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Public Bill Committee

HEALTH AND CARE BILL

Second Sitting

Tuesday 7 September 2021

(Afternoon)

CONTENTS

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Saturday 11 September 2021

The Committee consisted of the following Members:

Chairs: † Steve McCabe, Mrs Sheryll Murray

† Argar, Edward *(Minister for Health)*
† Churchill, Jo *(Parliamentary Under-Secretary of State for Health and Social Care)*
† Crosbie, Virginia *(Ynys Môn)* (Con)
† Davies, Gareth *(Grantham and Stamford)* (Con)
† Davies, Dr James *(Vale of Clwyd)* (Con)
† Foy, Mary Kelly *(City of Durham)* (Lab)
† Gideon, Jo *(Stoke-on-Trent Central)* (Con)
† Madders, Justin *(Ellesmere Port and Neston)* (Lab)
† Norris, Alex *(Nottingham North)* (Lab/Co-op)
† Owen, Sarah *(Luton North)* (Lab)
† Robinson, Mary *(Cheadle)* (Con)
† Skidmore, Chris *(Kingswood)* (Con)
† Smyth, Karin *(Bristol South)* (Lab)
† Throup, Maggie *(Lord Commissioner of Her Majesty's Treasury)*
† Timpson, Edward *(Eddisbury)* (Con)
† Whitford, Dr Philippa *(Central Ayrshire)* (SNP)
Williams, Hywel *(Arfon)* (PC)

Huw Yardley, Sarah Ioannou, *Committee Clerks*

† attended the Committee

Witnesses

Simon Madden, Director for Data Policy, NHSX

Saffron Cordery, Deputy Chief Executive, NHS Providers

Matthew Taylor, Chief Executive, NHS Confederation

Ian Trenholm, Chief Executive, Care Quality Commission

Keith Conradi, Chief Investigator, Healthcare Safety Investigation Branch

Cllr James Jamieson, Chair, Local Government Association

Professor Maggie Rae, President, Faculty of Public Health

Eluned Morgan, Minister for Health and Social Services, Welsh Government

Lyn Summers, Head of Health and Social Services Central Legislation Team, Welsh Government

Mari Williams, Senior Lawyer (Health), Welsh Government

Public Bill Committee

Tuesday 7 September 2021

(Afternoon)

[Steve McCabe *in the Chair*]

Health and Care Bill

2 pm

The Committee deliberated in private.

Examination of Witness

Simon Madden gave evidence.

2.1 pm

The Chair: This is the third panel. We will now hear from Simon Madden, the director of data policy at NHSX, who is appearing in person. We have until 2.30 pm for this session. Good afternoon, Mr Madden. Could I ask you to introduce yourself for the record?

Simon Madden: Good afternoon. I am Simon Madden, director of data policy, NHSX.

Q46 Alex Norris (Nottingham North) (Lab/Co-op): Thank you, Simon Madden, for your attendance this afternoon. I think it would be safe to say that the roll-out of the general practice data for planning and research scheme did not go as planned earlier this year. It was remarkable that despite the limited engagement, well over 1 million people opted out. What learning do you think we can take from that exercise for the data provisions contained in part 2 of the Bill?

Simon Madden: We have obviously set out the position. The Government have set out the position in respect of GP data for planning and research, in terms of taking a pause and having a conditions-based approach, rather than a clear timeline for the commencement of that. Above all else, I think that the overriding need for trust and transparency—to build public trust in the use of health data—is vitally important, and the ways in which this is governed need to be transparent in such a way that the general public can see quite easily how their data will be used.

Indeed, I think it is a responsibility on Government and those of us in the health and care system more broadly to really promote the benefits of sharing data. It is a public good and, while putting in place sufficient safeguards and then giving the public the opportunity to opt out of that process if they are not convinced by those safeguards, it remains a public good and contributes to the broader health, if I can put it that way, of the health and care system.

Q47 Alex Norris: Do you see the process enabled by the Bill running alongside a future resumption of the GPDPR process—or a conditions-based continuation, as you put it—or would they remain two separate things that overlap?

Simon Madden: Essentially, they are separate in terms of process. The general public will not make a distinction between any things to do with their health data. Whether it is the draft data strategy that we published earlier in the year or the GP data for planning and research programme, to the general public it is about their health data.

It is incumbent on us to make sure that we have a strong narrative that reflects all aspects of health data. We need to reset the relationship between the patient—the citizen—and their health data, so that a perception does not arise that we are taking their trust for granted, because that is certainly not the case. The provisions in the Bill around data are meant, to some degree, to provide clarification where there is some confusion in the current framework about how and when data could be shared.

Alex Norris: Building on that point—

The Chair: Hang on a second. I had better give somebody from another party a chance.

Karin Smyth (Bristol South) (Lab): Chair, I have another question.

The Chair: I will come to you in a second, Karin. I am just trying to balance it between the respective parties.

Q48 Dr Philippa Whitford (Central Ayrshire) (SNP): Obviously, a lot of the detail will only be there when the regulations are laid, but there has been a lot of concern in England about the talk of data being provided in a pseudonymised form to commercial companies. Is this not a repeat of the care.data issue, which lost public trust? A lot in these clauses could apply to Scotland. We have real issues in Scotland, where we have a lot of data sharing and analysis, and suddenly this gives NHS Digital to demand data, whether for a registry or for something else. It is about the commercial side; I do not think patients have an issue with Public Health England, universities or whoever learning from their data. The public concern is about the idea of pseudonymised data ending up with commercial companies.

Simon Madden: I completely understand that. We have to be very clear about what we mean by "commercial companies", because pharmaceutical companies that develop treatments and vaccines are also commercial companies.

Q49 Dr Whitford: But the public are not comfortable with that.

Simon Madden: I get that, but there is no doubt that, in order to improve treatments, we need to contribute to research in some way.

You are absolutely right. It goes back to my trust and transparency point. One of the things that we signalled in the data strategy particularly was a movement towards trusted research environments. That is crucial. In some ways, what we have announced on GP data for planning and research is an acceleration of that work. We have said that data will not be shipped around or disseminated; it will be accessed only within the confines of a secure, trusted research environment, with full transparency about who has access, who runs what queries, and so on. It will be held and will not be shared. That is the general direction of travel that we want to see, and that is why we set that out in the data strategy.

We do not have to make a choice now between enabling access to data, or sharing data, and protecting privacy. Technology has allowed us to create environments where it is perfectly possible for data to be accessed safely and securely, with strict safeguards, without privacy being compromised.

Q50 Dr Whitford: That is the public concern. My concern is that the data in Scotland lives within NHS Scotland. It is not under this Parliament or anything else, and yet there is no mention of Scottish Ministers being able to say, "We will share it in an anonymous form. We will be able to break that code if there is a safety issue on a medicines registry or if a piece of research needs to be traced back to a patient." You can set filters within your trusted environment without handing over pseudonymised data to a commercial pharmaceutical company.

Simon Madden: Data will not be handed over in a trusted research environment; it is only accessed in one place.

Q51 Dr Whitford: But by whom? That is the public concern. They have no issue with a public body. They are anxious and it goes right back to care.data. The danger is that it will set back your whole digital agenda if you get hundreds of thousands of the public all opting to not take part.

Simon Madden: I completely understand. That is why I mentioned that it is incumbent on us to have not only the right safeguards in place but the right narrative and to engage with the public so that they understand what those safeguards are, how they operate and how they can opt out of the system. One of the things we have been looking at in developing the final version of the data strategy following the engagement is how we can do much more on public trust and transparency. It is not just about a one-off marketing campaign; it is about an ongoing public dialogue and involvement of the public in future policy considerations. Again, it goes back to that resetting point; I think this is a reset moment. Technology now allows us to go that bit further than we have ever been able to go before in terms of protecting privacy, but we have to be in a stronger position to explain that to the public and how it all works.

Q52 Karin Smyth: I hope that this is in scope, Mr McCabe. I have just come from the Chamber, where the Prime Minister is still on his feet. He talked about integrated care records, but I am not quite sure if we are discussing the same thing. This may not be news to you, Mr Madden, but could you clarify whether we are all talking about the same thing? I appreciate that you were not there to hear the Prime Minister, but is it your understanding that what we are hearing today about social care is the same as the conversation we have been having about integrated care records, personal care records and so on?

Simon Madden: Forgive me, but I will take full advantage of the fact that I was not there and have not seen the statement that the Prime Minister made. A feature of our plans set out in the data strategy—not so much in terms of the Bill itself—is for each integrated care system to have a basic shared care record, so that throughout their whole health and care journey a patient or citizen does not have to do simple things like repeat test results or repeat their prescriptions, and so that their care journey between health and social care, with provisions for safeguarding and safeguarding information, is seamless.

The Minister for Health (Edward Argar): I will ask a couple of questions, if I may, Mr McCabe, and then perhaps the hon. Member for Nottingham North can come back in if we have time. Moving away from what has been explored by colleagues so far on the extremely important protections around data sharing and data use, can you set out how the changes set out in the Bill relate to and will help you deliver the data strategy that you have in place?

Simon Madden: It is important to set out that these provisions alone, while they do much within the Bill, must be seen in the context of that wider data strategy. They support our ambitions, and the integration and collaboration that is described in the Bill will be a huge enabler for the ambitions set out in the strategy itself.

The provisions themselves focus to some extent on tidying things up and providing a degree of clarification. I mentioned the provisions for clarifying NHS Digital powers: currently, there is sometimes confusion around what data NHS Digital can share and in what circumstances it can share it. Sometimes, that leads to problems when data may need to be shared for very good reasons—for justifiable reasons—but NHS Digital is sometimes not convinced that it has the legal power to be able to share the data. This puts beyond doubt its ability to share data appropriately.

Another provision is on information standards. We are making a provision in the Bill to mandate standards for the storage and collection of data. That is important to ensure that data can flow between different IT systems and organisational boundaries in the health and care system. That will then help individual patients and improve health outcomes. We want to ensure that providers of health and care services purchase only technology that adheres to that set of standards, so that we have that interoperability, and those improved outcomes for patients, through that mandation of information standards.

We have also put in clauses around sharing anonymous health and care information, which help to essentially set a duty to share anonymous information when it is legally permitted to do so. One of the lessons that we have learned over the pandemic has been that, although it is perfectly permissible for data to be shared—it is legally permissible to do so—the shift from "can" to "should" has a great impact within the system.

Our invoking of the control of patient information regulations under existing legislation, to enable that sharing of data and to say, "You should share data in these circumstances," has significantly helped the free flow of data safely and securely within the health system. That has had an impact on patient care. I think that the duty to share anonymous data will help to put on a more permanent footing some of those provisions that we have seen during the pandemic.

Q53 Edward Argar: To what extent would you consider it a fair characterisation that this is, in a sense, evolutionary, and that, actually, to a large extent, the provisions related to data—to go back to what you said—add

[Edward Argar]

greater transparency and legal clarity around some things that may have had to happen during the pandemic, and give them a longer-term basis in statute, as debated by this place? Do feel entirely free to disagree with that characterisation, I hasten to add. I am not leading you in any way, but to what extent would you consider that to be a fair reflection of these provisions?

Simon Madden: I think it is a fair reflection, to a certain degree. I think that the thing that we must always be conscious of, particularly in the field of data and technology, is that we see advances but legislation often does not keep up with those advances. It is about ensuring that everyone understands their responsibilities—not just that the public understands the responsibilities of organisations that are safeguarding data, but that those organisations themselves have the right powers to be able to share data safely and securely. I think it is evolutionary in that sense, but it is also about making sure that the provisions in the Bill are keeping pace with the development of technology and how data is used in the real, modern world.

Q54 Alex Norris: I will ask two questions in finishing, if I may, Mr McCabe. The first is a final one on the GPDPR promise. Mr Madden, you said that that is a separate process to the one in part 2 of the Bill—which I completely agree with—but that in the public's mind, the two are likely to be conflated, and that now would be a good moment to reset the relationship between people and their data. Again, I completely agree with that. Is there any technical reason why we could not run those two processes not as two but as one?

Simon Madden: I should perhaps caveat my previous comments by saying that they very much are, in our mind; it is all about health data. The focal point for us at the moment, which we are working through with Ministers, is the formulation of the final version of the data strategy. Of course, the legislative provisions are within the data strategy. It is very much the case that the publication of that document, I think, is the right moment for that reset where we have more intensified engagement with the public and we really step up the narrative around how health data is used. As one of your colleagues said, the real detail comes in regulations, if there are any regulations around that; and of course there would need to be consultation before the regulations were put in place.

Q55 Alex Norris: Finally, I remember from my time in local government that we would talk about the desire in social care to share data with the health service. We talked about, obviously, regulatory barriers that stopped us and we would welcome provisions that removed that, but a very practical obstacle on our list of things in the way was that the systems did not necessarily speak to each other. Do you think that health service systems and social care systems are ready to speak to each other now, or will there need to be, across all integrated care systems, a whole new provider brought in?

Simon Madden: Obviously, interoperability is absolutely key. The information standards piece that I spoke about is part of that, but also, outside the legislative piece, work is going on to create a unified data architecture. This is not about driving or having everything from the centre, so that everybody uses the same things, but about making sure that the architecture enables that interoperability so that the systems can speak to each other. There is certainly a degree of levelling up to do in terms of digital maturity, which is another area in which NHSX is involved, supporting the Department and NHS England. But yes, interoperability is key. We are not there yet; we have some way to go to make sure that everything will flow as it should and the systems speak to each other.

