

Health and Social Care Committee

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

Wednesday 1 May 2019

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

Questions 247 - 306

Witnesses

I: Christian Dingwall, Partner, Browne Jacobson LLP; Sharon Lamb, Partner, McDermott Will & Emery; and David Lock QC, Landmark Chambers.

II: Charlotte Augst, Chief Executive, National Voices; Sir Robert Francis, Chair, Healthwatch; Professor Jo Pritchard, Director for Health and Social Care, Social Enterprise UK; and Beth Capper, Head of Programmes, Richmond Group.

Written evidence from witnesses:

- [Healthwatch](#)
- [Social Enterprise UK](#)

Examination of witnesses

Witnesses: Christian Dingwall, Sharon Lamb and David Lock.

Q247 **Chair:** Good morning. Thank you very much for coming to the final session of our inquiry into the proposed legislative changes and the long-term plan. It would be very helpful for people following from outside this room if you would introduce yourselves and say who you are representing.

David Lock: I am David Lock QC. I am a practising QC at Landmark chambers specialising in public law. I represent anyone who instructs me, but today I do not represent anybody.

Chair: It is very helpful to have your views, thank you.

Sharon Lamb: I am Sharon Lamb, a healthcare partner at McDermott Will & Emery. Today I am not representing anyone. My views are my own.

Christian Dingwall: Good morning. My name is Christian Dingwall. I am a lawyer and a partner at Browne Jacobson. We act for many healthcare organisations, including the NHS, private sector and social enterprise.

Chair: Thank you very much. We have quite a lot to get through and we are really interested to hear your views.

Q248 **Dr Whitford:** How would you say the current legislative framework has become an impediment in any way to implementing the five year forward view, particularly integration, which is the key aim of the changes? Maybe we could start with David and work along.

David Lock: I spend about 80% of my time representing NHS bodies and 20% challenging them, so I see it from both sides. The fundamental problem is that the 2012 Act was set up with the concept of creating an NHS market, with all the legal structures of the market, regardless of whether the contracting party was another public body or a private sector organisation, so all sorts of rules, structures, procurement requirements and competition requirements emerged as an inevitable consequence of that fundamental belief. Essentially, the process of delivering better public services through that market mechanism has failed.

For the last five years the NHS has been struggling with a set of market mechanism laws in a managed economy public service, and the two do not mix. Therefore, the real problem is that, where NHS bodies are working with other NHS bodies, they still have to operate market structures with all the EU laws that apply to those, which of course is a choice; it is not mandatory. You could set up your public services without reference to market structures, and then EU laws about the market obviously do not apply, but they apply by law, and therefore what NHS England calls workarounds are in fact partly workarounds, partly crossing our fingers and hoping that nobody challenges us and we get away with



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it, and partly blatantly ignoring what Parliament set up in 2012 in the hope that Parliament did not define its views closely enough. Essentially, in the litigation, that is where the touchpoints come.

The big picture is that you have a market system. If you do not want a market system and you want to run a public service, you need a different form of legal structure.

Q249 **Dr Whitford:** That is what people forget. We often talk about it as the NHS competing with private providers, but actually it has created NHS bodies competing with each other as well, which I assume has contributed to the fragmentation.

David Lock: There is nothing wrong in principle with NHS bodies being in some form of competition with each other. The question is whether they have to do it within the full structure of an external market, where if you are deciding how you want to allocate a particular service and there may be two or three providers, NHS trusts, that can provide it, you have to do it at the moment within the structure of a market economy, with procurement laws and competition issues. In fact, it is a choice. The moment you bring private sector operators in, the moment you cross the line away from public bodies, you are in a different world, but that is a choice.

Sharon Lamb: I have a slightly different take on what the impediments are. Like David, I represent a wide range of NHS bodies and independent sector bodies—and have done so for a long time. A lot of the work I have done has been working with NHS bodies, NHS Providers particularly, on how they are able to create integrated care networks or groups of providers. The issue when you really look back at that is that the term “integrated care” is not brilliantly clear. It can mean anything to anyone. I do not think it is necessarily saying that if we put all services into one contract specification it makes integrated care. I think a patient would say that it is a feeling of being lost in the system when they move from provider to provider—for referral, discharge—and a sense of being lost between providers.

In fact, on integrated care, we already have existing providers on contracts for those services. We are talking about the gaps between their contracts rather than necessarily those contracts themselves. To give you an example of a typical system, in an integrated care system where you have an ambitious plan—not a small, marginal out-of-hospital service integration but a big system plan—you may have 30 to 50, probably more, GP providers. Those GP providers are mainly on statutory contracts; they are not regulated in the same way by NHS Improvement. Effectively, they are contracts that are sustained for life. You will have two or three NHS providers. Most of their contracts are not procured. In my personal experience, 95% of contracts are rolled on every year. The acute provider does not have its contract tendered, but it is under a regime of NHS Improvement and the CQC, as is the mental health trust and probably the community provider. Then, typically, there are social



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enterprises, voluntary care sector providers and independent sector providers.

The issue is that the contracts that have been written for them, as they currently stand, do not match, and the regulatory regime does not match. Is that answered by awarding a single contract to a new body? Frankly, we could have a new trust created any minute under the current legislation. The legislative proposals say that it is not proposed that that new trust would provide all those services, so we are not talking about a giant merger, say, of 80 or so organisations in a system. We are talking about a single contract going to a trust and then that trust subcontracting all those contracts down to all the existing providers. When you draw that out, as lawyers are prone to do, effectively, you end up with the same contract lines again, but with the same issues that you currently have; if you cannot write the contracts now to write what you want to achieve, how does all of that regulation work at the subcontract level, which is where the work will actually be done?

The real problems are on pricing, risk transfer and making sure that patients move smoothly, effectively ensuring volume contracts at each level. If you look at the tariff changes, tariff only applies on the commissioner to the first trust; tariff does not apply at subcontracting level. Effectively, that is done, if you like, in a darkened room, negotiated on a case-by-case basis.

I have found that those are the issues that cause problems. You have a year on a kind of contracting round and a year on budget allocation, when effectively you may have more spend in your first few years. As an observation, yes, procurement will affect a small proportion of those contracts, but is it the tail wagging the dog, when actually, in practice, you are having much more substantive conversations?

Q250 Dr Whitford: Do you think that the problems are more regulatory than to do with contracts, and do you think these changes are going in the right direction or that they will have unintended consequences?

Sharon Lamb: Some of the changes are definitely in the right direction. For example, the ability for CCGs and NHS England to work together with 7A pricing is eminently sensible because that is helpful. What I cannot see, and it is perhaps something that needs to be looked at—it might be in the last pages of the legislative proposals where they talk about a regulatory system and greater control—is a regulatory system that governs a network of providers, that looks at the gaps and in fact answers the question about the many practical things that need to be purchased for those gaps, such as data tools and population analytics, real tangible things. Who is responsible in that network for providing it, and is that effectively allowed for in the pricing?

Q251 Dr Whitford: Do you think the regulators that currently exist would need to change or would need to take on new responsibilities, or are you thinking of some completely new regulatory approach within that?



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Sharon Lamb: Probably there could be some subtle changes—not large changes, but subtle changes—to the way NHS Improvement currently regulates on a single-body basis. CQC currently regulates on single registered providers, and that can cause issues when groups of providers are working together.

Q252 **Dr Whitford:** Do you see them regulating perhaps an ICS or something like that?

Sharon Lamb: Yes, a system.

Christian Dingwall: Inherent non-integration is a design feature of health and social care services. I am sure that you have heard before of how in 1948 primary medical services stood outside the rest of hospital and community services, and health services and social services stand apart from each other. That is inherent design in the services.

Since the 1990s, the reforms have perhaps, to some extent, exacerbated the risk of non-integration, but it would be unfair to say that it is simply the Health and Social Care Act, and regulations made under it, that is responsible for non-integration. When one looks at the NHS competition regulations, for example, I think that most people would agree with the objective that they state: “When procuring health care services for the purposes of the NHS...a relevant body must act with a view to...securing the needs of the people who use the services...improving the quality of the services...improving efficiency in the provision of the services, including through the services being provided in an integrated way.” I do not think that anybody who is minded to suggest reform would say that, in principle, that objective of the regulations is objectionable, so what has been the problem?

