PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

HEALTH AND CARE BILL

First Sitting

Tuesday 7 September 2021

(Morning)

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not later than

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

Danny Mortimer, Chief Executive, NHS Employers

Dr Navina Evans CBE, Chief Executive, Health Education England

Amanda Pritchard, Chief Executive, NHS England and NHS Improvement

Mark Cubbon, Chief Operating Officer, NHS England and NHS Improvement

Public Bill Committee

Tuesday 7 September 2021

(Morning)

[Mrs Sheryll Murray *in the Chair*]

Health and Care Bill

9.25 am

The Chair: I have a few preliminary announcements. Please switch off all electrical devices or turn them to silent. Tea and coffee are not allowed during sittings of this Committee. I encourage Members to wear masks when they are not speaking; this is in line with Government guidance, and that of the House of Commons Commission. Please also give each other and members of staff space, both when seated and when entering and leaving the room. Members should send their speaking notes by email to hansardnotes@parliament.uk, and when officials in the Gallery communicate with Ministers, they should do so electronically.

We will consider first the programme motion on the amendment paper, then a motion enabling the reporting of written evidence for publication, and then a motion allowing us to deliberate in private about our questions before the oral evidence sessions. In view of the time available, I hope those matters can be decided without debate.

I call the Minister to move the programme motion, which was discussed yesterday by the Bill's Programming Sub-Committee.

Ordered,

That—

1. the Committee shall (in addition to its first meeting at 9.25 am on Tuesday 7 September) meet——

(a) at 2.00 pm on Tuesday 7 September;

(b) at 11.30 am and 2.00 pm on Thursday 9 September;

(c) at 9.25 am and 2.00 pm on Tuesday 14 September;

(d) at 11.30 am and 2.00 pm on Thursday 16 September;

(e) at 9.25 am and 2.00 pm on Tuesday 21 September;

(f) at 11.30 am and 2.00 pm on Thursday 23 September;

(g) at 9.25 am and 2.00 pm on Tuesday 19 October;

(h) at 11.30 am and 2.00 pm on Thursday 21 October;

(i) at 9.25 am and 2.00 pm on Tuesday 26 October;

(j) at 9.25 am and 2.00 pm on Wednesday 27 October;

(k) at 11.30 am and 2.00 pm on Thursday 28 October;

(l) at 9.25 am and 2.00 pm on Tuesday 2 November;

2. the Committee shall hear oral evidence in accordance with the following Table:

Date	Time	Witness
Tuesday 7 September	Until no later than 10.30 am	NHS Employers; Health Education England
Tuesday 7 September	Until no later than 11.25 am	NHS England and NHS Improvement
Tuesday 7 September	Until no later than 2.30 pm	NHSX
Tuesday 7 September	Until no later than 3.15 pm	NHS Providers; NHS Confederation
Tuesday 7 September	Until no later than 4.00 pm	Care Quality Commission; Healthcare Safety Investigation Branch
Tuesday 7 September	Until no later than 4.45 pm	Local Government Association; Faculty of Public Health
Tuesday 7 September	Until no later than 5.15 pm	Welsh Government
Thursday 9 September	Until no later than 12.15 pm	UNISON; British Medical Association
Thursday 9 September	Until no later than 1.00 pm	Royal College of General Practitioners; Royal College of Nursing; Academy of Medical Royal Colleges
Thursday 9 September	Until no later than 2.45 pm	The King's Fund; Nuffield Trust
Thursday 9 September	Until no later than 3.15 pm	Gloucestershire Integrated Care System; NHS Confederation's ICS Network Advisorate
Thursday 9 September	Until no later than 4.00 pm	Centre for Governance and Scrutiny; Centre for Mental Health
Thursday 9 September	Until no later than 4.30 pm	Healthwatch England
Thursday 9 September	Until no later than 5.15 pm	Association of Directors of Adult Social Services; British Association of Social Workers

3. proceedings on consideration of the Bill in Committee shall be taken in the following order: Clause 1; Schedule 1; Clauses 2 to 13; Schedule 2; Clauses 14 to 16; Schedule 3; Clauses 17 to 25; Schedule 4; Clause 26; Schedule 5; Clauses 27 to 38; Schedule 6; Clauses 39 to 41; Schedule 7; Clauses 42 to 59; Schedule 8; Clauses 60 and 61; Schedule 9; Clauses 62 to 66; Schedule 10; Clause 67; Schedule 11; Clauses 68 to 72; Schedule 12; Clauses 73 to 93; Schedule 13; Clauses 94 to 106; Schedule 14; Clauses 107 to 118; Schedule 15; Clauses 119 to 125; Schedule 16; Clauses 126 to 135; new Clauses; new Schedules; remaining proceedings on the Bill; and

4. the proceedings shall (so far as not previously concluded) be brought to a conclusion at 6.00 pm on Tuesday 2 November.—(*Edward Argar.*)

Resolved,

That, subject to the discretion of the Chair, any written evidence received by the Committee shall be reported to the House for publication.—(*Edward Argar.*)

The Chair: Copies of written evidence received by the Committee will be circulated to its members by email and made available in the Committee Room.

Resolved,

That, at this and any subsequent meeting at which oral evidence is to be heard, the Committee shall sit in private until the witnesses are admitted.—(*Edward Argar.*)

The Chair: If everyone is agreed, we will go into private session to discuss lines of questioning.

9.27 am

The Committee deliberated in private.

Examination of Witnesses

Danny Mortimer and Dr Navina Evans gave evidence.

9.29 am

The Chair: Some of our witnesses will be giving evidence today by video link, while others will appear in person. It is helpful, particularly when witnesses are giving evidence by video link, if Members could direct their questions to specific witnesses. Before calling the first panel of witnesses, I remind all Members that questions should be limited to matters within the scope of the Bill and that we must stick to the timings in the programme motion that the Committee has agreed. We have until 10.30 for our first panel. Do Members wish to declare any relevant interests in connection with the Bill?

The Parliamentary Under-Secretary of State for Health and Social Care (Jo Churchill): I have no relevant interest to declare, but we are unable to see a screen. Would it be possible to erect a screen so that we can see those giving evidence?

The Chair: Yes, we can do that. As there are no witnesses giving evidence in person, it would be okay for Members to sit at the witness table, if that would be better.

Jo Churchill: That would be great.

Dr Philippa Whitford (Central Ayrshire) (SNP): I want to declare an interest as a medical practitioner, although not commonly practising, and as a member of the British Medical Association.

Dr James Davies (Vale of Clwyd) (Con): Likewise, I declare an interest as a serving general practitioner in the NHS, a member of the BMA and as a member of the Royal College of General Practitioners.

The Chair: Thank you. I am very keen that we continue this session as quickly as possible. We will now go to our witnesses. Good morning and on behalf of the Committee, thank you very much for agreeing to give evidence. Please introduce yourselves for the record.

Dr Navina Evans: Shall I go first?

The Chair: I think that would be good; ladies first.

Dr Navina Evans: My name is Navina Evans and I am chief executive at Health Education England.

Danny Mortimer: Good morning. My name is Danny Mortimer and I am the chief executive of NHS Employers, which is part of the NHS Confederation.

The Chair: Thank you very much. Members who wish to ask questions should please indicate that.

Q1 Edward Timpson (Eddisbury) (Con): Good morning to you both. Having taken big Bills through Parliament before, I am aware that a lot of scrutiny goes into the detail on the statute book, for obvious reasons, but sometimes we also need to reflect on the implementation and how we can make the legislation turn into a reality. Based on the proposals in the Bill, what role do you think you can play to bring about that reality through the development of the workforce to meet the demands on the healthcare system that the Bill is trying to improve the prospects of meeting?

Dr Navina Evans: Thank you very much for the invitation to give evidence today. I am really pleased to note the prominence the Bill gives to the workforce, and the important focus on systems working together, and working together with social care. I think that implementation will work well because we can build on what we are already doing. There is a great deal of collaboration between all parts of the system, and I can give you lots of examples if you wish of how we have developed the workforce over the past few years, particularly through the pandemic. We can build on what we have done together with other parts of the system. HEE plays a unique role because we have relationships with educators, providers of healthcare, the regulators, the professional bodies and NHS employers and other partners, as well with NHS England and the Department of Health and Social Care. We play a convening role, and we have already used that experience, ability and capacity to develop the workforce so far. We think the Bill will enable us to build on that.

Danny Mortimer: Navina captures really well the work that is already going on, not least, as she has said, through the pandemic. My members, who are the trusts and ICSs around the country, are already trying to find ways of developing joint approaches to developing their workforce, not least with their colleagues in social care, but also by thinking about different ways in which they can recruit and perhaps make employment in the NHS more accessible to people from harder, under-served communities. Some fantastic work has been going on with the Prince's Trust, for example, around the NHS, and that has increasingly been done through the organisations that are being formalised through this Bill.

I also think that the commitments that the Government are expected to make later today, not least around investment in social care, will help organisations to work together. We have a pressing need in the health service to invest in the longer term in our workforce, but that is even truer for our colleagues in social care. Again, that is a significant step forward today, which we hope will go even further in the spending review, in helping employers to ensure an adequate supply of people in the longer term, not least with the support of Navina's organisation, and also by being able to innovate together in developing roles that better meet the needs of the communities they serve.