Q56 The Parliamentary Under-Secretary of State for Health and Social Care (Jo Churchill): Mr Madden, I would like to know specifically how the strategy will help us to deliver integrated care within the confines of the Bill, so that we can give better patient outcomes, because ultimately that is what I have assumed the Bill is striving for. You did allude to how that interoperability gives us greater vision into the system. I wonder whether you could help us by bringing that to life. Thank you.

Simon Madden: The best example is something that I have already cited to a certain degree, which is the shared care record. To some degree, that would happen irrespective of whether ICSs and the Bill were in place, because health and social care need to come together; that is something that needs to happen in any event. But what the Bill does is create the proper framework of integration and collaboration. There are other powers in the Bill, for instance the duty to co-operate and collaborate, that I think are going to be absolutely crucial. From a public perspective, they see the NHS and see one organisation, whereas we all know that it is a confederation of organisations, each sometimes with different aims, pulling together. The ICS structure set out in the Bill, plus the data provisions that support that broader approach, will help provide that free flow of information so that clinicians and care professionals have access to the information they need to be able to treat patients in the most effective way.

The Chair: Anyone else? I will assume there are no more questions. Mr Madden, I thank you very much for your evidence.

Examination of Witnesses

Saffron Cordery and Matthew Taylor gave evidence.

2.25 pm

The Chair: This panel is mixed. We have Saffron Cordery, the deputy chief executive of NHS Providers, who is joining us remotely via a video link, and Matthew Taylor, the chief executive of the NHS Confederation, who is appearing in person. Can you hear us okay, Saffron?

Saffron Cordery *indicated assent.*

The Chair: In that case, Saffron first, then Mr Taylor, can you introduce yourselves for the record, please?

Saffron Cordery: Yes. I am Saffron Cordery and I am deputy chief executive at NHS Providers.

Matthew Taylor: I am Matthew Taylor and I am chief executive of the NHS Confederation.

Karin Smyth: Good to see you both. Thank you for coming. I want to talk about accountability. I asked NHS England this morning about how accountability works in the new system and it was clear that local accountability lies with the integrated care board—the chief executive and the finance director, in the first instance. We were then taken through the system up to NHS England and Ms Pritchard then said "through Parliament", which she corrected to "through the Secretary of State through Parliament". I asked at what stage the Secretary of State becomes involved in the accountability, a question that she did not answer and which I would like you both to answer for me.

We have also heard that the Bill is something the NHS asked for. I have not met a single person working at any level in the NHS who says that the powers given to the Secretary of State directly, added to the Bill after conversations with the NHS, are a good thing and are clearly workable. That is my pretext.

Perhaps I can give the example of a constituent who came to me about ear wax removal, which was a subject that concerned him greatly. Will I write to the Secretary of State as a Member of Parliament to ask him about the lack of ear wax removal services in my integrated care board area, or will the chief executive be the final arbiter of such decisions? Mr Taylor, do you want to go first on behalf of the confederation?

Matthew Taylor: Yes. There are two points here. The first is around the structure of accountability at the centre and while that is important, ultimately, it is a less important consideration for health service leaders than the relationship between central accountability and local accountability. That is the focus of the major concern we have about the Bill: the extension of the Secretary of State's powers in relation to reconfiguration, which we think is a mistake. We think the system, as it is, is not perfect but works pretty well. For the Secretary of State potentially to be embroiled in making decisions not just about major reconfigurations, but really relatively minor reconfigurations runs the risk not only of delaying necessary changes in the system, but of putting less emphasis on the views of local people and of clinical advice.

Representing my members, while the question of the relationship between the Secretary of State, Parliament and NHS England is one that we take an interest in, the issue of the relationship between the centre and local accountability is stronger. Where constituents write to their MPs, the Secretary of State or wherever when they have a problem, they will continue to do so, but I hope in such a system that the first thing to happen to such a letter is that it would be sent back to people locally who could address that issue in a local way. It would be ill-advised for a Secretary of State to try to involve themselves in a question like that.

Saffron Cordery: I agree with Matthew's point. It is this central-local relationship that is absolutely critical to those who are working on the frontline—trust leaders from my perspective, and from NHS Providers' perspective. Coming back to some of your points about the NHS supporting the legislation, I think that is absolutely right. The NHS has come together to support the direction of travel of this legislation, but I think it is worth saying that that agreement was based around an August 2019 set of proposals, when the whole NHS came together on the basis of some recommendations from the Health Committee. It is important to remember that the legislation has changed somewhat since then. We have had a number of elements added to the Bill that sit around the central bit that the NHS agreed with, which probably changed the context somewhat. It is worth remembering that the local reconfigurations issue that Matthew Taylor raised is a very important one.

There are elements as well in the nature of the relationship between the Secretary of State and NHS England in terms of the operating context and its ability to intervene in what goes on nationally, and the knock-on effect locally on trusts. There are some really big issues there, which come together.

The other thing to say is that, often, Secretary of State powers may seem like small elements, but taken together, the cumulative impact can be seen to erode that local accountability. We would hope, whatever happens, that if someone has an issue with ear wax removal, they speak to someone at the most appropriate level to get something done. That is what subsidiarity is about: the delegation of powers to the most appropriate level, and it is really important. It is also important for accountability, because you cannot have a Secretary of State saddled with taking a thousand tiny decisions in an organisation and a system as complex as the NHS. That is one of the challenges of this local reconfiguration issue that is arising.

Karin Smyth: Chair, can I come back?

The Chair: I will come to you if there is time, but I want to move on. Dr Davies.

Q57 Dr James Davies (Vale of Clwyd) (Con): Thank you. I have a general question about the key feature of the Bill: integration of services. What is the experience of your members with regard to that and have those views changed thanks to the pandemic? Perhaps we can hear from Saffron first.

Saffron Cordery: The experience of the pandemic, which is a seismic and far-reaching event, really put the frontline of the NHS and other local public services in the frame for delivering for their local communities, and for supporting each other and helping each other out with mutual aid. What we saw there was one very good and important example of how local partnership working, local collaboration and local integration was working in very different ways up and down the country.

We had some common features of all integration, something you would expect at a time of crisis, where there is a lot of command and control and procedures that go on in a state of civil crisis such as this one. We also saw different communities responding in different ways. That is one of the most important points that I want to make about this legislation. In terms of collaboration, we have to see a piece of legislation that is as enabling and permissive as possible. Obviously, legislation has choices. You go down different routes. Really prescriptive legislation will not help in this situation, though. We have to reflect the progress made in some areas and the need for encouragement and support in other areas to get where we want all ICSs to be: that is, really effective and delivering what local populations need. A permissive framework is critical. Going back to your question, it is right that the pandemic has shone a

light on both the potential of ICSs and collaboration in particular and the challenges we face right now in implementing any new proposals due to the operational pressures facing the NHS, local government and other public services.

Matthew Taylor: I agree with Saffron. There have been some very good examples of local collaboration, such as the vaccination programme and reaching out to communities where initial take-up may not have been what we had hoped. There is some really impressive work there. That work presages the wider commitment within the health service to a strategy of population health, which addresses not only those people who express demand but those who do not. We wish that they would, because that is one of the things driving health inequality.

I have been at the confederation only three months, so I look at the legislation from the perspective of a wider interest in public policy over 30 years in government and outside it. This is a very interesting and innovative example of policy making. We have these integrated care systems in large parts of the country, so the policy has already been enacted ahead of the legislation. Though that may raise democratic issues, it enables us to see in practice how people are taking the principles of service integration and focusing them on population health. Despite the challenges of covid, a challenging funding context, and the issues around social care—which are hopefully being addressed in one way or another—we see across the country that there has been a whole array of interesting bits of innovative, collaborative work around issues of population health, prevention and addressing health inequalities.

I want to emphasise a point Saffron made. If you look around the country, you see some systems that are well advanced in their collaboration and other systems that are not. This is for a variety of reasons; in some cases there are issues to do with boundaries and such. Like Saffron, I think it is really important we have a permissive regime that allows these systems to evolve at a pace that is right for them and the places in which they operate. Over time, the systems will move forward, but it is actually a really effective way of working. It would be a mistake to try to impose exactly the same way of working on every part of the country. It would mean those who were ahead will be pulled back and those who are not quite ready to make integration work will be compelled to tick boxes, as it were, rather than work on the development of the relationships that we need.

Q58 Edward Timpson (Eddisbury) (Con): I want to build on that point about permissiveness and take it a step further in terms of the specification in the Bill around ICBs and ICPs—the boards and partnerships. A lot of us on the Committee have been requested to look carefully at individual parts of the healthcare system. That does have a generality to it, covering mental health, children, palliative care and so on, and their representation is very clear within partnerships and boards. Based on your views around permissiveness and flexibility and the different paces ICSs are currently at, how do you see this? How do we reassure people that their views and the particular parts of the health system they represent will get a fair hearing and that the accountability structures will be in place to make sure they are able to come back if they feel they are not being addressed properly?

Matthew Taylor: That is an important point. Let me be completely open about the conversation within the confederation about this issue, for example. We have a mental health network representing mental health providers. Their preference would be to specify the need to have a mental health leader on the board. We as a confederation recognise that view and represented it, but that is not our view overall. Our view is that, partly because configurations differ from place to place—in some places, mental healthcare and community are together, for example—but for a variety of reasons, we would not want to specify further the membership of those boards. Again, that is to maximise local flexibility.

If people feel their voice is not being heard, then that is something they are going to say. We will have to see how this system evolves, but let us start with—going back to a word used earlier—the permissive regime and see how that goes, because after all it is in the interests of everybody in the local health system that they hear the voices they need to hear.

Saffron Cordery: I agree. This is a thorny issue but I suppose it is one of either, depending on how you look at it, the opportunities or the casualties of creating another level of governance in a local system. When you are thinking about putting collaboration on a statutory footing, you have to surround it with some kind of governance to ensure the effective operation of that body.

It is a tricky issue. You cannot have an integrated care board—the board that will govern how funding flows through and how priorities are agreed, decided and implemented—that is so enormous that it becomes unworkable, but there has to be a clear balance between making sure it is not only the big and the powerful who are represented there, but also all the rights and appropriate interests. There are a number of positions specified in the ICB board arrangements, and it will be interesting and important to see how different ICSs use those roles, particularly the non-executive or wider partnership roles that are specified, in order to have a broad range of voices around the table.

It is worth remembering that many other organisations and structures will be taking part in the ICS arrangements. You will have things like provider collaboratives, which are not in the Bill but feature heavily in the guidance that comes from NHS England and NHS Improvement, which are precisely about organisations working together to deliver on local priorities. Many of those are led by mental health organisations focusing on what they need to deliver.

There are other structures within these arrangements, but no one would say it is ideal. It is not the most ideal solution, but it is very difficult to get to a final configuration that is both workable in terms of numbers and reflects the multiplicity of voices in a locality. It is important to have the right engagement at every single level and the right channels feeding up information and priorities, and to understand what is really important in a system.

Matthew Taylor: Today the Government have been talking about the importance of integration in the context of its announcement on health and social care. One of the big questions is going to be about the powers that are devolved within systems to places, and I think it will be at the place level that we will see service integration. The evolution of place level forms of accountability is an important part of that, and again a reason why it is really important to allow these structures to evolve

locally. I suspect that in some areas more power will be held at the system level and less at the place level. In other places, it will be the reverse, with most of the action taking place at place level. That reflects the nature of places, the legacy of those places and the relationships that have built up.

Q59 Chris Skidmore (Kingswood) (Con): I wanted to turn to workforce planning and your views on clause 33. The NHS Confederation, in its written evidence, has suggested that the five-year period for a strategic review on workforce planning is too long. That mirrors my amendment, which has a crack at this. I have suggested an annual review. It was suggested this morning that two years might be the right time length. I see that the NHS Confederation has suggested three years. I want to get your organisations' views on what a strategic review should look like, but also on the format and how a strategic review should be undertaken so that it actually works as an act of co-creation, rather than being directed centrally by the Secretary of State on to Health Education England.

Matthew Taylor: My area of expertise before coming to the NHS Confederation was work and the future of work, on which I advised the Government, and one of the things I know from that work is how quickly the world of work is changing. It is impacted by a whole variety of things—not least, of course, substantial technological change. In a world where work is evolving very quickly and population needs are evolving, five years is simply far too long. If it were one year, we would be happy. We have fastened on to two years. That would be the minimum that we would want as a gap between assessments of workforce need.

It is also—to emphasise the point that I think you are making—important that this review gathers evidence from a whole variety of bodies, because an enormous amount of extremely good work is taking place around work. Predictions of workforce need are imprecise, so hearing from a variety of voices is important. This should be an independent process, in which independent expertise is brought to bear; there should be wide consultation with those who think about these issues; and a two-year plan would, I think, be an improvement on what is in the Bill.

Saffron Cordery: We also support this amendment and the work that has been done by the confederation and others on this. There is one other element that I would add to this that supports this perspective. It has been really hard, across NHS workforce planning, to light upon one version of the truth, in terms of workforce numbers. Anything that starts to move towards a collective perspective on workforce needs and workforce planning will be absolutely critical.

Getting an agreed perspective on how we create that figure will be fundamental. In my time working across the health service, there have been many different perspectives on workforce—on the gaps, the numbers who are in roles, and what those roles need to be. It is important to have lots of views, but I think this is also important. Although, as Matthew says, it is not a precise science, we need to light upon a version that is independently agreed, but that we all sign up to as the numbers we are working to.

