Witness Name: David Hare
Statement No.:
Exhibits:
Dated: 28 July 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DAVID HARE

I, David Hare, will say as follows: -

About IHPN

1. I am the Chief Executive of the Independent Healthcare Providers Network (IHPN) and held that position during the relevant period covered by the Inquiry. IHPN is the representative body for independent sector healthcare. Our members deliver healthcare in England, Scotland, Wales and Northern Ireland to both NHS and private patients. We play a leading role in the sector by bringing providers together, supporting them to deliver great care to patients, and enabling them to play a key role in the UK health system.

2. IHPN's members include providers of primary, community, diagnostic, hospital and specialist services. The biggest group of these is private hospitals which make up around half of IHPN's membership. We have ~100 members across England, Scotland, Wales and Northern Ireland. The majority of our members are based in England.

3. IHPN was first established as the NHS Partners Network (NHSPN) in 2005 with the aim of enabling dialogue between private healthcare providers and Government. The sole focus of the organization at the time was on the range of NHS services provided by member organizations. NHSPN was for many years a hosted network of the NHS Confederation. Over time, IHPN has expanded its

remit to include private services – those paid for by individuals or insurers – and took on greater responsibility for collaborative work on safety and quality in the independent sector. In 2019 the organization changed its name to reflect its broader role and became known as IHPN. From 1 April 2020 IHPN has been a standalone legal entity independent of the NHS Confederation.

Independent providers and the NHS

4. Independent providers have played a key role in the NHS ever since its inception in 1948. Indeed, most GP practices are independent providers, as are community pharmacies. From roughly the mid-2000s onwards, it was a conscious policy of first Labour and then the Conservative and Conservative-led governments that followed to enable the NHS to contract with independent healthcare providers to deliver a range of NHS services. The general aims of that policy were to increase the amount of independent sector capacity available to NHS patients; to give patients a greater choice of providers; and to introduce a degree of competition into the NHS thus encouraging providers to improve their services over time. By 2020 independent providers were well established as key providers of NHS services.

5. Before the Covid pandemic independent providers delivered a range of services to NHS patients – always free at the point of use and subject to NHS cost and quality standards, including regulation by the care regulator the Care Quality Commission. In general, these services were commissioned by local NHS Clinical Commissioning Groups (CCGs). In some cases, independent providers delivered services to CCGs as a result of a competitive tendering process. Examples of this included walk-in centres and community Musculo-skeletal (MSK) care. Independent providers also provided services as part of a range of options made available by the local NHS. This included hospital-based services (such as joint replacements, cataract operations, and hernia repairs as well as more complex care) where patients can choose their provider. Independent providers also delivered services directly to an NHS Trust or Foundation Trust without the involvement of a CCG. This included diagnostic services, where

many independent providers delivered scans and other diagnostic services directly within hospital trusts.

6. In 2019 500,000 NHS elective surgical procedures were carried out in the independent sector, including over 20% of all NHS-funded ophthalmology and trauma & orthopaedic care, in addition to the roughly 750,000 privately-funded operations carried out every year in the sector. Millions of NHS scans were carried out in the independent sector every year. Independent providers delivered hundreds of different community services too, commissioned by NHS Clinical Commissioning Groups across the country. Importantly these were contracts to deliver particular services – something that was very different from the special arrangements put in place for Covid-19.

IHPN and Covid-19

7. In early 2020 it became clear that Covid-19 was an emerging public health threat and IHPN's members began to seek advice and guidance about how to manage the emerging situation. We passed on information to independent providers as and when it became available and on 18 February we held a briefing session for members with Professor Keith Willett, National Director for Emergency Preparedness and Resilience at NHSE, so that independent providers could align themselves with the NHS and follow best practice as it was then understood. This briefing covered topics such as what healthcare providers should do if a patient or member of staff travelled to or from what were then known to be high-risk areas (such as parts of China) or if they developed Covid-like symptoms. At that point our primary objective was to monitor the situation and ensure that the industry was availed of all of the latest information and insight.