Q2 Edward Timpson: Do you see the principles set out in this Bill, along with the details in each of the relevant clauses, around integration and collaboration as a natural progression from a lot of the work that has already been undertaken by yourselves and others working in the healthcare system?

Dr Navina Evans: Yes, I do. I think they build on what we have already done well and strengthen our ability to go further.

Danny Mortimer: I agree with that. I think there are some risks. At the heart of the Bill, it is formalising organisations that can lead, innovate and perhaps do things differently from each other in local areas. We

have a very centralised healthcare system in this country, and one of the risks is that the vision in Bill of integration and devolution to local areas is not realised, because the centralising impetus is very strong. However, the Bill absolutely captures what has now been many years of growing collaboration and integration between health organisations but also, importantly, with our colleagues and friends in local authorities and social care.

Edward Timpson: Thank you.

The Chair: I now call Mary Robinson.

Q3 Mary Robinson (Cheadle) (Con): It is really interesting to hear—I have seen it, as I am sure you all have—how partnerships have been built through covid. There has been a huge amount of joint working and integration. Have you been able to pick out any specific areas of learning over the past year and a half that we would hope to see as we go forward and which would be really useful as we build this integrated network?

Dr Navina Evans: I can give you three areas of learning that we in HEE were really pleased to see. One is around flexibility and better collaboration, which meant that our students and learners had a different kind of learning experience and also were able to contribute in a very real way to the care in service. This has led us to build on the reform agenda for education and training, and we are working with partners in education, the professional bodies and the regulators to see how we can use what we have learned to enhance that.

That is the first thing; the second thing is that we have seen quite a lot of barriers between organisations and systems being broken down. Again, that is something that we in HEE feel we should make the most of, together with partners, for future ways of working. The third area is the use of technology, digital and new ways of working. We have really moved quite significantly in how we work, including in how we learn, teach and train. Again, those are areas that we are very excited to build on. In many of them we had started before, but we accelerated during the pandemic, and we will not be going back. We will only be moving forward.

Danny Mortimer: I think that Navina captures really well that catalysing effect that the pandemic has had. I think that in many parts of the country there has been a much greater sense of there being one team within localities and communities. There have been some fantastic examples of health and social care teams coming together to respond, given the particular impact of the pandemic on social care settings and on the most vulnerable members of our communities. There is more to do, but the recognition that actually there is one workforce and one team, cutting across the NHS and other health organisations in other parts of the public service, is absolutely growing.

I think that the Bill, by formalising arrangements and stretching what is expected of systems, provides real opportunities for those systems increasingly to inform the kind of national work and planning that Navina and her colleagues lead, as well as the kind of informed work that the Secretary of State and the Minister want to take forward for health and social care.

Mary Robinson: Thank you.

The Chair: I call Dr James Davies.

Q4 Dr James Davies: I am interested to hear your views on the adequacy of the requirements for workforce projections within the legislation as it stands, in relation to both the NHS workforce and social care, potentially, and how you think the devolved Administrations should be brought in. Dr Navina first, please.

Dr Navina Evans: HEE has recently been given a ministerial commission to lead on developing a strategic framework for future workforces planning. We think that this is really timely in relation to the Bill. What we feel really matters in workforce planning is driving actions and solutions. We need to be able to identify future needs and shortages, and then ensure that the systems develop plans, but these plans need to be able to access all levers at all levels. It is quite a complicated business, but we feel that it is timely for us to pay particular attention to it.

There are a number of areas to consider. We need to look at service redesign; workforce redesign and transformation; employer roles, in terms of retention and recruitment; other supply interventions, such as international recruitment; and then—this is particularly relevant for HEE—future supply through education and training. We then want to pull the system together, through our convening role in HEE, and to have two principal ways of thinking about this: the future needs more and different, in terms of workforces and people; and we want to focus on skills, not necessarily just roles. The really critical point about this commission is that it asks us to ensure that we include the regulated social care workforce in our planning, which is a real step forward. We are looking to ensure that planning should track long-term trends in demand, that we should not be too tied to short-term fiscal cycles, and that we are prioritising supply for the whole health and care workforce.

Danny Mortimer: It is very welcome that the Department has commissioned HEE to do the work that Navina has described, but the NHS Confederation is clear, alongside a whole range of other organisations that work on behalf of the health service in particular, that clause 33 is insufficient for the task that the NHS faces in workforce planning. What it sets out, as Committee members will know, is a requirement for the Secretary of State to describe the process of workforce planning every five years. We have proposed to Parliament that that needs to move from setting out the process to actually setting out the requirements that health and social care have, and to do that much more regularly—we propose every two years.

For us, what is in the Bill is positive, because it is good to have the process described for the first time, but actually, as Dr Evans has just touched on, we need to spell out what the health and social care systems need in the longer term, but also in the immediate term. In some ways, that would mirror the work of the Office for Budget Responsibility in terms of advising the Government and Parliament about likely health and social care spending. We then need a corollary that sets out what is needed to respond to that in terms of people. Health and social care is fundamentally made up of the 3 million people who work in it. We sometimes fixate on the buildings and the technology, but it is fundamentally, in its essence, a people business. We think that that is a pressing issue, not least because of the pressures we face. That is not to say that the Government have not and do not invest in workforce numbers—significant

decisions have been made in recent weeks around expanding medical school places, for example. But what we do not have is one coherent, single plan that is presented to the country and particularly to Parliament, which sets out what the NHS and our friends in social care will need to meet the demands that are being placed on us by the population, their health needs and quality of life, and also of course any priorities that the Government might set for social care and health services.

Dr Davies: Thank you.

The Chair: Thank you. I call Karin Smyth.

Q5 Karin Smyth (Bristol South) (Lab): I appreciate that people working together and perhaps substantiating some of those informal arrangements might, in theory, do some of what you hope. However, the employers remain the institutions that make up the integrated care boards—that is the effect of the Bill. You have started to talk about the process. Could you perhaps talk a bit more about how that is enforced, what that means in practical terms for employers and how employers might behave? I am partly thinking of one of the trusts in my area, which, a number of years ago, set up a wholly owned subsidiary company, with the benefit for them of different terms and conditions for staff as a way of saving money. That was obviously detrimental to the healthcare system generally because you are competing for the same sorts of staff. We made the trust stop doing that because we wanted the staff to be treated the same. My point is: the employers, the terms and conditions, the benefits and the way that they will attract staff remain the same. The Bill does not make the ICB the employer or the way to deliver those terms and conditions or ways of recruitment. I think it is a theory. Can you convince us otherwise and show how in practical terms the Bill solves some of those problems?

Danny Mortimer: It is absolutely the case that the individual organisations in the NHS, social care, charitable organisations and local authorities that make up the partnership as well as the board will remain separate legal entities. We do not see that it is desirable for the NHS to move from having 250 separate employers to having 42 employers. What we have in the NHS is a set of national terms and conditions. My organisation has a particular responsibility on behalf of the Secretary of State to negotiate those with our trade union colleagues. We see that they work well for the NHS and I detect no movement among my membership to move large scale away from those national terms and conditions, which cover the vast majority of staff who work in the statutory NHS.

What we see with ICSs is that organisations are increasingly coming together to address shared challenges. We observe that those challenges are not about pay and conditions but about supply. They are about working together to think about how to promote a specific area for people to come and work in, whether that is Nottinghamshire or West Yorkshire and Harrogate, where there has been some fantastic work in promoting careers in the sector as a whole. We see people coming together to work with directly elected Mayors around the skills agenda. There has been some really fantastic work, for example, in the west midlands, with health and social care organisations coming together with local authorities. We see similar work and engagement with the Mayor of London on the skills agenda that he is taking forward. Again, that is being done by organisations working together. That helps partners—local authorities are engaging with health and social care as a team rather than dozens of separate organisations. It also helps us promote careers that span the whole range of settings that we operate in and speaks to the particular priorities of our colleagues in social care. We see some really fantastic examples of that in various parts of the country.

Finally, we see a real opportunity to take forward the work that I have just talked to Dr Davies about. Systems, as they look at their services and their knowledge of the things that they are providing in their communities to your constituents, can inform the national plans that Navina described in her answer to Dr Davies. We can have a much greater connection between local priorities and some of the decisions that are made nationally about how we invest longer term in education. Of course, the NHS workforce is about 50% degree educated or degree equivalent. So there are significant investments that the Department of Health and Social Care, the Office for Students and the education sector make in our workforce. Being able to root that in what it is that local services need and how they are developed seems to us like a fantastic opportunity, and would help us to avoid the problems that we have got into in the last couple of decades with pressure points in various parts of our workforce.

Dr Navina Evans: I will build on what Danny has just described. You have given some really good examples of how local employers are coming together in systems to address workforce issues. I would add a bit more about how we do it and how we can do it even better going forward. Health Education England has a role in developing careers and attracting young people—all people—into the health and care workforce. We play a really big part in that. First, we have found that doing that locally, at a very local level with the communities and organisations that really understand their local populations, has been a really good thing to do. Some of the examples that Danny gave have built on that and we will move forward on that.