Q60 Karin Smyth: If I may, I will return to the permissiveness and place conversation. I agree with the Bill's direction of travel around place. I do not like the word "permissiveness", because we have essentially a local cartel of healthcare providers deciding on resources and their allocation, and that locks out local communities. I am a bit suspicious of the NHS being given permission to do as it sees fit. That is why I put forward the example about ear wax removal—because that matters to local people, as we all know; that is what some of these things come down to.

The Bill falls apart because of the governance arrangements and the accountability, which does not follow the logic of place-based commissioning. My solution for the Government, should they wish to take it, is something around a good governance commission, based on the previous appointments commission-type process. It would bring in skilled people, with clear role descriptions, clear skills and a degree of independence. It would have the trust of local people, and would bring these very powerful chief executives together with local leaders to explain why, in Bristol, you cannot have ear wax removal, or why you are closing certain provision and opening it in Derbyshire or wherever. Have you had an opportunity to look at my proposal for a good governance commission and locally accountable chairs—perhaps elected, or appointed? What do you think of that as a solution that would bring power and accountability closer to local people?

Saffron Cordery: The issue of accountability is absolutely fundamental. One of the things we have not talked about much in this sitting, and which is not talked about that much, is the presence of two bodies in the system. We have the ICB, but also this partnership body that brings together a number of wider partners—particularly local government—with democratic accountability, which I think is really important.

I am wary of adding too much into the structures in the Bill. I understand your perspective on permissiveness, and we need to make sure that there are checks and balances across the whole system, but I would be wary of adding in another structure alongside everything we have. One of the features of this legislation, as I have said throughout the process—we have met the Department of Health and Social Care and talked to their Bill team, who have been very open and helpful—is that it does not really streamline in the way that it thinks it might. It adds to existing structures and processes, rather than starting from a clean sheet of paper and building something that might be deemed to be a good enough model; we will never get to the perfect model.

Right now, what we do not need is a root-and-branch dismantling of NHS structures and something wholly new put in their place, but I think there has been a missed opportunity to look at where we could streamline more. On that basis, I think it is important not to add more in, and it is fundamentally important that we look at the different roles and structures that already exist. From a trust provider perspective, working both at place and within provider collaboratives, and looking at the governance of unitary boards with non-executives and in some places also with governors and members, we see that there is that element of engagement with the community that you perhaps do not see in other places. I do not think it speaks entirely to your cartel point, but it is a step along the way that is well established and well used in many places.

This is a thorny and tricky issue. Using existing structures of accountability will be really important, as well as using the new ones, but I would not want to see anything new added in there.

Matthew Taylor: I largely agree with that, but another point is that if there is a broad policy thrust in this legislation, it is away from a medical model of health towards one that focuses more on social determinants. In the best partnerships—we talk often about West Yorkshire and Harrogate, for example—there is an incredibly strong relationship between health service leaders and local authority leaders. That will be a critical factor in the success of the system. When I look at the best practice emerging in the integrated care systems on issues such as prevention and population health, I see leaders starting to talk about issues such as housing, employment and public space, recognising their importance to health. In one way, that is a progressive move, and one that will probably lead to a louder voice for a variety of local interests, if we understand health much more in these socially determined terms, rather than simply through the medical model.

We had a big announcement today about social care reform, and there is a set of issues that are not in this Bill—issues around health and social care integration, how it will work and how accountability will work. It remains to be seen how the Government address that question.

Q61 Dr Whitford: Matthew, you mentioned that the degree of local integration varies, and that it is impacted by things such as boundaries—particularly the relationship between NHS and local government boundaries in the shift to a wider view of wellbeing. How much of a problem is it that the number and the footprints of the ICSs are different from those of the proposed sustainability and transformation plans? Are people who were growing together suddenly finding that they are no longer working together, and that they will have to start working with someone else? Do you not see that as something that will hold things back?

Matthew Taylor: It is a challenge.

Q62 Dr Whitford: Is it a necessary challenge?

Matthew Taylor: Whenever Government are faced with issues of boundaries, there is no solution that will not upset a lot of people, and this of course has been a vexed issue. I go back to the need for local flexibility. I will not name particular systems, because I do not want to speak for them, but I am thinking of two systems. In one, there have been many years of integration and collaboration, and an enormous amount of collaborative work. There, boundaries are probably much less important than they were in the past. In the other, an ICS is being established that will oversee two places—a city and a county that do not have an enormous amount in common. There, the ICS will have to develop its own proposition about the value that it will add. It would be a mistake for that system to want to draw up an enormous amount of power from two places that are working pretty effectively and would not benefit a great deal from deep integration.

The pattern is different from place to place. That is why we need to allow things to evolve in the light of local circumstances. It is always difficult when boundaries are not coterminous or shift. All I can say is that health services are used to these kinds of challenges, and most who have reached the top have probably worked through at least one of these challenges in the past, and know how to go about it as best they can.

Q63 Dr Whitford: Obviously, the delivery will be different, but the aim will be the same. What mechanism do you see evolving to allow the sharing of good practice? The integration of health and social care has been going ahead for seven years in Scotland, and we know how difficult it is. It is exactly as you say: some areas have made amazing innovations, and others are struggling. In what forum do you see one place being able to learn from another's experience?

Matthew Taylor: That is a fascinating question. My view, which goes back many years, is that you need the right combination of strategy from the centre and identification of the right thing to do, where there is clearly one best thing to do, although Whitehall has a slight tendency to exaggerate the number of areas in which there is one best thing to do. Then you need peer-to-peer, or horizontal, learning. Providers and the confederation do a lot of work with our members to share best practice. A week will not pass without one of us publishing something around good practice, and bringing our members together to share that. This is another reason why it is important to have local difference. It is in a system of local difference that you will get more innovation. As long as you have innovation coming through, really strong organisations spreading good practice and a centre that focuses on where it can add value, you have the capacity for a self-improving system.

Dr Whitford: But how do you—

The Chair: I am wondering if we should hear from our other witness.

Dr Whitford: I was going to ask Matthew all my questions, and then go to Saffron with them all.

The Chair: Well, you only have about two minutes.

Matthew Taylor: By the way, I think it is important for us to learn from Scotland. We have been having a conversation in the confederation about the importance of recognising that we have different health systems now across the UK, and that there is an opportunity here for good learning.

Dr Whitford: Saffron?

Saffron Cordery: In the interests of time, I will say that I do not have a huge amount to add. Peer learning, peer challenge and peer support are absolutely critical. Variation, in its broadest sense, is important, and you can call that innovation or whatever you want. How you respond to local circumstances is critical. That is why cookie-cutter mode does not really work. Going back to your point on boundaries, they are, of course, a vexed issue. I know from my time in local government how vexed an issue it is there. Any kind of local government reorganisation can tie you up for years and years. It is worth remembering that boundaries were challenging at the start of this process. A number of STPs, which were the forerunners to ICSs, had boundaries imposed on them, rather than choosing those boundaries.

There have been a few policy developments that perhaps have not been as widely discussed as they might have been, including the fact that coterminosity with local government, although not necessarily the wrong step, was brought in relatively late in the day and did lead to

some of the later boundary changes, as we have seen. I am not saying that that is wrong, but it demonstrates the need for wider discussion, consultation and engagement with the NHS and local government system as a whole before the decisions are made to help understand how best to do it. Sometimes just saying that it must happen and decreeing that is not the best way of making something a smooth operation that gets the best out of local systems. On occasions, there is something in the process of policy-making that could be looked at.

The Chair: We had better move on.

Q64 Justin Madders (Ellesmere Port and Neston) (Lab): Good afternoon. Obviously, you have the ICB and the ICP both within an ICS. If there is a disagreement between them about the direction of travel on a particular policy issue, who arbitrates? In your opinion, who is likely to be sided with in such a dispute?

Matthew Taylor: I defer to Saffron on that one.

Saffron Cordery: I think this is one of those elements that we have seen quite a lot of throughout the legislation in terms of where is the recourse—that is not the right word, but I cannot think of another one right now—if things go wrong. Collaboration by its very nature is a positive process where willing parties come together to reach agreement. Everyone's hope and aspiration is that that is how ICSs will work overall, and that is how the ICB and ICP will work together. It is not currently clear how there will be recourse to arbitration or dispute resolution, if you like, in the process of this legislation. We have seen an optimistic approach to how this legislation has been brought together—rightly in some senses—and of course we do not want a situation where we are anticipating that the evolution of a new way of working will not be functional. At the same time, the role of legislation is to anticipate what can go wrong, as well as to support what needs to be done. It is not yet clear how some of this will shake out in terms of where ICBs and ICPs need to turn to should there be challenges, issues and disagreements. We have to remember that those bodies, once they have their independent chairs and accountable officers and chief executives, sit within the NHS system, so they sit within the regional NHS England system and within the overall NHS system. Routes will be pursued, but at the moment it is not clear to me how disputes, for want of a better word, will be resolved.

Matthew Taylor: The only thing I would want to add is that during covid, we have understood the scale of health inequalities. The evidence has been that those inequalities are growing. That has demonstrated that we need a conversation between the health service in relation to how it deals with the demand that is presented to it and the wider question about how we address population health. In some cases, that might mean that you have some creative tension between those two levels. As Saffron said, it will come down to the quality of relationships, and if those relationships break down, I am sure that the centre will need to intervene to address that because the system cannot work if it breaks down. But the fact that those two bodies might have a slightly different emphasis and focus is probably a good thing because this debate about how we best use our health resources to address population health and health inequalities is an important debate for us to be having nationally and locally. Let us face it, we have not got this right up till now.

Q65 Justin Madders: On the Secretary of State's powers of intervention on reconfigurations, is it your understanding that a local system could agree across the board that particular changes were necessary and actually that it was important for reasons of patient safety that those changes were made but that the Secretary of State could intervene at any time to stop them?

Matthew Taylor: Yes, unfortunately that is our understanding, and we think that it would be a retrograde step. It is not a power that I would want if I were a Secretary of State and I wanted to focus on strategic policy questions. I would not have advised the Secretary of State to want those powers.

Our view would be that we should remove the extension of the Secretary of State's power entirely, but, failing that, we should put some guard rails on in relation to hearing the views of local health overview and scrutiny committees, getting local clinical advice on what is best and having a public interest test that should be passed. If those guard rails were in place, we could cope with this.

What we do not want is a chilling effect on the capacity of local leaders to make the decisions that they need to make to use their resources effectively. The third element of the triple mandate is the effective use of resources, and that involves making decisions at a whole variety of levels around how you configure services. If you feel you are going to go through that process and potentially engage local populations in difficult conversations, and then at the end of the day a local MP, for whatever reason, is going to kibosh that by appealing to the Secretary of State, why would you embark on the process in the first place? That is why, while we are very supportive of the Bill, as you have heard from both Saffron and me, we do think that the powers of reconfiguration are the Achilles heel. I appeal to you to recognise that that is unnecessary and goes against the spirit of the Bill.

Saffron Cordery: I wholeheartedly support what Matthew says, and it speaks to a point I made earlier about adding to existing structures in a way that really is not necessary. I notice that you have representatives from the Local Government Association as witnesses later on. I am pretty sure that they will have some strong views about what these measures do for the powers of local health overview and scrutiny committees, because they already have the power to refer to the Secretary of State should they need that to happen. The powers that are currently in place are a really effective way of doing it. People getting something past a local health overview and scrutiny committee is a really important hurdle for any service change. It is already well respected, well used and very effective. This is one of those elements that at best is redundant and at worst is going to create a lot of work and a lot of unnecessary tension and friction where we already have challenge.

Q66 Edward Argar: I have just a couple of questions, because a lot of the issues have been explored. My first one is something that we have not touched on yet in our questioning of witnesses. I welcome both your thoughts on the proposals in the Bill to delete and replace section 75 of the 2012 legislation, around procurement, and your reflections on the opportunities or challenges that that presents.

Saffron Cordery: As we see a change in the system, obviously the nature of how we have procured services in the past does have to change. It is obviously a

complex area, but one of the things that we really need to look at is the effectiveness of the current contracting regime, which for certain parts of the provider sector in particular is incredibly burdensome. If you sit in a mental health or a community trust, you are subject to a whole host of retendering, which can have a potentially far-reaching impact on your trust's sustainability or the future operation of key services. For many bits of the system, that will be very important.

The procurement regime is fundamental. It underpins how this will operate. We need to make sure that the elements of fairness are upheld and that it does not disproportionately put a burden on any one part of the system in particular.

Edward Argar: Matthew?

Matthew Taylor: I agree with that. It is important to remember that one of the goals of the Bill is to reduce the weight of bureaucracy in the system. If we can reduce the weight of bureaucracy as it applies to procurement, that is only a good thing.

Q67 Edward Argar: My second question—I think this has come through in what both of you have said, but feel free to challenge it when you answer if I have misrepresented what you have said—involves one of the key things I have detected, which is that we must be careful not to forget that no one size fits all in this context. Back in the dim and distant past when I was a councillor, I sat on a primary care trust board as a local authority representative, and I found that joint working could be highly effective, so what is the right balance? You have touched on this in some of your previous answers. Recognising that it is sometimes as much about relationships as about formal structures, what do you think is the right balance between permissive and prescriptive in what we are trying to do here? How do we strike that balance appropriately, and have we struck it appropriately?

Matthew Taylor: Of course, one of the most challenging questions in all parts of central Government is to get that balance right. The one point that I want to make is about the nature of system leadership. If you lead an organisation—I lead an organisation—the parameters of what you do are reasonably well defined and you lead that organisation as best you can, and you can be regulated as an organisation in relation to its objectives. The thing about system leadership is that it involves developing a concrete and specific account of how you want to add value in a particular local circumstance—how is it that, working as a system, you will make a difference?