8. Our involvement with the broader UK Covid-19 national response dates from early March 2020 when we were contacted by Neil Permain, Director of NHS Operations & Delivery at NHSE. Neil had responsibility, among other things, for NHSE's work with independent providers. He told us that Simon Stevens, then Chief Executive of NHSE, had asked him to arrange a meeting with the CEO's of

the main independent sector hospital and diagnostic providers to talk about their contribution to the national Covid-19 response. We advised Neil about who would be best placed to attend that initial meeting and provided contact details where needed. Our role here was one of co-ordination and facilitation. While a meeting of this kind was certainly unusual, one of IHPN's functions is to act as a conduit between national organizations like NHSE and the independent sector, so it was natural for NHSE to ask for our assistance in setting up the conversation to enable the meeting to happen rapidly and with all of the key players represented.

9. That meeting took place on 12 March 2020. In attendance were Simon Stevens and several other senior NHS leaders including Professor Keith Willett. From the independent sector were representatives from the main hospital and diagnostic provider organisations – largely at CEO level. I was on leave at that time and IHPN was represented by our Director of Policy, David Furness who kept me updated throughout.

10. At that meeting, Professor Willett and Mr. Stevens set out what they knew about Covid-19 from both a clinical standpoint and the potential impact on the health service. They also provided an update on the latest epidemiological modelling relating to spread of the disease. It was clear from what they said in that meeting that the UK faced a significant challenge and that there was the real potential of the NHS becoming overwhelmed. We were all aware of the situation at the time in northern Italy and other areas where health services had effectively been overwhelmed and what was described to us that day simply reinforced the possibility of this happening in this country. They made a request at the meeting to 'block book' the entire capacity of the independent hospital sector in England for an indefinite period of time. We understood this to mean that they wanted access to all the staff, equipment and facilities of independent sector hospitals. They also requested to 'block book' the mobile CT scanner capacity available in the sector – which we understood to mean all the mobile CT scanners operated by independent sector diagnostic providers. It was acknowledged in the meeting that there was considerable uncertainty over the possible course of the Covid wave and therefore there was a requirement for maximum flexibility. Because of this, the request from NHSE was for capacity – staff, equipment, and facilities – that could be used as needed by the NHS. The meeting concluded that both

sides (NHS and independent sector) should work together rapidly to explore how such an arrangement could quickly be brought into place.

National hospitals and mobile CT contract

11. Following the meeting with Simon Stevens IHPN facilitated further discussions among independent sector providers. At this stage I had returned from leave. We all wanted to do whatever was needed to prevent the NHS from being overwhelmed. There was unanimous agreement that the sector should do everything possible to respond positively to NHSE's request to contract capacity and play its part in dealing with a national emergency. It was agreed that any agreement must be on an at-cost (not for profit) basis and that it should cover the full range of capacity available in the sector.

12. IHPN's role was to facilitate the negotiation between the NHS and the independent sector over the contract that would exist between NHSE and independent providers. NHSE made clear that for practical reasons they wanted to reach a single agreement that would cover all relevant providers. However, there would be two separate contracts – one for hospital capacity and another for mobile CT capacity. Our role was to make that possible.

13. IHPN therefore worked closely with both NHSE colleagues and our members to conclude the contracting process as rapidly as possible. This included agreeing key principles such as open book accounting and the appointment by NHSE of an independent auditor to consider qualifying costs. These discussions took place over the course of week commencing 16 March with Heads of Terms on the hospitals contract agreed by 20 March and a public announcement of the deal made on 21 March, with the contract itself effective from 23 March. The mobile CT contract came into effect on 1 April 2020.

14. IHPN's role was as a facilitator. This meant convening a lead group of members to negotiate the primary terms of the contract; working with NHS England to identify the providers who could deliver the qualifying services; and setting up a Project Management Office staffed from people within the industry to develop a

plan for delivery. At no stage was it anticipated that IHPN itself would be a party to the contract and it was for each provider to decide whether to enter into the arrangements negotiated. Ultimately it was the case that 27 organisations including all of the main hospital providers entered into the arrangements.

