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Public Bill Committee

HEALTH AND CARE BILL

Fourth Sitting

Thursday 9 September 2021

(Afternoon)

CONTENTS

Examination of witnesses.
Adjourned till Tuesday 14 September at twenty-five minutes past
Nine o'clock.
Written evidence reported to the House.

No proofs can be supplied. Corrections that Members suggest for the final version of the report should be clearly marked in a copy of the report—not telephoned—and must be received in the Editor’s Room, House of Commons,

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Monday 13 September 2021

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The Committee consisted of the following Members:

Chairs: † STEVE McCABE, MRS SHERYLL MURRAY

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

Witnesses

Richard Murray, Chief Executive, The King's Fund

Nick Timmins, Senior Fellow, Policy, The King's Fund

Nigel Edwards, Chief Executive, Nuffield Trust

Dame Gill Morgan, Chair, Gloucestershire Integrated Care System and NHS Confederation's ICS Network Advisorate

Louise Patten, ICS Network Lead, NHS Confederation's ICS Network Advisorate

Ed Hammond, Deputy Chief Executive, Centre For Governance and Scrutiny

Andy Bell, Deputy Chief Executive, Centre for Mental Health

Sir Robert Francis QC, Chair, Healthwatch England

Stephen Chandler, President, Association of Directors of Adult Social Services (ADASS)

Gerry Nosowska, Chair British Association of Social Workers

Public Bill Committee

Thursday 9 September 2021

(Afternoon)

[STEVE McCABE *in the Chair*]

Health and Care Bill

Examination of Witnesses

Richard Murray, Nick Timmins and Nigel Edwards gave evidence.

2.1 pm

The Chair: We are going to hear from Richard Murray, chief executive of the King's Fund, Nick Timmins, senior fellow, policy, at the King's Fund, and Nigel Edwards, chief executive of the Nuffield Trust. Thank you very much for coming. Could I ask each of you in turn to introduce yourself for the record?

Nigel Edwards: I am Nigel Edwards. As previously stated, I am the chief executive of the Nuffield Trust.

Nick Timmins: I am Nick Timmins, a senior fellow at the King's Fund.

Richard Murray: I am Richard Murray, chief executive of the King's Fund.

Q155 Edward Timpson (Eddisbury) (Con): Good afternoon, Mr McCabe, and good afternoon to each of our witnesses. I am Edward Timpson, the MP for Eddisbury, in Cheshire. I want to start by contextualising the discussion about the Bill, particularly off the back of the pandemic and with regard to the timing of the Bill and the issues that it is trying to resolve, which perhaps have been highlighted even more by the demands and pressures that have come through over the last 18 months. Do you think that this is the right time to be taking forward the principal measures in the Bill, particularly around moving from competition to a more collaborative approach and the integration that it is looking to achieve through many of the measures that we have seen with the integrated care system, board, partnership and so on? I will start with you, Richard, and then we will move along the panel.

Richard Murray: There is obviously a risk with any large-scale transformations, and particularly ones in the NHS, that they will cause too much disruption, and they distract people from the day job. I think that is the clear case against. If I may, I will just say a few words, though, on the case for. The existing system already causes disruption, so there are complicated workarounds; there are procurements being done that do not really need to be done. I would not underestimate the fact that there is a headwind in the system from trying to apply the 2012 legislation. There was a real head of steam, coming through covid, of people working together, trying to make this system work, still having to deal with some of those workarounds and still having to deal, sometimes, with doing things in an emergency that you probably would not be able to do in peacetime, so to speak.

The key thing is to try to keep the disruption to a minimum—wherever possible, and particularly for staff, to keep that degree of unnecessary churn down. I have to say, unfortunately, the NHS is quite good at doing large-scale churn without too much benefit. But I think on balance that as these changes are already under way and there are problems with the previous system, stopping now would be more disruptive than simply carrying on.

Nick Timmins: I do not want to take up a lot of time. I particularly agree with that last remark: stopping now would be worse than carrying on. A lot of this is already happening. We have been merging clinical commissioning groups ever since the new system came in in 2012. It is sort of completing a journey. You may not be entirely happy about all the arrangements around the different sorts of board and what have you, but to stop now, I think, would be not sensible.

Q156 Edward Timpson: So it is a natural progression from what is happening practically.

Nick Timmins: In large measure.

Nigel Edwards: I do not have anything to add, given the time. I agree with everything that has been said.

Q157 Mary Robinson (Cheadle) (Con): Do you have any thoughts on the new HSSIB and its powers, which are set out in the Bill? I know that you are likely to be probed further on this later, but do you have any thoughts on how it will be implemented, the investigatory powers it will have and the safe spaces and protections it can give? Do you have a view on how it will sit with existing legislation on the protection of whistleblowers?

Richard Murray: I am afraid that is not an area we have focused on—sorry.

Nigel Edwards: Likewise.

Mary Robinson: Nice and easy—thank you.

Q158 Karin Smyth (Bristol South) (Lab): I have three obsessions with the Bill, some of which I have shared with you. First, on local governance and accountability, I have tabled an amendment to follow the logic of the Bill and make accountability local rather than going via some obscure route to the Secretary of State.

Secondly, there is the treatment of capital in the system and how local communities, healthcare systems and trusts will be able to develop estates and capital planning. The third obsession has completely eluded me for the moment. It is generally about the tariff—that may be your subject, Mr Edwards—and how the vague nod to a new tariff framework in the Bill is working out. You may be more privy than the Committee to the details on how that might work out; it is about the flow of money within the system. Would you like to start, Mr Edwards, on governance, tariff and capital?

Nigel Edwards: Richard may be able to give a more up-to-date account on capital. You will be aware that the mechanisms for the allocation of capital in the NHS are a little arcane and somewhat out of date. There have been various attempts to update the mechanisms. Richard has been looking at this and can perhaps tell us more, but my impression is that it will flow following the allocation formula for revenue. There will still need to be a tariff. Despite the fact that there is integration, a

tariff allows you do to a number of useful things. Certainly, patients will flow between different ICSs, so there will need to be a mechanism to account for that. It is also quite a useful budgetary tool, so in terms of financial control, it is probably quite important that the tariff is maintained.

We have been promised guidance on the flow of funds more locally, but we have not yet seen it. My presumption is that there will be a negotiated process rather than just a straight use of the tariff in the way that we have seen up until now, with variations on block contracts, maybe using the tariff—or, more likely, the historical budgets—as the starting point. The business-as-usual capital, as opposed to major capital projects, remains as it always has been. Although it is subject to some review, at the moment I do not think a major change is proposed for it, but Richard probably knows better.

Nick Timmins: I have nothing particular to say about capital. I do think you need to retain a tariff—not for everything, because in some areas of healthcare it just does not work, but for electives and those sorts of procedures. That has two advantages: it means you need to understand your costs to construct the tariff in the first place so it is a driver of efficiency, and, equally importantly, it gives you a benchmark price with which to negotiate with the private sector whenever you do outsource some operations and procedures. You are able to say, “This is what it costs us, so this is what we’ll pay you.” If you do not have that, you are subject to a seller’s market and can be charged what you like because you do not know what your own costs are.

Richard Murray: On the flow of money, we are expecting revenue allocation to ICSs based on the current formula, trying to reflect need, inequalities, deprivation and age. The uncertainty is then how much those ICBs will allocate down to place level on a local government footprint. The expectation is that quite a large proportion of that funding—general practice, community services, quite a lot of mental health, and some acute services, too—will go down to that level, but none of that is in the Bill. The allocation to ICSs stops at that point, and as has been said, you need a payment mechanism to get the money off what are, effectively, commissioners and over into providers.

The changes to tariff are mostly about flexibility, so it should still be transparent; you should still be able to work out what people are being paid, which I think is important, and you should be able to benchmark between different providers, but instead of paying for each operation and each widget bit by bit, you can have formulas that try to reflect fixed costs. You can do it in a different way that adds some flexibility into the system, which I think is important when you are trying to bring providers and commissioners into common alignment over where the money is going. Tariffs had the problem of setting them at each other’s throats sometimes, because every time someone was admitted to a hospital you would get another payment, so commissioners wanted to keep it down and providers wanted to keep it up. There is the chance to try to align some of those incentives, but there is still a lot of gap around what actually will go down to place and what will determine it; of course, again, the budgets need to be equitable.

Nigel Edwards: Richard, if I may, I think a very important point that ought to be made here is that because the allocations will now shift from 100-plus

clinical commissioning groups to 42 ICSs, the variations between them will be evened out. There will need to be some way of recognising the fact that within an ICS, you have very different patterns of need, which at the moment are recognised by the allocation formula, but in the future will not be. The money will be received by the ICS, so I think there is a question there. I know that local authorities—and, indeed, GPs and primary care networks—will want to say, “If we are in a particularly deprived area and we have historically had higher funding to recognise that, we would expect that to continue.” There ought to be a line of sight from the national allocation formula based on need to the money that is received by our locality.

Sorry, Richard. I thought you made a really good point.

Richard Murray: That is absolutely all right. On capital, the Bill does not really change the way that capital works in this system. The only difference is the ability of the Department, through NHS England, to cap the spending of foundation trusts, which they have not been able to do in the past. There are some limits around them being able to do that, but it gives an additional lever at national level. Having said that, the way that capital is working in the system has changed fundamentally already: some capital goes through an allocation system, a bit like the revenue funding, and I am leading a review for NHS England now on how that money flows.

The bit that I think is really uncertain is how the big hospital schemes get picked. That is the bit that looks very different. Obviously, there is a manifesto commitment. There used to be a process by which it was determined whether providers could afford to repay—if they could do it through loans, or if there was a need system. That is now going off in a completely different place, and I think that is the bit that is not quite clear. How does that work within this system? Who gets to choose how those projects get picked, so to speak? That is the big change but, again, it is not actually in the Bill; it is being done under the existing rules.

Karin Smyth: But it all has to be in place by April.

The Chair: I am really sorry, Karin, but I think we have to move on, because we have about seven minutes left for Back Benchers, and three indicating. Jo Gideon.

Q159 Jo Gideon (Stoke-on-Trent Central) (Con): We have had a pretty large consensus across a large number of organisations that the Bill is welcome as an enabler. Also, earlier this morning, we had a comment that no Bill has ever changed people’s behaviour. To what extent do you think the Bill will enable people’s behaviour to change, in terms of how partners work together at a local level?

Richard Murray: It will certainly make it easier. You remove some of the unnecessary impediments that have got in people’s way and pushed them into complex workarounds. It creates a structure through ICBs and integrated care providers to bring people together, so in that sense, it enables these things and makes them easier. However, if I am honest, you could still have NHS England and the Department deciding to run everything through ICBs and making them behave an

awful lot like NHS bodies of the past. It enables those things, but the legislation by itself cannot prevent some of the older behaviours from living on. That is why implementation and what happens afterwards is critical, to try to ensure that it delivers on the things that I genuinely think it is trying to do. There is a heavy weight from the past of very centralised control that focuses very much on the independent republic of the NHS. That is the cultural issue that the people who will have to implement this will have to work against.