By looking towards population health and engaging local people, that proposition will vary from place to place. It is important that, when we look at how systems work, we allow them to develop a value proposition that is specific to their local circumstances and their local needs. That is why, for example, we would be very resistant to any kind of Ofsted inspection regime for systems, because systems are not the same as hospitals or as schools; they are very different and their aspirations will be very different.

When you look at the Bill, the reality of central-local relations is that rules are set out in legislation, but then there is the custom and practice of how Departments and other bodies actually work. Sadly and inevitably, the drift of custom and practice tends to be towards centralisation. That is why it is important to avoid things in the Bill that create an opening—this is why we can have our concerns about reconfiguration—which can get ever wider and thus undermine the key principles that lie at the heart of the Bill. So we are happy with the intentions of the Bill, but we are worried that there are certain elements of it and certain elements that might be involved in the operationalising of it that could undermine its intentions.

Edward Argar: Thank you. Saffron?

Saffron Cordery: I go back to a point that I made earlier in this session, which is that this balance between permissiveness and prescriptiveness is critical. The August 2019 agreement, when all the stakeholders came together to look at how we might legislate for an integrated care system that got that balance right, I think is there. You have to remember that what sits around a set of proposals will have a massive impact on it, so the Secretary of State's powers as we have seen them, and the operating environment overall, will have an impact on how these proposals will be implemented, and how effectively they will be implemented.

We cannot forget covid in this. We cannot forget the extreme financial pressures that we are seeing. We cannot forget demand. We cannot forget an incredibly tired workforce. That is not going to change any time soon; that is going to be for the next few years, so we are implementing something against that backdrop. But if we go back to the slightly lighter touch of the August 2019 proposals, we will probably get to a place that would hit the spot, as it were. I reiterate that we support collaboration in systems and the direction of travel.

The Chair: Given the time, we will leave it there. I thank our witnesses, Saffron Cordery and Matthew Taylor.

Examination of Witnesses

Ian Trenholm and Keith Conradi gave evidence.

3.15 pm

The Chair: We will now hear from Ian Trenholm, the chief executive of the Care Quality Commission, and Keith Conradi, the chief investigator at the Healthcare Safety Investigation Branch, both of whom are appearing in person. We have until 4 o'clock for this session. May I ask you both to introduce yourselves for the record?

Ian Trenholm: Good afternoon. My name is Ian Trenholm and I am the chief executive of the Care Quality Commission.

Keith Conradi: I am Keith Conradi, the chief investigator for the Healthcare Safety Investigation Branch.

Q68 Jo Gideon (Stoke-on-Trent Central) (Con): Thank you for attending. Can you characterise the contribution this Bill will make, in your opinion, to patient safety and quality of care?

Ian Trenholm: The Bill will add value to patients in a number of different ways. There are four areas that we have particular interest in. The first is around the work we expect the Government to ask us to do on oversight of the individual ICSs. Building on the comments that have just been made, our contributing to the assurance around ICSs will be an important part of how we can add value. We will do that by drawing to the attention of local communities both the good work that is going on in a particular place, and areas where there are some challenges. We will also be able to look across the

country, demonstrate where things are going well and help with improvement, as we do with the regulation of individual providers.

The Bill also contains a provision for us to provide assurance regarding the way local authorities discharge their Care Act 2014 duties. Again, that gives local people the certainty that local authorities are discharging their responsibilities. If you bring those two things together and connect local authority duties around the Care Act and social care with what is going on in healthcare, you get a whole-system view, and we are able to give an independent overview of that, which we report to Parliament and the public.

There is also a provision in the Bill relating to food standards in hospital. It is well known that people's recovery is aided by good-quality hydration and nutrition that is appropriate for the social and cultural needs of that particular place. As part of our work, we will be asked to look at that.

Finally, building on the comments Mr Madden made a couple of witnesses ago, the miscellaneous provisions within the Bill on data sharing and the requirement to co-operate are also powerful and enable us to do our job as an intelligence-driven regulator. From the point of view of reducing bureaucracy, they mean that we collect data once and then we can share it among the many partners involved in regulating different parts of the health and care system. Those are four particular points where I think the public would see value in the work we do.

Keith Conradi: From our perspective at the Healthcare Safety Investigation Branch, we welcome the introduction of this part of the legislation. We have been working in shadow form for the past five years, without any real powers, and the things we have missed there are likely to be introduced in the Bill, such as power of entry, so that we can access people quickly in an investigation. Any investigator will tell you that the quality of the investigation evidence, particularly interviews, degrades quickly over time, so the ability to go in quickly is hugely important. Also, not being able to access data that we know people hold has been quite frustrating in our current guise. We have sometimes had to wait for months and months for data in order to be able to complete an investigation.

The other thing that we are particularly keen on is being able to properly protect information that people give us in a protected environment, so that we can ask them to be as candid as possible with their experiences. We want to be able to protect that information from being released more publicly.

Jo Gideon: Can I ask just one more question, Chair?

The Chair: I am not being flooded with a whole array of hands, so why not? On you go. I will come to you in a second, Edward.

Q69 Jo Gideon: I just want to come back on the hospital food standards. I know that malnutrition is an issue that has been raised within the hospital setting. Would you be able to set parameters for what the reporting requirement is in order to measure standards in that regard, for instance?

Ian Trenholm: We will be inspecting against the hospital food standards—is that what you mean? We are not going to be setting individual nutritional standards; we will be inspecting against the NHS's food standards. We are going to deliberately make sure that our work does not overlap with organisations such as the Food Standards Agency, for example. To be very specific about it, we are not going to be inspecting vending machines or taste-testing food in canteens. What we are going to be doing is looking at the hydration and nutrition strategies that, say, a board in a hospital has set for its particular area. As we go around the hospital, we will be looking at whether that strategy is being enacted for the cultural and social needs, in particular, of the people in that hospital. Does that answer the question?

Jo Gideon: Yes. Well, it was more from a medical point of view than from a vending machine point of view. That is absolutely helpful. Thank you.

The Chair: Do you have anything to add to that, Mr Conradi?

Keith Conradi: I think that is outside the HSIB's experience.

Q70 Edward Timpson: Just to follow up on the answers that we had about the healthcare safety investigations branch and putting it on a statutory footing, I am speaking as someone who chaired the first national child safeguarding panel, which was looking at investigating what were then called serious case reviews and trying to understand how you get to the bottom of the why question, as opposed to simply what happened. In fact, we used the air accident investigation branch as an exemplar of that. It would be helpful to understand how you think these new powers, and the statutory footing that you will have, will help enhance your ability to answer those all-important why questions within the health system, and get away from the potential for it to become a finger-pointing exercise that does not necessarily improve the outcome for patients.

Keith Conradi: Having come from the air accident investigation branch as my background, the whole idea of these investigations is that we do not apportion any blame or liability, and that we are really looking at why an event took place when somebody came into work planning to do a good job, and what the circumstances around the environment were that allowed a tragedy to occur. We use a lot of investigation science methodology to ask those why questions, really looking at systems-type thinking, so we do not mention anybody's names in the reports. We do not, at the moment, mention where the actual occurrence took place, because in our view that is almost irrelevant. It is the system that we are trying to change, and the safety recommendations that we make are, by and large, to the national bodies—often the regulators—because we think they are best placed to make the changes that we think are necessary.

The Chair: Do you want to add anything to that, Mr Trenholm?

Ian Trenholm: No, thank you.

Q71 Mary Robinson (Cheadle) (Con): I declare an interest as chair of the all-party parliamentary group for whistleblowing. I am interested in the powers that you are going to be taking on—how those will enhance your work—and also in what you said about properly

[Mary Robinson]

protecting information. Of course, part of this is about properly protecting the person or individual who provides that information in very many cases. I am wondering whether this is going to enhance the ability to whistleblow and to highlight these issues, and whether there is more to be done legislatively and whether you see this as being a forerunner to it.

Could I also ask about the regulatory role? With regard to whistleblowers who raise these issues—we are talking about safety and the best interests of patients here—will this enhance the powers and abilities that you have, or is more needed still.

Keith Conradi: One of the clauses actually will require people to speak to us, so there is a compulsion on people to provide evidence. In a way, that might help some people who are undecided about what they should be doing. But to balance that, it is very important to be able to protect the evidence that is given, and there are protections within the clauses. I think they could be improved. But the whole idea is that we create this space, where really the only safety valve is the High Court, and I believe that is appropriate as the only place where that information can actually be released.

I think it is worth saying, however, that when people talk to us and use this sort of safe space, the whole idea is that it is not a place where they are going to unload stuff that will never see the light of day again; we use that information, either in our final reports or to help us further the investigation. It is just that it is non-attributable, so we do not mention people's names. The idea is that we use it to further patient safety.

My concern about the way the Bill is currently written is that there is a provision for coroners—some coroners—to be able to see this information. I think that will inhibit some people from speaking to us—and the whole point is that people are uninhibited from doing so. Having that potential release of information into that sphere will, I think, degrade the ability of the investigation to do its job.

Ian Trenholm: Building on what Keith has just said, I think we would see the Bill as giving an opportunity to create a safe space. It creates an opportunity for people to talk about things that they may not otherwise have wished to talk about. What Keith's team can then do is look at that information. We need to make sure that we have the right data-sharing protocols in place. Keith's team can then talk to my team about what is happening on the ground. They can do whatever anonymisation is necessary. So we might get to hear about things that we perhaps would not otherwise get to hear about.

That is a real positive at provider level, but if you click up a level, you quite often find that, from a safety and quality point of view, people's poor experiences are driven as much by their experience of it as a system and the way they transit between different providers as it is about the experience in an individual provider. So if you have a person who perhaps is working between providers or in some kind of community provision, they will see multiple providers and they will become, if you like, better whistleblowers. Our work on systems and our assurance on systems will help as well, I think. Of course, Keith's team make recommendations to us as a regulator, in the way they do to other people. So I think this is generally a move in the right direction.

Q72 Karin Smyth: Mr Conradi, could you talk a little about what the branch will be doing in relation to maternity cases and how that is seen to be investigated? You have talked about systems, but will there be a look at all maternity cases in a system? Could you elaborate a little on that? If I may have a second bite, you could also talk a little about discussions now as to where we think the relationship lies with the health service ombudsman and being clear on the roles within this Bill and how that might look in the future.

Keith Conradi: We currently have a maternity programme that investigates about 1,000 cases a year, based on quite specific criteria. At the moment, the Department is deciding what it wants to do with that programme—where its future lies. As far as we know, it will stay with us, certainly until the HSSIB—the health service safety investigations body—starts, but I think a decision has yet to be made on whether it will actually just fall into the work that the HSSIB does, or whether it will do something separately with it, so I am not aware of that at the moment.

On the second point, I am aware that the ombudsman would like the same power to access the statements that we take under safe space. I think that is a major concern. Over the last five years, the ombudsman has been able to investigate any complaint brought against us in our current guise. It has not seen fit to do so, so I would suggest that on the rare occasion that might be necessary, the provision for the High Court to carry out the balancing test and decide whether to disclose information or not is the appropriate way ahead.

Q73 Dr Davies: Mr Trenholm, you referred to the fact that the CQC will be assessing ICSs in future, which was a recommendation of the Health and Social Care Committee. You also referred to oversight of social care provision. Can you clarify whether that is by virtue of your assessment of the ICSs as a whole, or is it through a local authority-targeted assessment that the Health and Social Care Committee has also called for in an Ofsted-style rating?

Ian Trenholm: Can we not call it a CQC-style rating? There are two separate things. The Bill currently contains an explicit provision about providing assurance on how a local authority is discharging its responsibilities in relation to the Care Act. That is important because the way in which care is commissioned is as important for outcomes as the way in which it is delivered. That is one part and that is a discrete piece of work. There is a broader piece of work that we are expecting Government to ask us to bring forward on assurance on ICSs. It will look at the ICS partnership board, how that works, the ICS strategy and so forth. They are two complementary pieces of work, but they are separate, as you describe.

Q74 Dr Whitford: Mr Conradi, you have talked about this coming from Air Accidents Investigation Branch, where the safe space is very tightly protected. That is very much as has been put forward. The key concern is the fact that coroners are listed in the Bill. The ombudsman is already lobbying and many of us are being lobbied to get access to safe space testimony. The Campaign for Freedom of Information is also lobbying for that. Will that not just kill it dead, in that you can compel people to come and give you testimony, but you cannot compel them to talk about all the soft weaknesses within a

system that contributed to that tragedy or failure? Should it not be that maybe we need to define more tightly what is protected? All these bodies should be able to investigate as they do now. They are not losing anything because you would have safe space.

Keith Conradi: I totally agree with you. I think it will have a major impact on people's wish to speak to us. It is not just me that thinks that; the medical unions have said that their members are concerned. The whole idea is that you want people to talk about, as you say, the "soft" things. They tend to be things like the culture of an organisation and the pressures that are brought upon them to do various pieces of work. In the past that has been a bit of an Achilles heel in terms of safety in the NHS. People have often been blamed for these things. They have been disciplined for speaking out—we talked about whistleblowers earlier.

Anything that we can do to bring that information up to an investigation body, which is not about blame and liability, is going to help patient safety in the long run. They will find their way into our final reports—that is the whole idea of getting this information. We want to encourage that as much as possible. I do not think this helps. I think a previous Joint Committee looked at a similar piece of legislation, and that came to exactly the same conclusion. As you say, what is the problem with other bodies such as coroners conducting their own interviews to get the same piece of information or any information they require?