Secondly, we have structures in which people boards, at integrated care system level and definitely at regional level, now bring collections of the different organisations together. We have systems that are starting to think about themselves as anchor systems, which means that they can influence employment, the economy and the success of local communities.

Finally, the population health issue has been something that we have really woken up to, and we are cognisant of the fact that we have to focus on and rebalance the health and wellbeing of the population. Through the pandemic, we have learned a lot more about where we need to target our efforts to reduce inequalities. That can only be done really well through collaboration at a local level. Organisations such as mine need to work closely with our partners in NHSE, with the Department and with other national organisations to make sure that we support those local efforts to be sensitive to the needs of their particular population. It is bringing the national priorities, principles and policy into life at a very local level by making sure that we have the systems and structures in place to deliver what is needed locally.

We had already started working on that—the work is well under way—and the Bill will enhance our ability to get on with doing that.

Q6 Chris Skidmore (Kingswood) (Con): I want to return to the issue of workforce planning, which obviously is integral to both of your organisations. You have discussed the strategic framework you have been working on, and hopefully that will evolve into a workforce strategy, which is addressed in clause 33 of the Bill. I have tabled an amendment to clause 33 which is to make the workforce report annual rather than once every five years. I think that the pandemic has demonstrated the futile nature of trying to produce a report once every five years, when we know that the nature of the workforce could change radically during that period. Would your organisations agree that it would be better for that report to be produced on an annual basis? Clause 33 states that NHS England and Health Education England

"must assist in the preparation…in this section,"

but only

"if requested to do so by the Secretary of State."

You have talked about locally led decision making and planning. Do you both agree that we need better co-creation? My amendment covers the fact that a plan should be developed and agreed by stakeholders in particular. Would your organisations welcome this amendment, which would result in an annual workforce strategy and require it to be developed by all other healthcare organisations working in this sphere?

Dr Navina Evans: From HEE's perspective, we will deliver on the duties that Parliament decides that we ought to deliver. We feel that we have the capacity and the capability. We can organise ourselves to deliver whatever is required of us by the Bill. The work that we do is lithe—it is iterative. We do iterative planning, in a meaningful way, at the national and system level, so we will be able to respond and fit in with whatever is required of us by the Bill and Parliament.

Danny Mortimer: Thank you for the question. Absolutely, there is an opportunity for the Bill to define a wider range of stakeholders. The systems at the centre of the Bill—integrated care boards and integrated care partnerships—are central to that, and their perspectives, as we have just talked about with Ms Smyth, in terms of the needs of their population and the services they need to put in place to respond to them, need to be at the centre of the process that Navina and others would lead on behalf of the Secretary of State. That is the first thing. Secondly, there is an opportunity through those systems to broaden our conversation to include social care as well as health. That is really important to us on this day of all days, in terms of the announcements later.

In terms of the regular appraisal, we absolutely believe that five years is absolutely insufficient for the task. We also believe that it cannot just be about process. It has to be about setting out clear requirements and clear specificity about those requirements over different time periods. There is something about the short-term need, and there is also something about five, 10 and 20 years. It needs to be regular. We have proposed two years because it is a huge amount of work and that feels to us to be a minimum in terms of how regular the perspective could be, but it may well lend itself to an annual update, as you have described.

We also see that organisations such as Health Education England and Skills for Care, which operates in the social care sector, absolutely have the capacity and capability to lead this work. Their way of working, similar to the Department's way of working throughout the preparation of this Bill, is about engaging, convening and trying to bring stakeholders together to get a broad range of perspectives. That is our experience of the long-term process that Navina and her colleagues are leading on behalf of the Department at the moment. The Bill confirming that would confirm ways of working that we are starting to see develop with stakeholders in a really healthy and constructive way.

Q7 Hywel Williams (Arfon) (PC): Good morning. This Bill is mainly about services in England, apart from the part about the health services safety investigations body and clause 112 on Welsh health bodies requesting help. However, there is significant traffic from Wales to England, and a certain amount in the other direction, to access health and care services. This might impact on services in the north-west of England and along the Welsh border. This is a very broad and quick question: in what ways do you see yourselves and other health bodies in England taking account of the priorities and needs of the Welsh Government and of the Welsh population to access health services in England?

Danny Mortimer: There are important links with Wales, and of course with Scotland as well, in many parts of the country. There are a couple of things to say. The first is that there are undoubtedly things that the English system can learn, and is learning, from our colleagues in Wales, Scotland and Northern Ireland who are taking similar approaches in terms of how they respond to the challenges we face in social care and health. In my own organisation, we represent organisations in Wales and Northern Ireland, and there is a really rich learning that we can do there.

Secondly, in practical terms, there are good lines of communication and liaison between healthcare organisations that operate along the borders that you have described. It will carry on being really important that those lines of communication, that liaison, the financial arrangements and the sharing of care between different teams on various sides of the borders continue, and we see nothing in the Bill that prevents that. If anything, we see opportunities through better co-ordination in England at a system level to be able to help patients who travel across from Wales into England, or patients who travel from Scotland into England. If anything, I think we can improve the planning and liaison through what is in this interesting Bill.

Dr Navina Evans: We already have very strong four-country relationships, particularly in the education and training space, where we make sure that we share standards, that we do planning around the curriculum and the reform of education, that we ensure quality and that we go for improvements in the way in which we support and train our future healthcare workers. In the regulation space, we work very closely with the General Medical Council, the Nursing and Midwifery Council and other bodies, to make sure that that happens. They obviously have four-country oversight, so we already work very

closely with them. Also, all our professional bodies, such as the royal colleges, have to represent members from across the whole UK. In that space, there is a lot of good work that we can continue to build on, learn from and share as a result of this Bill.

Q8 Hywel Williams: I am very glad to hear what you have said. Professional staff are notoriously footloose, as far as Wales is concerned, so there is a certain issue about workforce planning. In my own area, I used to teach in social work education. We have a nursing school at Bangor University, which is a very valuable provision, but I am not sure how many are retained in the health service in Wales—or the other way around, of course.

There is one other point I would make, and this is more philosophical than practical. The Welsh Government's approach to health is based on a wellbeing model. It is much more proactive than other models. I hope that, philosophically, that sort of approach is useful and interesting for you, and that you will be taking full notice of it.

Danny Mortimer: The second point, in particular, is really well made. That is absolutely the focus that we see integrated care systems taking. The engagement with population health that Navina described is about trying to gear a system much more to long-term investment in the quality of people's lives.

We have become, in recent years—even before the pandemic—much more geared towards crisis response. That is not in the best interests of the long-term health of the population. It does not help us to address the inequities that we see in our population, and that we saw very starkly during the pandemic.

Navina may be aware of the issues around workforce mobility between the four countries. The co-ordination that Navina leads, and that we have with our professional regulators, is really important. We have a shared workforce, and we have shared approaches to education as well as things such as pay and contracts. That is really important to ensuring that the job market is stable, particularly if we experience supply issues in particular geographies or parts of the workforce.

Dr Navina Evans: I have nothing to add on the movement of the workforce between the four countries, but I take the point that this is something we need to be mindful of, and I will make sure that the issue is a priority in our conversations with our counterparts in the four countries.

On wellbeing services, that is absolutely the way in which the reform of education and the curriculum is moving. Health Education England is working with partners to develop that. Our integrated care systems, and our colleagues running services who are closest to the point of care, and who know their populations best, have been saying for some time that we need to focus on wellbeing, prevention, intervening earlier and keeping people well. That is a priority for our partners in NHS England and NHS Improvement as well. We already have programmes of work to take this forward.

Hywel Williams: Thank you.

Q9 Justin Madders (Ellesmere Port and Neston) (Lab): Good morning. Thank you for coming. I am sure that you will be aware that everyone in the country, and the whole Committee, is very grateful for the work done by frontline health and social care staff, not only over the past 18 months, but over many years. The consequences of that work have been starkly drawn to everyone's attention by the Health Committee report on staff burnout. What in the Bill will address the issues raised in the report?

Dr Navina Evans: I will give you three points that are really important. One is the absolute priority, focus and prominence given to looking after our workforce. Again, we will build on work that we have already been doing in the last few years. For example, in the interim pupil plan, there is a very strong focus on wellbeing, culture, leadership and retention. We have been working, together with Danny's organisation and others, on thinking with staff about retention. One thing that is really important is looking after people. There are lots of good examples of work being done all around the country to improve wellbeing and therefore retention, and to minimise or prevent burnout. This is quite high on the agenda for our partners in NHS England and NHS Improvement. It is very high on the agenda for us in HEE, because we look after our students, trainees and learners, who are also part of the workforce, and they tell us what helps to keep them well and prevent burnout. We need to start doing that work, which is part of our business, very early on.

I am pleased to say that our partners in the universities, royal colleges and other professional bodies are really mindful of this. They all have work streams around wellbeing and preventing burnout. In the Bill, we can highlight the importance of this, and build on work that is already being done to look after our staff.