15. The agreed Heads of Terms provided for the NHS to have access to all of the capacity (broadly understood as staff, facilities, and equipment) within contracted providers, with the cost of providing that capacity met by the NHS on an at-cost basis. The NHS would have total discretion over how that capacity was used and when the arrangement would conclude. Independent providers had no ability to exit the contract – only NHSE could do that, providing a month's notice at any stage. We understand that details of the contracts between NHSE and independent providers over this period are publicly available online.

Delivering the national contract

16. One key enabler of the contracting process was the arrangement of a Competition and Markets Authority (CMA) exemption order. This suspended some aspects of competition law which allowed independent providers to act collaboratively and collectively in a way that would not normally be appropriate but that was required by the exigencies of the healthcare emergency. IHPN's role was to work with NHSE, the Department of Health and Social Care (DHSC), the Department for Business, Energy and Industrial Strategy and the CMA to formally request an exemption order and then to ensure it was regularly reviewed with the CMA.

17. In parallel with the contracting process, IHPN and our members worked closely with NHSE to establish a delivery mechanism for the deployment of independent sector capacity into the NHS. This included protocols to ensure that staff could work across different healthcare organisations, and processes to manage requests for equipment moves. For example, we developed "Fast Track" Practising Privileges approval processes for NHS doctors to work in independent sector hospitals with appropriate clinical governance and a Memorandum of Understanding to help staff moves across organizational boundaries. We also

established work to enable the transfer of equipment and consumable items between different providers. IHPN established a Project Management Office (PMO) resourced by our own staff and member representatives to work with NHSE to deliver the contract as effectively as possible. At the start of the contract this group met daily and on a very regular basis thereafter with NHSE colleagues.

18. We understood that what the NHS needed was flexible access to capacity which was allowed for under the terms of the contract. This could take the form of enabling NHS clinical teams to work in independent sector hospitals, shifting whole services from NHS Trusts into the independent sector, delivering urgent care in independent sector facilities, or transferring staff and equipment such as ventilators to NHS Trusts or the new Nightingale hospitals.

19. IHPN did not collect data about the capacity that was available to the NHS as part of the national contract. NHSE conducted an exercise to collect that information directly from providers about the range of facilities, equipment and staff they had available. Our understanding is that around 8,000 hospital beds and 10,000 nurses were made available, alongside other clinical and non-clinical staff, equipment and facilities.

March – August 2020

20. In March and April 2020 much non-urgent healthcare was suspended following a decision from NHSE. This applied both to providers within the national contract and also the many other independent sector providers of healthcare. The situation at the time was developing very rapidly, including of course the imposition of national lockdowns. It really did feel like an unprecedented situation and healthcare providers were under a great deal of pressure to forge local connections quickly and put in place plans that would allow them to respond to what we all understood could be a medical and social catastrophe.

21. This meant that during that period independent hospitals were focused on supporting the Covid-19 response through providing their capacity as needed to

the NHS with a lot of variation over what that entailed at a local level. Much of the decision-making was rightly devolved to local NHS organizations to specify what was required – there was no national model imposed. Indeed, the clear message as we understood it from NHSE to local systems was "You have access to independent sector capacity - now use your best judgement to decide how it should be used in your local area". This differed from place to place. In London, for example, some providers were assigned to become part of a Cancer Hub that centralized cancer services across the city. For other providers, their ventilators and staff were removed to Nightingale Hospitals. Still other providers hosted NHS clinical teams to allow urgent care to continue. This initial crisis response showed the value of a contract that allowed the NHS to define what it needed from the independent sector.