Some areas have made good progress in the five year forward view, in areas such as Salford, Northumbria and Manchester city, you can see examples where they have been able to set up new models of care successfully. One of the features of those kinds of areas tends to be that they have good coterminosity between commissioners, different types of providers and health and social care providers, and that coterminosity lends itself to collaboration between them.

A problem for other areas is when there is lack of coterminosity, and different providers and different commissioners cross each other’s boundaries. One of the issues then tends to be to what extent there is a regime of compulsory competitive tendering. Some people take the view that there is such a system. It is probably legally much more nuanced than that. There isn’t compulsory competitive tendering, yet often there is a reflex reaction that we must undertake some competitive tendering if we think that there might be more than one potential provider.

Q253 **Dr Whitford:** Why do you think the Surrey CCGs, who tried not to break a contract but bring the next contract back into the NHS for the community, felt the need to settle out of court if there was not actually



that compulsion from section 75?

Christian Dingwall: There are two particular issues. One is whether or not you do a tendering process from the start. If you do not do a tendering process at all, if you decide to do an assessment without running an advertised competition, you may be able to manage the risk so that you avoid a challenge being made; but if you run a competition you have to stick to the rules of the competition, and if there is a breach of the rules of the competition you lend yourself vulnerable to a challenge being made.

Q254 **Dr Whitford:** So it was because they put it out to tender and awarded a contract previously, and they then could not change back.

Christian Dingwall: It is very difficult once you have taken toothpaste out of the tube to get it back into the tube. A risk that all commissioners run is that, if they are going to run a competitive process, they have to be scrupulous in mitigating the risk of a legal challenge being made.

Q255 **Dr Whitford:** Will the reformed section 75 not remove that issue and changing tariffs not remove the two blocks that people moan about?

Christian Dingwall: If one could remove the need to run a competition at all, you would not have the risks inherent in running that competition, but if you run a competition you will still have the risks associated with running a competition. Regardless of statutory obligations around a competition, almost inevitably you will have a duty of fairness; as public authorities, you must act fairly. That means that you will have to have rules of the game for that competition and make sure that you stick with those rules, because, if you do not, you put yourself at risk of challenge.

Q256 **Dr Whitford:** The Department of Health and Social Care is still talking about “involvement of other providers, external providers”, so actually some of that will still exist. They will need a mechanism, whether or not it is the same process as now.

Christian Dingwall: It could be a special NHS mechanism. The NHS has tried doing this sort of thing before. It has its own dispute resolution procedure for primary care disputes, so it has experience in doing that. If it did not have its own special regime, it would probably leave itself open to risks of challenge by way of judicial review, so it will not be possible simply to exclude the risk of challenge altogether.

Q257 **Andrew Selous:** I would like to ask about the legal basis for co-operation between health and local government, and how joint commissioning is going to work under the legislative proposals in trying to get good outcomes for patients, which is what this is all about. How is that going to work? Christian, your very helpful history of the origins of the NHS and the degree of segregation and separation from the beginning was a helpful reminder to us. David or Sharon, would you like to add to that and give us your take? The interface between health and local government is key if we are to get genuine integrated care. How is



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commissioning going to work under different legal rules, and where are the two partners going to be left on a legal basis?

Sharon Lamb: Christian is absolutely right to say that they are two different systems. At the moment, the regulation of those systems is separate, and the competition procurement rules are separate. It would be helpful if the other section 75 rules—the partnership rules between commissioning and local authority—were expanded; currently, they are fairly narrow. Perhaps the devil is in the detail and it is something still to be looked at, but, as it stands, these legislative proposals do not expand on how that might work in practice.

Q258 **Andrew Selous:** Could you say a little more about the local authority section 75 rules and what their relevance is?

Sharon Lamb: The question is whose money is going into a contract, effectively. As it stands, under the section 75 regs, commissioners and local authorities are able to pool their budgets and create joint commissioning arrangements. There are also additional flexibilities under the legislation. Some of them were brought under the delegation changes. Some of them have not been used. In practice, they offer some effective tools, but at the moment the secondary legislation is pretty narrowly written, so that only very narrow services fall within it, not the greater scope of services.

Q259 **Andrew Selous:** Local authorities have a duty to work within a balanced budget, whereas the NHS tends to put out its hand to the Treasury for more money, so how do you see the basis legally for working under those two different financial regimes in the future?

Sharon Lamb: Of course, the NHS also has the duty to act within its means, but there are some routes to payment. That is really a question, in my view, as to overall funding, which is rather beyond my scope to comment on.

Q260 **Andrew Selous:** David or Christian, do you have any thoughts on the local government issue?

David Lock: The key difference between local government and the NHS is that in local government the same body is both the organiser of services and the deliverer of those services. The local authority employs the social workers who then go out and deliver many of the services, whereas in the NHS there has been historical division between the commissioner and the provider.

Sharon is perfectly right that section 75 is one means for joint commissioning, and the joint commissioning body will then deliver a variety of services from a variety of providers who may well be the local authority itself. Therefore, the local authority is using its own money, through its joint pool, to commission its own staff to deliver services, but, hopefully, in a more integrated way, with other community providers—



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maybe a community trust, people working for a GP surgery, or a whole range of providers.

The legal problem, if there is a legal problem, is unpacking the arrangements so that the rules that apply to the way that process works are sufficiently fair and transparent, and that they comply with a duty of fairness and transparency, and, if necessary, with a duty to comply with EU law, because I think we all assume—maybe it is an unspoken assumption—that, in the planning for the delivery of the NHS, EU law on the rules of the market will continue to exist. If it does not, for one reason or another, and it is totally beyond my pay grade to say whether or not it is going to, in a sense the UK can write its own rules, and that is fine.

Q261 **Andrew Selous:** Can I press you on that? Are you saying that EU law will still apply as and when the UK leaves the European Union?

David Lock: Under the present arrangements, EU law will continue to apply for a transition period.

Q262 **Andrew Selous:** But, beyond the implementation period, is it going to happen anyway?

David Lock: Beyond the implementation period, who knows what is going to happen? Who knows what arrangements we will set up with the EU under which, even if we are not a member of the EU, we still have to apply some elements of EU law? Who knows the extent to which EU law will continue to apply? For example, in EFTA countries EU law still applies on procurement; they are not members of the EU, but they still have to comply with procurement rules.

The challenge, as Christian rightly identified, is how you set up a set of bespoke NHS rules that comply with the requirements of fairness, transparency and, to an extent, can comply with EU rules, but are sufficiently light touch that you do not end up with people drowning in red tape, as you can with the procurement process. The point that Sharon made is also important. Only about 2% of NHS contracts are in fact tendered, so, although there is an awful lot of focus on those that are tendered, the vast majority of the annual contracting round is between one commissioner and one provider.

There is only one hospital trust in Worcestershire, where I live, so there are always going to be contracts with that provider. In Birmingham, there will always be contracts with UHB and there are always contracts with the community trust because there is only one community trust. Therefore, the question is about how you structure the arrangements so that you make sure you get the fairness and transparency that avoid the sort of Spanish practices that are not in the interests of patients, but also do not drown the officials in red tape. It is a challenge, but it is not really a challenge at the primary legislation level. If the primary legislation level



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can create the right framework, the details will come in secondary legislation; if they do not work, they can then be changed.

Q263 **Andrew Selous:** Christian, do you have anything to add? There is no need to repeat anything.

Christian Dingwall: Yes. The section 75 partnership regulations were originally designed for the joined-up commissioning of mental health services and some community services. They were not really designed for the joined-up commissioning of acute hospital services. For example, surgery is excluded from the jurisdiction of section 75 regulations. Anything knife to skin has to be commissioned only by a health commissioner; it cannot be commissioned by a joined-up health and social care commissioner. That is reasonably easy to tweak. One can amend the regulations, and that will take some consultation. Nevertheless, as I say, it should be relatively simple to undertake that kind of legislative amendment.