The Chair: Thank you. I intend to move to the SNP spokesperson at 10.15 am, and to the Minister at 10.25; the session ends at 10.30. If we can keep questions and answers succinct, that would be appreciated.

Danny Mortimer: Noted, Mrs Murray.

I agree with everything that Navina has said, and it is a huge focus for the health service. In terms of supporting the health and wellbeing of staff, I think the Bill can go further under the terms of clause 33—it represents the conversation that we have had with them a couple of times. Absolutely we should support people and absolutely we should care for them, but if there are gaps in their rotas and in their teams that only increases the pressure on people who are already working flat-out. The pandemic has shown us starkly where those gaps and needs are, but we were experiencing them before the pandemic. There are parts of our workforce—mental health, learning disability nursing and some of our smaller allied health professions, such as therapeutic radiography—that absolutely need urgent long-term investment. We need that investment in staff as well as in the pressing need that we saw covered in social care settings and in hospitals during the pandemic. The requirement for a regular assessment of what the health and social care system requires to meet the needs of the population would help us to support that.

Q10 Justin Madders: You were very clear in your view of what was needed to make clause 33 more effective. In your opinion, would the clause also require some funding requirements to meet the demand?

Danny Mortimer: I do not know to what extent Parliament is able to, or is willing to, pre-commit Governments to funding decisions such as you have described. Absolutely, that would bring clarity for us all in terms of what was needed, and it may well offer clarity in terms of the prioritisations that we have to make on investment in the workforce. We have seen a massive expansion in our medical workforce, particularly in hospitals, in the past 20 years, but we have not seen a similar expansion in the nursing workforce. That is not something that was clearly set out for us and for a Government to help make decisions about. I think a clearer, more effective clause 33 would help a Government to do that, and in turn help a Parliament to support a Government in that.

Q11 Justin Madders: Thank you. I have a quick question for Dr Evans, and then one more question for you both. You have mentioned the commission that you have been asked to form to draw up that strategy. When is that expected to be published?

Dr Navina Evans: We expect to go back to the Minister with our findings by early March. After that, we will have a clearer understanding of when we will publish our framework.

Q12 Justin Madders: May I ask you both whether you have given any thought to, or been able to quantify, the amount of staff and management time that will be taken on implementing the Bill?

Dr Navina Evans: From our perspective in Health Education England, our input is quite confined to the workforce planning. We are able to manage within our existing resources and to redefine and redeploy them. We are also able to work collaboratively with partners who are very willing to help us in this work.

Danny Mortimer: I cannot give you an exact figure, Mr Madders, but I can reassure the Committee that the way in which the proposed change will be implemented is much more about minimising the organisational disruption change that we have experienced with previous reforms, either the one 10 years ago or the one a decade before that. We are seeing a clear commitment to move staff who are currently employed in clinical commissioning groups—the Bill will disband those groups—to the new ICS organisations. That is a very positive way of managing the change rather than that experienced previously, which was hugely time-consuming in terms of management time and hugely unsettling for vital staff in terms of planning services. We are avoiding the problems that we faced in the past. Amanda and her colleagues at NHS England are to be commended for the proportionate and sensible manner in which they are looking to implement the changes, especially in terms of how they impact on people and organisations.

Justin Madders: Thank you. For the last minute, I am going to hand over to my colleague.

Q13 Alex Norris (Nottingham North) (Lab/Co-op): I have a very quick question for Danny Mortimer. You have the unenviable task of negotiating with the staff and their representative unions on all sorts of issues—pay, terms and conditions, safety. When you have such negotiations, how high up on the list does a commissioning restructure come in terms of the things that our front-line staff are really after?

Danny Mortimer: We have a really constructive set of relationships in the NHS with our trade unions, on both terms and conditions and the social partnership forum, which the Minister's colleague Helen Whately chairs and which brings trade unions and employers together.

There is an interest in how the health service organises itself, and there is an interest in how the health service and our friends in social care can better work together to relieve the pressure that our colleagues were experiencing even before the pandemic. Of course, there are other things that people are interested in as well. There are outstanding questions about long-term pay strategy, and there are other issues around working environments and support that Navina touched on. Those are really important as well.

There is a recognition, when I speak to trade union leaders and representatives, of the opportunities available through system working to improve service delivery, and therefore to help their committed members do their jobs better and relieve the pressure that they have been under for far too long.

The Chair: I call Dr Phillipa Whitford, the SNP spokesperson.

Q14 Dr Whitford: Thank you very much, Mrs Murray. Dr Evans, we have talked quite a lot about workforce and highlighted the fact that the workforce move around the UK, and therefore work in the four different nations. Registration of nurses and doctors is UK-wide, although only Scotland has registration for care staff. Do you not think that that needs to be recognised to some extent in clause 33, so that we do not end up having Peter robbing Paul? This year, we have seen a shortage of foundation places. Although all four nations have increased medical student places, a young doctor cannot practise unless they get their two years at foundation level. Do we not need to be consulting specifically with the other health Ministers and looking at the workforce in general? I do not mean transferring control of that workforce, but recognising, for the next five, 10 or 20 years, the needs and the strategies of the different nations so that we do not end up stealing from each other.

Dr Navina Evans: Thank you for the question. It is for Parliament to decide what goes into the Bill. We will, of course, work accordingly with the duties. We already work with the four nations around the foundation year programmes, we share a lot of intelligence and recruitment work and we are continuously looking for ways to strengthen that. It is an important priority for us to share learning and recruitment between countries.

Q15 Dr Whitford: Sorry to interrupt, Dr Evans, but this year the foundation places are managed on a UK basis, and this year, at the beginning of the summer, there were several hundred graduates who did not have a foundation place—I hope they have all got one now. That can mean people literally being sent to a different part of the UK, away from their family and their support mechanisms, and we all know how tough these years are. This is being managed at a UK level, and yet the three devolved nations are also trying to tackle workforce issues. If they are not included in this, or at least consulted, do you not see that as a weakness?

Dr Navina Evans: I see that we are addressing exactly those problems around where people go to do their jobs and where the placements are. Having to travel to get

the right training jobs is something that we have been grappling with for a very long time in Health Education England, and I remember that we were grappling with it when I was a trainee. That is something that we focus on anyway, and if it were to be strengthened in the Bill we would, of course, look at the duties that were expected of HEE in terms of working across the four nations to solve this issue. We would be building on what we are already doing to address that.

Q16 Dr Whitford: Thank you. Danny Mortimer, we have talked about the change that is coming, and a lot of it is to enable the innovation that has come through the pandemic. I was back in the NHS in Scotland in the first wave, and I saw that creativity. How do you think it can be done without consuming a lot of the bandwidth of frontline staff? You talked to the shadow Minister about management, but it often takes up frontline staff. Would you see a gradual change? Are you concerned that the footprints of some of the ICSs that have already evolved are apparently going to change? Is that not going to add new upheaval in certain geographical areas?

Danny Mortimer: Thank you, Dr Whitford; there are a couple of things there. On the geographical changes, what ICS leaders wanted was clarity. They have now been given that by the Department and NHS England, and they will move forward and can adapt accordingly.

On the impact on the frontline, throughout the pandemic, and increasingly before it, we saw a much greater sense of teamwork across some of the boundaries that we can create between parts of the health service, and between the health service and other public services. There is an opportunity to accelerate that in lots of our settings. That will be a positive. It will help people care better for their patients. Most importantly, it will help patients and their families to have a much more seamless experience.

This is not a magic thing—you know yourself how complicated the hand-offs and transitions between different teams can sometimes be—but this Bill formalises the recognition that we have had over recent years in England that to start to properly and truly focus on what individuals need, we have to have better co-ordination between our teams. It is not about the institution first; it is about the team first, and obviously most importantly the patient first. The absolute opportunity for us is to do those things better for the patients in between our services.

Q17 Dr Whitford: Yes, I totally recognise that. In Scotland, we reintegrated primary and secondary health back in 2004, and in comparison with the last seven years of trying to integrate health and social care, that was a walk in the park. It is much more challenging, but equally it is where we are all trying to get to. If I can ask you, on a different subject—

The Chair: I think we are getting close to the last question.

Dr Whitford: This is the last question.

On the health services safety investigations body, I was on the pre-legislative Committee, where there was an aim of protecting the safe space disclosures quite thoroughly to ensure staff had the confidence to discuss very sensitive issues. In the version that is in this Bill, much more is covered by safe space protection, but then there are exemptions such as the coroner. Although staff can be summoned and made to give evidence, if they feel that that will end up being shared through a lot of disclosure exemptions, do you think they will really believe that that space is protected, in the way it is in the airline sector?

Danny Mortimer: There is a very difficult balance that health service leaders know they need to strike. The requirements around transparency to the public are much higher for the health services and for people such as you and Dr Evans, as health service practitioners. The coroner's ability to review what happened is a really important step for families, and we are very respectful of that.

