends on the nature of the decision under consideration.

More broadly, some decisions need to be made at a level higher than local, such as specialised commissioning. I was just hearing from Sara the dreaded "workforce" word. To decide workforce, in the consultant idiom, is an enormously difficult thing to do, bearing in mind that the lag time between starting your training and finishing it is about 15 years. It is extremely difficult to predict, and it is hard to see how that would be done at a local or a regional level to cope with national variation. There have been some awful examples; I am trying to think of a good one, but that is a very difficult thing to do and almost impossible to do locally.

Dame Donna Kinnair: With regard to nursing, we have seen the impact of the lack of accountability for workforce. Some of the decisions that have been taken have put us back many years in having enough nurses to deliver safe care, having enough people on the ground to deliver the long-term plan.

I would definitely say—this is the mantra of the Royal College of Nursing—that, when we tried to find out who was accountable for workforce as we saw supply being diminished, we could find nobody who admitted accountability. If you need primary legislation around some of these things, you certainly need primary legislation for that, because we have seen Secretary of State after Secretary of State taking decisions putting us in a bind, and we cannot deliver the long-term plan without the workforce on the ground. Of course there is local decision making. We are not talking about accountability just for structures. We are talking about accountability to Parliament for the workforce of our biggest treasure—the NHS.

Q244 **Chair:** And, of course, we have the huge uncertainty of Brexit ahead of us.

Dame Donna Kinnair: Yes. Equally, don't forget that the NHS trains for the independent and other sectors.



Dr Gerada: I absolutely agree with what everybody has said. I do not have an expert view on this at all. My only desire is that we move towards a population health system where hospitals are responsible for the entire population of their footprint, join forces with their local GP and care providers and that the system is well enough planned that we get sensible distribution of resources at national level and more local level, depending on what you are trying to deliver.

That is all I hope for. We have gone around the block so many times. I have now been working in the health service for 30 years and I get confused. I remember strategic health authorities—a sensible NHS—but hey-ho.

Q245 **Chair:** Finally, Clare, in your role as co-chair of the NHS Assembly, has the NHS Assembly been given any assurance that its views will be taken into account during the development of these legislative proposals?

Dr Gerada: Yes, absolutely.

Q246 **Chair:** The plan was for it to come from the service working alongside local authorities. In your capacity as co-chair, where do you see the NHS Assembly being involved in developing these proposals?

Dr Gerada: Clearly, the NHS Assembly is not there to hold the NHS executive to account. It has a lot of spaces and places that does that. We had the first meeting last week. This regulatory issue was a major item on the agenda. I am sure you all know that the Assembly has about 55 people on it, ranging from service users, carers, medical students, nurses, people who are at the top of their office, to senior managers and so forth. There was overwhelming agreement that this was the right direction of travel. I mentioned I was coming here and that their views would be fed straight in. By the way, also, overwhelmingly, they did not want forced mergers of CCGs and they do not want any more top-down reorganisation. So, yes to this, but not a new NHS Act.

With respect to feeding it back and to getting their involvement, we have a whole series of meetings planned. We are going to be looking at workforce issues next, which feeds into that. My co-chair Chris Ham and I will meet the executive and the service out there on a fairly regular basis. We have around 550 people who applied to be on the Assembly but who could not be put on it, whom we will be using as a reference group as well to communicate with.

Chair: Thank you very much. We look forward to hearing from you again in that capacity in due course.