There may be a more profound difference, though, between local authorities and CCGs, and it is, in a way, related to best value. There is a suggestion for the legislative change to introduce a best value test for the NHS, and, when one thinks about best value, one immediately thinks of local authorities, which are subject to the best value test, but there is a fundamental difference because local authorities are subject to the public contracts regulations. There is no suggestion that they should be extracted from the remit of the public contracts regulations. Even when we leave Europe, they would continue to be subject to some procurement competition law.

Local authorities differ from CCGs because local authorities are not simply commissioner organisations; they are commissioner/provider organisations. CCGs are commissioning-only organisations. When undertaking a best value assessment, the local authority often decides whether or not it should be providing a service in-house or going to the market and running a competition to get a third party, or testing the in-house provider against the open market. That is not open to CCGs to do. CCGs have to get somebody else to provide the services.

For as long as we are subject to the EU directive, which gives rise to the public contracts regulations, it seems to me, therefore, to be in some ways unhelpful to say, "How do we get out of the public contracts regulations by amendment or revocation of the public contracts regulations?" It may be more useful to work out what we can do to the NHS statutory framework that will make the NHS fall outside the jurisdiction of the public contracts regulations.

Some of the legislative suggestions—for example, the triple aim, the joint committees, those types of arrangements—may lend themselves to being able to work with the public contracts regulations in a way that means that you are able to commission services without having to run a competitive process. For example, one might be better able to take



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advantage of regulation 12(7) under the public contracts regulations, which used to be known as the handbook exemption, where public authorities are able to collaborate in their commissioning and, by collaboration, avoid running a competitive process. That is not straightforward, but nevertheless it may be that you can undertake some tweaking that will facilitate it.

Q264 Andrew Selous: What would be the most helpful definition of best value to go into these legislative changes, to enable the system to work as well as it should?

Christian Dingwall: If one looked at a better value regime, notwithstanding the appalling press that the NHS competition regulations receive, it would not be far off undertaking a most capable assessment, in line with much of what the NHS competition regulations are saying. You may want to get rid of the fact that you cannot discriminate against organisations on the basis of ownership, but a lot of the material is there. It would be, in effect, an agile development of the competition regulations as they are at the moment.

Q265 Dr Williams: Will the proposed legislative changes from NHS England result in the NHS in England falling outside the public contracts regulations?

Christian Dingwall: That is a really big question to answer in a few minutes, but I will do my best to highlight the fact that we have systems in Scotland and Wales that fall outside the public contracts regulations and that is because they are administrative arrangements. If we have administrative arrangements, we can take the NHS in England outside the public contracts regulations, but that is difficult to do; even if you, for example, reverted and all foundation trusts became NHS trusts and all contracts became NHS contracts rather than legal contracts, those might not by themselves be enough to make you into an administrative arrangement.

It may be better to recognise that, as I said, the toothpaste is out of the tube; we have competition, and you will continue to want some competition. There is no suggestion that we get rid of competition altogether—just that the NHS should be able to prefer to commission an NHS organisation, but at the same time still run a competition—so it is difficult to see us, as the law is at the moment, being able to take the NHS completely out of the public contracts regulations. That is why I am suggesting that there should be agile development of the current system so that it can work more effectively in the regulatory structure under the public contracts regulations.

David Lock: Could I offer a view? I think the question is the wrong one, if I might say so. It is perfectly proper for UK domestic law to exempt the NHS from the public contracts regulations. Whether or not that is a good idea is a matter of policy, not a matter of law.



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The question in law is whether or not the NHS is exempted from the scope of the procurement directive under the EU. What I think Christian is talking about is the extent to which there is, in broad terms, sufficient central control of the way that public services are organised as allocated between a number of different public bodies, which means that it is treated in EU law terms in accordance with recital 33 to the directive, whereby effectively it is the internal organisation in a public service.

To take an example, if in Parliament you have a system whereby the Health and Social Care Select Committee gets re-charged for its photocopying by a Parliament photocopying department, that contract is not tendered; an invoice goes back and forth and it is an internal re-charge. It is treated purely as a service agreement in the parliamentary system. There is no external contract; you do not have to put your photocopying out for tender. Why? Because it is all part of the same system.

You can expand that concept beyond one single organisation and have groups of public bodies that work together, and, in broad terms, as Christian is rightly talking about, in Scotland it is precisely that. The reason that the public procurement regime does not apply is that the whole system is set up by way of internal service agreements usually, no external contracts, and that was the system that operated in the NHS for many years prior to the creation of foundation trusts—internal contracts, not proper contracts and everyone directable by the Secretary of State. It was all treated as part of a single public service. Therefore, it is outside the directive, and, if it is outside the directive, UK law can, quite rightly, repeal the public contracts regulations.

Q266 Dr Williams: If the policy outcome we desire is for the NHS in England to be outside that EU procurement directive, will these legislative changes achieve it?

David Lock: Not quite. They need to go a bit further as to the degree of public control that the centre has over the process. Without necessarily spelling it out in detail, that is what the process appears to be moving to. There is one big proviso: that all works very well until the point at which, as part of your arrangements, you want to bring in a private provider, be it a GP practice, Virgin Care or a physiotherapy company, as part of your primary contracting arrangements. At that point, it is extremely difficult to have a mixed economy where the directive does not apply.

Sharon Lamb: I was going to make a very similar point but also say that some of this is a matter of fact, so is it operating as a market? You already have a mixed economy. Is the proposal to remove all of those contracts so that the independent sector no longer plays any role? It is a matter of fairness. If you are allowing parties to participate, many of whom have invested heavily in the market, does what you are proposing actually mean a kind of nationalisation of those arrangements? Those are quite significant questions that certainly cannot be answered in quick, short replies here.



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Chair: I want to bring Philippa in because, in Scotland, at some point they presumably use some non-NHS provision.

Dr Whitford: It is about 0.7%. It is largely waiting list initiative-type things. There is nothing—

Dr Williams: It is still a mixed economy, as Sharon was describing.

Q267 **Dr Whitford:** Only as an emergency back-up. It is not part of the system, but we have GPs, so I want to clarify this with David. Our GPs are contracted to the NHS in the same way as England, as far as I understand it. I can understand bringing in totally private providers, but I do not understand why it is an issue that we have—

David Lock: How long have we got? Of course, you are correct that GP contracts with GP practices are private sector contracts, which in principle ought to be tendered under the directive like any other system. I cannot talk about Scotland, I am afraid, as I am not an expert on Scotland, but in England most GP practices work under what are, in effect, perpetual contracts. Under the standard GMS contract, the general medical services contract, the identity of the provider is maintained and is perpetual. The typical example was a four-partner practice, somebody retires, somebody else is brought into partnership, the contract continues, somebody else retires, somebody else is brought into partnership, and 15 years on you have a public contract with totally different people and it has never been put out to tender.

Q268 **Dr Whitford:** There have been no new GMS contracts in England since 2013 or 2015.

David Lock: No. If it is an APMS contract, for example, they are put out to tender, and if there is a vacancy, typically with a sole-handed practitioner but sometimes with more, NHS England puts a GP contract out to tender. Probably they have to, as they cannot take advantage of the single capable provider under regulation 5—I think—of the 2013 regulations because there are plenty of people who could potentially offer their services to provide GP services. Therefore, they probably have to go through some form of procurement process, or they would be subject to challenge. But you are right that it does not happen very often because most of the time the contracting structures are that GPs sort out themselves who is going to carry on the business.

Dr Whitford: It may well be that a tiny amount, when they want a waiting list tranche or something, is put out to tender, but it is not a part of the internal system, other than predominantly GPs.

Q269 **Chair:** I am very conscious that we have an awful lot to get through before our next panel, whom we are keeping waiting. This is absolutely fascinating, but could I ask you to respond briefly to that, Sharon, and then we are going to move on?



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Sharon Lamb: One question about waiting lists is of course that those are choice services, and the proposal appears to be that choice would continue to be enhanced, but by removing the 2013 regulations you actually remove a fundamental part of how providers are accredited to provide, so in England particularly the waiting list issue should be dealt with through choice, but only if those choice proposals are enhanced. My concern is that, the way it is written, the removal of the regs would undermine those significantly.

