I have no doubt that one of the main reasons why I was elected to the House was because I promised to bring my clinical experience to bear on the health debate and to stand up for our NHS. I would therefore like to set aside party politics for a moment and give my personal take on the direction that I hope the proposed reforms will take and where we should go from here.

At the heart of the Bill lie issues of choice, competition and clinical commissioning. My right hon. Friend Mr Dorrell set out clearly the huge funding challenges that face the NHS. We have always had rationing in the NHS, but we are squeamish about discussing it. In an ideal world with unlimited resources, unrestricted choice would of course be a good thing, but it is not deliverable. Because of the limited budget, we need to focus on getting the very best value while openly and honestly involving communities in how we do that fairly. If that happens locally, one person's local commissioning becomes another person's postcode lottery.

The central problem with unrestricted choice in the form of the "any willing provider" model is that it forces commissioners to act as bill payers and has the potential to undermine good commissioning. What is the point of commissioners designing high-quality, locally responsive clinical pathways that deliver good value for money for the whole community if patients have a free choice of any willing provider and commissioners have no choice but to write the cheques?

Chuka Umunna (Streatham, Labour)

The hon. Lady has long experience of working in the sector. One of my concerns about the "any willing provider" model is how it will potentially disadvantage teaching hospitals. [Interruption.] The Minister of State, Mr Burns, might want to listen to this, because one of the hospitals involved is St Thomas's, which serves the House, and if he fell ill here he would probably go over there. One of my concerns is about how teaching hospitals will be able to compete with other providers given the extra burdens of training and supervising those who are learning to work in the NHS. Does the hon. Lady share that concern?

Sarah Wollaston (Totnes, Conservative)

Of course, one of the greatest burdens on many hospitals is that of the private finance initiative, and I will come to the issue of training later. I am not opposed to competition in the NHS, but it should not be an end in itself. It can have a role in improving some services—take, for example, the provision of mental health services and talking therapies, on which I am repeatedly told that the voluntary sector delivers better results. If I were facing a long wait for an MRI scan, for example, I would not mind if it was provided by the private sector as long as it was free to me at the point of use as part of the NHS.
The point is that competition should be used only where there is evidence that it can deliver real benefits for patients and value for money for the whole patient community. If competition becomes an end in itself, that can actually increase costs and risk fragmentation. For that reason, I hope that as the Bill moves forward, there will be fundamental changes to the role of Monitor. The NHS cannot operate like a regulated industry, and I believe that concern about the proposed role of Monitor is the impassable barrier to co-operation from the professions, without which we will not achieve the great success that we need from these reforms.

We must return to the original promise of the reforms, which was about clinical commissioning and a focus on outcomes rather than targets. For years, commissioning has failed because decision making in primary care trusts has not been clinically led. The NHS has been dogged by illogical care pathways, top-heavy management and a target-driven mentality, often completely divorced from any evidence base. The idea that clinicians should be put at the heart of decision making is still very sound, and it has become divisive only because of the stipulation that GPs should hold all the cards and be the sole commissioners.

Where clinical commissioning is already successful, that is achieved through a collaborative process with multi-disciplinary input. I hope that as a result of the Government’s welcome listening exercise, the call to broaden the membership of commissioning consortia will be heeded, along with the need for a more graduated and phased introduction so that consortia are authorised only when they are ready. The same should apply to foundation trusts. They should take on functions only when it is right for that to happen.

If commissioning consortia are to achieve the best results for their patients, they will need to focus on the integration of health and social care, as my right hon. Friend the Member for Charnwood said. I pay tribute to Torbay, which was at the forefront of moves that were widely applauded nationally and internationally, including by the King’s Fund, and that achieved real results for patients, driving down unnecessary admissions and improving outcomes. The integration of health and social care is complicated to achieve, so perhaps Monitor could have a relevant role in it—not arbitrating in disputes about competition law, but driving down costs and facilitating integration. We know that splitting tariffs, for example, could benefit community hospitals. Again, that is complex to achieve, so perhaps Monitor could also help in that regard.

For consortia to succeed, not only do we need to focus on the make-up of their boards, but they must be geographically logical and, I am afraid, cater for geographically defined populations. Giving a free choice to register with any consortium risks encouraging consortia to cherry-pick their patients. One striking feature of the Bill is its sheer scope. All junior doctors will remember the fiasco of MTAS—the medical training application service. We currently have a successful model of deaneries in this country. I hope that we can retain them as the Bill goes forward, because they have a vital role to play in encouraging quality. Of course they are not perfect, and they need to look at regional variants, but we should keep our deaneries.

Speaking of quality, at present, PCTs play a vital role in maintaining what is called the performers list, on which all GPs have to be registered in order to practise in an area. As we move forward, we need to clarify who will take over that role. That is particularly important because we have a crisis with many doctors coming here, particularly from the European Union, who do not speak adequate English, as we saw in the case of Dr Ubani. We need to
ensure that the person responsible for the performers list can get rid of this nonsense, so that all doctors not only have the necessary qualifications, clinical skills and experience, but have good spoken English.

I welcome this listening exercise, which I believe is genuine, and I hope that the Opposition will engage with it constructively. The public’s affection for the NHS is well justified. At its best, the NHS is outstanding. Where that is the case, it is not competition that has delivered those good results, but a relentless focus on what is right for patients. We need to do the same in this House.

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