22. From May onwards NHSE took the decision to recommence non-emergency care, starting with the most urgent work before over time re-starting a broader range of treatment. This was possible because the immediate threat that the entire system would be overwhelmed with Covid patients seemed to have passed. It was recognized that the system needed to find ways of enabling non-Covid related care to continue alongside the continuing treatment of Covid itself. At this point, independent providers were generally expected to become "Green Pathway" sites. "Green pathways" meant those where, through testing for both staff and patients and other rigorous Infection Prevention & Control processes, Covid would not be present. This was important since almost all NHS sites were treating Covid-19 patients and to have mixed Covid and non-Covid patients together, particularly immunosuppressed cancer patients, would have been highly dangerous. Therefore, the independent sector became a critical part of the infrastructure that kept non-Covid treatment including cancer and cardiac care going over this period. This enabled thousands of patients to receive treatment or diagnosis that would otherwise have been delayed or cancelled. From May onwards, the role of the independent sector was, by design, not to treat Covid patients but to focus on other areas of need.

August 2020 – contract changes

23. In August 2020 NHSE decided to terminate the contract with 9 providers giving one month's notice of that decision. These terminated providers were largely (though not exclusively) based in central London. IHPN played no role in making that decision, which was a matter for NHSE. While 9 providers left the contract in September 2020, those remaining included the four largest national hospital groups (Circle/BMI, Nuffield Health, Ramsay Healthcare, Spire Healthcare), meaning that while the number of providers had reduced by one-third, more than two-thirds of the capacity of the sector remained available to the NHS.

24. Alongside terminating the contract with those providers, NHSE indicated that it wished to revisit some of the terms of the original contract. This was because in some cases local NHS systems were not choosing to make use of 100% of the available capacity of independent providers in their area. There was a desire from both NHSE and providers themselves to ensure that capacity was utilized as much as possible. This led to a contract revision that permitted contracted providers to re-start more privately funded services. This was subject to two very important conditions. First, private care could only take place where the local NHS had actively decided not to use the capacity of the independent provider. Second, most of the revenue from private care was to be rebated to NHSE to help offset the overall cost of the contract. The revised contract continued over the autumn and into the winter of 2020.

25. I view this as a pragmatic solution that enabled NHSE to reduce its overall expenditure while still retaining first call on independent sector capacity for treating NHS patients. In summer 2020, with the first wave of Covid having passed its peak, there was an increasing sense that the measures taken in March 2020 should be adjusted in recognition of that new reality. Our understanding at the time was that NHSE saw the role of the independent sector as maintaining planned and urgent care in "green pathway" sites, while providing 'insurance' in the event of further Covid waves that might mean more widespread disruption to services.

December 2020 – further contract changes

26. The Covid situation in the autumn and winter of 2020 was highly volatile with time periods and geographic areas of relative normality and others where health services came under significant pressure due to rising case numbers.

27. Over this period a concept emerged of 'surge' capacity. The NHS leadership was understandably keen to ensure that, as far as possible, normal services were continued despite Covid pressures. And, at this point, the predominant role of the independent sector was to deliver planned care (diagnosis, surgery etc) in Covid-free 'Green pathway' sites. There was concern among the NHS leadership that some local NHS systems might prematurely suspend planned activity when facing significant Covid pressures. In such cases, this might mean that independent sector providers could be asked to cancel planned surgical lists in order to provide spare capacity that could be drawn on by NHS Trusts in a flexible way if they felt they were at risk of being overwhelmed by Covid pressures – but then find that the capacity was not needed and that the surgical lists had been cancelled unnecessarily.

28. To avoid this occurring, but to ensure that NHS systems could still draw on the independent sector as needed, the idea of triggering 'Surge' provisions was developed. Essentially this would be a formal process with governance from the NHSE national team so that a local system could trigger 'Surge' and then have permission to suspend or cancel planned care so that the capacity (including staff) of the independent sector could be drawn on for the direct Covid response. This was jointly felt to be a sensible solution and one that we at IHPN supported.