Q270 **Diana Johnson:** I am sorry, I was having a conversation with the Clerk, but I am particularly interested in what you were saying about choice. I wanted to know about the changes that are being proposed and the idea of choice for patients, so could you repeat what you said?

Sharon Lamb: I apologise for the technical detail, but currently the choice rules are contained in the 2012 standing rules and in the 2013 patient choice regulations, the ones we are speaking about, on revocation. They are also contained in other provisions.

The issue of revoking the 2013 regs is that effectively you remove the right for providers to be listed if they achieve or meet commissioner requirements or standards. By removing the 2013 regs, you effectively remove the right to be listed on an AQP list on NHS Choices, so you have cut off half of the choice entitlement. It is not enough to say that patients have a constitutional right to choice if you do not also allow the market to provide.

A key point in that is the best value test. There are two limbs at the moment—most capable provider and best value. If it goes to best value, is that just chopping off the most capable provider part, leaving yourselves with best value? I am afraid that all of us here are likely to give you some good examples of procurements recently that have gone out, not only on elective services but other services, sometimes at a significant mark-down from tariff, 20%, 30% or 40% down on what would be previous costs of provision. If you are going to keep choice and if you are going to keep the right to provide, you need some of the market levers, like fairness on price, treating providers evenly and transparency. They need to be there, otherwise you save with one hand and take away with the other.

Diana Johnson: Thank you. That is helpful.

Q271 **Andrew Selous:** We want to ask you about the legal position in relation to VAT because I think there are some issues. Could you briefly give us a helpful pointer as to what we should do to sort out the VAT issue, please?

Christian Dingwall: I will try to help a little. We start from the proposition that health is exempt from VAT. Where you have an exempt service, that means that the provider of the services cannot recover the VAT that he or she incurs on the provision of those services; for example, if you undertake a hospital building programme and you have to pay VAT,



the starting position is that an NHS organisation is not able to recover the VAT that it incurs.

There are, though, some special provisions made for the NHS, and there is something called the contracting-out services regime. That means that where an NHS organisation contracts out certain services—for example, hospital building—it is able to recover VAT. That is a saving of many millions of pounds to the NHS and it is therefore important that the NHS does nothing that upsets the ability to recover VAT under the contracting-out services regime.

The contracting-out services regime only works where there is NHS-to-NHS contracting, so, when a CCG commissions the NHS provider, the NHS provider can recover the VAT. If, however, the NHS commissioner contracts to a private organisation, what might be a care integrator, and that care integrator then subcontracts to the NHS provider organisation, we break the chain of NHS-to-NHS contracting and—

Q272 Andrew Selous: I am sorry to interrupt your flow, but I thought we had been given pretty cast-iron assurances from Simon Stevens and everyone down that the integrating organisations would be public organisations.

Christian Dingwall: That is why it will be necessary, in order to ensure that they are going to be public organisations.

Andrew Selous: So if they are—

Christian Dingwall: They have to be NHS organisations in order to maintain the ability to recover VAT under the contracting-out services regime. In the past, attempts have been made, for example, with UnitingCare in Cambridgeshire, to introduce a non-NHS organisation—a limited liability partnership in that case—and that created VAT problems. There have been problems in others.

It is very important in looking at reforms that we maintain that and that, when we look at joined-up decision making, we keep that joined-up decision making within the NHS. It is not simply the private sector, though, because if the NHS were to delegate, under the section 75 partnership regulations that we have discussed, its NHS commissioning to a local authority, we will run into the same problem about upsetting the contracting-out services regime. That is a problem in respect of local authorities getting involved in the contracting.

Local authorities themselves have issues around VAT, in particular relating to something called the partial exemption rules. If a local authority delegates its commissioning to the NHS, it may run into problems with VAT recovery under the partial exemption rules. It is the contracting-out services regime and the partial exemption rules that we need to be careful about in undertaking any reform, to make sure that we do not upset the abilities of local authorities and the NHS to recover VAT.



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Q273 **Andrew Selous:** Would it be possible to sort out the VAT issues in a piece of NHS legislation? It would have to go through the Finance Act, I presume.

Christian Dingwall: I think it would have to go through the Finance Act, but one has to bear in mind as well that VAT is based on a European directive.

Q274 **Andrew Selous:** When—I am going to say when—we leave the European Union, will that not apply?

Christian Dingwall: Then we will be able to make changes to the VAT regime of the type that you are describing, if that is what Parliament wishes to do.

Dr Whitford: Unless we don't.

Sharon Lamb: I have an observation, although I am not a VAT specialist, so you should certainly speak to a VAT specialist. In the past, the contracting-out rules have been amended by Treasury direction. I do not believe it was a matter for primary legislation, so I think there are simple fixes that do not necessarily involve the matters for discussion.

Andrew Selous: Thank you.

Q275 **Dr Williams:** Obviously we are producing a report. Do you think it is going to be necessary, in order for this whole new system to work, to make amendments to the contracting-out services rules and to the partial exemption rules?

Sharon Lamb: Some of it is a question about the nature of the body that holds it. Let us say, for example, that a GP provider, as a private organisation, held the contract. There are the same issues in any case, and it may be that in a mixed economy, where, as I described at the very beginning, you have a whole lot of providers working together, it naturally means that there has to be some exchange of staff and some exchange of supplies. The whole system has to work together, assuming you do not wipe away everything, and actually has to allow for that flexibility with funding flowing through, and not having artificial constraints—putting them in in an artificial sense. It seems to me that that should not be the driver; you really want to create the right incentives so that all organisations in the system work together in the same way.

Dr Whitford: Losing the VAT exemptions would be a big financial hit, so it is something that would need to be dealt with.

Q276 **Dr Williams:** We are talking about potentially recommending that there is some kind of consultation on protecting or extending it.

Sharon Lamb: Remember it is only VAT on supplies that is affected; it is a certain percentage; but in the Cambridgeshire example that was not there before, effectively; it was not charged when it was NHS bodies. It



was simply the way they tried to find a way to govern themselves together, because it is difficult for two organisations to hold a contract.

Chair: I am very conscious that we need to move on to our next panel, but you have highlighted an issue that clearly needs to be looked at very carefully in the next stage of development of these plans, so thank you very much for pointing out the pitfalls to us. We are grateful to you. Thank you for coming.

Examination of Witnesses

Witnesses: Charlotte Augst, Sir Robert Francis, Professor Pritchard and Beth Capper.

Q277 **Chair:** Good morning. Thank you very much for your patience in bearing with us. I am conscious that we are running rather late after our fascinating first panel, but we are keen to hear your views. For those following from outside, could I ask you each to introduce yourselves and say who you are representing?

Professor Pritchard: I am Jo Pritchard, a consultant in health and social care at Social Enterprise UK, which is the national representative body for social enterprises in this country. For those who are not aware of our world, social enterprises are organisations that operate with a social mission and are completely aligned with NHS values—for those in the world of health and social care—but use any surplus in patient care. My background is that I am a nurse, and I was also chief executive of the first social enterprise to come out of the NHS, back in 2006.

Beth Capper: I am Beth Capper, head of programmes at the Richmond Group of Charities. We are a coalition of 14 of the leading health and care charities in the UK, made up of single condition organisations such as Macmillan Cancer Support and the Stroke Association, as well as those interested in the care of people with long-term conditions, such as Age UK, the British Red Cross and the Royal Voluntary Service.

Charlotte Augst: I am Charlotte Augst, the chief executive of National Voices, which is a coalition for all charities in health and care, large and small. We have about 160 members. It is week eight of my job; I was at the Richmond Group before, so we are good friends, and we all talk together.

Sir Robert Francis: I am Robert Francis, the chair of Healthwatch England, which co-ordinates and supports a network of 152 local healthwatches, one for each local authority. Our collective job is to ensure public engagement in the decisions made by the NHS and social care, and transmit back to people information about those services.

Q278 **Chair:** Thank you all for coming this morning. If possible, I would like to give each of you an opportunity to give us a pithy summary of your key points about these proposals, both the pluses and minuses. Then we will



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explore some aspects of them in more detail. I want to give each of you a chance to set out your main points.