Q75 Dr Whitford: I was on the pre-legislative scrutiny Committee and we spent a lot of our time debating this. It can be very easy as MPs to say, "Everything should be available to everyone." In actual fact, we need to learn rather than blame. Obviously you do not want it to be with coroners, but do you think there needs to be redefinition within the Bill to make it clear that it is only the testimony and documents that you are holding? You are not stopping anyone else getting medical records, calling witnesses and doing what they should be doing now. The Bill almost gives the impression that you will squash other investigations.

Keith Conradi: Yes. In a way, the powers are so sweeping that they go well beyond what we think we would need, and well beyond what is used in other sectors—the transport sectors. We know that parallel investigations will take place into many of the things that we look at, and that is fine. The problem is that if we have these sweeping powers, which pretty much say that anything we touch or come across we then have to protect, and that we can then unwind and release some of them with a fairly bureaucratic process, that will be difficult in terms of transparency and our ability to share the information with others who have a legitimate need. The key things that we absolutely want to protect are statements given to us by witnesses and any draft notes, opinions and reports that we generate from doing the investigation. It is the final report that is our piece of work that we want to produce at the end of the day, and that is it.

Dr Whitford: Thank you. In the interests of time, I am happy with that.

Ian Trenholm: If I could make just one point, I think you are absolutely right: the broader responsibilities of an individual provider, particularly around such things as duty of candour, would still stand. Therefore, at an institutional level, people will still need to do the things that they always needed to do, but there is a very specific set of circumstances that Keith was describing where safe space may apply.

Q76 Justin Madders: I have a couple of questions for Mr Trenholm. You mentioned the importance of co-operation with other agencies. At the moment, are there barriers that the Bill could help with in terms of identifying people who may provide inadequate care under the guise of a company and then dissolve it, move on and create another? Is there anything in the Bill that will help you to track those people?

Ian Trenholm: I do not think that there is at an individual provider level. What you have just described is our normal registration regulation process at an individual provider level. As we start to look across individual places and ICSs, we might be able to talk to individual partnership boards about people who are operating locally, but I do not think the Bill explicitly gives us more powers to look at individual providers in any more detail than we already would as part of our normal registration process.

Q77 Justin Madders: In terms of what you are required to do under the Bill, have you made an assessment of what additional resources you will need to deliver that?

Ian Trenholm: Not yet. Obviously, as the Bill goes through Parliament the breadth and size of what we will be asked to do will become clear. We are talking to a range of different stakeholders at the moment. The NHS Confederation and NHS Providers are on our list, as are the Local Government Association, the Association of Directors of Adult Social Services and, of course, various representative groups that represent people who use services, so we are having those conversations now around what they would expect from good-quality assurance at a system level—but no, we have not really got to the point of assessing this in any detail.

Q78 Justin Madders: Mr Conradi, in your submission to the Committee you mentioned a concern about the powers of the Secretary of State to order investigations. You used the term "undue political influence". I wonder whether you could expand on what you mean by that exactly, and what your concerns are.

Keith Conradi: We see ourselves as very much an independent and impartial investigation body that can sit outside the system and look into it. We would not want to have any barriers really on where we might look to see where patient safety could be improved. As I mentioned earlier, we tend not to dwell on the incident at the trust level, but try to work our way up through the system. Ultimately, we end up making recommendations to the Department of Health and Social Care, and in the future I would like to ensure that we have that complete freedom to be able to make recommendations wherever we think that they most fit. That independence of the system is crucial for the success and the credibility of the organisation.

Q79 Justin Madders: In terms of recommendations, how are they monitored to ensure that they are actually implemented?

Keith Conradi: At the moment, they are monitored fairly informally. There is a part of NHSEI—a patient safety team—that looks at whether the actions that

were promised in the response to the safety recommendation have actually been carried out. We believe that that might sit more appropriately with this body in the future—NHSEI receive a rather large number of our safety recommendations, so I do not know whether they are the right body to monitor the actions that are taking place, whereas I think that could sit with us. It is important that that is just monitoring the actions, not judging the outcome, and I think that there needs to be a separate, probably pan-regulation-type body that looks at whether the outcome at the end of the day mitigated the patient safety risk that we first went out to investigate.

Q80 Justin Madders: So in terms of what NHSI do at the moment, presumably you are interested in their investigations and ongoing work, but there is no formal method by which they can report back to you so that you can be satisfied that things are progressing?

Keith Conradi: Informally, we have a good working relationship, so we are interested. We get the response to the safety recommendation and we internally look at that and consider whether we are happy with it. If we are not, we would send out letters to say that we would like further information. We want to put this on a more formal footing to see that in the future.

The Chair: Do have anything further you want to add? No. Minister.

Q81 Edward Argar: Thank you both for your evidence. I have one question for Mr Trenholm, two for Mr Conradi and then one for both of you, if I may, time permitting, Mr McCabe.

You will have heard in the evidence just before, Mr Trenholm, the comments by Matthew Taylor about the difference between assessing a system versus a provision. How do you see how the CQC would square that circle, because he highlighted the very different approaches and his reservations about some of that? How do you see that issue being resolved, or what would you like to see in that space?

Ian Trenholm: If I compare one large hospital with another large hospital as a comparison in terms of what we do now, one would argue that they are quite different enterprises, differently run and serving different communities. There are some common themes, but equally there are some differences. We built a methodology that was able to be applied to both of those very separate entities and to provide a common rating at the end of it.

I would see a version of that at a system level: there would be things that we would want to see that would be common and necessary— decent quality governance, for example—as well as a lot of things that many of you were raising as questions and concerns. But equally we want to see some evidence that the partnership board was cognisant of its local community and it was genuinely delivering a suite of services that its local community genuinely wanted and that was consistent with the needs of that community.

Over the next 18 months or so, we will be building our methodology in collaboration with the people who are also building the ICS boards and frameworks. I am hopeful that we can get to a point where we have a methodology that gives you, as parliamentarians, and local people the assurance that things are working well locally. However, it is not just about what is not working, but about looking for really good practice and looking to accelerate that. Previous people have made the point that doing things differently often leads to good practice and innovation, so how can we help accelerate that innovation through the work that we do. That is broadly how I see it working.

Q82 Edward Argar: Thank you. Mr Conradi, the first question is probably a relatively quick and simple one, but I will not prejudge your response. Given that the HSSIB aspects have been in preparation for quite some time—I am alluding to the work that Dr Whitford and other colleagues did some time ago—what would your view be on the appropriateness of getting this done and the timeliness of bringing these measures forward? I am asking a number of witnesses whether this is the right time to be doing what we are proposing. In the case of HSSIB, is it the right time?

Keith Conradi: Absolutely.

Q83 Edward Argar: I suspected that might be the answer, but I did not want to prejudge. My second question goes to a slightly knottier area, and one that you have already alluded to. I think you have said—by all means correct me if at any point I misinterpret what you have said—that ideally you would prefer the safe space to be as absolute as possible, given the nature of what you are seeking to do. There is, as we recognise in the Bill, a challenge about the specific statutory rights of coroners as members of the judiciary; I note what you have said about that. Would it be fair to say, first, that notwithstanding that, you would not want that safe space to be eroded further for other groups? I think you have been clear that you would prefer it not to be eroded at all, but you would not want its erosion to go further. The second element is this. Although you would prefer it to be preserved intact, do you think that if there is going to be that exception in the case of coroners, for example, the High Court is the right level of arbitration in something like that? I know you suggested that it might be.

Keith Conradi: I certainly think so. My previous experience in aviation is that we had a similar space, and only the High Court could overturn or order disclosure. It was used on a handful of occasions, and it produced very interesting debate. The balancing test—testing whether the benefits of the disclosure outweighed the adverse reaction that there might be to future investigations—was well argued in each of the cases. I think that is the appropriate place to do it.

Q84 Edward Argar: Thank you. My final question is to both of you. Your organisations are separate but key elements focused on patient safety and the safety of outcomes for individual patients. How do you see the work of your two organisations fitting together and complementing each other, while recognising that they are both very distinct?

Ian Trenholm: We do work at the moment in terms of registering and regulating individual providers, and we do that right across the country, so we have a picture of health and social care right across England. Part of the Bill will give us enhanced powers looking at the way in which individual systems and individual ICSs work. Our view is, if you like, a broad and moderately shallow view, whereas I think Keith's team do more in the way of specific investigations. I am sure Keith can talk to that.

Keith Conradi: I would characterise the relationship as a healthy tension. We make very few recommendations to the CQC, but the vast majority of recommendations we make will, we hope, have an impact on the work that is going on across the system. The ideal people to have a look and see whether that is having an effect will be the CQC, from time to time, as it comes across things that have changed as a result of what we have done. I think the relationship works very well, in that respect.

Edward Argar: Thank you very much.

The Chair: Mary, did I see you trying to come in with another point?

Q85 Mary Robinson: Thank you so much, Mr McCabe; that is very kind of you. I have just a very short question. How does any of this relate to the Public Interest Disclosure Act 1998 and the way you are required to protect the disclosures given by individuals, in terms of the issues that you have already raised?

Keith Conradi: I would probably need a lawyer to give you the proper answer, but I do not think any of this would trump anything else. We would still need to acquiesce and accept those disclosures as they happened, so I do not think that would be an issue for us.

The Chair: Anyone else? It does not look like it. I thank both our witnesses for their evidence.

Examination of Witnesses

Councillor James Jamieson and Professor Maggie Rae gave evidence.

3.49 pm

The Chair: We now move on to our sixth panel of witnesses. We will hear from Councillor James Jamieson, chair of the Local Government Association and Professor Maggie Rae, president of the Faculty of Public Health, both of whom are joining us remotely. Could both witnesses introduce themselves for the record, please?

Professor Maggie Rae: Good afternoon. It is a great pleasure to be able to join you today. My name is Maggie Rae and I am currently president of the Faculty of Public Health.

Cllr James Jamieson: It is a great pleasure to be with you today. Thank you very much for inviting me. I am James Jamieson and I am chairman of the Local Government Association. Until January, I was leader of Central Bedfordshire for nearly 10 years.

The Chair: Thank you.

Q86 Dr James Davies: First to Councillor Jamieson on the changed procedures during the pandemic for the discharge of patients into social care, do you welcome the embedding of those changes into legislation for the future?

Cllr James Jamieson: Certainly, we are very pleased that we have repealed some of the legislation, which basically made people focus on targets rather than what is best for the patient. Focusing on discharge to assess at hospital led to some at times frankly perverse incentives just to get people out, often into care homes, when the right solution was to assess after they had left hospital, in their normal setting, not in the setting where they were in maximum need. That change has given much better solutions and outcomes for our residents, which is what we want.

Q87 Dr Davies: Very good. Thank you. As a follow-up question to both panellists, could you comment on the benefits arising from the preventive measures in the Bill on the fluoridation of tap water and obesity?

Professor Maggie Rae: Obviously, from my position as president of faculty, I want more emphasis on prevention, so I am very pleased to see that focus on it, but I do not think it is quite enough yet. I think we would all recognise that part of the reason why we seemed to take the biggest hit on covid in terms of deaths and the effects of the virus was the ill health of our population. We are recognised as having one of the most unhealthy populations in Europe now, and that was not always the case. Yes, it is very pleasing to see the measures on obesity, but we need to recognise that most of the influence could come from the very local level.

I am sorry to say to colleagues and this eminent Committee that we could probably spend the whole meeting talking about fluoridation. I recognise the attempt to tackle the problems of oral health. Children's teeth being extracted under general anaesthetic is a national disgrace; that money is so wasted in the NHS when we desperately need it to be spent on other health matters, and the time it takes for that operation is so dangerous for children. It is good to have this recognised, but I think it will be quite a slow burn, even with the legislation.

Some areas have tried to implement fluoridation. It has taken them years and they still have not succeeded. Could we perhaps persuade people? As well as focusing on fluoridation, could we have just a small investment in other methods to tackle oral health? One that is really effective, which I used myself as DPH, is simple toothbrushes and toothpaste. Sometimes we think public health measures take a long time, but I can guarantee that if that measure were implemented effectively you could see the changes within 12 months and would also end up saving the NHS a lot of money. I work closely with Councillor Jamieson in his role at the LGA and I hope that he would agree with me.

Cllr James Jamieson: I am going to agree with Maggie. I think that that is a general point we would make. Better healthcare does not start in a hospital; it starts in the community and it starts before you are born. It is about prevention, early intervention, public health, good food and all those things. We welcome measures to support that.

On the point about obesity, I would particularly say that although, yes, it is nice to be able to produce advertising, there is so much more we would like to do. This is not necessarily within the scope of the Bill, so I am not suggesting that, but, for instance, in licensing legislation, being able to take account of public health, which at the moment is specifically excluded, as well as being able to do so in planning legislation as regards where fast food places are and so forth, would be immensely helpful. This is a start; it is a small but positive step.

Q88 Mary Kelly Foy (City of Durham) (Lab): One of our earlier witnesses touched on the social determinants of health—housing, green spaces, good jobs—being the greatest factor in a person's healthy life and life expectancy.

[Mary Kelly Foy]

I am disappointed that there is nothing in the Bill that addresses those fundamental issues. Do you think that there is scope for them to be touched on, as well as in working with local authorities?

Even more remarkable as regards reducing health inequalities is the absence of any detail, duty or provision to tackle alcohol harm and tobacco control, which of course are the greatest factor in determining a person's life expectancy—and further down the line they have the greatest impact on local authorities' social care bills. Do you think they should be included in more detail in the Bill, with a duty to reduce health inequalities rather than just having "regard" to reducing them?