29. It was therefore decided by NHSE to enter into a new contract to include the idea and mechanism of 'Surge' provisions. This meant that providers would be paid on an activity basis (rather than for capacity as before) as the default but NHSE could approve a local request to trigger 'Surge' provisions and again have access to all relevant capacity when certain conditions were met. If 'Surge' was triggered then activity based payments would be suspended and providers would be paid instead on an at-cost basis for their capacity. This amendment was also a step towards more 'normal' contractual arrangements where, now, the assumption was that planned care would be the default service provided – as it was and is outside of the Covid emergency. The contract was therefore negotiated to reflect

the new arrangements and came into effect on 1 January 2021 with a defined end date of 31 March 2021.

January – March 2021

30. The process of 'Surge' was managed very effectively by the NHSE national team over this period. In the event, relatively few areas ever used the provisions and in general the period Jan-March 2021 was one in which the independent sector continued to deliver high volumes of planned care for NHS patients whilst being available to 'surge' should the need arise.

31. By the end of March 2021, the Covid vaccination programme had started. We understood that the future health system strategy would see vaccinations as the first line of defence against Covid and that, barring unforeseen developments, the threat that the NHS would be overwhelmed had passed. At this stage the national contracts expired with all remaining providers.

December 2021-March 2022

32. From April 2021 to December 2021 independent providers returned to a variety of local contracts with NHS systems, continuing to make a considerable contribution to a wide range of NHS services, including helping to begin work on reducing NHS backlogs which had built up as a result of the pandemic.

33. In December 2021 news emerged of the new Omicron variant of Covid-19 and its potential to be sufficiently infectious to overwhelm the ability of the health system to respond, even with the vaccination programme by then well advanced. At this point we were advised by DHSC and NHSE that they would like to enter into a further national contract, this time with a smaller range of 10 providers, to enable them to utilize the same 'Surge' provisions as in 2020 – providing a backstop that could be drawn on if needed.

34. IHPN again facilitated direct dialogue between independent providers and NHSE. This led to a further national contract, one that came into effect on 10 January 2022 with a time limit of 31 March 2022. As it was, the Surge provisions of the contract were never triggered and the providers therefore returned at the end of

March 2022 to the local contracts with the NHS that are the normal way of securing independent sector services for NHS patients and have continued since that point.

Utilisation of independent sector capacity

35. As I mentioned earlier, in March 2020 IHPN established a PMO team to deliver independent capacity into the NHS. This included both clinical and operational leaders and we developed a regional structure to mirror that in place in the NHS. The aim was to develop tools and guidance that could help local NHS systems and independent providers to work most effectively together, and to deal with issues as they emerged.

36. The Independent Sector Co-ordination Team at NHSE was a key partner throughout the life of the contract. With and through them we were able to develop key principles that helped deliver high levels of support and to respond flexibly to the needs of the NHS. For example, we worked jointly to produce guidance for the NHS about how they could most efficiently transfer patients from NHS waiting lists into independent sector providers. One challenge was that there was a relatively high level of turnover within the NHSE team, with colleagues sometimes re-deployed to other key areas such as the Vaccination programme. This meant that sometimes there was a loss of institutional memory but overall the joint working relationship was constructive and effective.

37. The activity delivered by independent sector providers under the contract was collected by NHSE and has since been published by the National Audit Office. This data shows that from March 2020 until April 2021 when the national hospitals contract ended, independent providers completed 3.3m NHS activities, including:

    a. 2.15m outpatient appointments
    b. 613,085 diagnostic tests
    c. 340,504 day case procedures
    d. 103,332 inpatient procedures

38. This data does not include equipment or staff transferred to NHS organisations and nor does it include activity delivered when an NHS team moved over to make use of an independent sector facility. This means that overall, the activity delivered under the contract was higher than the stated figure. At all times NHSE had full visibility at national level of how the capacity contracted for was being used. IHPN does not take a view on whether equipment like ventilators was well used – our role was to ensure that the NHS had what it wanted and we did that. In any case, it is not a straightforward yes or no. For example, I understand that some ventilators from independent sector providers went to Nightingale hospitals. Thankfully, the Nightingale hospitals were never filled with Covid patients. This may have meant that fewer patients used a particular ventilator than if it had stayed in place at the original hospital – but that does not mean it was not the right decision at the time to put it there.