Sir Robert Francis: Thank you. We welcome this opportunity to comment on the proposal to have legislation about the changes taking place in the NHS. Our particular viewpoint is that a lot of conversation has been going on between people who are already in the system about changes that will profoundly affect the way the public is served by health and social care. A lot of that will be for the better—there is no doubt about that; but for it to have traction it is vital that the public are engaged in the processes that bring out the changes.

Healthwatch, among other organisations, is well placed to do that, and already has played a part, in that we provided the views of 85,000 people, which were used in the long-term plan. We are now commissioned, through local healthwatches, from NHS England, to undertake a consultation exercise in relation to the implementation of the plan. If changes in integration and so on are to work, we think it is important that the position of Healthwatch, and public engagement and involvement, is fully taken into account, so that it is not just a one-off exercise but something that continues. Without that, the public will not understand what is going on and are therefore unlikely to accept it.

Charlotte Augst: Like Robert, we welcome this exercise and the broad intent behind the legislative proposals to improve integration. In a nutshell, we would argue that so far what we have heard from NHS England is very NHS focused, and it is about better integration of better NHS bodies. We need to expand that thinking and get to a point where we are better able to integrate across boundaries—NHS, local government, the VCS, local communities and service users. We need to get to a place where we have shared leadership for health and wellbeing in places, and that shared leadership needs to come out of the NHS silo.

Significant obstacles are in the way of achieving that shared leadership in places, and I shall focus on the ones for the VCS. We would probably argue that legislation is only a small part of that. There is something about the vulnerability of infrastructure organisations, locally and nationally, which can help with sharing leadership for issues and for places. But there is also something about IT infrastructure, behaviours, culture and data flows—all the stuff that we do not need to explain any more, because we think it is how the NHS works, but which gets in the way of integration. As always, the law will only ever touch a very small part of that, so we would probably be a bit sceptical about hoping that a legal change will get us all the way.

Beth Capper: I echo a lot of those points. Colleagues who have spoken previously welcome the direction of travel and anything to promote integration, but it must be a system approach to integration; it cannot look just at the NHS. As Charlotte said, we need to think about local authorities, the voluntary sector and communities themselves, and how they are involved. We need to think, too, about patients' experience and



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people's experience of care and outcomes as critical to that, understanding what value means in a health system.

Also welcome is the move away from a focus just on competition, which can create some unhelpful behaviours, but there is a risk of unintended consequences around that. Again, there is a focus on the NHS as providers, which arguably narrows the field. There is an important place for the voluntary sector in service provision and bringing innovation, and making sure that that is clear, as well as involving people in the process, as has been said already, and making sure that they have a say, and participate in and understand what is going on.

Professor Pritchard: We believe there is great potential for improving collaboration, and clearly there is great scope for that. The long-term plan talks about integrated care delivery, which is absolutely the right thing to be doing. However, the proposals are light in some detail, and you could see, through the proposals being enacted, a reduction of providers and a reduction in challenge for poor practice.

We are very interested in the outcomes that we are seeing with social enterprises, as you would expect, with much improved workforce engagement—a happier workforce. We should bear in mind that social enterprises coming out of the NHS have all been staff led; they are large groups of staff who see better outcomes for themselves, so they are happier and more engaged, with better outcomes for patients. Also, they are financially sustainable, because you cannot operate in deficit if you are an independent organisation.

We see social enterprise as key in the NHS, and part of the NHS family. One of the issues in the proposals is the definition of NHS providers. We would wish to see that widened to include organisations that are not-for-profit-sharing but are completely aligned to NHS values, even more so, and looking at wider social impact. We would like to see primary care included as well, some of which is in social enterprises, as it seems perverse that we are excluding our GP colleagues from these discussions.

Chair: An important point. Thank you very much.

Q279 **Dr Williams:** First, I have a very brief question. Have any of you or any of the organisations that you represent been directly involved in drawing up these proposals?

Sir Robert Francis: Do you mean the long-term plan or the legislation?

Dr Williams: We are talking particularly about the legislative proposals.

Sir Robert Francis: No. Healthwatch England has been involved in some pretty high-level discussions. It is a pretty high-level paper, if I may say so, and I have discussed it briefly in a private meeting with Simon Stevens. We have been involved to that extent. We think that our anxieties are being taken on board as to where the local healthwatch network should be in the process.



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Q280 **Dr Williams:** Was anybody else directly involved?

Charlotte Augst: The Richmond Group and National Voices were involved at the margins with a small workshop, and we managed to bring a few members of National Voices along, but we have not been part of a more strategic or sustained engagement with the VCS, locally or nationally.

Beth Capper: We were involved after the event, after the proposals were published, not prior to the publishing.

Q281 **Dr Williams:** I have a much more detailed question, which might allow you to expand a bit on what you have just been saying. How do you think the proposed changes will either help or hinder the ability of frontline services, whether NHS or non-NHS services, to integrate care for patients?

Professor Pritchard: It comes down to behaviours and culture more than to some of the legislation changes. If you look around the country over the last few years, you can see areas where there are mature commissioners and good relationships, and it is already happening; people do not require changes in legislation to make significant sea changes in how they work together. It comes down to relationships and behaviours.

Where there are less positive and less mature commissioners and providers in place, people tend to resort to legislation. I am aware that there are examples where it has been unhelpfully enacted and sometimes used not to improve services. I can see that the proposals could address some of that, but, as I say, it is a very tiny part of it, because it is actually far more around relationships and behaviours.

Beth Capper: I agree with the point about relationships and behaviours. There are some opportunities to help to address some of the challenges with the fragmentation of commissioning and possibly to support on some of the issues around the postcode lottery and delegated powers. There are some benefits. To go back to the question of who is being integrated, it is about looking beyond just the NHS and understanding where the local authority fits in, and where the voluntary sector fits both as a possible service provider and, in a perhaps neglected area, with a role in enabling co-production and the involvement of local people. It is about where they sit in these proposals.

Q282 **Dr Williams:** The legislation does not say anything about that. Do you think there would be a need for different legislative changes, or does it have very little to do with the legislation, and is more a strategy and a behaviour and culture issue?

Beth Capper: It is largely about culture and behaviour. As I said, some areas are already doing it incredibly well, but some areas are not. Possibly, there could be some strengthening around expectations of involvement in the legislation that could help, but there is a need for



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guidance, and helping to understand what it looks like, and what good looks like, promoting the best practice that is out there, but is not widespread or happening consistently.

Q283 **Dr Williams:** And that is not legislative.

Beth Capper: No.

Charlotte Augst: In order to get to a point where people perceive that their services are co-ordinated around them, which is probably a good definition of integration from a people perspective, the people who commission and deliver services need to understand what communities and individuals actually need. The VCS has a big role to play in helping commissioners and providers to understand what communities and individuals actually need. They can do that only if they are around the table. There is no legal impediment to that happening, because some places get it right.

There is sometimes a misunderstanding that commissioning is procurement and that, therefore, one must not have people around the table who might in the end be procured to deliver a service. That is a misunderstanding where it would help to fully clarify; commissioning is so much more than procurement, and it needs to start with trying to understand what communities actually need and what they aspire to. The VCS is much more than a provider, because it can help with understanding needs and ambitions in places.

One member got in touch before this inquiry, because we reached out and asked for views. They said that commissioning guidance already says that the VCS should never be commissioned for less than 24 months, because you cannot do anything meaningful in shorter timeframes. By December, we should have all the commissioning and contracts in place for a start in April, in the new year. That is from a charity that has contracts with dozens of CCGs and has a turnover of just under £1 million. It says that it has one contract and one situation where that actually happened. It has a contract for 24 months that was in place in December for April, in the new year. All the other contracts are shorter; they embark on work without being contracted, and money flows are very late. There is a lot of stuff that is not working around how charities interface with the system.

Q284 **Dr Williams:** Is there anything in the legislative proposals that will make it work any better?