Q160 Jo Gideon: How might we implement the changes that you suggest?

Richard Murray: I would really ensure that local government is part of this. It is an independent voice, and has already been a useful counterweight to some of those centralising forces, as local government comes closer to the NHS. Ensure that people from the voluntary sector are there. They do not follow the orders that come out of NHS England, so you are putting people directly into the system who carry some of that independence and are looking out fundamentally to their local communities. That really is the strength of some of the ICP structures—that you have those people round the table and, indeed, some of them on the ICB itself. Really invest in that place-level work. That is where a lot of the excitement will come from working with local government, and again with the voluntary sector and primary care. Do not get too focused on the ICS as this interim middle step, because it is quite distant from where a lot of the action goes on.

Nigel Edwards: It is not just upper tier local authorities that have an important voice in this. I think that Richard is right: a lot of the most interesting and bigger changes are likely to happen at the place level. It is probably the case that quite a lot of legislation has not really affected how patients are cared for or how professionals work. In some senses, that is not a bad thing. I think this does remove some of the behavioural oddities of the hybrid market and other systems that we had.

It will introduce some other hazards, in particular—Richard sort of referred to this—the slight danger of ICSs becoming inward looking, and some organisations, and the independent and voluntary sector, being excluded and not feeling that they have a voice. The challenge that local authorities can bring to that will be important, as will behavioural change from NHS England and some of the regulatory machinery, but you cannot legislate for that. That is a cultural change that is probably beyond the scope even of legislators.

Nick Timmins: Yes, and you can see that in evidence that you have already heard about the construction of the board and the partnership. It seems clear to me—you have heard from the Local Government Association—that some local authorities were happy to join a single board and others felt that that was too much of a loss of sovereignty, which is why we have ended up with this slightly complicated system of an NHS board and a partnership board. Probably, in an ideal world, it would have been better if it was one, but you have to live with what people are prepared to do.

Q161 Dr James Davies (Vale of Clwyd) (Con): Nigel Edwards, you mentioned the word “reconfiguration” earlier. In an ideal situation, from your point of view,

how would you see a reconfiguration decision being reached, and how do you balance that with the need and expectation for ministerial accountability?

Nigel Edwards: The current system dates back to Andrew Lansley, who set up four tests. Do not ask me what they are. I can look them up, but I cannot remember them. However, they were good. They involved local people and clinical support. You had to make an evidence-based case. Then there was a process that involves local stakeholders, and then there was the opportunity for review by the Secretary of State and referral by local authorities and the independent reconfiguration panel, which has been a remarkably longstanding innovation, given the way that NHS organisations are formed and then abolished. It has done, I think, a very good job.

The current system seems to me to work quite well. The Secretary of State still has a say, particularly around controversial decisions, but they do not get sucked into every small reconfiguration and change. You also do not have a point where there is an opportunity for local participants to say, “I’m not going to contribute to this conversation any more. I’m going straight to the top,” and undermine people working together locally. I am of the view that the current system works quite well. I think we said to the previous Secretary of State, “You need to be really careful what you wish for. You may think that your intervention is going to help to move things along and improve innovation. It’s quite likely, from both previous experience and experience in other similar types of systems, to have the opposite effect.”

Richard Murray: I would not disagree with anything that Nigel said. Also, the clauses in the Bill as they stand at the moment are really, really unhelpful. There may be things you could do to make reconfiguration easier, but I think they would be working around the margins of what Nigel said. It would not be wholesale intervention without limit by Ministers in local decisions—that would mean any change, of any service, could go up to the Secretary of State. Also, if you need to make an emergency move for an operational reason, you would need to write to the Secretary of State in advance—you kind of think the clue is in the fact that it is an operational crisis. I think that the legislation as drafted would not give Ministers what they want, so I really think it is not helpful at all.

Nick Timmins: Can I just add to that? I think it is really dangerous for both Ministers and the NHS. Not many people know about the Independent Reconfiguration Panel. It has worked very well. It has dealt with about 80 controversial cases. It quite often suggests some amendment, and the Secretary of State does not have to take its advice, but the Secretary of State almost invariably does take its advice. I think that if we end up with lots and lots of reconfigurations hitting Ministers’ desks, Ministers will come to regret that. If you listen to the views of previous Secretaries of State, they almost always say, “It’s ludicrous we ended up having to make a decision about what was going to happen”—in Nether Wallop or wherever—which was the case before the Independent Reconfiguration Panel was around.

Q162 Chris Skidmore (Kingswood) (Con): I want to touch on the King’s Fund’s comments in its own white paper in which it welcomed the Bill’s removal of the “cumbersome competition rules” that were introduced in the 2012 Act; and to discuss some of the consequences

of competition and why it is welcome that we remove that; and to ask this question. Are there any unintended consequences from also introducing the duty on the triple aim in commissioning decisions?

Richard Murray: There are a couple of things around competition. Probably the most obvious one is that it never really worked. A lot of care, particularly urgent or emergency care, is not an area for choice in the first place, so you are already dealing with a fairly specific part of the health service and drawing an awful lot of attention into that one element of the service when a lot of the interest is in care for people with long-term conditions and how you stop overuse of A&E and emergency services. There are lots of examples of things, particularly uncertainty around competitive procurement. Commissioners were anxious about where they stood in law so they used, and probably overused, competitive procurement.

I know from speaking to some commissioners that they sometimes felt slightly powerless to influence the provider side so they would put it out to procurement instead. There was very little sign that all the effort and bureaucracy that went into that really did any good at all. Let us step away from that and enable more co-operative working, to try to get the kind of change that we need for long-term conditions, for the real health conditions that this country faces. I should say that a lot of the academic evidence has found no benefits of competition, so not only was it not a helpful thing, it just did not seem to work—probably reflecting the fact that we have such shortages in this country. Competition works only when there is a meaningful choice.

On the triple aim, you would not want the system to get tied up in a new round of bureaucracy, form filling and ticking boxes, to show that it has duly considered the triple aim. I think it is also important to make sure you do not lose the issue of inequalities from the triple aim. I would not want to exaggerate: does legislating a grand vision make people do things differently on the ground? I think it is helpful to remind NHS providers and others that absolutely they should be thinking about the quality of care; absolutely they should be thinking about value for money and making sure they are efficient. But they also have a duty to the health of the wider population. You can then, through that triple aim, bring the different parties in this system closer together, and I think that for some non-executive directors and for governors, it is quite helpful to know that they are all working in the same direction. So I would not exaggerate the kind of change it would bring, but I think it is a move in the right direction.

Nigel Edwards: Can we just nuance the competition point? Actually, there were two elements to the competition regime. One was the very formal going out to tender and big, bureaucratic procurements—often resulting in the reappointment of the previous provider at significant expense. But the other component was patient choice—for diagnostics, for maternity and for elective surgery. I think that dynamic has benefits. One of the slightly worrying things in some of the plans produced by the ICSs' predecessors—the STPs or strategic transformation partnerships—was a wish to “repatriate” work, as they called it, which meant to bring work back from providers outside their patch into their own. That was not necessarily a good thing; patients should have the opportunity to have a choice of provider and, particularly in the case of

specialised services, one would be concerned about people saying, “Let’s grow our own services locally,” rather than, “Let’s use centres of excellence.”

The maintenance of patient choice, and ensuring that ICSs do not act to limit patient choice, particularly for those patients living on their margins, is quite an important dynamic; almost all ICSs have borders with someone else, and patients naturally flow across them. People want to be able to make choices, because they have an existing relationship with a provider or because they have a relative who lives nearby and could care for them while they are there. There is international evidence that that dynamic has a beneficial effect on providers’ behaviour.

The Chair: I think we had better move on. Dr Whitford?

Q163 Dr Philippa Whitford (Central Ayrshire) (SNP): I will start with you, Richard, on tariffs. I have a background in the NHS. I and colleagues south of the border know of people doing outreach work from a hospital trust into a community. They developed services that were successful in reducing admissions, but sometimes the service was shut down precisely because the hospital’s income disappeared. I will come to your colleagues, but are you comfortable that the funding going into the ICB will give that integrated vision of how money is spent, to ensure that people who can be supported or treated by a community project do not end up in hospital just because that is the way the ICB generates money?

Richard Murray: That is a very fair point; it did create that tension within the system, because more activity was what made you successful and gave you your bank balance. The flexibilities that the Bill gives to step away from those more mechanistic tariffs that pay for activity should enable that, with two caveats. First, much of this will come in guidance from NHS England about exactly how this will work; there is clearly not enough detail in the Bill to do that, and why would there be? That still needs to be worked through.

Secondly, it is quite complicated to get right; this is a very difficult thing to do, and one of the pointers we see in some other countries, such as New Zealand, is a focus on everybody working together and not getting too caught up in trying to divide up the pie between competing parties. Again, that is where things such as the triple aim may help to keep people’s minds focused on the purpose, which is good quality care, value for money and a healthy population. There are more flexibilities in this system to do that, so that we do not get the kind of perverse incentives we have seen in the past.

Q164 Dr Whitford: Do you think there will be a friction where, say, a foundation trust has had good financial management and a budget that is not too bad is asked to work with one that has been struggling—particularly in social care, where we are looking for integration?

Richard Murray: I think there will need to be a change in culture here; it is almost inevitable that if you look within different ICSs, you will find extremely financially successful institutions next door to some that are deeply troubled and that are facing problems in community services, general practices and other services. There will be a need for a culture change, but one that does not lose sight of the fact that you want organisations

to be well run. You do not want to end up with some of the weaker organisations thinking, “I shall now pass this problem on to my big brother down the road who has very deep pockets.”

You need to try to maintain the right incentives and support for institutions to run themselves well, to keep the value-for-money element of the triple aim, while also being able to move money around the system without getting caught in silos such that the acute trust has all the money and mental health does not. We need to be able to begin to move money across those different boundaries, which the old financial system did not help us to do.

Q165 Dr Whitford: Obviously, the idea is that the ICBs would have that vision and power.

Richard Murray: You would hope that the ICBs would have that power and the ICPs would try to set the direction. For many of the really tricky pieces between community services, general practice and social care, it is probably more at place; the ICBs are often so big that they are unlikely to get directly involved in those decisions. They can set the framework and try to ensure that in some sense it is working as a whole, but many of those decisions will come down at place level.

Q166 Dr Whitford: Nick?

Nick Timmins: I have little to add. This is really an issue of behaviour, culture and financial flows. It is not something that the Bill can lay down or dictate.

Q167 Dr Whitford: But obviously the tariffs created some problems.

Nick Timmins: The tariffs definitely caused some problems. Changing the way the tariff is used is very important, but that does not mean that you should get rid of it entirely.

Dr Whitford: Nigel?

Nigel Edwards: I agree with all of that. This gives a vehicle that will allow many of those perverse incentives to be removed. People found ways of working round them previously, but this simplifies things. Richard made the point that it is definitely the case that some trusts, particularly acute trusts, have done very well out of the tariff. They will find it quite painful to make the adjustment, but that is not a reason for not making the change.

Q168 Dr Whitford: Perhaps I can start with you on this question. We obviously hear about the ICB, which appears to be the power base, and the ICP, which is more flexible and will put forward an agenda and an idea. How do you think the power balance or imbalance between those two is going to work?