39. Work undertaken during the national contract also enabled an increase in medical training in the independent sector. IHPN, NHS England, Health Education England (HEE), and the Confederation of Postgraduate Schools of Surgery (CoPSS) reached an agreement in September 2020, which resulted in over 4,000 trainees working in the sector from 2020-2022.

40. IHPN does not have any information relating to the costs of the hospitals contract. We did not communicate with Government, NHSE or any other relevant body about the costs of the contract or the perceived value derived from it. We considered that a matter for Government and NHSE and any relevant provider organization. Despite this, we were informed about the processes involved in determining qualifying costs under the contract and it seemed to us that NHSE rightly gripped that issue tightly and, through the work of its appointed auditor, was rigorous in ensuring that it understood what it was paying for and why. As an example of this, we would note that staff within independent hospitals not required to deliver the contract (for example marketing staff) were never included within it and, in some cases, those individuals were furloughed as part of the public health measures imposed to deal with Covid.

41. Independent providers are rightly proud of the contribution they made over this period. As well as high numbers of patients treated, independent providers also showed a flexible and collaborative approach in responding to the needs of the NHS. Some independent providers changed their normal model of care almost overnight – perhaps becoming a main cancer centre for a local area having previously focused on surgical care, or providing services for vulnerable patients including those needing dialysis and people with cystic fibrosis. There were high levels of trust at a local level between NHS and independent sector teams with a sense that everyone had a shared objective to do their very best for patients at a testing time for the health system. I have included in my submission two exhibits which are publications featuring case studies of what was achieved by independent sector providers over the period in question including a wide range of independent sector providers not on the national contract who responded heroically to the challenges of the pandemic on the UK health system. I hope that they will be read alongside my witness statement as an example of the wide range of services where independent providers played a crucial role in patient care. The exhibits are:

    DH-1 INQ000216434 - *Working together during the covid19 pandemic: How NHS and independent sector partnerships are ensuring patients get the care they need during covid* (IHPN, 2020)
    DH-2 INQ000216435 - *Working together during the second and third waves of covid19: How independent primary, community and diagnostic providers have supported the NHS during the pandemic* (IHPN, 2021)

42. It is a testament to the hard work of all involved that a contract agreed in just a few days in March 2020 delivered such excellent results. This contract gave the NHS what it needed – flexible access to capacity that could be utilized by the local NHS as it saw fit but which would, in time, allow for a return to business as usual. There is no other model that could have offered that flexibility while also attempting to set activity targets at a time when the impact of Covid was still almost entirely unknown.

Other considerations

43. One way of thinking about the national hospitals contract is to consider what would have happened if it had not been in place, both from the perspective of the NHS and the independent sector, For the NHS, I am convinced that it is right that it sought to secure all the additional capacity it could in the runup to the first wave of Covid19. The contract then developed over time as the situation changed – giving the NHS the flexibility it needed in leading the national Covid response.

44. From the independent sector perspective, it is difficult to say what the situation would have been if the contract had never been put in place and whether, in that case, what level of activity (both NHS and private) providers would have been able to carry out. There are simply too many variables to consider, including counterfactuals about whether the restrictions on planned care imposed in March 2020 would have applied and for how long, public attitudes to risk in leaving their homes to receive treatment and appetite for private treatment in areas where NHS access was closed off or restricted.

The future of public and private partnerships in healthcare

45. The Covid19 response undoubtedly broke down barriers between the NHS and the independent sector as a result of the joint work undertaken by clinical and administrative teams across the country. I hope that a legacy of this will be better levels of trust and collaboration to help improve patient safety and clinical quality in the healthcare system as a whole.

46. We know that independent providers also have an important part to play in dealing with the backlog of care that was exacerbated by the delays in treatment caused by Covid19. We are working closely with government and NHSE, including through the Prime Minister's Elective Recovery Taskforce, to ensure that independent provider capacity can be utilized well for the benefit of NHS patients.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 28 July 2023