Charlotte Augst: There is a risk that, if the concerns of the VCS are not addressed, we will need to use the legislative process to turn some of those arguments into legislative arguments, which is probably not very helpful. If this eventually arrives in Parliament and we all jump up and down saying, "Another duty on the NHS, and another and another," is that the best way forward? In a way, we would much rather have this conversation in prelegislative scrutiny and find ways of supporting better



behaviours, with recourse to the law as a last resort, rather than being locked out now, or our concerns not being addressed, so that it then has to be done through a legal framework, which is not going to achieve all that much.

The social value Act is a good example, whereby all public commissioning needs to take account of the social value generated, which is about environmental and social impacts and creating cultural and local assets. National Voices and Social Enterprise UK did some research on that and published a report in 2017; they found that only just under half of commissioners were even aware of it, and only 25 CCGs had an active strategy on how they could improve social value, which at the time was something like 13% of CCGs. Creating legislative duties does not really change behaviours.

Sir Robert Francis: In sympathy with that, I believe that there is a value to legislation. It is difficult to comment on the value of this legislation because, at the moment, the proposals are of such high principle that it is a little difficult to say. One anxiety we have is around the arrangements being made for integration, the purpose of which is absolutely fine and desirable, but there is a danger of lack of certainty about accountability. Some of the barriers to integration at the moment seem to be around people's accountabilities. They revert to their individual organisations because there is no mechanism for joint accountability. That is important not only for the people providing the services but for those to whom the services are provided. There needs to be a degree of certainty about that.

There also needs to be certainty around the obligation to involve people, so that their experiences are taken into account and their needs listened to at the stage when decisions are being made. For instance, as we said in our written evidence, at the moment there is a well-defined structure for Healthwatch to be involved at local level, with local authorities and so on. There is no provision for that to happen at ICS or regional level. In some places it is happening, and, according to the CQC local systems review report, things seem to be going better where that is happening. We would like to see the involvement of people, such as Healthwatch and other organisations, recognised, and it is better to do that by way of legislation so that everyone knows that it has to happen, rather than by a developing culture, because the culture might develop in the wrong way and too late.

Q285 **Diana Johnson:** I would like to move on to your views about how or whether you think that the proposed changes will affect patient choice.

Professor Pritchard: There is significant risk that the proposals could lead to a reduction in choice, because commissioners will be able to make decisions using the best value test, which we have yet to understand, about where services could be placed, and that could lead to other non-NHS providers, as currently defined, not being able to continue to provide those services. In that case, we would see a reduction in the diversity of



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provision, which in my view would reduce the opportunities of patients and citizens to access services from a range of expert providers. That reduction in number and diversity will lead to a reduction in choice.

Q286 **Diana Johnson:** And that relates to your earlier point, doesn't it, about the definition and the need to expand it?

Professor Pritchard: Yes.

Beth Capper: What we know is that people want to understand how they can access services, with a recognisable access point into getting care, and that they can get quality services that are accessible and close to them. On choice, it is not just about the options available to people; it is also about having meaningful decision making. People often do not understand the range of options already available to them, so understanding what patient choice means is critical.

Going back to the point about ensuring that the range of provision available is not hindered by these changes, the voluntary sector is in some ways a smaller partner in the service provision sector, and it often provides innovative and exciting new ideas, but it cannot compete at the same scale and size. There are already existing interesting commissioning models for engaging with the voluntary sector, exploring alliance contracting and innovation partnerships, but we know that they are not being explored as widely as we would hope. It is often about culture, understanding and flexibility, and almost the permission to use them, which is not necessarily about these legislative proposals.

Charlotte Augst: Our experience is that people want to take part in shared decision making; they want to understand how any treatments on offer will help them to achieve their ambitions for their health and wellbeing. That is more important to people, in our experience, than choosing between providers, so we need to understand choice in a different way.

Where charities provide, there are obviously some that provide instead of NHS services, but the majority of National Voices members provide next to and alongside NHS services. It is not about choosing between having chemotherapy in hospital and having information and support from Macmillan Cancer Support; it is about needing both. Choice is probably not quite the right way to understand what quality means for people; they want holistic care, and that requires plurality of provision. Where these proposals are a bit too NHS focused and too focused on a narrow definition of provider, there is a risk that people might be locked out of arriving at a place where they have plurality of provision.

Sir Robert Francis: I am not sure that the actuality of patient choice depends on what is proposed in the legislation, as opposed to the policies that get implemented as a result of the long-term plan. What is important, as others have said, is that, if the choice is to be real, people must have information that they understand about what services there



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are and how to access them. There is a danger, as I mentioned earlier, of the conversation about the changes being entirely between experts and people in the system. If the public get left out of that, they will understand less and less about where their services are coming from and how they get to them.

It is important that the obligation to provide useful and meaningful information to promote patient choice is at the forefront of the proposals. The extent to which that needs more legislation is a matter to be considered, perhaps, but there are routes. To plug my organisation again, one of Healthwatch's current duties is to provide advice to the public about these things, but for that to happen the local healthwatch needs to understand what is going on, and be part of it.

Q287 Diana Johnson: If there is to be real choice, there also has to be some enforcement mechanism when that choice is denied. We heard yesterday that the plans around NHSI mean that the appeal route would disappear. How would patients be able to enforce their choice if that option had gone? Is there another way they could do that?

Sir Robert Francis: If there is a duty to provide a choice, the rather unsatisfactory route of judicial review is potentially available, although I would not recommend it to anyone in a hurry.

Q288 Diana Johnson: It would not be something your organisation would want to take on.

Sir Robert Francis: We have no power to do that. It would turn us into more of a regulator than we are. Scrutiny is important, and part of Healthwatch's job is to be part of the scrutiny system—and that needs to match whatever arrangements are made to integrate care. At the moment, the scrutiny system is pretty local. There are examples of collaboration between scrutiny groups, but the scrutiny needs to follow the way in which the arrangements are made.

Q289 Diana Johnson: Jo, you talked about the definition needing to be broadened. Is there anything else that needs to happen to make sure that social enterprises are not disadvantaged in the NHS? Are there any other changes?

Professor Pritchard: I have quite a long list. We would suggest the best value test, when we look at that. We have the social value Act already, and it is well recognised. There is a real opportunity to build on that and use it as a basis, and then add the wider social determinants of health.

We should also consider the expert provider; there is a bit of a history in the NHS of organisations acquiring services that they have had no track record in providing. We need to make sure that they have a strong history, because patients deserve expert providers. We need a strong, happy workforce, because, given the workforce challenges we have, we need to make sure that we can recruit and retain the workforce. We need



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organisations that are capable of delivering care and have high quality ratings; it must all come down to quality.

We want all of that, but based, we think, on the social value Act. If we get it wrong, we are in danger of seeing funding earmarked for community services—the long-term plan helpfully outlines that—potentially being siphoned away into acute trusts. We need to make sure that that does not happen. We have a whole range of new and innovative services that we need to fund, and we need to make sure that they actually happen. One of the unintended consequences of this could be a loss of community funding back to larger organisations that have deficits and other challenges to address.

I have two other quick points. ICP leadership is at the moment considered to be purely for statutory providers. We believe that where we have examples of very strong other organisations—bearing in mind that social enterprises provide about a third of community services across England, so we are talking about a significant size of organisation—they are as well placed as others to provide leadership in integrated care systems, and should be considered as such.

My final point on the proposed changes is about joint committees. The joint committee proposals are concerning, because at the moment it is proposed that they are between commissioners and NHS providers, where they are considered to be statutory providers only. Yet again, you could envisage scenarios in less mature systems where you have almost a cartel, with the NHS sorting out its own homework behind closed doors and having an impact on the various organisations that all of us represent.

Q290 Dr Whitford: The tariff system was put as being a barrier, in that we want more care in the community, but hospitals earn only when people are admitted. Do you think that the proposals relating to the tariff will improve care for patients? Are there any unintended consequences that might have a perverse effect?

Professor Pritchard: The tariff largely affects the acute sector and services. The area I represent tends to be on block contracts, so it tends to suffer every year by reduction in the size of that contract and the expectation for less, in a very different financial regime. The proposals will be beneficial for local systems, for those who currently are on the tariff, but there is still another funding issue to be addressed.