Nigel Edwards: I have sat with a number of different geographies and tried to work that out, and it is probably going to be different in different places. Some of the ICSs are quite geographically coherent and have a lot to do with each other. For others, such as Cheshire and Merseyside or BOB—Buckinghamshire, Oxfordshire and Berkshire West—there is less in common at the strategic level. It will be quite different in different places, particularly where there are powerful upper-tier local authorities within ICSs. They will want to have a strong voice at the place level.

One of the virtues of the legislation as currently formulated is that it allows some flexibility, and it allows people to tailor some of those relationships to fit their local geographies. But I would see the partnership part of this having a very important role in shaping the overall strategy. For quite a lot of people, the risk is having too many meetings and too many partnerships. It is very important that the partnership board sets the agenda and then the places and the ICB get on with it.

Q169 Dr Whitford: So the challenge you see is more about things like footprints and boundaries making it clunky in some areas. It is about trying to get that right.

Nigel Edwards: Yes. The NHS has always had a bit of an obsession with neatness and uniformity. If there is one thing that I have learned from working with these different ICSs, it is that they are very different in terms of their physical, political and psychological geography. Trying to fit a standard model of governance to them would be a mistake. We need to hold them to account for how well they are implementing their plans and how far they are improving outcomes for their population. We need to know whether they are making the best of the money that we are giving them, rather than whether they are conforming to a centrally designed governance model that will work on average, and that will therefore work nowhere.

The Chair: I think we had better move on now. I call Justin Madders.

Q170 Justin Madders (Ellesmere Port and Neston) (Lab): Good afternoon, and thank you for coming today. You will have heard the Prime Minister’s statement on Tuesday. He referred to a White Paper on integration. As the Bill is primarily concerned with integration, perhaps you could save him some time by pointing out the deficiencies in the Bill—in terms of integration—that need to be included.

Nigel Edwards: This took us all somewhat by surprise, I think it is fair to say. Richard may have had a different briefing from the Department of Health and Social Care on yesterday’s announcement. I picked it up on reading the document; it was not pointed out to me. I think I read it slightly differently. It seemed to me that the plan was likely to be a formalisation of all the activities that are currently going on, rather than a new direction of policy, but I am probably the wrong person to be asking about that. If it is not that, it would not be very helpful.

Richard Murray: One of the things the documentation speaks about is the planning of the health and social care workforce. You asked where I think the Bill is deficient. One example is its inability to help with the very poor track record, over quite a long time, in planning the health and social care workforce—hence all the problems that we have with the workforce right now. There is a nod in the White Paper to that. It may only be that the crossover between those two workforces is not the fundamentals of the numbers that go through them.

Otherwise, I really hope that the White Paper is not about further legislative change. It might be about setting out, for example, the outcome measures that would really work for an ICS, meaning that it will cover

both critical issues for the NHS and critical issues for health, public health and social care, to make sure that you have that rounded and meaningful measure so you know who is doing well. If it is another round of legislation, I must admit that I would pause before saying whether that is a good idea, with the exception of the workforce issue, which remains the critical factor here.

Justin Madders: Anything to add, Nick?

Nick Timmins: The workforce does need to be tackled—it is just a glaring hole in all this. The NHS has plenty of policy at the moment; it has had an eight-year drive towards better integrated care—that is what the Bill is focused on—and a lot of that will not come through legislation, beyond what is in the Bill.

Q171 Justin Madders: Nigel, can I ask you a specific question about tracking where the money is distributed within an ICS, which you referred to earlier? You have already mentioned the Cheshire and Merseyside ICS, which my constituency falls within—what was 12 CCGs moved not so long ago into one massive beast, for want of a better description. If I wanted to hold someone to account on whether the money was distributed on a fair and equal basis consistent with historical distributions, who would I speak to and who would be responsible for that?

Nigel Edwards: Each ICS is supposed to have a chief finance officer—a director of finance—and an accountable officer. That is the starting point. I think the question to ask them would be to what extent they are spending money in a way that reduces health inequalities and improves outcomes in an equitable fashion—I think they would want to do that. One of the things that has very much struck me in my conversations with ICSs—this is very much influenced by local government, which will be a powerful advocate for this, as will primary care networks—is that quite a lot of people will be scrutinising this. The person to ask who is clearly accountable for answering that question is the accountable officer of the ICS.

Of course, ICSs do not have a legal obligation to distribute money below place level. You might not want to do that, because there is a need to be flexible, and sometimes you might want to spend more in a particular area if there is a sudden strategic priority, but over the long term, the expectation is that those accountable officers should be able to demonstrate that they are spending money in ways that relate to the objectively assessed needs of their populations.

Q172 Justin Madders: Thank you. I have a question for all three of you. The Secretary of State is seeking some quite broad powers of direction. What problem do you think he is trying to fix by giving himself those powers?

Nick Timmins: I think that is exactly the right question to ask. What have Ministers not been able to get the NHS to do without the powers of direction that he is seeking? When they were presented, it was as though the NHS was somehow unaccountable when, as I am sure you all know, Ministers can tell the NHS what to do through the mandate. The difference in the current system is that NHS England has to agree that what it is

being asked to do is reasonable. If NHS England does not think it is reasonable, resourceful or doable, it can object, and the Minister then has to come to Parliament and explain why he is, in effect, instructing the NHS to do something. A measure comes before you and is subject to a negative resolution. If someone rejects it, it can be debated, so there is a perfectly good mechanism there right now. I think the really, really important question is: what are Ministers not able to get the NHS to do that means that they now feel the need for new powers of direction?

Justin Madders: Does anyone wish to add to that?

Nigel Edwards: I have no answer to that question.

Richard Murray: If the reason is not made clear, you end up starting to get worried and suspicious: “Are they trying to direct money towards one part of the country rather than another and overturning the allocation mechanism? Do they want powers to intervene in procurements?” Those are all the things that you would not want them to do which, to be honest, health Ministers generally have not done anyway. Even when they had the powers, they tried desperately not to get involved, because it is extremely poor governance and extremely poor value for money. However, without that explanation of why they want it, the temptation is to start worrying about what they want the power for.

Some of the behaviours could be governed through the framework agreement, or they should be able to be. You have the mandate that sets direction over the short to medium term, but the framework agreement also sets out the way NHS England should work with other parts of the system, so there are other things that you can use within this system. As it stands, and if it stays as it is now, to provide comfort to people, the temptation is to start listing the things that Secretaries of State should not direct—they should not direct allocations to individual parts of the country; they should not interfere in procurement decisions. You end up with quite a long negative list, but I would probably rather have a negative list than no list.

Nigel Edwards: The problem with negative lists, of course, is that you will forget something.

The Chair: I had better move on at this stage. I am really sorry, Nigel. Minister?

Q173 The Minister for Health (Edward Argar): Thank you, Mr McCabe. I will only ask the one question, because I am conscious of time and keen that Opposition Front Benchers have their time. My question goes to the heart of this, and I am afraid it is a subjective question, but with all your expertise in this space, your answers will be instructive. In framing this legislation, we sought for it to be both evolutionary in reflecting the changes that are already under way, and permissive rather than prescriptive. Do you feel we have struck the right balance in terms of permissive versus prescriptive? If not, where is that balance missing? Shall we start with Nigel, and then work along?

Nigel Edwards: I think we have shared our anxieties about the reconfiguration and direction powers. In terms of what this does to the organisational architecture, it seems to me to strike the right balance between permissive and directive.

Nick Timmins: I would echo that. I have major reservations about the new powers of direction and, I think, major reservations if you build in reconfiguration service changes. The good thing about this—it has been the good thing about the development of the integrated care system so far—is that it is quite flexible. That is unusual in the NHS's history: we tend to come up with very prescriptive solutions for what the system should look like everywhere, when in practice the circumstances are different, so I think the balance is pretty good.

Richard Murray: You could easily criticise the degree of permissiveness; you could criticise the degree of direction in there. The question should be, “Can anyone come up with a better one?” We have not been able to do so, so I think it is a balance well drawn. Of course, a lot will then rest on the behaviours that are shown after the Bill is through—whether people live up to that kind of core belief around that permissiveness and the freedoms that have been given.

Edward Argar: Thank you all very much. No more questions, Mr McCabe.

The Chair: We have time to squeeze in one very quick one, if anyone has something else to ask.

Q174 Justin Madders: Thank you, Chair. Do you see any risks attached to the flexibility the Secretary of State has given himself with the mandates?

Richard Murray: I think a longer-term mandate is a better thing. The idea that each year, sometime between December and March, you can set a different expectation on the NHS is operationally unreal for the system. They cannot do it, so I think we want to get back to something where you set out a clearer medium-term objective for the things you want the NHS to achieve, whether that is reduced waiting times or better health, and allow them to try and work towards it.

Budgets on that basis would also be incredibly helpful—if you are working in the service not knowing what capital you might have two years down the line and what revenue you might have. I think there is a real chance to do that in the spending review. That is a move in the right direction; we just have to make sure that if the budgets are still set on an annual basis, you do not get a diversion between what it is you have been asked and the budget then being suddenly moved on that annual basis. I would strongly encourage the Government to also try and set multi-year settlements for the NHS, as used to be done, so that people can plan at local level.

Nick Timmins: If memory serves me right, the original idea of the mandate was a rolling three-year mandate. You set the objectives of the NHS and what you want it to achieve, and you can have a little review of it each year, but it is clear. I probably should have said that if the money was also planned on the same basis, that would help no end.

The Chair: That brings us to the end of our time. I thank our witnesses very much.

Examination of Witnesses

Dame Gill Morgan and Louise Patten gave evidence.

2.45 pm

Q175 The Chair: We will now hear from Dame Gill Morgan, the chair of Gloucestershire integrated care system and the NHS Confederation's ICS network advisorate, and Louise Patten, the ICS network lead for the NHS Confederation's ICS network advisorate. Thank you very much for coming. We have until 3.15 for this session. May I ask you both to introduce yourself for the record?

Dame Gill Morgan: I am Dame Gill Morgan. I am chair-designate of Gloucestershire ICS, but I have been involved there for over two years, so I have seen the development of this movement. I am now the elected chair of the terribly titled NHS Confederation advisorate. What is important about that is that it includes all the ICS chairs that have been and all the ICS people who have been acting in as accountable officers for the work that has developed thus far, so I think I bring a perspective on the reality of what people worry about.

I have been involved with health service Bills for well over 20 years. This one is an exemplar of how people can work with a service to develop a Bill that largely has the support of the system. People have engaged, listened, changed things and taken the frontline views seriously into account. We do not agree with everything, but you asked our think-tank group of people about some of the issues and changes and the permissive approach, and all those things are truly endorsed. For me, it has been the best experience in 25 years of involvement in healthcare. I want to have that noted because people worked really hard to do that.

