

## **We can't go on meeting like this .....**

Given the increasingly valuable materials the 'Nuffs' are creating and sharing now (interesting how once a Lilley nickname has been generated it becomes difficult to use anything else!) it was a pleasure to sign up for their<sup>1</sup> conference 'Competition for Care : understanding the NHS market and role of independent providers'.

Having been, I'm still not sure whether it was a conference or a rather brilliant simulation of life in the NHS market today. See what you think...

We spent the day in a grey-lit room with no daylight, among an audience mostly clothed in grey, being lectured by economists, managers and data enthusiasts, about the health and dynamics of the NHS market. Despite a promising room layout of round tables and the title 'conference' there was no conferring, no discussion. Instead a number of Q and A sessions were just that: questions from the floor were reframed by the chair and 'answered' by the experts. There were few if any clinical leaders in this conversation, and indeed what talk there was of clinicians wasn't enthusiastic. Doctors were described as 'not being part of the public sector', of the NHS being a 'collaboration between the State and the greatest private sector profession in the country', and some speakers suggested that if they had angered doctors then they must be doing something right. I can't recall anyone mentioning nursing.

I missed the last session so I still don't know whether there was a mirror holding denouement that challenged mindsets and behaviours in ways so sorely needed. Oh I hope so.

It was heartening however to be introduced to the five guiding principles of NHS England and signed up to by Monitor. 1. Patients must come first. 2. Evidence not ideology. 3. Commissioners should decide how, when and where to use competition, because it's their role to be close to clinicians and their patients. 4. No hiding place for poorly performing incumbents. (who apparently want to go on hiding behind lack of information). 5. Encouraging experimentation, being agile how we evaluate, and not being embarrassed to say if things are going wrong. We don't, after all, need to worry about section 75 because these were shown to ministers before they framed this legislation and NHS England 'assumes' they have ensured the legislation supports them. One of the tweets of the day questioned whether assumption was enough.

The subject was (as billed) the health of the NHS market rather than of patients, and occasionally a link between the two was attempted. There was an interesting history lesson from Health Watch about the origins of consumer rights (to safety, to information, to choose, to be heard, and to redress), originally, apparently, sponsored by JFK. These rights, so we were told, put the consumer in an empowered position, in health care that means they become 'partners in care'. They are why choice and competition are so important.

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<sup>1</sup> Jointly with the IFS

Really? Is that what we see around us? Has the fiercely competitive food industry where consumers have complete freedom of choice empowered our citizens to live the lifestyles they would like to? Is this an example of ideology over evidence?

A charming and very definite speaker from a pro-market liberal think tank in Sweden overtly challenged that principle, saying we need both ideology and evidence, on the same grounds: that choice is about power and worth fighting for per se. She also came up with the most practical observation of the day: that we get the markets we deserve and that in a distrustful climate far too many demands are made in a contract, leading to reductions in innovation and to the number of small and medium sized business involved as they cannot afford the processes involved. Surprisingly and amusingly she turned out to be a very bossy sort of libertarian, wanting to scold the middle classes for their choices when she did not approve of them, and to prescribe the criteria that people included when making their choices.

There were other good observations: a CCG chair made the point that joined up care for the patient and integrated organisations are two completely different things, Monitor gave a very convincing description of the factors inhibiting CCGs from actively making decisions about the nature of their local market, and NHS Partners talked of the importance of providers of all sorts really understanding their customers and also their costs. That was truly refreshing.

It was very good to hear of a new information network for the private sector and their commitment to the ensuing parity of data with the NHS, which will allow outcomes to be compared for the first time and all sorts of myths to be laid to rest. And the ardent enthusiasm of the founder of *iwantgreatcare* was infectious, especially when he reported that the aggregate results of asking patients for a single measure (the cleanliness they observed for example) correlated with more sophisticated statistics for (in this case) incidence of MRSA and C Diff.

There was also the usual enthusiasm, including from Health Watch, to match these patients rights with their responsibilities, with the usual call for giving them information on the costs of their care options.

Funny isn't it, how information we want to give to patients is so partial. If we were radically transparent we would let them see how much money they have contributed (or had contributed on their behalf) each year, and the amount over their lifetime. We would let them see exactly what this is being spent on: how much gets through to care at the front line and where else it goes, and how much everyone involved gets paid. If we fully informed our patients we could start to get the pressure we would all benefit from, for 'lean', for wise and effective use of resources, and the pressure to justify parts of the system that make more sense to policy makers than they do to patients.

Indeed not all information was welcomed, data appears to be good, direct involvement and experience bad. One questioner suggested that people with local knowledge would inevitably have a conflict of interests and should rule themselves out of deliberations. This feels like just what we don't need: the people with the greatest insight being silenced . A properly, robustly, thoughtfully facilitated discussion could handle such conflicts of interest pretty straightforwardly – but then we wouldn't need the market at all if we nurtured skills in challenging and supporting high status clinicians so that they reflect no their own performance and the design of their services. The whole market paraphernalia arose because no-one wanted to do that and we've been avoiding it ever since!! Funny, the market can only work to our benefit if within Trusts there are people who can do that – genuinely engage clinicians in collective decision making – and if that were happening we probably wouldn't need the market.

So the question and comment from NHS England at the start of the day remains hugely important: 'Can competition help? If so how? What do we know? Not nearly enough.'

There is of course one area where competition is absolutely VITAL, and that is competition between different discourses, different forms of evidence, and different ways of framing the discussion. There is currently a monopoly held by economics and economists, and we need to ensure it has to compete with those of sociology, anthropology, psychology, history, moral and political philosophy, clinical disciplines and more. (Why? Because we need people with expertise in things like the use and misuse of status, about the influences on how people feel and behave when they are caring for others) . And for that to happen our practising clinicians and clinical leaders and academics from other disciplines need to muscle in on these debates. They need to insist on being invited and on showing up even if they are not. We cannot separate a debate about the dynamics of the NHS market from the dynamics of the NHS itself and we have to ensure that the people directly involved, and those who have legitimate ways of viewing those dynamics are a full part of this discussion.

But also we can't go on meeting like this. This was billed as an interactive discussion, and perhaps this was another aspect of the simulation, after all patients are promised no discussion about us without us.

We do desperately need interactive discussions, where there is room for unstructured, unscripted dialogue, between people who are new to each other with differing views and experience, responding in ways of their choosing to what they have jointly heard. Where people go away having discovered for themselves something new and thinking differently, in ways that the organisers may never know of.

There was potential here for just that. Many participants were as interesting (in different ways) as the speakers, and the opportunity to genuinely engage was there. Organising a real interactive discussion requires a different approach though. It depends on insightful questions, faith in your participants, and time. Putting the speakers on tables instead of the

podium for example, giving much more time to discussion than formal input - this needs a different kind of facilitation, but without it we do not produce the kind of thinking that we will all need to address the very real problems we are facing.

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