What the Bill does—this is how it describes the investigations branch—is to build on work that the NHS and the Government have been taking forward since Robert Francis's inquiry into whistleblowing to ensure that we have cultures, practices and processes that enable people to be candid and open without fear of consequence, in terms of what has happened. We realise that that is how we learn and improve. We also realise that have a lot of work to do to help all parts of our workforce—clinical and non-clinical—feel much more comfortable and supported to raise concerns, give feedback and be honest about what happened. As you will know, there is an enormous amount of work going on across the four countries to create those kinds of cultures, but at the same time, we also recognise that we have that responsibility in terms of transparency to the public, and to patients and their families.

Dr Whitford: Thank you.

The Chair: Thank you. I call the Minister.

Q18 The Minister for Health (Edward Argar): Thank you, Mrs Murray. I will try to be brief, with just two questions. Morning, Danny; morning, Navina. My first question is this: what do you see as the potential role of legislation in addressing future workforce needs—both the limitations of legislation in doing it and the opportunities?

Dr Navina Evans: I will start with the opportunities. We in HEE are really pleased to see that workforce is prioritised in the way that it has been. For us, that means that there is an expectation and an understanding of the need to tackle complex issues of future workforce planning, and that is hugely important. We can do it; it is a difficult task, but through collaboration and bringing people together, it is something that we simply must do, so that we can have more and different, and we can be really future-focused and progressive in the way that we deliver health and care. It is all down to our workforce. So that is the huge opportunity, as we see it.

There are risks. For us, one risk is that too much bureaucracy and added layers of hoops will get in the way, and the other risk is that we have to work hard to make sure that we address culture and collaboration to make this truly successful.

Danny Mortimer: The opportunity, we believe—along with colleagues across the health service—is in clause 33, going further and deeper there in terms of the assessment of need, as well as an assessment or a description of

process. Clearly, what legislation cannot do is set out the kinds of behaviours that make that a well-informed and inclusive process. To reassure the Committee, though, what I do see is that the way of working we experienced during the development of this Bill, the way of working we are experiencing with Dr Evans in terms of the process she is leading at the moment—the long-term framework—is inclusive. It is trying to bring different voices in. Difficult decisions may well need to be made about prioritisation, and we understand that, but that is much easier to do and much easier to understand if it is based in that kind of process and behaviour. However, clearly, that is one of the risks.

As I have already said, we have had an increasingly centralised healthcare system over these last few years, and that is also one of the risks. If we stifle the local leadership and local innovation, and if we do not seek that local input in terms of how the development of local services needs to inform, in particular, the long-term planning for workforce, then that is a real risk for the legislation.

Q19 Edward Argar: Thank you. One final question from me, if I may, Mrs Murray. I think it was Dr Mortimer who touched on a couple of points in his comments. One was that the way it is envisaged that this will be implemented would minimise any impact or burden, as it were, on the system, and I think that both witnesses touched on the learnings from the pandemic—the opportunity to build on what was done during that. To what extent, or not, would the witnesses consider that this is the right time to be doing this?

Dr Navina Evans: We in HEE think this is absolutely the right time to be doing this. We are at a moment where we have a lot of learning from what we have been through this last year. We have a real opportunity where many different pieces around innovation and improvement are coming together, and we have learned a lot from our previous experience of delivering the Health and Care Bill. For us, we think that this is absolutely the right moment to be doing this work.

Danny Mortimer: We would agree. NHS Confederation members were clear about the need for this approach before the pandemic, and I think that is even more pressing because of the pandemic. Actually, given the announcements that the Prime Minister is expected to make later today, it reinforces that need to better integrate health and social care, so the timing is very good.

Edward Argar: Thank you both. Thank you, Mrs Murray.

The Chair: Thank you, Minister. As there are no further questions from Members, I thank the witnesses for their evidence. We will now move on to the next panel.

Examination of Witnesses

Amanda Pritchard and Mark Cubbon gave evidence.

10.30 am

The Chair: We will now hear from Amanda Pritchard, the chief executive of NHS England, and Mark Cubbon, the chief operating officer of NHS England and NHS Improvement. Both witnesses are appearing via Zoom, and we will run this session until 11.25 am. Could the witnesses please introduce themselves for the record?

Amanda Pritchard: Good morning. I am Amanda Pritchard, the chief executive of NHS England.

Mark Cubbon: Good morning. My name is Mark Cubbon, and I am the interim chief operating officer at NHS England and NHS Improvement.

The Chair: Thank you very much.

Q20 Karin Smyth: Welcome to our witnesses. Ms Pritchard, welcome to your new role.

We have just heard some interesting evidence, and I want us to be very specific about our terminology when we refer to integrated care systems, integrated care partnerships and the integrated care board. In your view, who is accountable for the spending in my local area under the new arrangements? Approximately £1.5 billion is spent in the local area. In the new system, who is accountable for that spend?

Amanda Pritchard: Thank you. If I start, Mark can come in and add. In the new proposals, the integrated care board carries the statutory responsibility, on behalf of the NHS, for the allocation of spending, performance management and the delivery of NHS services within the system. That, of course, has a delegated set of responsibilities, as per the current commissioning arrangements, down to individual organisations—be they groups of GPs, hospitals or community services—for the spend within those organisations, but the accountable part of the system is the integrated care board. As the proposals set out, it has a very important relationship with the integrated care partnership, but without the line accountability for the funding flowing through that part of the structure.

Q21 Karin Smyth: That is really helpful and very clear. The chief executive and the finance director of the integrated care board are clearly accountable. To whom are they accountable?

Amanda Pritchard: In the current structure, they are accountable through the NHS—sorry, not the current structure, because you are talking about the future structure. In the proposed future structure, they would be accountable to a combined NHS England and NHS Improvement structure. At the moment, we operate that through seven regions, and then through to the national NHSEI executive. We are, in turn, accountable to Parliament.

Q22 Karin Smyth: So when I have an issue that I want to bring to my local integrated care board's finance director and chief executive, I will take it through to NHS England and then back to Parliament, of which I am obviously a Member. At what stage does the Secretary of State get involved with my issue?

Amanda Pritchard: We have a clear accountability to Parliament through the Secretary of State in the current structure, and the Bill is not proposing that that will change. The other thing that we should say is that CCGs have a clear accountability to involve the public and patients in their decision making. Again, in the current proposals, that responsibility would transfer through to the new integrated care system, and particularly the integrated care board. While we just talked about formal line accountability, that does not detract from the clear expectation that flows through, that the integrated

care board would have accountability to involve the public and to consult with them. The transparency that is expected now of the CCGs and NHS organisations is written into the expectations and would flow through to the expectations of the new integrated care boards.

Q23 Karin Smyth: Can I ask about clause 20, which is about externally financed development agreements? In your view, is there a role in that clause to develop primary care and community estate? I am particularly interested in whether that provides the ability to continue the LIFT arrangements that were undertaken by primary care trusts but not by CCGs.

Amanda Pritchard: I do not believe, although I may ask Mark to come in on the detail, that there is any proposed change to those arrangements. Mark, would you like to pick this one up?

Mark Cubbon: Thank you, Amanda. I am not aware that there is any significant change proposed by the Bill to the arrangements in place at the moment.

Q24 Karin Smyth: So how do we, in the system, ensure the development of primary and community estate? Are we in the queue with the Treasury, behind the 40 or whatever hospitals? Is there any way in which we can develop primary and community estate within the scope of the Bill? If we cannot do that through the Bill, how do we do it?

Amanda Pritchard: I will give you a headline answer, because I think this is really important. Part of what we would welcome in the Bill is that, by working as a system, one of the things that all partners will want to do is to come round the table together to make some of those important decisions about where the investment goes. In particular, if we are thinking about capital, I know there are examples already of where organisations have chosen to invest in community estate, additional diagnostics facilities or other parts of primary care estate. In fact, Mark and I were on a visit a few weeks ago to an ICS where they were telling us about some of the work they have done on that.

Moving to looking at system funding envelopes, particularly around capital, allows much more flexibility about how some of that resource is used in the interests of the whole population and the whole health system, rather than, at the moment, where putting things into slightly more siloed funding arrangements can end up being detrimental to certain parts of the system.

That comes back to some of the guiding principles of why the NHS has welcomed, certainly, the thrust of these proposals where integrated care is concerned, because it is all about building on some of the direction of travel that has been in the NHS for some time about trying to work much more collaboratively together. This helps remove some of the barriers that currently exist, for local systems to do that.

Q25 Karin Smyth: Just to be clear, where would this capital come into the system? Presumably it would come to the ICB, as the accountable body. Where would the capital separately come from?

Amanda Pritchard: Through the existing capital allocation processes. Rather than just going to each individual organisation to then make their own decisions about how they spend it, it would now go through the ICB, so there is a process that allows consideration in the round of how the system spends that money most effectively on behalf of its entire population.

The Chair: Thank you. We now go to Jo Gideon.

Q26 Jo Gideon (Stoke-on-Trent Central) (Con): Thank you, Chair. I would like to expand on the previous questions. It is my understanding that the integrated cared boards are the accountable bodies when the funds come in. But is the spending—the actual allocation funds—to be delegated down to integrated care partnerships, or is that at the discretion of individual integrated care boards?