In contextual terms, you have to realise that this is the first time the NHS has tried to do something fundamentally different. We always legislate for things that look the same—they quack the same, they walk the same, they waddle the same—yet systems and communities are fundamentally different. My ICS, which I am proud to be part of, has a population of about 600,000, and 15 other ICSs have populations of under 1 million. They have our characteristics of closeness of community and long-standing trust. On the other hand, there are some very big ICSs. What the Bill has done well thus far is to create a permissive environment that allows us to see how we can flourish as well as the big places. If you try to define it—

The Chair: I am sorry to interrupt you. This session is intended for Members to ask you questions rather than for you to make a statement. I would prefer to move to Louise Patten and ask her to introduce herself so that we can get on with the questions.

Louise Patten: Good afternoon everyone. My name is Louise Patten. I head up the ICS network and NHS clinical commissioners at the NHS Confederation. I am also a clinician.

The Chair: Thank you very much. I call Karin Smyth.

Q176 Karin Smyth: I broadly agree with the direction towards permissiveness and the logical direction of the Bill. I am profoundly disturbed, and most of the NHS representatives are making me feel more disturbed, about the lack of local accountability and scrutiny that local people will have of the power that we are giving, with due respect, to people such as you, designated

within and by the local health service to police and manage itself. In your drive for permissiveness and power within the system locally, how does a local patient hold you to account for, in my area's case, the £1.5 billion-worth of decisions that you are going to be making? How do we break the national power and make the local power better?

Dame Gill Morgan: What is different about this Bill is that it is the first time that local government will be very actively involved in those decisions. It has always been involved in scrutiny and big changes, but it will be heavily represented on our partnership board. We have four local government people, including two elected members on our ICB—integrated care board—so we are bringing in the local government elected people.

We intend our partnership board to meet in public and we are looking at exactly how many of our meetings of the ICB should be in public. Clearly, when talking about quality and clinical stuff, the actual deliberations need a private bit—[*Interruption.*] When talking about named individuals, yes, they do; but when talking about the quality of the service in general, that is something that needs to be clear and in the public domain. We need to get the balance right between what we need to do publicly and what we need to do privately—as we will, because we will have so much local government involvement, with elected members, as well as Healthwatch and other people like that. They are all intrinsic parts, in a way that they have never been before. It has never felt as engaging to me as it does now, certainly in my patch.

Louise Patten: From my point of view, having experienced health overview and scrutiny committees as an accountable officer, the patients and public certainly feel that there is the voice of that local place. It is important to NHS leaders that that continues—that ability to have local scrutiny at local level, which is very much where patients and service users feel is the right place to do it.

At the strategic level, we must not forget that ICSs comprise both the integrated care board and the partnership. This is a real opportunity to tether the NHS to always thinking about the wider determinants of health, social value, public health and, again, patient experience.

Q177 Edward Timpson: I am Edward Timpson, the MP for Eddisbury in Cheshire, so coming into the Cheshire and Merseyside ICS, which is a very different proposition from Gloucestershire's. In that context—it is encouraging to hear how engaged you feel in the process to date, so reflecting on that engagement—what do you think you have discovered already from the preliminary work in Gloucestershire? You have used that example in our evidence sessions. How has that helped to inform the way in which collaboration can best work, bearing in mind that there will be different political, social and economic geographies in each area? In doing so, where do you think clinical representation needs to fit within an ICS, or even within the ICP or the ICB, to ensure that the decisions made are the best for patients and their outcomes?

Dame Gill Morgan: Our big learning about all of this is that, at the end of the day, many of the structures do not matter; what matters is people being in the same room, having the conversation about common purpose, and getting to know and trust each other. The reflection on that has been why we now have such an emphasis on place. If you have a really large ICS and you are trying

to do it all, you are so distant from patients, citizens and clinicians that you will never have the contact. Place, in those bigger systems, has to be where you begin to pull those things together, by getting the right people to engage and developing the right level of trust.

As far as clinical engagement is concerned, the ICS is about three things—the triple aim, which is, basically, how do we get better health services today, which are responsive, high-quality and all those things we want; how in the long term do we create populations that are healthier than they are today, which means thinking about employment and all those bigger things; and, in the middle, how do we take services that we deliver today and transform them to be more community-orientated, better for citizens and delivered where people want them? In each of those three boxes, clinicians are absolutely fundamental.

A lot of our effort—in particular around covid and some of the successes—has been in getting that synergy, with clinicians in the transformation box feeling that they can not only write on what the hospital does, but define what the community does and what the GPs do, because they are all working collectively. That has been transformational. Certainly, we would not have managed covid as effectively as we have without those sorts of relationships running all the way through the system as a thread.

Louise Patten: The clinical leadership has to be multi-layered, right the way through from the strategic level to place. We have to have clinical advice and we must heed it when we are talking about planning clinical services. That is fundamental. I think it will involve different groups of people. If it is a care pathway about cardiovascular disease or a professional pathway about social care, we must heed clinical and professional advice when we are planning these services, so it is multi-layered.

Q178 Edward Timpson: All the way up to the board?

Louise Patten: From strategy right the way down to grassroots implementation.

Q179 Dr Whitford: In the morning sitting we heard from Professor Marshall, who was talking about your own ICS. I asked about the problem of the power imbalance between the partnership and the board, and he mentioned that you have a primary care sub-group. We have had a lot of discussion about how we gather the voices and ensure everyone is there. What led Gloucestershire to develop that? How do you feel it is working? Do you think that is a good model? How do you ensure the board listen to what the partnership come up with?

Dame Gill Morgan: It is about multi-layering of advice. We will have a primary care sub-committee partly because managing primary care, and all the things that come through GMS and the opportunities, is expert; we do not want it to be subsumed by a generalist groups. We want it to have proper focus, because if our vision of the future is right, we need better and more engaged primary care at local level that can link its services more effectively with support in the hospital and the community. That is the objective, so we will have that.

We will also have an ICB. GPs will have different views. That is one view, which is about me as a jobbing GP. I go in in the morning, and I do my work and all of

those things. I need to be supported to do that, but I also need GPs in the system who are engaged in management. We are very proud of our primary care networks, which are beginning to pull together around our localities, because we are smaller and it is not a big place.

There are models where they are working with second tier local government, where they are beginning to think about housing, and they are working with the voluntary sector, so when they are talking about frailty, it is not a GP or a hospital conversation; it is a system conversation in this place. All of a sudden there are things that can be unlocked. If we leave it in any one box, as we have always done in the past—there is a box for acute, for this and for that—we do not get this. Our task is to make those boundaries semi-permeable, with the expectation that we look at the patient flowing through all those boundaries, rather than pretending that patients sit in an individual box, because they do not.

Louise Patten: Frankly, stakeholders who are anxious about whether they have a place on the partnership board or the integrated care board need support in being helped to co-ordinate their response, so they have a collective voice. The variations for ICSs are huge, from a population of 600,000 right the way through to just upwards of 3 million. Supporting those stakeholders to have a united voice and providing assistance will be really helpful.

Q180 Alex Norris (Nottingham North) (Lab/Co-op): Thank you both for coming this afternoon. Dame Gill or Ms Patten—it is fairer to ask the question more generally—suppose the integrated care partnership itself put forward plans for the footprint. The integrated care board, under this draft legislation, has to pay due regard to that. If you disagreed with that as a board, how would you manage that? How would that be resolved? How would that manifest locally?

Dame Gill Morgan: The first thing is that you would try to make sure that you have developed a mechanism for engagement and trust, so that you do not get into those sorts of disagreements. If you get into those disagreements while you are sat around the board, you have failed to do the task of integration and partnership. That is what happens in the conversations about how we solve it. If we ever got into that sort of difficulty, it would have to be resolved at the integrated care board, and we will have local government, public health and social care on our board as full and equal partners.

Q181 Alex Norris: That is a very helpful answer, thank you. Obviously there would be old informal mechanism. From my time as chair of health and wellbeing in Nottingham, I remember that the best thing you could ever do was just phone someone up and talk about it. Beyond that, for systems that may not be advanced or relationships that may not yet be embedded, is there a good formal mechanism that we could be writing in to ensure that that existed?

Dame Gill Morgan: The more you try to write in legislation, the more it becomes the lowest common denominator and the less you unleash the innovation that you want. I would do something quite different. I would probably write something that requires the different

models of ICSs to be formally evaluated over a period of time, so for the first time we could look to structural change and say, “This is what it has demonstrated, not just against the outcome measures measured by the Department of Health and suchlike, but this has been a structural change that has added benefit, or not.” If you are going to do that, it must be done from day one. I think that is more important than trying to put something about solving problems in the Bill. You will never hit the particular strange circumstances of a locality that has problems, because they are always serendipitous.

Q182 Alex Norris: Louise, with your broader advisorate hat on, what do you feel about the selection of chairs and how we could get local voices into both the selection and—hopefully never needed—removal of chairs?

Louise Patten: The selection process for chairs and the executive team has got to be about what this integrated care system requires, what sort of leadership, and what are the partners that we have got. No two ICSs are the same. In order to achieve that, it needs to be a local discussion about what it is that this system needs to make sure it has the best leadership to take it forward. That will involve discussion with local people, local stakeholders and potentially the public to sort that, because the leadership will be different in different ICSs.

Q183 Alex Norris: You said, “What does the area require?”, so you would say that local people would have as good or a better understanding of that than, say, NHS England at the centre in Whitehall.

Louise Patten: The two will have a very good idea collectively about what leadership is required: one from experience of leaders and the other very much from the grassroots level of, “If this is our system, this is what we need.” It is a combination of the two.

Q184 Alex Norris: So in your modelling it would be a partnership of the two.

Louise Patten: It is both/and.

Q185 Edward Argar: I only have a couple of questions, Mr McCabe. I welcome the witnesses and thank them for their evidence so far. One question will be one that I have asked witnesses in previous sessions. We are seeking with this legislation to recognise the existing evolution of the system and the limitations of legislation in driving implementation and behaviours on the ground, as opposed to people finding their own ways of working within a framework. We have therefore focused on a permissive as opposed to a prescriptive approach. Do you believe that we have got the balance right in seeking a permissive framework rather than a prescriptive one? Are there any examples that you would add to what you have already said to illustrate your perspective on that?

Dame Gill Morgan: Yes, I think you have got the balance, and that is the joy of working with a Bill team. I think the balance is right. You have tried not to be prescriptive and tie our hands, but you have been clear in the sense of setting a direction and focus that we will all take into account, so you do not have to tell us things to make the NHS do it. We do it because we pick up the runes.

On the issues that we would be more concerned about, I personally am concerned about the ability of the Secretary of State to call in changes. In part that is because the one thing I think the NHS has learnt in the time that I was out and came back is how to do relatively good consultations. We have just finished a massive consultation. Patients have gone with us. The local communities have gone with us, mostly. We have had citizens juries and all sorts of things to reach a consensus about the direction of travel. The worst thing in the world would be that people say, “There is no point in engaging in those mechanisms locally because, at the end of the day, we will just complain to the Secretary of State and it will not happen.” If that becomes the way people manage that part of the Bill, it will take us backwards, not forwards, in terms of proper citizen engagement.

Louise Patten: On balance, it is about the Secretary of State’s powers of reconfiguration, and NHS leaders in general are concerned about that. It is not so much about the Secretary of State having an early understanding of the reconfigurations or the intent, but about the fact that that decision could be taken at a point where all the evidence is not ready to be properly considered.