Q291 Dr Whitford: The issue is when the tariff keeps sucking people into hospital, along with their tariff. I remember meeting a paediatrician doing outreach work in a part of the country where they had reduced acute admissions of children with serious needs by 40%, and then, because she worked for the trust, the whole project was stopped because of course income went down. Although groups are not paid on tariff, they must be affected by that kind of sucking into the acute side.



Professor Pritchard: Absolutely.

Q292 **Dr Whitford:** Do you think that it will improve care? Do you see any unintended consequences?

Professor Pritchard: It should improve care, but I do not think we are yet clear enough about how funding is going to flow through the integrated care systems. That is the area in which we could see some unintended consequences. There could be some initial benefit, but then what is passed through in subcontracts could be less beneficial for those organisations.

Q293 **Dr Whitford:** The devil is in the detail.

Professor Pritchard: Absolutely.

Beth Capper: Very broadly, anything that moves incentives away from keeping money in particular parts of the system and prevents it from moving more broadly is helpful. There are a couple of examples. Breast Cancer Care gave an example where tariffs can have a negative impact on the treatments available. With particularly complex breast reconstructive surgery, there was a suggestion that some surgeons considered the tariff rate not enough to reimburse a particular type of treatment, so people out of area were not referred. It depended on whether the particular service was on site and available in their local hospitals.

There could be some benefits to the move away, but there is a worry that, for example, national tariff pricing used for out-of-area treatments could exacerbate the problem. Probably a lot more detail needs to be worked through to think about the implications for a range of services, but flexibility of payments would be helpful. We need to look at integration more broadly and what it might look like to wrap up non-clinical support and how it is funded, looking across the system and not just narrowly focusing on the NHS.

Q294 **Dr Whitford:** Some patients, following on from choice, were not allowed to go out of area because, obviously, it takes the money out of area. Therefore, it diminishes choice. Have you come across that? It is not just a tariff issue regarding reconstruction but commissioners actually not wanting to have the service at all.

Beth Capper: There may well be examples. We can go back and talk to our members and come back with some case studies, if that exists. It sounds as if it probably does; I just do not have the examples to hand.

Charlotte Augst: If we want to wrap population health into this thinking, which is obviously the endpoint of the purpose of a lot of the integration effort, we need to find much cleverer ways to make the money work. The current tariff does not enable good population health thinking.



To build on the point that Beth made at the end, we need to understand how to move money much further upstream, which means into non-clinical support. If you believe the figures that a quarter of young girls and women have such severe mental distress that you could actually call it mental illness meriting some degree of intervention, to think that we can solve the problems of a quarter of all young girls and women by the kind of services that we now run, with six interventions, and assessments and tariffs, is fanciful.

If a place wants to take responsibility and do something about that experience, they need to go to non-clinical places. They need to go to schools or social media; they need to understand where those young women are already turning for support. We need to find a way of making money follow that insight, which will be a massive challenge. The datasets that the NHS holds do not support the money going to those places, because we do not know whether doing something on social media helps to prevent that kind of distress and helps girls to rebuild their lives.

We will probably have to take a leap of faith on some of this, and listen to the inside, to the VCS partners who say, "We find this works for this cohort of people. We understand the needs of young black men with mental distress and why they are not using current arrangements for counselling services." Ultimately, the money does not just need to be locked out of hospital; it needs to be locked out of a focus on medicine.

Q295 Dr Whitford: Is that not an issue of having made it transactional in the first place, whereas the idea is to take a more population view within a footprint, including schools, with more of a health-in-all-policies approach?

Charlotte Augst: And wellbeing. A lot of the charities that ultimately do an awful lot around health do not have a health focus; they have a wellbeing focus, as do a lot of local government services. We might see now some of the consequences of a lot of that support falling away. Distress among young people is endemic, and so is violence and self-harm. It is very hard to say that it is about this boxing club, parenting club, library or pub, but ultimately, that is the social fabric we live in, especially the people who cannot consume their way out of the constraints. We can fly to the Maldives if we feel like a break, but many people cannot. They need their local park, their youth club, and this and that. That is the social fabric a lot of healthcare provision needs to be embedded in, and if all of that social fabric is whittled away it will all wash up in A&E.

Q296 Dr Whitford: It is about looking at health as absence of illness instead of looking at it as wellbeing, which was obviously the whole point of calling them health and wellbeing boards. Do you think that there will be unintended consequences in this, or is it just a first step in at least not locking the money into secondary and tertiary care but moving it a bit closer to where we want it?



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Charlotte Augst: It is useful to ask questions about the tariff, but we have asked questions about the tariff for as long as I can remember, and it would be nice to see some action around money flows.

Sir Robert Francis: Surprisingly enough, national tariffs are not at the top of the issues that the people to whom Healthwatch talks talk to it about. Indeed, it is quite low down in the order of priorities of things that people think is important, believe it or not, and funding generally. I am not sure that is right or wise on the part of people, but it is because the opacity of the system does not enable them to understand how that influences their choices.

As others do, I can see advantages to moving away from national tariffs to make things more flexible so that local need can be responded to. One has to sound a note of caution on that, in that we do not want to get unacceptable variation. It is one thing to have funding allowing responses to local needs that have been identified; it is quite another to do things that actually take money away from genuine need, which is when it becomes a postcode lottery. There has to be some cohesion around the way the system is paid for, and I worry in that context that there is a broader question over how any of this makes a great deal of sense until we know what is happening with social care.

Q297 **Andrew Selous:** Yes, I completely agree with your point about social care. The Green Paper is long overdue, for reasons that we probably all understand. I want briefly to follow up that really interesting line of questioning with you, Charlotte, if I may.

To go back to the legislation, the new shared duty proposes a triple aim, the first of which is better health and care and efficient use of NHS resources. On the prevention agenda, on which you have just had an exchange with Dr Whitford, how are we going to give the legislation some teeth? You gave an excellent narrative of where we need to be to get better population health. How do we make the legislation right to make that a reality?

Charlotte Augst: We would probably argue that the triple aim is too narrow and too NHS focused. It is a way of describing whether quality health services are provided, and, as we have just discussed, that is only a part, but an important part, of the whole wellbeing agenda. We want to make a partnership and shared responsibility approach in places happen.

Local governments do not subscribe to the triple aim; they are held accountable for the wellbeing of their communities through the Care Act. Many VCS organisations would not work towards the triple aim. They do not provide health services in that way; they are engaged in improving people's wellbeing. We think it would be useful to start a conversation about whether wellbeing would not be a more useful outcome, if we want to lock an outcome into legislation. We could put that in, but it is actually available and of relevance to a wider set of partners, rather than just to the NHS internally.



Q298 **Andrew Selous:** That would change the first part of the triple aim to health and wellbeing, for example.

Charlotte Augst: Yes.

Professor Pritchard: We in the world of social enterprise are particularly interested in added social impact. If you look at the hundreds of health and social care members, you can see some real impact on health inequalities. We have talked about patient choice, which is great for those who have the opportunity to use that choice, but we have a widening gap in health inequalities across this country, which is of concern.

We see, through some of the social purpose we have, an amazing organisation that works with the homeless and refugees, and another in the world of community dentistry, which does not often get mentioned. Isn't it concerning that the greatest reason for an under nine-year-old in this country to have a general anaesthetic is tooth decay? Yet it is free. We have two social enterprises that do amazing things in improving oral health for the under-fives, and they have halved the general anaesthetic rate in their local population.

We have all of that happening, so there is a real opportunity in local systems to look at what the inequality is, to look at targets and have objectives around local populations. It will be different in different parts of the country because there will be different issues, but that is where you can see the VC sector really playing its role.

Q299 **Andrew Selous:** Best value is mentioned in the legislation. What does the proposed best value regime need to consider for it to work? Perhaps you could give us your take on how it is used in local government and what lessons we can learn from that. Robert, do you have any thoughts on that?

Sir Robert Francis: If you want to establish a definition of value, you need also to consider the mechanisms to engage with the public in assessing that value—what is valuable to them and the impact on them—as well as whether the change being made enhances social value, as opposed to merely being value for money. In other words, there are issues around it that are not just about money, and it is important that they are not forgotten. We know what has happened when they have been forgotten in the past.

Q300 **Andrew Selous:** It is public value as opposed to financial value.