Amanda Pritchard: Again, I will ask Mark to add to this if he would like to. At the moment, the proposal is that funding would go formally through the integrated care board. The expectation is that, in developing the constitution and the detailed ways of working for each integrated care board, they would describe how the decision making is done, at not just the ICB level, but the place level, with the expectation that part of the principle would be subsidiarity.

If you are looking at the most sensible place for making decisions, for big, strategic investment the oversight of the overall allocative decision making may well sit best at ICB level; if you are talking about something that might have more of a borough footprint—thinking about London—you would want a lot of the decisions about local services, community primary care services and capital decision making to support those local initiatives to be made there. There would be a number of layers within the ICB involved in that decision making, but ultimate accountability would sit with the ICB itself.

Mark Cubbon: The only thing I would add is that this is essentially why we are bringing leaders together to form the ICS body. The key thing will be how the resources allocated to that ICS can be deployed in such a way that strategic objectives can be delivered. The allocation down to place, as you have said, is important so that decision making can be as local as possible to where the service is, so clinicians and frontline staff can make the changes they want in order to deliver improved outcomes for their patients.

Q27 Jo Gideon: If I understand you correctly, place sits within the partnership rather than the board? I know the design has been about flexibility for each local board and partnership, to involve as many people as is relevant for local priorities. Do you think there is a tension about who sits on which, and what level of clinical representation do you think should be specified on boards?

Amanda Pritchard: I will start off, but Mark has led the work for NHS England and NHS Improvement on developing guidance to support local systems exactly in the area you ask about, on how to bring this to life and plan now for what we hope will be legislation coming into effect in April '22. I do not want to steal his thunder on any of this.

One thing we warmly welcomed in the proposed legislation, and something we have heard about time and time again from our key stakeholders, is the flexibility. There is a minimum mandated legal set of requirements

and structures, but, as you say, also an expectation that local systems will develop for themselves the structures and ways of working that make most sense for them. This is an obvious point, but what will work in Devon will by necessity look quite different from what you would want to put in place in somewhere such as Greater Manchester.

On behalf of our stakeholders, we have already welcomed the flexibility around that that has been described, but we have rightly said that, in addition to the suggested roles written into the legislation, there are some roles we would expect to see included on boards—we describe this as "mandatory guidance". We have used that partly as an opportunity to pick up on exactly the point you make about clinical leadership and clinical representation. As a national health service, it is clearly right that we ensure that we have that strength of clinical voice.

At the moment, the mandatory guidance describes the need for a medical director and a director of nursing in addition to the expectation written into the legislation, which is that there would already be a representative from primary care as part of that ICB. Mark, you have done all the work thinking about how this is going to work in practice; do you want to pick up on that?

Mark Cubbon: Right at the core of the new working arrangements, we believe that clinical decision making and clinical input and engagement are an essential part of how the new arrangements will be put in place, so that frontline clinicians can shape how services should look and be involved in the planning and delivery of those services. In the guidance that we have put out, we are leaving a lot of flexibility for the ICB to bring in the appropriate number of clinical professionals to support those endeavours, and that is in the shaping of services, the planning and the execution of plans to deliver them.

While we talk a lot about doctors and nurses, there are 14 other allied health professions, and it is quite difficult to allow everyone to have a seat around the top table. We are strongly encouraging all ICBs to ensure that they have the right level of engagement and the right forum in place to ensure that the voices of all those professionals can be incorporated in the development of plans to deliver better services for patients and improve outcomes for members of the community. That is what we are asking all the organisations to do, and it has all been built on evidence that we have gathered from the clinical community over quite an extensive period of engagement. In fact, we published the guidance that Amanda referenced only last week, and it refers to the importance of clinical leadership at all levels: where the services are delivered at place; where services are planned for more local arrangements in the way that we have described; and then sitting more strategically at the ICS board as well.

The Chair: Thank you. I call Dr James Davies.

Q28 Dr James Davies: Thank you, Mrs Murray. To follow on from the discussion about special interest groups and particular clinicians on the ICS boards, are you saying, therefore, that you do not think the legislation should specify, for instance, that there is a representative for mental health in relation to children, or in relation to social care? How do we explain to the representatives of those very important subject areas that it is down to local flexibility? What happens if local flexibility results in a lack of attention to those issues?

Amanda Pritchard: On a positive, it is great that so many people want a seat on the boards, because I think that actually shows the level of engagement in ICSs. In practice, this is a very organic development from where the NHS has been since 2016, when we first started talking about STPs, as they were known then. This has been very pragmatic, bottom-up and testing as we go, and it now feels as though it is very much with the grain of where the NHS is.

I am not surprised, but I am really pleased, that so many different groups want to be involved. The balance that Mark has just described, which I think the legislation gets right at the moment, is in recognising that to be functional, we have to have the right number of people around the table. At one point we added up how many there would be if you allowed everybody who wanted one a formal seat at the table, and I think Cheshire and Merseyside ended up with 63 people who would be formal members of the board. That is completely unworkable.

It is about trying to find a balance that says, "Let's be clear what you must have. Let's use the opportunity that we have through NHSEI to introduce both mandatory guidance—things that people have to do—and guidance that sets out what we would consider to be best practice." We have been very clear about, for example, the need to have arrangements in place to hear from all those terribly important stakeholders, and indeed for some of the duties, as I have mentioned already, that CCGs continue to carry around engagement with patients and the public, which is the other critical voice that we do not want to lose in any of this. That is the right balance, because it allows us to use some of those tools to keep some safeguards in place to give some clear direction, but it does not try to end up with either a one-size-fits-all solution for ICBs or something that is just unworkable because of the scale.

Dr Davies: Thank you.

The Chair: Thank you. I believe Mr Edward Timpson indicated that he wanted to ask a question.

Q29 Edward Timpson: I did; thank you, Mrs Murray. I want to ask a brief question, if I may, about the proposed merger of NHS England and NHS Improvement. I assume, although I do not know, that this is part of the long-term plan that was set out by NHS England, but I hope it is a direction of travel that you are both comfortable with. Could you explain what you see as the practical benefits of the merger, in terms of both the working behind the scenes to ensure that we keep quality high in the health service and the experience of patients, who will be on the receiving end of those services?

Amanda Pritchard: This absolutely, again, falls into the category of formalising, in large parts, the way NHSEI already works, but removing some of the slightly more bureaucratic and legal barriers that we have in place at the moment. I came in two years ago as the chief executive of NHS Improvement and into Mark's role as the chief operating officer of NHS England at the same time. Certainly, my experience over the last two years has been that, in practice, NHSE and NHSI really do work, to all intents and purposes, as a single organisation—but, as I say, with some of the bureaucracy

that is still around that—and that has been absolutely essential over the last 18 months, particularly through the pandemic.

NHS leadership absolutely has to speak with one voice and has to be able to have consistent decision making. We have to have a way of managing, where this comes up, the tensions that sometimes arise between different parts of the system, but also leading in practice that integrated working and joined-up approach, right from the top. It was really only, I think, the 2012 Act that brought in the separation formally, legally, so in a sense what we are doing is stepping back to something that was always the way the NHS worked prior to that. As I say, we are really now just formalising the way things currently work, and have needed to work over the last 18 months or two years.

Edward Timpson: Thank you.

The Chair: Thank you. Now we will hear from Mr Chris Skidmore.

Q30 Chris Skidmore: I know we have spoken about the need for flexibility in the composition of ICBs and also their related duties. I wanted to ask, though, whether it would be helpful if there were greater clarity in the Bill on the role of universities when it comes to training and education. I would think I am the only person in Parliament who has been both a Health Minister and Universities Minister, and it was very clear to me, when dealing with healthcare education, that there was not the integration around higher education and health in the way ideally we should have set it out. The Bill provides an opportunity to perhaps rectify this.

Also, I wanted to ask for your views on the duties for the ICBs, particularly around research and innovation. It may be a terminology issue, but the duty to promote innovation and to promote research, through the ICBs, is only

"on matters relevant to the health service"

or

"in the provision of health services".

It does not cover the care system. I would have thought that when we look at the very definition of an integrated care board, it should actually be promoting research and also innovation when it comes to the care system, as well as health services. I would greatly appreciate your thoughts on that.

Amanda Pritchard: It is a very good reflection on the importance of education as one of the key partners that would absolutely come round the table. I think that is where the ICS structure really helps us as well, because it allows that broader partnership construct, including education and local authorities. I would say—again, from some of the visits I have done recently—that people are really clear about the importance of things such as housing as part of the partnership, as colleagues would expect. Lots of people with different perspectives and different important roles in the system absolutely need to come together around that broader ICS structure, I think, to really give us the maximum benefit from the legislation that is proposed.

To pick up specifically on education, you are right to say that there are two parts to it. Clearly, there is a role for education providers, whether that is schools, universities or other providers. Part of what we have written into the expectation of ICSs in this core role, which is about contributing to the broader economic and social inequalities agenda within their own area, speaks directly to that. That is as much about education, training and employment within health and care as it is, of course, about the wider economy. The NHS, as an anchor institution in many parts of the country, can be an important player in that as well; so it is very clearly our expectation that education will be a key partner in all those different ways.