Building on Gill’s point, patients and the public would be very frustrated if they felt that they had not had an opportunity to be answered, so we are asking, if not for the clause to be removed, for at least the clinical case for change to be considered from the ICB. Coming back to clinical decisions about clinical services, we want that accountability to local communities, not just up to Whitehall, and some transparency about why the decision was made, and on what basis and information it was taken.

Q186 Edward Argar: Thank you. My next question follows on from that, acknowledging that point about reconfiguration powers, and builds on your clear answer to Karin that you think that what is framed here strengthens local accountability and engagement, and relates to something that you may have mentioned earlier, Gill, in some of your answers. Do you think that it is the right approach, in terms of ICB membership and others, to set a de minimis core membership and then allow that local flexibility to reflect local needs, local accountability and local engagement, to expand it as the local system and local people feel appropriate? Do you think that strikes the right balance?

Dame Gill Morgan: I think you are absolutely right: de minimis. What I have argued throughout is that if the centre, if you and then NHS England, which issues guidance, are clear about the principle that we have a proper engagement mechanism with our local authorities and citizens, they need to ask us how we are doing that, and to ensure that our constitution meets that. There are plenty of checks to ensure that it happens without you telling us that we have to have this, this and this.

In our case, we will have mental health and social care around the table, not because we are told to but because we could not imagine how we could do our work at a local level without having those people feeling that they are full partners and sitting around the table. There is a set of concerns about having local government involved in making decisions about the expenditure of large amounts of NHS money. I do not care; they are the local people who need to be involved in the decision

making. Actually, if they see the deliberations and challenge first hand we will get better-aligned budgets. At the end of the day, that is to everybody’s benefit.

Louise Patten: There are already five mandated board positions in the legislation. A further five will be in the mandated guidance from NHS England. We are up to 10 already. I think the most important thing here is: where do you stop? There is a risk that there is a perception of two tiers—that those who have a mandated position on the board are of more importance than others. That flies in the face of partnership working.

Q187 Edward Argar: A final question, if time allows. I entirely take on board your point about the aim, the underlying point about implementation being key here—almost more so than the legislative framework—and the point about a single pot and sense of ownership. I remember the old section 75 of the National Health Service Act 2006, rather than the Health and Social Care Act 2012, being the mechanism that I used when I was a councillor to work with the primary care trust. It worked, but it was a bit clunky at times. My question is one that I have asked other witnesses, so I suspect that it will not come as a surprise to you. Do you think that this is the right time to be introducing these changes and legislation and, if not, when would be?

Dame Gill Morgan: My view is that we are where we are and we need to progress. Going backwards would be a problem, but actually I am a bit more positive than that. Covid has demonstrated to people that if they think innovatively, out of the box and in partnership ways they can get solutions that are quicker than they would have been before, so in the system as a whole there is a recognition that partnership has offered more. We will all retrench as the world moves on from where we are, but there is real learning from covid on which we can capitalise. Many systems have done reviews of what worked and why, looking for the silver linings in that learning. I think the Bill goes with the analyses that have come out.

Louise Patten: At the NHS Confederation, we have that sort of umbrella view. We must not forget that, on collaboration and integration, people have been working to this for some time. There are some great examples of it, and this legislation moves that opportunity to really accelerate it. People recognise that it is a tight timescale, but they are absolutely committed to doing it.

Edward Argar: Thank you both very much. No more questions, Mr McCabe.

The Chair: Dr Whitford, did you have anything else?

Q188 Dr Whitford: It was really just about other groups. You talked about having a primary care sub-group, and there has been a lot of discussion about how to harvest voices up. Could you expand a little on how your sub-group is working and what other sub-groups you would have? How do you make sure the ICB pays attention to what the partnership comes up with? For me, from outside, it seems like it is the board that has the power in the end. Therefore, how do you ensure that? I understand the need for relationships, but what voices other than primary care are you bringing forward with sub-groups or other ways of working?

Dame Gill Morgan: There are a couple of statutory sub-groups that we are going to require, like accounts, audit and remuneration. More importantly, over the last few years, systems like ours have developed ways of handling finance and quality that have been about a partnership approach, so you do not have a head of quality covering all the organisations, but you have the heads of quality from all the organisations coming together to problem-solve. The heads of finance come together to work out how to allocate the money. That is a very, very effective way of doing it. It teases out the tensions and gets people who are expert in delivery in those conversations. We will have a number of committees like that. The question is: which ones of those become statutory? Which ones do you do through officers? Where do you build people in? All of them will have primary care build-in, because you cannot do service otherwise.

On the partnership forum, which is a different sort of animal, we had already got into the vehicle whereby the full ICB board took cognisance twice a year, because these outcome measures do not change very rapidly. All we do is talk about those longer-term agendas, so it is not just us saying, “Here’s our plan, over to you.” It is about saying, “What really worries you? How can we help? What is important? How do we do it?” We had a wonderful session on apprenticeships. NHS apprenticeship levy money is being used to support some of the stuff that county councils want to do. That would have never happened in the old days because we were not sat in a room with mutual trust and a single purpose.

At the heart of this, every ICB and every partnership board will have to define, “What’s my purpose? What’s your purpose? What’s our shared purpose?” That managerial trust-developing, partnership-developing work is what will make this a success. I started, and I was rapped across my knuckles by Mr McCabe for saying too much—quite appropriately. At the end of the day, you are not going to get that through legislation. You are going to get it by creating an environment and properly holding us to account for what we are doing in these boxes.

Q189 Dr Whitford: Obviously, we have heard a lot of discussion about voices that are missing or not listened to, so a sub-group approach might actually be a model for other areas to think about harvesting ideas up towards the partnership and the board.

Dame Gill Morgan: Indeed. This is guidance, not legislation, so we have to develop a constitution of what we are doing, and we are committed to reviewing it. If today we think that we know what we will need in three years’ time, we are not asking ourselves the right questions, so we need to be reviewing constantly. That is one of the things that we have historically been very bad at in the NHS. We do something, we enshrine it, and then a few years later we throw it all away and start with a new thing. How do we evaluate it? How do we say, “This has been brill, this has been flaky. Let’s get rid of the flaky, and let’s put more of the brill in”? It is that sort of managerial question with us, rather than the very flat, “How do you hit this today?”

Q190 Dr Whitford: Do you feel that there will be enough evaluation of what works and what has not worked within the structures that are being proposed through audit and formal evaluation?

Dame Gill Morgan: I personally think that we have to be very careful. I do not know if this is a role for legislation. A joke in the NHS is that pilots are phase 1 implementation. That is an old joke. It is not this Government; it is every Government. We have always said that. We have to be really careful that we build in evaluation across the piece and do not pick two or three metrics that look as if they have gone the bad way to prove what we wanted to argue before. That is done both in favour of things and against things, and we end up with this sort of noise in the system. Let us plan now and get a proper, effective academic unit to build in some evaluation at the end of this time, and then let us all take stock in two and a half years and say, “Hasn’t this been brilliant”—in my opinion, it will be brilliant—or, “It won’t do any harm, but it’ll be nothing”. We have got to do better than nothing.

You will gather that I am in favour of ICSs. [*Laughter.*]

The Chair: I think we drew that conclusion from your evidence—absolutely.

May I just thank you both very much for giving evidence today? I am sorry that I had to interrupt you, but I am an obsessive timekeeper. Such is life. Thank you very much.

Examination of Witnesses

Ed Hammond and Andy Bell gave evidence.

3.15 pm

Q191 The Chair: We will hear next from Ed Hammond, who is the deputy chief executive at the Centre for Governance and Scrutiny, who is appearing in person, and from Andy Bell, who is the deputy chief executive at the Centre for Mental Health, who is appearing remotely. I will just remind Members: if you are directing your question at Andy, can you make that clear, so that he is aware of it?

Good afternoon, both. Can you both introduce yourself for the record, starting with Ed?

Ed Hammond: My name is Ed Hammond and I am the deputy chief executive at the Centre for Governance and Scrutiny.

Andy Bell: I am Andy Bell and I am also a deputy chief executive, but at the Centre for Mental Health.

Q192 Dr James Davies: Andy Bell, how do you think this legislation can help to address current mental and physical health inequalities in this country?

Andy Bell: It is a really good question and I think that, on its own, the legislation certainly has some potential to assist with that. Of course, there also need to be a number of other things and I can talk about those if that would be helpful.

The first positive thing to say about this legislation is that the idea of integrated care—the practice of providing care that actually links across between mental and physical health, NHS and social care, and prevention and treatment—undoubtedly is the way to go. I think we have a number of areas within the system where we know that people at the moment get very poor support for their mental and physical health, as a result of the lack of integration in the system.

Examples would be people who have both alcohol and mental health difficulties at the same time; people living with long-term physical illnesses, such as diabetes or kidney disease, who get really inadequate and often very poor emotional support, if indeed they have any emotional support at all; and, indeed, people living with long-term mental health conditions, whose physical health is very often very badly neglected, and they have very little support. Integrating care—actually doing that on the ground—and achieving a real change in the way that services are organised around people's needs would undoubtedly make quite a significant difference and reduce some of those inequalities.

I think the way that the Bill and the various bits of guidance are written gives us some hope that that may happen; it certainly does not answer all of our questions about it. In and of itself, I think it is potentially a step in the right direction, but we need to give some thought to a number of caveats around that.

Q193 Dr Davies: That is very promising. Can you just give an indication of those caveats, if that is possible?

Andy Bell: Yes, sure. Again, “integrated care”—we like the words; they are good—but the difficulty in a way is, first of all, the fact that this is very much an NHS-dominated set of proposals. It was written by NHS England for NHS England. I think that if we have a genuinely integrated system, where people will get support across the whole range of services, we need this to be an equal partnership between the NHS, local government, and voluntary and community organisations.

If you look at the proposals, in a sense what they are doing is taking decision making and power within the health and social care system further away from local communities into what are effectively sub-regional groupings. There is not anything very local about integrated care systems in many places, and that gives us some pause for thought. It is very much NHS dominated. If we look at the current health and care system, public health and social care are often the less well-funded and less well-resourced parts of the system. From what we see from the spending plans, it looks like that will become even more the case if you have legislation that, in a sense, reinforces the power of the NHS over other partners. I worry we are not going to get that real shift.

Q194 Dr Davies: Ed Hammond, on the same agenda of scrutiny of outcomes, how do you think those are best measured, and how does the Bill assist with that?

Ed Hammond: In terms of scrutiny generally, it is a challenging picture, as Andy said. There is a challenge around the need for effective local accountability. That scrutiny is best exerted at a local level. Local scrutiny is much more able to assess and make accurate conclusions about what outcomes have been reached. We do a lot of work as an organisation supporting local councils in their formal health scrutiny functions. The past 20 years of that has demonstrated a significant degree of success in local government being able to lead with local healthwatch in, alongside and on behalf of local people, seeking to understand how local health services design and deliver effective outcomes, challenging, where necessary, through the referral power for substantial variations.