Cllr James Jamieson: I think we need to be cognisant of the fact that this is a Bill providing a framework. I completely agree with the comments made about health inequalities, good housing, green space and all those things—absolutely. I am a full advocate of the idea that health is three quarters determined by somebody's environment and choices, and probably only a quarter by what the NHS does. That is really important. My slight concern is that if we get very prescriptive in legislation, it limits the ability to do the right thing.

The really important thing about this legislation is all the guidance and so forth that will come out of it, and where the funding goes. Our preference is to say, "Try not be too prescriptive in the legislation, but really engage with local government and public health on the guidance that comes out of this legislation." A real priority has to be better places, better communities, better jobs, less pollution and all those things, but I do not think that that is something for legislation; I think it is very much about getting the guidelines right, and they will be different in different parts of the country. The issues that might be faced in a rural area are very different from those faced in an urban area. I do worry that if legislation is too prescriptive, it hampers rather than helps.

Professor Maggie Rae: Would you mind if I added some comments please, Chair?

The Chair: Please do.

Professor Maggie Rae: Just building on those comments from Councillor Jamieson on what I think is a very important question, there is a line in the Bill saying that the ICSs have to take note of advice from directors of public health. If we want ICSs to be population health organisations, we have to make sure that the legislation is strong enough to ensure that the advice is acted on. Our directors of public health have been highly trained and are able professionally to identify the needs of the population, identify where the health inequalities are and make sure that they can provide the ICSs, in terms of both the NHS-side board and the partnership board, with all the evidence they need about what will make a difference. It is the action that will make a difference and improve those outcomes that we all want. It would be very helpful to ensure that the Bill, if possible, is more explicit about that advice and which source it is coming from. We have worked very closely with the legislative team and the Bill team. I do not think anyone could fault the amount of hours they have spent discussing with stakeholders the details of the Bill, and Councillor Jamieson is also right that we cannot have everything in the Bill, but we want a true population-focused organisation.

That has to be the change that this legislation brings; it has to be an enabling legislative framework. We then need to ensure that the guidance, and, most importantly, the assurance process, allow some of the public health expertise to determine whether it is fit for purpose. It is possible that these organisations, and the excitement of the changes, could result in our having a more place-based population focus, but that will only be the case if we get it right and take account of those wider determinants such as education and housing—all the things that contribute to good health.

Q89 Edward Timpson: This is principally for Councillor Jamieson, if I may, in relation to the role of local government in the new integrated care structure. As you will be aware, there was initially a one-part structure, and partly through the input of the LGA, I think, we have ended up in the Bill with a two-part structure, with both the board and the partnership. For the first time, in many respects, that puts local government very much at the heart of NHS decision making. How do you think that that will assist in addressing both health inequalities within the local area and—I note your point about the flexibility of the board and the partnership—what barriers do you think it will help remove, so that we get a truly integrated system and service that the local government level will have a positive influence on?

Cllr James Jamieson: Looking at the current situation with health and wellbeing boards and so forth, that has worked well in some places and not so well in others. That is largely down to local factors, relationships and the willingness of the NHS to participate in a place-based approach. Our hope and expectation is that this formalises it, not in absolute terms, but in emphasising the role of local government and other partners that the NHS has to take account of. In essence, it is strengthening our ability to influence the NHS.

Why is that so important? I come back to the comment that I made earlier about how much health outcomes for an individual are based on non-NHS factors. I have forgotten who raised the question of health inequalities, environment and so forth, but those are all place-based factors. Getting more investment in public health, less pollution, better community health care, a better GP service and better occupational therapists will make huge differences to people.

At the end of the day, nobody wants to go to a hospital; they would far rather be healthy and not need to. Therefore, empowering local councils and partners to have a greater say in how we improve the health outcomes of our whole population has to be a good thing.

Professor Maggie Rae: To add to what Councillor Jamieson has said—he is making some excellent points on that agenda—it is important to get the balance right. In England, we had the legislation on health and wellbeing boards. One of the principles should be not to ride roughshod over legislation we already have just because we like the new bright and shiny legislation. On the commitment to stakeholder engagement, we managed to get the Bill team to understand that we have legislation already.

Some of that legislation is still there—we still have directors of public health and the powers in local government—and those things are important, but we also know that if we do not get this legislation right, we will not be able to get right the ambitions on health

inequalities and on improving health either. The detail of this is really important. As I think was indicated in what Councillor Jamieson was saying, we know that legislation alone does not always fix problems. I do not know how we can get good relationships just through legislation. We can enable things to happen, but we need to ensure that the legislation is enabling and that there is some holding to account for the standards that the legislation is trying to set.

We cannot afford for the health of our populations to be affected by unhelpful variations. I am very supportive of place-based—action happens at the local level and it can be effective at the local level. We need good national legislation, but if we want to do justice to the population in this country, we cannot have unhelpful variation, because that is what will undermine this legislation. We have to make sure that everyone is working for the same aims and that at the heart of everything is the commitment to reducing health inequalities and improving health outcomes, regardless of where you are. Whatever your own organisation, whether a hospital, a local authority or a mental health trust, we have to have something that overrides loyalty to the organisation—to put the population first.

Q90 Karin Smyth: Following up on that point, I do not know whether our witnesses heard our earlier session, but I asked them about this very issue of decision making, governance and accountability. Professor, I hear what you are saying and I understand that you had lots of discussions with the Bill team, but I am not entirely clear what your ask is for the legislation. It would be very helpful if you could spell out what could be added into the Bill to achieve the outcome that you are seeking and the assurance that the drive and logic of the Bill around place-based commissioning, which I support, are made reality somehow.

My point to Councillor Jamieson, which I made to earlier witnesses, is about the integrated care boards, which are the decision-making and accountability bodies locally—the ICPs are essentially a committee of these boards. The accountability, responsibility and decision making lie very clearly with the integrated care boards, which are essentially, as I have called them, a cartel of local healthcare providers—largely the acute sector trusts, which are responsible for vast sums of money. Councillor Jamieson, you have gone to the effort of putting your name on a ballot paper and persuading local people to put their cross by your name. Should you fall foul of them, or make decisions that they do not agree with, you will soon no longer be Councillor Jamieson. That is very clear accountability. With that hat on, can you talk us through your understanding of the role of local government statuswise—beyond "Let's all work together in partnership"—when we reach that real decision-making, push-comes-to-shove crunch about where accountability to local people could lie for decisions if we improve this Bill?

Cllr James Jamieson: In the ideal world, one would probably like one board. However, that would mean that all members of that board had equal status and so forth. Obviously, the NHS partnership would have budgetary responsibility for hospitals, and there is a technical issue with, "Can you have a bunch of non-NHS people having budgetary responsibilities for the NHS?" We understood the difficulty, and that is why there is the need for two boards. The clear point here is that this legislation provides us with a framework that enables that to have real traction.

But I come back to my earlier point, which is that this is a framework; this is not a solution in itself. Legislation does not solve all the problems. This is about how budgets are managed; it is about all the guidelines and regulations that come out. One of the big requests that we have as local government—I am sure Maggie will have it as well—is that we are deeply involved in those guidelines to make sure that they work. I have to say that, so far, we have been, but many more bits of guidelines will come out. That is the crucial bit.

There are some changes we would like to the legislation, but they are not that great—I will come to them later, because they do not refer to this point. We want statutory and non-statutory guidance around things such as the implementation of the Bill, a comprehensive list of guidance that will be issued and clarity about the flexibility. We want some statutory guidance on health and wellbeing boards to ensure that they are at the heart of this. So there is a lot going on, and I am pleased to say that we have been involved in some of the guidance that has already been issued, such as "Thriving places". As Professor Rae said earlier, engagement has been very good so far, and we would like that to continue, because this is our chance to get this right. We will do that through getting the statutory and non-statutory guidance correct and making some changes, no doubt, to the Bill. But I do not think that this Bill can accomplish everything, so the LGA would certainly not be in favour of significant change to the Bill.

Karin Smyth: Can I just clarify—

The Chair: Actually, in view of the time, I am going to ask you not to, Karin. I am sorry, but if we are going to hear from Professor Rae and give Chris Skidmore a chance, we had better just move on.

Professor Maggie Rae: Again, it is good that you have asked for some specifics and related this to governance, because it is very important that we understand how the legislation will be implemented and that the governance is right.

The concerns that members of the faculty would have are quite broad based. While people might be genuinely pleased that we are moving away from a market economy on health, some are very concerned about opening the door to further privatisation. I want to give you some detail on specific public issues on which you said you would like more information. The legislation includes some public health hooks that will make it easier for us to ensure that we have good public health, but I question whether they are explicit enough.

The issue of taking advice on the needs of your population is a fundamental skill of public health. Whether nationally, regionally or locally, the professional job of directors of public health is to assess the needs of the population and provide organisations with the evidence about what will make the biggest difference—cost-effectively, of course. The idea of "taking advice" is a little vague, but strengthening the need for that advice to come from the statutorily appointed directors of public health—the regional directors of public health have been trained to do that and put the needs of population first—might give some strength to the Bill.

In my day job I do a lot of ICS development for the organisation I work for so I have experience of working with ICSs, and many current ICS leaders—I know there has to be an appointment process—are passionate about

health inequalities and public health. We have to make sure, as we said earlier, that we have something substantive that guarantees that public health is not down to individuals and personalities, and that we have a framework. We cannot expect Cornwall to be the same as Newcastle, but we cannot have the population suffering from unwarranted variation. If I had a bit more confidence that the role of directors of public health—and the regional directors of public health—would be instrumental in the legislation, the guidance and the assurance process, I would be able to give you more guarantees that things will be better in the future. At the moment, it is a little vague.

Q91 Chris Skidmore: This is a question to Professor Rae about research. I am sure you will agree that research is vital when it comes to demonstrating the changing nature of health care inequalities and potential solutions. Clause 19 places a duty on ICBs to promote research. Is that enough, or would you agree with new clause 9, which I have tabled, which would place a duty on the Secretary of State to promote research? You can promote research, but there is still a need to protect the budget, especially of the National Institute for Health Research. Should that be ring-fenced, so that integrated care boards have the opportunity to finance research, let alone promote it?

Professor Maggie Rae: Again, that is an excellent question. I strive for excellence in our country in relation to all matters covered by the Bill. It is with great sadness that I see that health outcomes have plummeted since the start of my career. Early in my career we had the best health outcomes for cancer in the whole of Europe. I am sorry to say that that is not the case now, and ensuring that the scientific underpinning of this is seen as essential will make us more leading edge.

There are many examples in the covid pandemic in which we have been leading the world, and that is certainly true of the vaccination programme. I heard in a meeting this morning about some amazing research that is just about to start.

There are lots of areas of cancer where we have not progressed in the last five years. I could name the different cancers; we do not have time to go into them. If this research was going to test people's blood early to get earlier diagnosis, as Councillor Jamieson said, it does not all have to be high-tech, high-cost NHS services. Lots of interventions are low cost. You will not find anything more cost-effective than getting people to give up smoking. That is a classic low-cost intervention. We want our country to be leading, and we want to put everything behind these new organisations and ensure that there is that scientific underpinning and that we do not fall behind other countries. I tend to side with your view that we may need to strengthen that.

The problem with this sort of legislation is that you want to be very enabling, but then you are very dependent on what the biggest problem is in the NHS today. Many of these organisations are trying to balance the books. We have tried to say that it is not all about targets. We can hit the targets and miss the point. The thing is, we are not hitting the targets at the moment either. Thank you for speaking up about the scientific underpinning. I would like us to remain where we are, and do better on science.

Q92 Dr Whitford: Obviously the pandemic has highlighted the impact of health inequalities and social and economic inequalities across the UK. Tackling them would be critical to improving population health, but how do you think the local systems will manage to balance need versus demand? Often we have the loudest voices expressing demand and the people with the greatest need are either silent or simply not listened to, so how will these changes help to get their voices listened to?

Professor Maggie Rae: That is right at the heart of health inequalities. If we did not know that before covid, we certainly know it now. An area where we could strengthen the legislation is in having that responsibility for all the people in your population. I led on health inequalities in the only time we have narrowed the gap, so health inequalities are not something that are just there and that we cannot do anything about except talk and say how sympathetic we are to them. We can deliver these changes. If we get the legislation and the organisational functionality, we will not change this unless we engage with communities. That is absolutely right, and we must engage with the local authorities.

Unless we target every intervention that we apply to the most disadvantaged and ensure that they have a good opportunity for uptake, we are widening health inequalities. I could take you to any health intervention, whether it is the covid vaccine, the flu vaccine, any uptake on health programmes or cancer screenings. They are all skewed to the most affluent population. In our country we want general population services, because we need everyone to be healthier, but we have to try to ensure that these organisations understand population need and know where the deprived populations are.

I have never met an MP or councillor who did not know where their deprived populations were, so we need those organisations to know that, but just knowing it is not enough. You have to then see the pattern of services and service delivery change to give a better chance to the people who need to take up these services. We have all understood that it is not that those people are hard to reach; it is just that we do not run the services to suit them and get a better uptake. I would like to see us concentrate on that. We probably cannot mention every single intervention, but for me it would not be enough to concentrate on obesity and fluoridation and think that the job is done on health. We have higher drug deaths than the rest of Europe—Scotland, as you know, is probably one of the worst in the world, if not the worst—and alcohol and all the other issues there, but I believe we can make a difference, and it will not take us 25 years if we focus on the right things, having the right interventions and making them readily available for people, and have a nice balance with what the NHS can do.