On research and innovation, as you have rightly noted, there is again a carry-over from the CCG responsibilities, which carry over into integrated care. We have made it clear in guidance that we see this as a really critical opportunity. Certainly, that is not and should not be limited to health. However, again, we have seen during the pandemic in the last 18 months that the power of bench-to-bedside translational research could not have been clearer, as well as the opportunities now to write in, right from the start—certainly through what we have been doing on guidance—the expectation that that research would be strongly supported and encouraged by integrated care systems as they go forward. Again, that is absolutely with the grain of what the health service wants to do and intends to do. Mark, did you want to add to that?

Mark Cubbon: Just two key points. With universities, we would expect them to be heavily engaged at place level. We have recently published some guidance with the LGA, which considered how we get place-based activities and partnerships so that we have places thriving—the guidance is called "Thriving places". We also talk about the benefits of the university sector being involved with place-based arrangements, to do all the things that Amanda just set out.

Therefore, we certainly expect that local arrangements and local dialogue, co-ordination and planning around education for local communities can help with recruitment and the workforce contribution that it can make, but also for the betterment of the local community itself.

We would also expect, probably at partnership level, some university input, whether from an academic health science network or indeed colleagues at NIHR. We have recently been doing sessions with NIHR to talk about how to ensure that our clear ambition for this translational research and this health and care research can really be brought to the fore. It is a key pillar of activity that has seen us through some really difficult times during the pandemic and one that will also be essential as part of our recovery.

The Chair: Thank you. We now move to the shadow Minister, Mr Justin Madders, and Mr Alex Norris.

Q31 Justin Madders: Good morning and congratulations on your appointment, Ms Pritchard. Obviously, the NHS has got lots of challenges. Covid is still very much in play, and there are the waiting lists and the workforce crisis. To your mind, which is the biggest challenge that the NHS faces and how will it be addressed by this Bill?

Amanda Pritchard: One of the really important things in all of this, of course, is that we do not over-claim for what the Bill will achieve. If I look at what has happened in the NHS over the last 18 months to two years, it is absolutely clear to me that the ability to work together

has been critical to the ability of the country to respond to covid, and the opportunity now to strengthen those arrangements, write them into legislation and remove some of the barriers that exist will be an important factor in helping the health service now, in partnership with local government, education and others that we have talked about, absolutely to recover from the challenges of the last year and to continue to build on those really strong local arrangements that have been such a hallmark of the way that things have worked over the last couple of years.

But of course, that is only one part of what it will take for the NHS to respond to the challenges that we have at the moment. It is absolutely right that the NHS staff, who have worked so tirelessly over the past two years and of course beyond to look after what we now know are over 400,000 covid in-patients, get the backing and the funding they need, not just to deal with what is very much still with us, with covid in our hospitals and communities right now, but absolutely to make sure that we are as front-foot as possible in tackling the inevitable backlogs that have built up over the past couple of years.

There is a complex set of things. Workforce is critical: the support we give to the people who have already done so much for us—we continue to invest in them and support them, so that we have the right pipeline for new staff joining, the right skills and the right support. Then there is the funding that we need to do the work that we have, and the capital funding to invest in some of the transformation that has already begun and needs to continue. But also, I think the Bill provides us with the framework to continue to support that really powerful local joint working that we have seen over the last two years, and which we are already seeing really at the heart of the covid recovery within the NHS and more broadly.

Q32 Justin Madders: You touched on funding. You will obviously be aware of what NHS Providers and the NHS Confederation said last week about what might be required to address the operation backlog. Do you think that figure is about right?

Amanda Pritchard: It is worth saying that there are some big unknowns in the position at the moment. We just do not know, really, how covid is going to play out over the next few months and years. One of the things that colleagues have talked about, and are very aware of, is that a lot of people did not come forward for care over the past two years. One of the messages that I would like to give again is that, for anyone who is concerned about symptoms, the NHS is absolutely open for business. Please do come forward and seek diagnosis, treatment and support.

We do not know, as we sit here today with two big variables, quite how things are going to play out. What we can say for certain is that today we have over 6,000 people with covid in hospitals. It is costing the NHS more both to care for those patients safely, with all of the infection control arrangements that need to be in place—

The Chair: Thank you for that, but I just remind the shadow Minister to keep within the scope of the Bill.

Q33 Justin Madders: Of course. I was merely responding to the answer that was given. In terms of how the Bill is implemented, what would you say success will look like in five years' time?

Amanda Pritchard: Actually, in some ways that does link to what I was just saying, because—you would expect me to say this—just to reflect the reality of where we are now, covid is still with us, but we also have a real commitment and opportunity to lean in now to that recovery of routine services. I think success looks clearly like we now have the platform right to be able to continue to evidence that local partnership working is really making a difference. What does that mean? It means partnership in practice, both to deal with the current challenges that the NHS is facing and will continue to face, and to start to show that we can really eat into the backlog of routine care that we know is with us and make the commitment, which I know is felt so deeply across the NHS, to tackling inequalities and really trying to think about some of those long-term planning commitments that talked about prevention and outcomes.

We want to see progress against all those things, but we also want to continue to support local systems, as they have been all the way through, to partner together to continue to deliver things such as the vaccine programme in really innovative ways. For me, this is all about putting the NHS on a firmer statutory footing, whereby partnership becomes the way that we do things, building on what has happened over the last few years and removing any remaining barriers that we know exist and which stop us progressing with the really important job now of improving care for the population and for our patients.

Q34 Justin Madders: Could you just turn that around to the patient's experience? I know that there are so many different variables in this, but from a patient's perspective, how will the Bill improve their experience?

Amanda Pritchard: Thank you for that, because from the NHS perspective, the reason we have been supportive, particularly of the integration parts of the Bill, is that it is all about what it enables us to do for patients. Mark and I have done a lot over the last few weeks and months. We have seen so many examples in practice of where it is about the ability to work in partnership, whether that is about mental health crisis lines that are partly delivered through the voluntary sector, with a bit of funding from the NHS, but with support from specialists and mental health trusts as well as primary care. It is about coming together to create those sorts of innovative services, whether it is children's and young people's services, such as in south-east London, or whether it is in schools, picking up where children and families have medical and health problems. It is about linking them to the right support within local government, housing and so forth.

That is the sort of thing that we have seen develop over the last few years. As I say, it has been turbocharged through covid, but what we now want to do—this is the critical part of the legislation—is to make that easier. We want to make it the norm and allow people the right opportunities to come together and think about what their population needs and what will make services. It is back to the triple aim of improving the health of the population, the quality of care for patients and the sustainability of services. But ultimately, it is about being able to work together to set up those sorts of innovative arrangements, to see them embedded in practice and to see the NHS working in an integrated way around individuals as the norm. Let me bring in Mark, because this is absolutely his operational space.

Mark Cubbon: Thank you, Amanda. Going back to what patients can expect to see, I think they can expect our local integrated care systems to continue all the efforts to engage with our communities and talk about how we are planning to provide more joined-up care for our communities, because that is one of the key benefits that we will get from the new arrangements. There will be fewer hand-offs in care and fewer organisational boundaries for patients to bump into occasionally, so that we can have joined-up conversations and talk about how things are going to be better. Our local systems, leaders and clinicians will be better placed, so that we really face into and talk about how we will reduce the inequalities and deliver better outcomes. That engagement will be really important, and I think we will build on what works well at the moment and continue to make sure that the patient point is front and centre of all that we are trying to do. We have clinicians leading the charge, in terms of the delivery of those services.

Justin Madders: Is there time for a quick question?

The Chair: Absolutely.

Q35 Justin Madders: In terms of the reorganisation, we know that they always come with a price tag. Do you have a figure for how much the reorganisation that will follow, which is being undertaken as a result of the Bill, will cost the NHS?

Amanda Pritchard: Mark, do you want to pick this one up? I know you have been leading on this issue for us.

Mark Cubbon: I will indeed. This is definitely a different change from 2012, and probably different from any other changes that have been put in place in previous times as well. We are very much approaching this in the way that we have done. From the outset, we have given a clear message and reassurance to staff who are working in CCGs on job security, so that they know that almost all posts, and the individuals holding those posts, will transfer over to the new organisations. There are not big redundancy bills attached to these changes. We very much want to make sure that the job security is there and that the roles are transferred—

Q36 Justin Madders: Sorry to cut across you, Mark, but I am running up against time and do not want to upset the Chair. I was just looking for a figure. Do you have a figure for how much this is all costing?

Mark Cubbon: We do not have a figure for all the changes, but we know that the CCG cost envelope, which is attributed to every CCG as it stands at the moment, is the cost envelope that will be allocated to each of the ICSs as well. We are not expecting the running costs to be significantly different from those that we have for CCGs.

Justin Madders: Thank you.