My worries echo Andy's in that the Bill as it stands moves a lot of decision making, commissioning and direction activity up to system level. Depending on the

character, relationships and personalities of the key individuals involved, there is a risk that decision making therefore becomes remote from local accountability, making effective scrutiny of outcomes more challenging to achieve.

Q195 Karin Smyth: That leads neatly on to my point. We have just heard a great defence of ICSs as the system of accountability, and you have said that system level is where decision making is happening. The chief executive told us very clearly on Tuesday that accountability for decision making was clearly located in the ICB. The ICP—the partnership—is formally a committee of the ICB. I think each of our witnesses—very experienced people—have actually confused those three acronyms. They have also confused the accountability, which NHS England has told us is very clearly in the ICB. The finance director, the accountable officer at the ICB, carries the can. The other person will ultimately be fired, should the accounts not balance and there be some sort of health and safety patient scandal. I think that is clear. First, do you think that is clear? Secondly, how can we encode the good direction of travel in the Bill around local accountability to somebody who could oversee it in a more independent way and better hold that accountability locally?

Ed Hammond: In answer to your first point, I think it is clear. As we become more familiar with what is a complex system—and health governance is complex—some of this confusion will dissipate. As we start to operate practically within these systems, familiarity will breed a degree of confidence in understanding whose roles relate to what. As with all complex systems, it is vital that everybody understands their individual and collective responsibility for governance within those systems and accountability.

It is great when you have a partnership-led framework, in which everybody in the system is working together, and everybody has some stake in the system and in decision making. It is not a hierarchical, dictatorial system; it is one based, hopefully, on dialogue and, to an extent, consensus. The risk of that is that it necessarily dilutes accountability. Where everybody has a stake in decision making, you need some kind of external source of local accountability. That leads on to a second question. I think there is a need for a distinct and separate form of local accountability within these new arrangements at system, place and neighbourhood level. That role is currently performed at a local level in two main places: through local Healthwatch, from whom you will be hearing later, and through local health overview and scrutiny committees.

For me, the risk of these new arrangements is that, first, the removal of the power of referral to the Secretary of State by health overview and scrutiny committees on matters of concern relating to substantial variation of local health services is a worry for us, as it is for NHS colleagues. Also, the focus on system-level decision making will, by definition, make it more challenging for local health overview and scrutiny committees to co-ordinate to form, where necessary, joint committees to effectively oversee, scrutinise and hold to account ICS, ICB and ICP activity at system level.

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

Andy Bell: Yes. It is a really important question. From the perspective of mental health, we have seen an enormous amount of progress in recent years from local Government really embracing the mental health agenda in many areas and becoming both a partner but also a scrutineer of the NHS through scrutiny committees and through the role of health and wellbeing boards too. The importance of that natural connection through, between the health and wellbeing board with the ICP in particular, the partnership bid, feels like there needs to be a very clear and close relationship and, again, where possible, decisions being made at place level—in the new language—feels really important to allow for that kind of relationship to build and actually become a really positive relationship, because so much of this does come down to relationships. However, clearly, the need for some kind of external scrutiny is incredibly important.

When we think about it from the mental health perspective, where systems or governing bodies—be it the integrated care board or anything else—are allowing mental health to slip through or particular groups of people are being poorly catered for by the system, some kind of external scrutiny and clear accountability is incredibly important. One thing we have said we would like to see in the Bill is an extended and expanded role for the Care Quality Commission to really scrutinise the degree to which integrated care boards and the decisions they are making—and, indeed, partnerships in their strategies—are looking across the board at health inequalities.

At the moment, the Care Quality Commission is very good at inspecting services for whether they are working appropriately with individuals they are seeing, but it has no powers to scrutinise whether the health system as a whole is working fairly and appropriately across all different groups of people. Unfortunately, that means, certainly from what we see in the mental health world, that there are a number of groups of people who get very poor support for their mental health—actually, very little help at all—and there is no current means in the system to address that.

The Chair: Thank you. Mary Kelly Foy.

Q196 Mary Kelly Foy (City of Durham) (Lab): This is for Andy. It is noted that mental health provision has for far too long been seen as the Cinderella service of the health system. Indeed, there is very little in the Bill specifically around mental health. Given the growing number of people suffering with mental ill health and the shortage of services, is there enough in this Bill to satisfy you that mental health will be given parity of esteem alongside physical health?

Andy Bell: It is difficult to tell; the Bill is largely silent on mental health. If we had a system where there was genuinely equal regard for both mental and physical health, we would not have to worry about that, because we would know that the system would treat mental health fairly and equally, and there would be no disparity in the way it was thought about. Unfortunately, all our experience tells us that that is not what happens within many health systems at different levels, from very local to national, so we would like to see some assurances in the Bill.

From our point of view, that could happen in one of two ways. Legislation only gets you so far, but it could place specific duties on both NHS England and integrated care boards—I am being very careful in specifying integrated care boards here—that they must take action to ensure that mental and physical health are given equal regard in their decision making, particularly on resource allocation. We feel strongly that there needs to be a voice for mental health within integrated care boards. That is highly likely to happen within integrated care partnerships, but within integrated care boards we do not have confidence that mental health will be properly represented at the top table where important decisions about resource allocation are made.

We think that would help. There are no 100% safeguards in legislation, but one positive thing we have seen with the 2012 Act is that a clause at the very top of the Act talked about mental and physical health as one of the key purposes of the NHS, and that has been used positively and helpfully to make the case for parity in health systems up and down the country. A few simple words can sometimes make quite a big difference.

Q197 Edward Timpson: This is a question for Ed, building on the fact that you have, I think, fairly extensive experience of working with local authorities and supporting them on governance and scrutiny. Having direct involvement in NHS decision making on funding and so on is a fairly new role for local authorities, and different ICSs will have different sizes and geography; for instance, mine is Cheshire and Merseyside, which is one of the largest—I think it is three or four times the size of some other ICSs. Over and above being involved in the board, for local authorities in larger ICSs, where the emphasis on place could be lost if they are not more fused into the system, how do you think the Bill could help to ensure that that is the case, so that we get the right balance between their involvement in the decisions, based on their knowledge of their own population, and the wider regional decisions?

Ed Hammond: For me it starts with an understanding of what decisions are best made at system level and what decisions are best made at place level. Certainly, I would imagine one of the first things that ICBs and ICPs would need to do, once established, would be to determine how to set up a system-wide framework for ensuring equality and equity in terms of how its health and care service is delivered, and then determine how and where it is most appropriate that more detailed decisions come to be made at place level. Otherwise, the system simply becomes too unwieldy.

There are risks that those partners sitting at that system level will draw decision making into those spaces, rather than pushing it back out to localities, because it is the simplest, in many ways the most efficient and apparently the most co-ordinated way of doing it, but in practice it will not serve the interests of local accountability or better outcomes. That raises the prospect of certain services being delivered in different ways in different localities, depending on the political priorities of different councils, but that is local democracy—that is local government bringing its understanding of the demographics of the populations it serves into the conversation.

I think this can all be made to work if there is sufficient transparency in the system, so that those within and those outside it understand how decisions

are being made, on what subjects, and by whom. When you have that clarity, it becomes easier to unpick what is happening at place level. Are decisions being made at system level that would be more appropriately made at a lower level? Is there consistency across the entire system? What does the geography mean for decision making and commissioning, and these kinds of things? It provides assurance, and it provides everybody with more confidence that decisions are being made properly in the interests of local people.

Going back to the point I made before, that is also why some external local accountability is so important, because effective local external accountability can challenge the system on whether the right decisions are being made at the right level, and whether they reflect and are responsive to what the local needs are. Local scrutiny committees are, at the moment, anchored at place level within local authorities. They are well able to publicly draw in the voice and concerns of the public about those kinds of issues, and transmit them to health and care partners so that there is a clear way for those concerns and issues to be responded to.

The Chair: Thank you. Dr Whitford.

Q198 Dr Whitford: Could I ask you a question, Ed? Obviously, you talked there about better outcomes. Regardless of who is judging it, you need evidence for that, and there are two aspects here to help to know what success looks like. From the perspective of local scrutiny of health improvement—improvement of health and wellbeing at a local population level—how do you see that being done? Obviously, that is what the ICB and ICP are being challenged with. Coming from a breast cancer background, where obviously you have specialist teams that need to be judged, what about the scrutiny of healthcare through quality improvement clinical outcome standards, which require audit and benchmarking against ICSs elsewhere in England, so that you do not have postcode variation in survival, treatment, or anything else? How do you see those two scrutinies working?

Ed Hammond: That is a challenge, because it brings into focus the role that different accountability partners play in the system. We have already heard a little about the CQC and the work it does in assessing and monitoring clinical outcomes. Of course, within ICBs and ICPs there will come to be—one would hope—robust and effective performance management arrangements. Certainly, looking at the Secretary of State's expectations around the exercise of new powers, one would expect that, for the Secretary of State to understand where he chooses to intervene and direct services, that would be on the basis of evidence that would need to be collected in a consistent and systematic way across England, but also within individual ICBs. Presumably, we can expect some kind of performance framework to be established nationally to provide evidence to support the Secretary of State in the exercise of their powers.

Then at local level, you have, as I mentioned before, local Healthwatch and local health scrutiny communities. Now, local scrutiny committees obviously cannot bring the clinical expertise to bear on issues of concern; the CQC naturally leads on many of those issues. I think what those local partners in local Healthwatch and scrutiny committees can do is understand where there

are gaps in the system; where there are concerns about aspects of performance that others have perhaps not picked up on; where there are concerns emerging from conversations within local communities that councillors are hearing about day to day, because they have direct contact with local people; and those concerns that might not otherwise find their way on to a performance scorecard, but might relate to things that are not being monitored, measured or managed particularly well. That local connection is a vital part of what makes health scrutiny work.

Q199 Dr Whitford: But you do think there would be a role for analysing data? My background is breast cancer. You know that what chemo you use and what surgery you did is going to affect the outcome for that woman in 10 years' time, so in Scotland we have that in clinical standards. Those kinds of metrics would not necessarily go to the Secretary of State initially, but local teams want to improve and clinicians want to drive quality performance. Would that be something that you would be involved in developing; or who would be doing that?

Ed Hammond: Yes. Where ICBs and ICPs are putting those monitoring arrangements in place, I would certainly expect local clinicians to have a role in assessing, evaluating and analysing that data and evidence. As I have said, committees of local councillors would also be able to do that. I think we have a resource challenge in how that local government scrutiny operates, but as a matter of principle local councillors are increasingly adept at that data analysis, despite the fact that they may not be clinical experts. They are able to carry out some form of analysis. Collectively, we can see that, together, those partners can bring to bear a form of local accountability, primarily at system and place level.

Q200 Dr Whitford: A brief question to Andy: there has been discussion over recent years about the need for greater preventative public health. Do you think there is enough discussion or enabling of that approach in mental health? Although we may not do it, we all know what we should do to be physically fitter and healthier—how good we are is up to us. But many of the public have no idea how to protect their mental health. Do you think there is enough population and preventative mental health work? And are there ways of strengthening that in the Bill?