The NHS is the greatest service in the world and it can really help with health inequalities, but it cannot do it all. I am not an either/or person; we need the wider determinants and everything we can do that is place based through the local authorities, but we need the NHS to do that too.

Q93 Dr Whitford: Councillor Jamieson, this talks about a shift, which we have seen some of the devolved nations also following, from treating illness to trying to promote wellbeing in a holistic sense. A lot of that, as we have already touched on in this session, falls under

local government. There is no budgetary discussion in this, but how much will that be impacted by the ability of local government to tackle the poverty and deprivation that are among the biggest drivers of ill health? As you say, housing, active travel, pollution and so on are your brief, but we know that local governments have been on a very tight financial leash for quite a long time.

Cllr James Jamieson: This is where the legislation is helpful, because it is enabling. The more we can move away from the NHS pound, the local government pound, the health pound or the DEFRA pound, and towards, "This is the pound for Newcastle or Cornwall; how can we achieve the best outcome for it?", the better. I know that is difficult and, as you say, things such as housing, getting someone into a job or promoting active travel can make a massive difference to people's health. They can make big differences, and having that forum and the opportunity to have those discussions is very helpful. A forum where we can start moving from investment in, as you rightly say, curing someone to preventing them from getting ill or, as Maggie said earlier, getting early cancer diagnoses is critical.

This Bill does provide a framework, but the important stuff will be the statutory and non-statutory guidelines and where the money is spent. That is very important, and we hope to see more spending on preventing and less on fixing a problem that need not happen.

Dr Whitford: You mentioned there—

The Chair: I am really sorry, but we had better move on to Alex Norris.

Q94 Alex Norris: Thank you, Chair, and good afternoon to the panellists. Councillor Jamieson, I will start with you, if I may. You have mentioned on a number of occasions that you see this as enabling legislation and that, rather than prescribing to your community or the community of your members what model they should pursue, it leaves you the space to do that. I have some enthusiasm for that, but one area where that is not the case is schedule 2 to the Bill, which sets out, in schedule 1B to the National Health Service Act 2006, that the chair of the integrated care board must be

"appointed by NHS England, with the approval of the Secretary of State".

Under paragraph 5, only NHS England can remove a chair if they are unpopular and not doing the job, and there is nothing that you can write into your local decision making to get around that. Are you comfortable with not having any say over your chair when they are appointed or whether they carry on in the job?

Cllr James Jamieson: Clearly, there are two chairs in this scenario, and one of them, as you say, is NHS appointed in effect and the other one could be anybody—it could be a councillor, a local government representative, or a local director of public health. There is a role. I think this is a difficult area, but that is the reality, because ultimately that chairman will be the person who is financially responsible for the NHS trusts in his or her area. I have some sympathy with it; if I could find a better solution, I would seek to find one.

Q95 Alex Norris: Thank you. Professor Rae, you have talked a lot about the challenges to the nation's health at the moment and the negative direction of travel in recent years. The King's Fund estimates that, entering the pandemic, the value of the public health grant was 15% less than in 2013. Is that a characterisation that you recognise? What does that mean we do less of than we did seven or eight years ago?

Professor Maggie Rae: I am still a fan of the fact that you need public health and local government. I started my career there and moved to the NHS; I moved back to local government; and now I am moving back to the NHS. What we need is flexibility, so professional groups can work there. I would highly recommend all my public health colleagues and public health registrars to get experience nationally, regionally and locally. That makes you a much better, capable public health practitioner. However, you cannot deny that you can do the same for half the money.

I know that when the announcement was made about public health moving into local government, I did do the rounds saying that it would be a really good thing. I have to say that some very experienced people from councils were saying to me, "Well, I know what will happen. We will get the responsibility, and then they will take the money from us." I said, "No, no, that won't happen because public health has always been ring-fenced." When we were in the NHS, the public health funding was ring-fenced. I have to confess that I was naive, wasn't I, because actually the grant was cut. I do believe that every pound you spend at the local level in that local government setting you will get back tenfold because of all the social capital you can get from it. That is the reality. If your plans are ambitious, you do not need a lot of money. Lots of the interventions on obesity, smoking and all the other things do not take a huge cost in comparison with some of the high-tech NHS ones. If you have the ambition, you need to follow it through with the necessary resources to do it.

I have been public in saying—I am probably with Councillor Jamieson—that in the ideal world, and I have been a director of adult social care, as well as a director of public health, we are not in camps with our bags of cash. We actually put all of our money together for the resources of the population. I would like to see the ICSs mandated to spend so much on prevention and health inequalities wherever the money comes from, because if we continue with what we are doing at the moment—waiting too long to intervene—none of us will be able to afford the mountain of the problem that you will build up. There is no money available in the world to do that.

There have been some early positive signs that we mean business this time with prevention and health inequalities, but we have to deliver. Having just looked at the social care paper today, I struggle to find prevention. I know from being a director of adult social care that if we do not intervene early and get people to be ageing well and healthy, we will not have the carers in the world who can look after them. Again, I make the plea for the resources. It does not take a lot—I am not asking for billions—but a small amount of resource could make a huge difference. If we continue to cut the public health grant, well, we will continue to have poor health, I think.

Q96 Alex Norris: I have a question on fluoridation. At the moment, there is broad agreement that the system does not work: local communities, through their local authorities, can try to lead the process and take it through. I know from my time on my local authority,

[Alex Norris]

where I was very keen to do that, that it was very, very hard to do, although not impossible. We are taking away that grassroots, ground-level approach and replacing it with a top-down, Secretary of State-led approach. That has many attractions, in the sense that it takes away from some of the parochial concerns and planning concerns about where you have pour the stuff in to make it work. At the moment, we are going from one to the other. Would you have any anxieties if, rather than moving from one to the other, we kept what we currently had and added the new model to it, so that rather than either/or, it is both?

Professor Maggie Rae: My experience is that there are some things you can legislate for—seatbelts would be the classic example, or smoke-free places—that work really well, but for most things, if you really want to get action, you need to take the public with you. Certainly, if you fluoridate the water, you will have some very direct oral health benefits. Dental decay, for example, is a classic. However, you probably will not fix every little problem you have got, because it takes more than just fluoridation. Most people's teeth fall out because of gum disease, so you have to have a wider educational programme with the public.

I also know from my work as the director of public health at the local level and my early days work in Scotland that I could take you to lots of families where they do not drink water, so it is not that obvious to me that that is just going to fix the problem as easily as we think it will. I think you need an all-encompassing programme. While we wait for any implementation of the fluoridation, today children will be having their teeth taken out—children of four or five. That is unacceptable because, alongside that, we should be ensuring that there are the educational programmes and the supply if people cannot afford toothbrushes and toothpaste. That would be a nice easy fix for something to do.

We obviously have a huge population who have already lost their teeth, and one of the biggest problems of the elderly is pure nutrition because they simply cannot eat. It is a problem that sometimes you think legislation will fix it top-down, but I think in everything you do it is much better to see public health people as being responsible to the population. In my experience, you really have to take the population with you to have any chance of implementation, whether you have legislation from the Secretary of State or not.

The Chair: I am going to go to the Minister now because of time.

Q97 Edward Argar: Good afternoon, Councillor and Professor. I have two or three questions; we will see how we do on time. I will get through as many as I can, and if I do not get through them all, I do not get through them all.

Back in the day, I served as a councillor and cabinet member for public health, adult social care and health, and worked very closely with my then local PCT, which probably shows you my vintage. One of the things that I found was that the structures were important, but the relationships and how it worked on the ground, and the ability to be flexible and build up the trust between the two organisations was more effective in getting better outcomes. We have heard from previous witnesses about the importance of local flexibility to adapt to local work arrangements and conditions. Do you think we are striking the right balance between being permissive in allowing that flexibility and not being too prescriptive, or do we need to go a little more in a different direction?

Professor Maggie Rae: In my experience, with the way that the ICS has been set up, we very much hope that we will not start from scratch again, because those organisations have been working on this agenda for quite some time. I think there would be cries of horror if we said, "We are going to throw out the work you've already done." Many of them have been on this journey for a while, and the leaders in those systems have indeed made some good progress. I think it is a delicate balance.

I will not repeat the points I have already made about strengthening the links to public health and making sure that is not forgotten. We will have 600 public health people going back into the NHS, but we very specifically have not changed the legislation that put directors of public health in England into local government. Of course, directors of public health in the three devolved nations are currently in the NHS. If you do not give people flexibility, you run the risk of your system not working. If we ensure that the framework and assurance process are right, the legislation takes us part of the way, but we want some checks and balances in relation to those freedoms, to make sure that there is a basic minimum standard across the country. If you have an ICS that is not working with its local authority, that is not a level where the ICS should be signed off. The ICS should be asked to go and demonstrate the commitment that the flexibility has allowed them. There is a statement in the framework that was released a couple of months ago, which said that the directors of public health will have an official role on both boards. I found that a pretty good statement to have, but it is only a statement that is effective if there is some assurance that that can be delivered on, and there need to be some checks and balances in order to make sure that those kinds of things are not ignored. Because of the variety—some ICSs cater for 2 million or 3 million people, and some for 1 million—you need the flexibility. If you want them to own and deal with the problems of their population, having a little bit of flexibility is the right approach, provided that the minimum standards are met across the whole country.

Q98 Edward Argar: Thank you. Councillor Jamieson, I have seen that councils can often be at the forefront of leading innovation and driving change in a dynamic way. From the LGA's perspective, do you think that we are striking the right balance between permissive and prescriptive, and is the approach to the ICP board and ICB an appropriate balance?

Cllr James Jamieson: From a legislative perspective, largely yes. I reiterate the point that I have made a couple of times already: the statutory and non-statutory guidelines will be critical in this area. We need to get them right and ensure that there is real embedded consultation. There are a couple of things that we are concerned about. I have not mentioned them yet, so I will use this opportunity to do so. One is the increase in the powers of the Secretary of State to call in NHS reconfiguration proposals and so forth, and the risk that that would undermine the existing local government

influence, overview and scrutiny, so we would ask for a change to schedule 6 of the Bill in order to ensure that there is consultation at a local level before those powers are enacted.

The second area—it is probably not what you are asking about, but it is important that we raise it—is assurance around social care. It is good to have assurance around social care, but we need to make sure that that assurance is proportionate and is in context. Bearing in mind how stretched social care is from a financial perspective, it would be unreasonable to expect social care to do more than its budget allows it to do. In the same way, social care is also very dependent on the performance of the NHS, community care and so forth. We have some concerns around that assurance framework, which needs some work.

Edward Argar: Thank you, both. Mr McCabe, I am conscious of time and our programme motion, so I will pause there.

The Chair: Thank you, Minister. I thank both our witnesses for their evidence.

Examination of Witnesses

Eluned Morgan, Lyn Summers and Mari Williams gave evidence.

4.44 pm

The Chair: We will now hear from Eluned Morgan, who is the Minister for Health and Social Services in the Welsh Government. I hope that I have pronounced your name properly. We will also hear from Lyn Summers, head of health and social services central legislation team, and Mari Williams, senior lawyer (health)—both from the Welsh Government. All witnesses are remote, and we have until 5.15 pm for the session.

Q99 Dr James Davies: Minister, would you outline your understanding of how the Bill will impact the people of Wales? I believe the areas to be the UK-wide medicines information system and social care discharge to assess measures, which may well be relevant in border areas, but there may be other points.

Eluned Morgan: Thank you very much for inviting me to give evidence this afternoon. Obviously the Bill mainly relates to England, but I want to say that I understand what the Bill is trying to do and achieve and I am pleased that it represents some moves towards removing market competition from health and care. I am very pleased to say that we have never had that in Wales because we have our system of unitary health authorities.

There are a number of areas of the Bill that impact Wales. I have set out the significant concerns I have in a letter to Minister Argar. I would be very pleased to present the letter if that is helpful to the Committee. To summarise that letter, there are nine areas of the Bill that I think require the legislative consent of the Senedd. I have set out these areas in a legislative consent memorandum, which has been laid before the Senedd. We are currently in a disagreement with the Department of Health and Social Care UK regarding some of the clauses that the Welsh Government consider to fall into the areas that require the legislative consent of the Senedd. There are a few where we both agree that legislative consent is needed.

In response to your question, Dr Davies, the aspects of the Bill will impact Wales are special health authorities; accounts and auditing; clause 78 on hospital patients with care and support needs—that is the one you referred to, I think, with the border issue; clause 85 on a UK-wide medicine information system; clauses 86 to 92 on transfer of functions between arm's length bodies; clause 120 on international healthcare agreements; clause 123 on regulation of healthcare and associated professions; and clause 127 on food information for consumers. We consider clause 125 on advertising of less healthy food and drink an important point for us. Clause 130 is also really important to us. The power to make consequential provision also falls within the legislative competence of the Senedd. I think that is something that is worth looking at. I am happy to go through some of the detail on those if that would be helpful to you. Should I continue with that, Dr Davies?

Q100 Dr Davies: Is it a fundamental objection to the content of those elements of the Bill or is it a procedural matter?

Eluned Morgan: Interesting. We do not necessarily have an issue with the policy of some of them, but we are very concerned with some aspects of the constitutional shift and power grab that is happening here from the UK Government's point of view. For example, the provision on arm's length bodies is going to impact Wales in several ways. The UK Government are suggesting a requirement to consult the devolved Administrations before those powers are exercised. Frankly, that is just not good enough, because that memorandum of understanding, which the UK Government offered to present to alleviate some of our concerns, is a passing thing. It cannot be enforced by law and it does not bind future Governments, so we are very keen to see all the areas that impinge on our powers move from a duty to consult to a duty to get the support of the Senedd. There is a fundamental shift that we would like to see because we feel that our powers are impinged on.