Sir Robert Francis: Yes, and social value.

Q301 **Andrew Selous:** Public and social value. That is very helpful. Thank you.

Charlotte Augst: I agree with that. National Voices published a very thoughtful paper on how we need to redefine what creates value in and around health. All the members who got in touch with us with their ideas around the legislative proposals found it very hard to comment on the



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proposals, because there was not enough detail to understand what is proposed.

Beth Capper: I agree. A lot more clarity is needed. The definition and understanding of what the best value test is has to be co-produced with colleagues from across sectors, including the voluntary sector, balancing the qualitative data that matters so much—patient experience data and patient reported outcome measures—and getting to grips with what people want and what they care about. You can do that only through involving and engaging people directly. The best value test cannot lead to the NHS by default. It is about making sure that it looks across the sector.

Professor Pritchard: I have two points. The long-term plan talks about the need for the NHS to improve its social value, yet the legislative proposals just talk about best value, which is not defined. There needs to be a definition, and I agree with colleagues about the need to have wide engagement; the public needs to be engaged in that. We have been doing some thinking on that, and, if it is helpful, we can send the Committee a note on our thinking to date. Some of our members have commented on the best value test used in Scotland and have commended it to us as interesting and good.

Q302 **Andrew Selous:** I see a bit of a smile.

Professor Pritchard: Absolutely. Of course, the local authorities are using theirs. Your previous panel talked about the challenges for local authorities that are following public contracts regs, which have a whole set of things. The long-term plan is all about integrated care. It seems slightly perverse that we are moving away from local authorities and how they approach everything, in essence. There should be something about aligning all the best value tests so that there is some consistency about what it looks like.

The second point is how it is applied. There is a risk that the NHS could be marking its own homework, applying best value tests and not having to show transparency about how that is done, with no ability to challenge. Both those things need to be considered.

Dr Whitford: Certainly the integrated joint boards in Scotland, where health and local government sit with a pot of money and discuss it, involve social enterprises; they involve the third sector quite broadly, particularly in chronic disease and disability.

Q303 **Chair:** Previous panels have raised the issue of the terminology and that it means something different to people who have been used to best value tests in local authorities. Would you all support the point that Sir Robert made about calling it a public and social value test, so that we separate it from its connotations within local authorities?

Charlotte Augst: Yes.



Q304 **Chair:** Thank you. Can I move on to talk about accountability? You have already touched on engagement, so I will focus on accountability. The point has been raised with us by previous panels about who is going to be accountable in this system. The point has been made very powerfully in the past that, if everybody is accountable, no one is accountable. Sir Robert, is that something you would be able to speak to?

Sir Robert Francis: I cannot remember who said it, but when you walk into any institution providing a service, you want to know who is in charge. The conversations going on are rather short, as I said in my remarks. It is therefore important that the vehicles of scrutiny, and maybe regulations, follow the event; they should not get in the way of changes that are positive for the public. We must know to whom we turn both organisationally and maybe, on occasion, individually, to say that you or they are responsible for what has gone right as well as what has gone wrong. That is an area where legislation could well turn its attention, and I am not sure we see much of that in the current paper. The more the levers are centralised, as some suggest, and brought together, the more scrutiny is required.

On that point, while we make the case that Healthwatch should be involved at the integrated level, or the regional level, it is also important that we retain local influence and local connection. We do not want to lose that, because people still live and work in places, and their wellbeing happens in a local area. That always needs to be remembered, however integrated the system to provide for it becomes.

Charlotte Augst: I am slightly sitting on the fence as to whether legislation is going to help with scrutiny. On a practical level, member charities of National Voices feed back clearly how hard it is to engage with these emerging structures. Because they are growing organically, and in a way that is how they have to grow, it can be time and labour intensive to understand who to influence about what in these places. So many conversations are needed, and there are so many meetings to go to. For a sector that is very pushed for time, and very thin in its capacity on the ground, there is a real need to rethink the role and infrastructure of organisations locally, helping to connect the diversity of local provision and the specificity of local community assets to these quite large-scale changes. Those infrastructure organisations are shrinking and are being decommissioned, and that is a real problem.

A space is opening up between the CCGs and NHS England, where a lot of the action is now happening without there being structural or organisational clarity. I see why that is the case, but it makes it very hard for local VCS organisations to stay engaged in a meaningful way. There is an extra wrinkle for rarer conditions, and some of the member charities, such as Parkinson's UK, have fed that back to us. If everything is produced organically in place, you can see why rarer conditions get forgotten about, because people only have so much bandwidth.



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Ironically, an awful lot of people have a rare condition. Put together, it is a large chunk of NHS activity, but it is in small pockets of rare condition services. There is a particular need to think through consistency and avoiding a postcode lottery for people who have a lot on their plates anyway and are often very vulnerable, and to make sure that that is not completely forgotten.

Beth Capper: Understanding the existing infrastructure around public accountability is critical—for example, health and wellbeing boards, and how they map into this, as well as Healthwatch. Making some of the lines more explicit would be very helpful. I won't labour the point, because we have talked about co-production already, but it ties into accountability and the feedback mechanisms for saying, "You told us what matters to you, and this is what we have done or not done in response." That has to be a mechanism we can understand. Others have said the rest.

Professor Pritchard: We are concerned about the lack of accountability in these proposals. Our engagement with NHS England has not given us much more information about how ICSs and ICPs will be held to account for poor practice. There has been some reference to using local councillors or politicians to engage in challenging poor practice, but we are not convinced there is sufficient capacity, expertise or process to do it. Therefore, patient communities would have little to protect them or their services.

Social enterprises and other voluntary and charitable organisations that represent marginalised and disadvantaged groups will find it challenging to make their voices heard, unless we have structures in place. The lack of accountability, as is currently demonstrated, means that potentially we are going to see more legal challenge, which is somewhat ironic, given that the proposals are being brought in to try to reduce some of the alleged challenge that is happening. There will be nowhere to go except through legal recourse. That is one of the risks we see. In our submission to you, we recommend that NHSI creates a new ombudsman or tribunal system, so that patient communities and others can challenge and try to avoid unnecessary legal expense.

Q305 **Chair:** Thank you very much; that was helpful. Are there any points that any of you want to make today that you have not been specifically asked about? This is a chance to put them on record.

Beth Capper: There is a small thing around mental health, and making sure that we are covering that. It is included in the expansion to wellbeing, where mental health is a huge part, but there is still a default to understanding health as physical health. That is really important.

As a call-back to the conversation around tariff, the majority of mental health trusts are still under block contracts; the five year forward view said that was no longer acceptable, yet it is still the case. There is already a huge amount to be done. We are talking about getting on with it and making change happen, and, yes, it is important to talk about the tariff,



but there are already changes that are not happening that need to. I wanted to flag those points.

Professor Pritchard: I have one small point. An unintended consequence is that, if commissioners are no longer required to go out to competitive process, because they are humans, they are instinctively going to be more interested in sorting things out without going through procurement processes. I have been a commissioner, and I know that they are resource intensive, and there is a potential legal challenge. Therefore, the unintended consequences are a reduction in diversity of providers and all the added value they bring. We see in social enterprise a level of innovation and commitment to local communities that we do not see in other organisations in the NHS or in statutory providers in a consistent way. Therefore, we are going to see, overall, a loss of innovation and added social value.

Charlotte Augst: For the record, the NHS sinks or swims together with social care and/or public health, so, if we do not sort out public health and social care, we are just moving the deckchairs on the Titanic.

Q306 **Chair:** We agree with you on that. It is a point we make regularly on this Committee, and it is helpful to have you make it on the record. Sir Robert, is there anything you want to add?

Sir Robert Francis: It is a plea to ensure locally and regionally that, when conversations about integration are going on, they are conducted in a way that is understandable to the public rather than being completely opaque. I worry that a lot of these conversations are strategic and high level, and very difficult for anyone to understand. The less the public is engaged in this, the less the public will trust the result. If the public do not trust the result, they will have no confidence in the system, and it will not achieve the strategic aims it is setting out to achieve.

Chair: Thank you very much. Thank you all for coming this morning. We really appreciate your evidence.