Andy Bell: We have hugely underinvested in it, and indeed very poorly appreciated it. What we have seen in recent years, which we hugely welcome, is huge progress on mental health awareness and understanding. That was not there 10 or 15 years ago. It has not been that long since in a debate in the House of Commons the first Member stood up and spoke about their own experience of mental illness; that was hugely powerful, and began quite a significant social movement. However, we do not yet have literacy around that issue, or indeed a real understanding about what we can do to promote the public's mental health. With the creation of the new Office for Health Improvement and Disparities—I must remember to get the name right—there is an opportunity to make public mental health as important as public physical health. How we translate that to local areas will be really interesting.

When I talk to people working in local public health departments, I see a huge enthusiasm for and interest in how they can better support mental support in the

communities they serve. We have seen incredibly creative work from around the country, such as in Leeds and Bristol, from public health teams that are leading the way who understand that the things that determine our mental health are very much about the society and environments we live in—the families we come from, the schools we go to, the amount of income we have, and the homes and neighbourhoods that we live in. There is a growing understanding of that. However, we have not yet put that into practice on a large scale, and indeed the resources available to public health departments to do that are very threadbare. Many have to be very creative in how they do that.

We very much welcomed the promotion and prevention fund set up recently by the Government, which gave funding to local authorities in the 40 most deprived local areas in England for mental health promotion activities. We are really looking forward to seeing what that money is used for, and we very much hope that it will be the beginning of something much bigger. Our worry, in relation to the Bill in particular, is the understanding of prevention, and indeed the understanding of prevention that I read in yesterday's Command Paper on the health and social care plan. It is still based on physical health, and the idea that public health is about telling people how to live their lives and how they should behave, rather than what really determines our mental health: how much money we have coming into our home, how safe we feel, and our position in society. It is really clear that very often the way that economic and social inequalities affect our mental health also affects our physical health. Very often it is poor psychological wellbeing that leads to later physical health problems, so we really have to start taking public mental health as seriously as any other part of public health.

Q201 Justin Madders: I have just one question for you, Mr Hammond. You obviously have the ICB decisions being made. What, in your understanding of the Bill, would happen if—hopefully this will not happen, but we have to look at every possibility—the chief executive of the ICB was making decisions that the ICP and other partners were not in agreement with, and they effectively lost confidence in him? Is there any mechanism that would be able to deal with that situation?

Ed Hammond: The obvious mechanism is the Secretary of State's power of intervention. It is all about that referral upwards really to the Secretary of State to act. Ideally, these kinds of things can and should be resolved through dialogue, because the Secretary of State can intervene only so much. One of my worries about the focus in certain elements of the Bill on the new and enhanced powers of the Secretary of State is that it sort of assumes that the Secretary of State will need to have fingers in lots of pies to be aware of where these issues are occurring across England, and be prepared to step in where they are happening, which requires the exercise of a significant watching brief across a wide range of areas in a way that does not currently happen.

Ideally, these kinds of things can and should be thrashed out by the people involved at local level. The Secretary of State can intervene but does that intervention persist if relationships have effectively broken down? What do you do then? You cannot run everything from Whitehall; there has to be some kind of mechanism to rebuild relationships and trust. One would hope that it

would not get that bad, but I know of past tensions. There are divergent priorities between local authorities, NHS partners and other partners in respect of health and care issues. The logic of ICPs is that you are aligning those priorities better, but that is not guaranteed.

That is one of the reasons we consider that there should be a role sitting with local health scrutiny committees to escalate matters of particular concern to the Secretary of State, so there is not this assumption that the Secretary of State is exercising a continual watching brief over everything that is going on. There is that formal power of escalation from an external body holding the system to account that can, before that escalation, exert some kind of influence at local level to try to knock heads together and bring some form of agreement in place, so that you are not in a situation where you have a persistent assumption that Whitehall will need to step in in every case where these kinds of issues occur.

Q202 Justin Madders: Thank you. Mr Bell, do you see this Bill helping to achieve parity of esteem for mental health?

Andy Bell: At the moment, it is really impossible to say. I would like to see the Bill achieving parity of esteem for mental health. As I say, the principles of integrated care could certainly enable that to happen, if combined with a lot of other very significant and important activity to shift the culture in the health service, apart from anything else. The lack of specific provisions in the Bill to ensure that parity is taken seriously is a real worry. I think there are still gaps in the Bill that could be very simply addressed and would help to ensure that system leaders, wherever they are—whether they are on integrated care boards or any other three-letter acronym that gets created—realise that their personal responsibility is to bring about parity for mental health.

I think we are at a point now where there is some recognition in most parts of the system that mental health is important, but very often, outside specific mental health services, there is still an assumption that mental health is something other people and other organisations do, and there is not that shared responsibility for it in quite the way that we think would help to move us forward.

Q203 Justin Madders: I have one more question, Mr McCabe. One of the consistent points we have heard from witnesses is that they are not convinced that the provisions in the Bill on workforce are sufficient to deal with the workforce challenges that the NHS faces. Would that be something that you feel is also the case for mental health professionals?

Andy Bell: This is incredibly difficult. We have some very ambitious plans now—the NHS long-term plan ambitions for mental health. There is, quite rightly, an awful lot of money going into that, because we have a very big gap in our ability to meet people's needs. The only way that is going to succeed is if we have a very significant expansion in the mental health workforce.

We need to remember that that workforce is not just what people think it is. It is obviously nursing and obviously psychiatry, but it is also social work—a lot of really important mental health provision is in local government under social care. We need to think about the importance of advocacy and the importance of peer

support, the importance of employment and housing rights workers, who we know make a big difference to people's lives. There is also the key role of the voluntary sector in providing forms of support that may not come under traditional clinical headings, but none the less make a huge impact in people's lives. We need to build the workforce.

The Bill gives some steps forward and summary assurances. In some ways, it is not quite the right place to be dealing with this. This is about whether the various parts of the system—the health education system, the NHS itself and its partners in local government—have the resources and the right ways to encourage people to come and work in mental health. It would be great to see the kind of recruitment campaigns we have had for the NHS as a whole to really help bridge that very big gap in the mental health workforce. At the moment, I think the Bill is probably neutral on it. It would be good to see some stronger assurances, at the very least holding the Secretary of State to account for how they are achieving the workforce ambitions set out in the long-term plan and future policies that will have to come.

Q204 Edward Argar: Good afternoon, Ed and Andy. Andy, in my first question, can I pick up on something you said there, before I broaden out to a question to you both? You talked there, quite rightly, about the importance of parity of esteem for mental health. As a local councillor years ago, I saw how important local councils and the NHS working hand in glove on mental health provision is, because if we get one half right but not the other half, it just does not work.

Building on what you have already said about the legislation, what would you identify as the opportunities of the legislation, if properly implemented or interpreted in the right way, for furthering that linkage and that joined-up mental health provision? Obviously, that goes beyond local council services and the NHS. There are a whole wraparound series of services that impact on someone's mental health. What do you see as the opportunities in the legislation that we either need to draw out further or at least not lose sight of?

Andy Bell: This is about building real, sustainable, long-term partnerships. One of the things I know colleagues in the NHS and local government find very frustrating is that they just find a way of working with each other and then the legislation changes again and they have to start all over, so it is about having a system that actually works and stays working, that builds on the best of what is there already. I think there is some frustration in places where they spent a long time building relationships between clinical commissioning groups and local authority colleagues, sometimes with jointly employed staff, and now they have to start all over again because we are moving to a different thing. That will be immensely frustrating for many folk.

If we take the principle that this is about integrating care and equal partnerships between different players, including the voluntary and community sector, and if we give that time to work, we will enable partnerships to form with a clear voice for people—for example, in the case of mental health, for people living with mental health difficulties—so that decisions are being made with and in partnership with the people who use them rather than remotely by professional experts on their own.

Collaboration is incredibly important too. One thing we really welcome about the Bill is that it is moving us away from a system of competing providers to providers working collaboratively—literally, in providing collaboratives. There is a slight risk that all the power will be vested in one organisation and there will not be that check and balance between commissioner and provider. But some of the early provider collaboratives working in children's mental health services that we have looked at have made really huge strides really quickly to reduce, for example, the number of children forced to go to hospital outside their local area in a mental health crisis. They have come together, looked at what support is needed for children in a crisis and put community services, in particular, in place to achieve that.

One further thing that will be important is that there is some positive provision in the Bill to ensure that ICBs—I think it is ICBs, yes, it is—have to take into account inequalities in access and outcomes. That is great, but there is not that requirement to pay attention to inequalities in health and to go out and identify which groups of people are experiencing health inequalities and what the system can do to deal with that upstream rather than waiting for people to need formal healthcare. That would be the other part that would really help in the Bill—to build on some of the positive noises and moves in the right direction in collaborating at the level of prevention and on the things that determine our health as well as in the provision of services when things have reached a point where people need care.

Q205 Edward Argar: In the two and a bit minutes I have, in order not to get cut off by Mr McCabe, I will direct my question to Ed and will bring you in, Andy, if I have time. We have heard about how what is proposed in many ways enhances local accountability and local authority involvement in decision making, but to go back to your earlier comments, would it be fair—you are entirely entitled to say that it would be unfair, and that I am misinterpreting—to say that alongside that your request was a request that in enhancing that we should not lose the local accountability mechanisms and processes that have already grown up over the years in local authorities, be that health and wellbeing boards, joint overview and scrutiny committees, or whatever? Is that a fair characterisation? Feel free to correct it.

Ed Hammond: Broadly speaking, yes, that is fair. My central point would be that those structures and the opportunity that local government has through this Bill for more direct and active involvement in health and care decision making are good, but there still needs to be that separate independent source of accountability that we feel sits properly at a local level with democratically elected local councillors who have powers through health scrutiny committees to talk to local people about their needs. That needs to be there and needs to be strengthened. In respect of the Secretary of State powers I was talking about, my worry would be that we would see ICBs and ICPs looking over their shoulder at what the Secretary of State might want to do rather than looking down to local communities to understand where local need lies, with decision making being led somewhat by what people think national priorities should be.

Part of the solution to that problem is the things we have proposed around, for example, requiring the Secretary of State to consult with local scrutiny committees before

exercising those powers, having the powers for local scrutiny committees formally to escalate things to the Secretary of State to act on, and what we have suggested for more effective joint scrutiny by multiple councils of the ICB at system level as well. Those are all part of that strength and accountability framework. It is about saying, “Okay, we have involved local government in decision making through the ICPs and through continuing the health and wellbeing process, but in doing so we also have to enhance and build on our existing health scrutiny arrangements.” As things stand, the Bill removes elements of those by removing the power of referral. It is about having a balance of accountability arrangements and ensuring that that strong external accountability continues.

Edward Argar: Thank you.

The Chair: We had better leave it there. We are out of time. I thank you, Andy and Ed, for your evidence today.

Examination of Witness

Sir Robert Francis QC gave evidence.

4 pm

The Chair: Welcome, Sir Robert. Could I ask you to introduce yourself for the record, please?

Sir Robert Francis: I am Sir Robert Francis. I am chair of Healthwatch England.

The Chair: Thank you very much. We have until 4.30 pm for this session. I call Mary Robinson.