The other point, which is quite interesting in the context of what is happening with Brexit, is that a number of clauses contain powers that enable the UK Secretary of State to make consequential amendments to provisions in a Senedd law. That is absolutely constitutionally unacceptable. It is fascinating when you think that part of the reason for the UK leaving the EU was to remove an outside institution's ability to legislate in relation to the UK, yet the irony seems to be completely lost on the UK Government when the same consideration is not applied to legislation in the devolved Administrations in areas where it is absolutely clear where the power should lie. Those are the two fundamental issues that I am concerned about.

Dr Davies: Can I have one further question?

The Chair: Why not?

Q101 Dr Davies: Thank you very much. Minister, we met recently about the NHS in north Wales and you very kindly sent a detailed response. I am very appreciative of that. One of the things we discussed was interoperability —the fact that the health service in a lot of Wales

[Dr James Davies]

interacts with that in neighbouring parts of England. We have talked today about data sharing in general, and I wonder what your thoughts are about the importance of comparable and interoperable data between England and Wales.

Eluned Morgan: There is clearly merit in having a system where data can be shared. We do not have a fundamental objection in principle to that and we would be very keen to set up systems that can speak to each other. I guess our objection would be where we are forced to share information that we do not necessarily feel should be shared. Why is that information needed and for what purposes? We would have to be very clear on that. It is not an objection in principle. In our discussion, I was very clear that I think it makes perfect sense for us to get those systems to be able to speak to each other. Again, it is more about the constitutional issues that have been thrown up and the UK Government's ability to work in our NHS system and to gain information that is not theirs to have. If we want to give it, we are more than willing to do that.

Dr Davies: Thank you.

The Chair: Before I move on, do Ms Williams or Ms Summers want to add anything to the questions that have been asked so far?

Eluned Morgan: I do not think they have got anything to add.

The Chair: I thought Lyn Summers was indicating that she had. Okay—anyone else?

Q102 Karin Smyth: The bulk of the Bill is about us in England looking at integrated care systems. Obviously, you operate according to a unitary provision already. I am not sure who is best placed to answer this question, but could you share with us any evidence, which might help inform our deliberations as we move to a different system, that the unitary integrated system provides better patient outcomes?

Eluned Morgan: We are all very aware that the care system is under incredible pressure at the moment. In Wales, we have been able to introduce new systems through legislation that give our health services the power to co-operate and work, within a legal framework, with the care services and local authorities. That has made a significant difference already. We have a long way to go, and this is only the beginning of the process, but that is an example of where a close working relationship, and providing the framework that allows that to happen, is working well. It needs to go a lot further, though.

The Chair: Thank you. Do either of you wish to add anything to that?

Eluned Morgan: Lyn or Mari, do you have anything to add?

Mari Williams: No, thank you.

Q103 Dr Whitford: Obviously, as a Scottish MP, I echo the same concerns from the Scottish Government about these areas. Although it is largely billed as legislation for England, quite a lot of clauses extend further, yet there is often no mention even of consultation, let alone of consent. Certainly, one matter than concerns me is medical information, so what consultation did the Welsh Government have? Unlike Scotland, Wales is mentioned in the extent of the Bill, so how early were the Welsh Government consulted when it was being put together before its launch at the end of July, which is pretty much when the Scottish Government got to see it?

Eluned Morgan: To be fair, my officials have had regular meetings with the Bill and policy teams, and I have met once with Minister Argar to discuss the Bill. However, I am afraid that that did not lead to our key concerns being addressed before the Bill's introduction.

I concur with you that we were really disappointed at the lateness of the notification of this Bill, and the absence of engagement with the Welsh Government in terms of the practicalities of the outcomes of discussions. For example, we received sight of the White Paper statement on the Bill only on the afternoon before it was published. We had sight of all the Bill's clauses only the day before introduction. With the best will in the world, we have some brilliant officials in the Welsh Government, but even they cannot work at that supersonic speed. We did not have the opportunity to look at all the final clauses and to respond to them before the Bill was introduced.

The point is that if the UK Government are serious about saying that we will be consulted, this is not a good model for them to show us that we have been consulted. Their stated aim was, "In your areas, where the power is rightly yours, you will be consulted." If this is the model that they are going to use, we are in for a really tough time. That is why I would concur with you that the real issue is that we want consent on areas that are rightfully and constitutionally ours.

Q104 Dr Whitford: We obviously heard in the Prime Minister's statement today talk about spending directly in health and social care despite its being devolved.

May I ask you a short, specific question? The healthcare services safety investigation body is England-only at the moment, but it is described that investigations could be requested in Welsh cases due to people coming over the border. Is that something that the Welsh Government are considering? At what level would such a decision be made? Would that be a local request, or would it go up through your central structures?

Eluned Morgan: Lyn or Mari may want to come in here. The key thing to remember—Dr James Davies will be aware of this—is that a huge amount of cross-border working happens between Wales and England, so it is important that we understand each system. I do not think that we would have an objection in principle to working in the way that you suggest, but where, for example, there is a body that is "England and Wales", it is rightly written in our legislation that we cannot be told what to do. It is not about the policy itself. For example, if there is an auditing issue, we will not go to war or have a fight about how something is audited; it is the process that we are concerned with. It is not that we would object, but it is rightfully in our power to determine whether we want to do something.

Q105 Dr Whitford: And that would apply also to things like sharing patient information of a certain type, and whether it was anonymised or pseudo-anonymised and so on? That would be a concern for you?

Eluned Morgan: Absolutely, and we are developing our own systems in relation to those things, of course. It is our patient information, and we should be deciding who has access to it and when.

Q106 Alex Norris: I thank you, Minister, and your officials for your time this afternoon. You mentioned correspondence with Ministers in the UK Government. Is that correspondence publicly available, or is it something you are willing to make publicly available?

Eluned Morgan: I am more than happy to send the correspondence that I have sent to Minister Argar to the Committee, so you can see it. It sets out all the issues that we are concerned with in relation to the Bill.

Q107 Alex Norris: In your conversations, have Ministers shared with you an impact assessment for the Health and Care Bill?

Eluned Morgan: I am not aware that we have seen an impact assessment. Lyn and Mari may have more to add.

Lyn Summers: No, we have not.

Q108 Alex Norris: That is helpful, thanks. To change tack slightly, in 2016 the Welsh Government brought in legislation around safe staffing levels. Are you able to talk us through that and say, five years on, what impact that has had?

Eluned Morgan: This is in relation to nursing. We have a law on safe staffing levels in nursing. Not only has it been implemented, but it has been extended since we brought in that Bill. It is something that the Royal College of Nursing is hugely appreciative of, and something that we are keeping an eye on. It has made a difference to patient safety, and we in the Welsh Government take it very seriously.

Q109 Edward Argar: Good afternoon, Minister and colleagues. Thank you for your evidence and answers so far. By my reckoning, of the nine issues on which we had a discussion, we reached an agreement on seven. I think there are two outstanding, which are the ones you have highlighted in your evidence. I owe you an answer to your letter, but I think we are meeting shortly to further discuss that.

I want to pick up on something that colleagues have touched on and which you have highlighted around the model of integration in Wales—the unitary model, for want of a better way of putting it. I acknowledge that you said it was early days, but I would like to get a sense of how you feel that model is delivering a national system but allowing local flexibility, and of the extent to which it is delivering, even in its early days, improved health outcomes for patients in Wales. As we look at ICSs and closer working between local authorities and the NHS in England, it may be instructive for us to learn from your experience, even if it is not a direct parallel, and from what you are seeing, even in these early days.

Eluned Morgan: We had a parliamentary review that looked at our NHS and care system, and went into a lot of detail about what we could change. A lot of it was about the need to integrate—*[Inaudible.]* What we have done as a result is take an interim step towards better integration. We not only set up the legislative framework for that, but put significant funding into driving these health and care systems to work together. We had an integrated care fund and a transformation fund. We found that both the health service and the care service really liked the new approach. They really have engaged. We have kind of allowed a thousand flowers to bloom here, and there have been some really innovative ideas and work. How do we get people out of hospital quicker? How do we drive that change? There have been some great examples.

What we are still struggling with, if I am honest, is that we are still finding difficulty getting both the health service and the care service to understand that what they have changed and what works well now needs to be mainstreamed. There cannot be additional funding forever. The purpose of that additional funding was to give the confidence to do it in the mainstream. We are finding that they have pocketed that money, saying, "This is great. Can we have more, please?" We have tried to make it clear to them that that was never the idea. The idea was for them to have that transformation funding to drive change.

That is our next challenge, and that is what we are working on now, but there are ways of doing that. Clearly, this is a difficult time to be doing it, but some health boards are frankly being driven into closer working relationships, because there are so many examples of delayed transfer of care given the infrastructure at the local government level. Do not forget that in Wales we have not seen anything like the cuts that have happened in England, but even we are feeling the pressure in quite a significant way, and we are having some real issues in relation to recruitment to the care workforce in particular. That is the biggest challenge for us at the moment.

Q110 Edward Argar: That is really helpful, thank you. As ever, I am grateful for your candour, because that will help us to learn from your experience. I am always frank with colleagues about the fact that we will look around to see whether we can learn from Cardiff, Edinburgh or Belfast. That is what we should be in the business of doing. You mentioned using transformation funding to allow local flowers to bloom. That goes to the heart of something we have discussed in a number of sessions today. To what extent, in how you are approaching this greater integration or joint working, have you adopted either a permissive or a prescriptive approach? How have you sought to balance those two ways of doing things to get the best outcome?

Eluned Morgan: It has been quite interesting. With care, for example, we have found that a lot of competition was going, such as between the independent care providers and the local authority—they were poaching from each other. All of that was damaging to the public purse and to the provision that we could give. Now we are in the process of developing an all-Wales framework within which people who want to provide care in Wales will work. That is what we are working on—a new legislative framework that will provide the infrastructure and give the minimal standards that they will have to meet. It is also making sure that we are driving quality through the system.

Q111 Edward Argar: I am conscious of time, but I have a final question that refers back to my first one. Do you have any evidence, whether anecdotal or that you will not share with the Committee, on how the approach is improving or changing health outcomes for NHS patients in Wales, quantitatively or qualitatively? What

[Edward Argar]

benefits are you seeing? Is there any evidence behind that? That is something we have explored with other witnesses—how ICSs will seek to do that—but given that you have started down this road already, is there anything you can share?

Eluned Morgan: What is difficult is that we started this process pre-pandemic but, clearly, with the pandemic we are in a very different situation. It is difficult to say what the model would look like in normal times, because we have had 18 months of something very different. It is hard for us to assess that evidence in the light of our circumstances at the moment, if I am honest.

Edward Argar: That is fair. Thank you, Minister.

The Chair: No one else? As there are no further questions, I thank you, Minister Morgan, and your officials for the evidence that you have provided today.

Eluned Morgan: Diolch yn fawr.

Ordered, That further consideration be now adjourned. *—(Maggie Throup.)*

5.10 pm

Adjourned till Thursday 9 September at half-past Eleven o'clock.

Written evidence reported to the House

HCB01 Michael Vidal
HCB02 Marie Curie
HCB03 Health Care Professionals Council
HCB04 Health Devolution Commission
HCB05 Health Devolution Commission
HCB06 Health Devolution Commission
HCB07 Royal College of Paediatrics and Child Health
HCB08 Healthcare Audit Consultants Ltd
HCB09 Gwyneth Clapham
HCB10 Fluoride Action Network
HCB11 Centre For Mental Health
HCB12 British Specialist Nutrition Association
HCB13 Marcus Chown
HCB14 Royal College of Midwives
HCB15 Age UK
HCB16 The King's Fund
HCB17 Susan Ghany
HCB18 Liz Hallworth
HCB19 Association of Dental Groups (ADG)
HCB20 Diabetes UK
HCB21 Healthwatch
HCB22 British Red Cross
HCB23 British Dental Association
HCB24 Royal British Legion
HCB25 Sabine Hirst
HCB26 John Puntis, co-chair of Keep Our NHS Public
HCB27 Royal National Institute for Deaf People (RNID)
HCB28 NHS Confederation
HCB29 Royal Pharmaceutical Society
HCB30 Professional Standards Authority for Health and Social Care
HCB31 Carers UK
HCB32 Company Chemists' Association
HCB33 Mental Health Foundation
HCB34 Paula Riseborough
HCB35 Association of Anaesthetists
HCB36 Virgin Care
HCB37 Family Hubs Network
HCB38 Coloplast
HCB39 Professor Allyson Pollock and Peter Roderick, Population Health Sciences Institute, Faculty of Medical Sciences, Newcastle University
HCB39a Professor Allyson Pollock and Peter Roderick: Attachment of Powerpoint slides containing screenshots of section 3(1) of the NHS Acts since 1946, and Clause 15 of the Bill
HCB40 Continuing Healthcare Alliance
HCB41 The Academy of Medical Sciences, Alzheimer's Research UK, The Association of Medical Research Charities, The Association of the British Pharmaceutical Industry, British Heart Foundation, British Pharmacological Society, Cancer Research UK, Medical Schools Council, Northern Health Science Alliance, Royal College of Obstetricians & Gynaecologists, Royal College of Physicians, University of Liverpool, and Versus Arthritis (joint submission)
HCB42 UNISON
HCB43 Healthcare Financial Management Association
HCB44 Royal College of Psychiatrists
HCB45 Macmillan Cancer Support
HCB46 National Pharmacy Association