Q37 Dr Whitford: Following on from Dr Davies's comments about the structure of the ICS board and the representation of some of the sectors, such as mental health, we have not talked much about the partnerships this morning, so could you explain what you think their role is? I know there are concerns about who will be represented on them, potential conflicts of interest—obviously, particularly around the lack of financial transparency if private providers are used—and some of the sectors, such as dentistry, community pharmacy, end of life and palliative care. People on the ground, at the frontline, are not sure who will represent them in either of those structures to ensure that that service is available for every community and that we do not end up with postcode prescribing. Will there be some guidance? How do you think that will work? I will start with Mark and then go to Amanda, because this is nuts and bolts.

Mark Cubbon: The ICB is essentially how the NHS leaders come together specifically to oversee how resources are allocated and how the NHS delivers its side of the bargain, in terms of how the rest of the ICS works and is able to support integration. The ICP—the partnership—is where we bring together other partners who will have a view, an input and a role to play in that integration agenda. That is essentially, at a very high level, the separation of the partnership and the ICB itself.

On how we get representative views from the whole breadth of the clinical community, again this was published in our guidance—we have further guidance that was published last week—which talks about the clinical community, based on all the engagement that has been done so far. The kind of arrangements that we are very likely to see are where we have clinical reference groups and clinical boards that start to shape all the representative views that give a holistic perspective on how services should be planned and how we should be delivering services for our patients and communities.

Although not every individual will have a seat around the board or partnership table, we are advising the boards and clinicians across the whole footprint to ensure there is deep-rooted engagement. We are trying to galvanise the clinical community and get consensus on the direction of travel in terms of how services should be delivered for patients to deliver better outcomes. That is what we are encouraging our local ICSs to do. We are giving as much guidance as possible, but it will be down to this local flexibility so that our clinicians locally can start to work out how they best come together to do all the things I just set out.

Q38 Dr Whitford: Obviously, there is quite a different balance, in both power and accountability, between the two organisations. Do you think there is an advantage in there being a split, or had you expected there to be a single body for each area making the decisions? That surprised some people when the Bill was published. Could you give just a brief answer on what you think about whether having one board or these two boards is an advantage or disadvantage? Amanda, you look like you want to come in on that.

Amanda Pritchard: I am happy to, and Mark may well want to add. You are absolutely right that when the NHS went out to consult as part of the exercise that we undertook back in February, we were describing a single board structure at that moment. It is a change that we proposed to Government on the back of the stakeholder feedback that we had, particularly from the LGA, which suggested the dual board structure, partly because it gives the real clarity, as we talked about earlier, about where the money flows and where the accountability for NHS service delivery sits. It therefore allows a wider partnership to play in, with a particular view to all the other aspects of population health and

the wider agenda. That is not where we started, but it is where we now feel very comfortable, in response to the strong stakeholder feedback.

Q39 Dr Whitford: The ICS board is very NHS, so how do we ensure that attention is paid to the strategy or the findings of the partnership, so that we do not end up with a very health model, when you are trying to get to a wellbeing model?

Amanda Pritchard: Again, you are absolutely right, and that is a risk, which is why we started where we did. What is now described—the requirement to have regard to and respond to that overarching strategy—is the safeguard that means you cannot have the NHS in any way separated from that broader ICS structure, and from that wider strategy for which the partnership will be responsible. As we have discussed, I am not expecting that that will necessarily be the only way in which wider partners are brought into the ICB, but the fact that there will be a local government seat on the ICB is another important way that stops the NHS just working on its own.

Q40 Dr Whitford: And you think "with regard to" is sufficiently strong to ensure that that happens?

Amanda Pritchard: It has quite a specific, technical meaning, so from our point of view we would understand that to be a very clear direction.

Q41 Dr Whitford: Okay. That's fine. In one of your earlier answers, you talked about improving clinical quality, which obviously goes along with patient safety, both of which were my background when I was in the NHS. But that is still going to involve procurement and a degree of financial competition. Something that has disappeared in England over the past decade is peer-reviewed audit of clinical quality outcomes, which is the outcome for patients. With the title NHS Improvement—and it did surprise me when I came to this place that that is not what it is about—how do you think that will come back, because it should not just be about money; it has to be about achieving better clinical outcomes? I understand that the report on breast cancer, "Getting it Right First Time", has still not been published, even though it was ready in December 2019. Having led on this kind of thing in Scotland, how are you going to drive clinical quality for patients? I will start with you, Amanda, and then go to Mark quickly.

Amanda Pritchard: I might let Mark come in on this, because it is something that we have thought a lot about. You are absolutely right that the purpose of all of this is to make sure that we are improving care and services to patients, but with regard to that triple A, it is also of course about the sustainability of services and the broader population health challenge. Part of the structure that the Bill will allow us to put in place on things such as the provider collaboratives absolutely begins to put back firmly at the core of how we do our business procedures such as the clinical peer review.

We have now got the data through things such as GIRFT, which means that we can incorporate it formally in a structure that brings together the providers and also crosses pathways, so that we are not dealing with acute on its own, or with mental health or primary care on its own. We can then look at each against best practice and see how different parts of the system are performing, assess some of the challenges and collectively think about how to come together to secure improvement. That is already happening, but the Bill will allow us to make that much more at the core of how the systems approach local improvement. Mark, would you like to add to that?

Q42 Dr Whitford: Just before we go to Mark, would you see a re-emergence of national quality audits such as for certain cancers, which have been largely lost in England over the past 10 years? Would you hope that they would return?

Amanda Pritchard: Yes. There is still a huge amount of national audit work that does take place. Thank you for mentioning GIRFT, because we do have some other really important improvement programmes that are very data driven, which have an important place in this conversation. We certainly see the proposed legislative changes as a real opportunity to bake that way of working in, not just nationally but through systems coming together to do it as part of their local activity as well.

Dr Whitford: Mark, do you have anything to add very briefly?

Mark Cubbon: One of the major changes is a move away from competition to much more collaboration, and that is one of the things that the Bill sets out. That is what we believe in and what people are looking for, from what we hear from the service. With that collaboration what we start to see is much more accessible input from people and organisations, so that we can share and learn from each other and start to instil the best practice that we see in one part of an ICS, and have the opportunity to discuss that and see how it can benefit other parts of the ICS, and so reduce variation and deliver much more consistent care to patients.

Before I started my job at NHSEI, I was chief executive of an acute hospital on the south coast. While there have always been opportunities for colleagues to come together and discuss how best to approach a challenge, and to ensure opportunities for sharing good practice and learning from each other, the Bill starts to take down barriers and is much more enabling than what came before. Yes, of course clinicians have informal ways of coming together to look at how changes can benefit patients, but these structures are intended to allow a much greater exchange of ideas, which will be of great benefit to patients; hopefully we can start to implement those ideas at greater speed.

The Chair: Before I call the Minister, I remind Members that there will be a hard stop at 11.25 am. If witnesses could keep their answers as brief as possible, it would be much appreciated.

Q43 Edward Argar: Thank you, Mrs Murray. I will try to rattle through three quick questions. I think this is my first public opportunity to put on record, as the shadow Minister did, my congratulations to you, Amanda, on your appointment.

If I recall correctly, your predecessor, now Lord Stevens, says that about 85% of provisions in the Bill were things that the NHS asked for in its 2019 consultation. Do you

recognise that figure, and how would you characterise the approach that has been adopted to the development of the Bill?

Amanda Pritchard: Thank you. I would struggle to give an exact percentage, but the Bill certainly contains widely supported proposals for integrated care. We have been working very closely with our stakeholders, colleagues across the system, you and others to ensure, as far as possible, the same approach to consultation, listening and hearing. You cannot please everybody all the time, but we want to reflect what feels genuinely like a consensus view about what will best help the NHS deliver on all the challenges we have discussed. That is reflected in the Bill, so thank you for that. As it goes through Parliament, we very much want to continue to see that spirit of joint working, consensus building and engagement, so that when it hopefully becomes legislation in April '22, it lands with all the support that I think it currently has.

Q44 Edward Argar: I will confine myself to one more question, Mrs Murray, to make sure that we do not run up against the time limit. This question has been asked of other witnesses, and I suspect it will be asked of others. To what extent is this the right time to make these changes?

Amanda Pritchard: As I said, I genuinely think that our experience across covid has strengthened the argument for moving to legislation now, because our way of working in the past two years has been characterised by integration and partnership, and that is how the NHS and partners need and want to work—now and as we head into next year, facing that set of challenges that people are so very committed to continuing to tackle together. Yes, Minister, I think this is an important Bill. The integration agenda is not the whole answer, but it is an important component of it, and the sooner it comes, the better.

Q45 Edward Argar: Mark, in the minute or so before Mrs Murray closes the proceedings, is there anything you want to add on those two questions?

Mark Cubbon: All I would say is that collaboration and partnership work is a key feature of our response to covid. It is ever more critical, in the light of the question of how we will approach our recovery. Fantastic working has been enabled locally through necessity; now, we hear from the whole service that we want to build on that. We look forward to the future with that in mind; the Bill allows us to do that.

The Chair: As there are no further questions, I thank the witnesses for their evidence. That brings us to the end of our morning sitting. The Committee will meet again at 2 pm in this room to take further evidence.

Ordered,

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

11.25 am

Adjourned till this day at Two o'clock.