Q206 Mary Robinson: Welcome and thank you for coming along, Sir Robert. I am Mary Robinson, MP for Cheadle and, with another hat on, the chair of the all-party parliamentary group for whistleblowing, so I obviously know about the reports you have conducted into these issues and about the Freedom to Speak Up review in particular. How will the Bill’s provisions on the HSSIB further the ability of people in the NHS to come forward and speak up in a safe space?

Sir Robert Francis: That rather depends on what arrangements are made in the new system. I have seen no guidance issued yet as to how this should work, and I am not surprised at that, because until you know precisely what the structures are and what the accountability and information flows are, it is quite difficult to do that. But I would agree that it is vital in the ICB and the ICP world that sufficient provisions are made for people who have concerns—whether they be staff, patients or the public—to make those concerns known safely to those responsible for doing something about them. In terms of this new world, that means that the ICB and, I suspect, the ICP need to have people who are directly responsible for that. Unless that happens, whistleblowers are going to find themselves in an even more parlous and uncertain place than they are at the moment.

Q207 Mary Robinson: Could you expand on that? Why would they be in a more uncertain place?

Sir Robert Francis: Unless there is certainty on guidance, policies and guardians, of which I am a great supporter, people do not know where to go. Clearly, where things

are going right in terms of an open culture, there are many people whom others will go to as a matter of ordinary business. But if we are talking about places where, unfortunately, that is not the case—I think they do exist—people do not know who to go to for help. They need to know that they have protection to go to places to provide information of concern, and they need to know that they are going to get support. If there is no guidance and no clear framework, none of that will happen, and secrets will remain at provider level, when they should be sent elsewhere. Existing mechanisms, such as going to the CQC and your local Freedom to Speak Up guardian in your trust, will still exist—I see no reason why those should not—but I suspect there will be areas and subjects where that will not necessarily be the answer to the question the individual wishes to pose.

Mary Robinson: Sorry, just to—

The Chair: I think I am going to move on. Jo Gideon.

Q208 Jo Gideon: Thank you, Mr McCabe. How do you think the public voice should be represented across the integrated care system at board and partnership level?

Sir Robert Francis: Healthwatch England welcomes the requirement for Healthwatch and representatives of the public to be “involved”—that is the word—in the strategy, but we would like to see that enhanced, as I am sure many people would, and we just heard that expressed very articulately. In order for these new reforms to work, it is absolutely essential that the public whom the system serves are able to engage with it and participate in the design of the services that they are going to receive. In order to do that, in our view, they need a visible presence on the ICB board and the ICB partnership. Although that can of course be done by local discretion and local arrangement, we think it would be a powerful boost to the importance given to the people’s voice if there was a representative on the ICB—not as a voting member but, in NHS England’s parlance, as a “participant”. It would be a requirement that one of the participants be such a representative, and you will not be surprised to know that we would advocate that person being a representative of Healthwatch.

That can be done through a coalition of local healthwatches—in many places there will be more than one—so that they have a presence on the board and are able to raise things. It is not just a question of the ICS deciding what to ask people about; they need to have a flow of intelligence coming in about what people are actually concerned about, and those two things are often different. It should be someone who is able to question what is happening in a constructive way.

Of course, part of that is done by local government representatives, and this is not a substitute for local democracy, but we consider that Healthwatch has a local and national ability to reach out to groups who do not often get considered, for instance, and that is particularly relevant if you are seeking to tackle health inequalities. Through the relationships that a good local healthwatch has with groups who feel—rightly or wrongly—that they have often been ignored, the questions that they

pose can be put and the answers given back to them. That is a two-way process; you need someone who is independent from the system but in the room, and they also need to be able to transmit into the room information from patient services and the public, and transmit information back. They are part of the mechanism for explaining to the world at large this extremely complicated new concept—namely, a system of which the public has no understanding at all at the moment. A lot of professionals do not either.

Q209 Edward Timpson: Sir Robert, a shift away from competition towards collaboration and integration is very much at the heart of the Bill. We heard earlier that competition is not just about the constant tendering for services but also has the element of patient choice. From the evidence you have gathered from your local healthwatches and more generally across the country, where do you think patient choice needs to sit within these reforms? I am particularly interested in children and young people from the ages of nought to 25, because we are talking about all our health system's service users.

Sir Robert Francis: Clearly, patient choice and view include information about people's experience of the service they have had, where they think the gaps are, and their needs. The less you have a competitive exercise with different organisations coming in and saying, "We can provide this better than X or Y," the more you need to know what people think about what you are proposing, or indeed the more you need to know to inspire creative thought about how you meet the needs that people are telling you they have.

Our view is that while we actually welcome the removal of the requirement for tendering and all the bureaucracy that, quite often in our healthwatches' experience, interferes with and delays getting solutions to things, that should not mean that we do not have a concentrated effort to involve patient services and the public in the design of what they are being provided with. In effect, that would include how you commission the service that they are going to be provided with. You then need a constant flow of information and dialogue about whether that is working. Frankly, I do not see a great deal of clarity in the Bill about how performance will be monitored after having commissioned services and worked out your strategy and so on.

Q210 Edward Timpson: Is my point about children and young people one that you look at and factor in?

Sir Robert Francis: Definitely, and it would be quite wrong to think that children and young people cannot be fully involved and consulted in the design of the services that are required for their benefit. Many local healthwatches have been very good at doing just that.

The Chair: Dr Davies.

Q211 Dr James Davies: My point is also about patient choice. I work as a GP in England and know that many patients enjoy being able to access secondary and tertiary care throughout England, if they wish to do so—something that my constituents in Wales do not generally have the opportunity to do. Are you satisfied that the Bill protects that opportunity to its maximum?

Sir Robert Francis: I do not think it prevents it, but the extent to which it allows for it will depend, as I understand it, on the strategic decisions being made locally within the system. The answer is that I am not quite sure.

The Chair: Karin Smyth.

Q212 Karin Smyth: May I take you back to the ideal person or Healthwatch person on the ICB? In my early days in management, in the 1990s, the community health council secretary and chair—I realise the situation was varied across the country—were important people locally. They had access culturally, and any changes to the system were expected to work with them. They had much access, regardless of their position on bodies. In my view, what has come since healthwatches were abolished—I will not say by who—has never really replicated that cultural relationship. You might wish to comment on that. Were you saying that having a person on the ICB would help with this situation, or is there another way in which we can embed a culture that recognises the importance of some sort of patient voice outwith the system?

Sir Robert Francis: First, there is no ideal person to do the job. I think that past iterations of what is now Healthwatch may have been slightly too full of people who were more interested in constitutional matters than the actual provision of health services. That was the impression I formed during the Stafford inquiry, but I think that is not true of Healthwatch. The presence of a Healthwatch person—by the way, this requires a new level of Healthwatch collaboration and function, but that is not difficult to provide in the Bill—will not produce, in itself, the culture that you talk of. The health service is still an organisation that, in the jargon, is top-down and is delivering things to people, rather than getting their ideas and responding to them. But the presence of the Healthwatch person, or some independent person, is at least a symbol of the need to have such a culture and to develop it. It will be someone whose principal task may be to question whether that culture is being led and developed.

If you have that person, you can back it up if you need to—in regulatory terms—with whatever form of systemic review the Care Quality Commission is tasked with doing. Its reports could certainly be a very valuable tool in relation to this, but you need a channel of communication between the ICB, if that is to be the centre of all this, and the wider world within its constituency. Unless there is someone whose independent role is to oversee whether that is happening, I am not sure it will. All organisations currently in the NHS have directors of engagement and communication. I suspect that, with the best will in the world, most of them see it as their job to defend the organisation. This is not about defending an organisation; it is about welcoming constructive comment from the public and responding to the needs that people communicate to them.

Q213 Dr Whitford: I want to look at the Health Services Safety Investigations Body, which is discussed in part 4 of the Bill. Obviously, you have been involved in the past with whistleblowers, Mid Staffs and so forth. We have talked a lot in recent years about learning, not blaming. What is your view on that part of the Bill? How do we protect what is given within the safe space,

paralleling Air Accidents Investigation Branch, but give the public the confidence through Healthwatch that this is not stopping any other investigation happening now, and that taking that approach can get under the bonnet of real issues that have led to tragedy?

Sir Robert Francis: What I am about to say in answer to your question is my personal view. Healthwatch England, for reasons you will understand, does not have a view on that—apart from welcoming the existence of this body and the fact it has a statutory function. I confess to some concern about the safe place provisions, and I said this in part to a parliamentary Committee before. On the one hand, I fully endorse the need to protect people who come forward to give information—sometimes potentially damaging to themselves—so we can learn the relevant lessons of safety. Therefore, I absolutely support the idea that anything said in these circumstances cannot of itself be used to prosecute or discipline them, or indeed be used in civil proceedings.

On that point, as a lawyer, I would be very hesitant on the advice I would give to someone on the basis of the Bill as it stands, because there is no certainty that what goes into the safe space stays there. It is all a matter of discretion, albeit a High Court judge's discretion or sometimes a coroner's discretion. That would have to be worked out. It is probably difficult to reinforce more, but if it could be it should be.

However, I think that is different from denying bereaved families and victims of an incident, if they are still alive, knowledge of what has been said to the investigation board. At the very minimum, I would like to see there be discretion to share that information with families. I can see there may be circumstances in which that is not possible, and I can see that it might be necessary for there to be quite stringent conditions around what they personally can do with the information they are given. What worries me about the position at the moment is that it starts from a presumption of dividing the staff from the patient from the families, and you get straight into, I presume, an adversarial situation. That is not necessary the case, and if we work the system and the learning culture properly, everyone will be trying to contribute to learning rather than blaming each other. You are not going to get that if you are denying one half of the incident the information that the other half has.

Q214 Dr Whitford: When we took evidence from Keith Conradi, he said that obviously the learning from the safe space is in the reports, so there is discussion. Obviously there is no naming of people. Are you talking about the family or the patient having access to the raw data?

Sir Robert Francis: Yes, or something closer to it. After all, it is rather artificial. The family will often know the people involved in the treatment of their loved one. Where there is already likely to have been a breakdown of trust and confidence, this would be perpetuated and possibly increased if they are not given access to information that it is possible to share responsibly with them. I can see circumstances in which that would not be the case—that is why it would have to be discretionary—but I think many concerns of people I know who would have possibly been settled if only they had seen something more than they get in the report.

Q215 Dr Whitford: HSSIB does not remove the duty of candour or the need for a local trust or hospital to investigate. It should not remove the need for significant

adverse event inquiries and discussion—the families not having been involved as an external on those. Often the family simply want to know what happened and that it will not happen again. However, we often talk about failures as system failure and that can be down to personality. It is not necessarily the case that staff are giving evidence that conflicts with the patient, but often it is quite sensitive things about poor personal relationships within a hospital or team that have had an impact, or a lack of something.

Sir Robert Francis: Often, if I may say so, things that patients and their relatives have seen for themselves. If I were a relative of someone who died in hospital and I was being told, “This is due to a systematic fault. It was not down to the nurse or the doctor,” I would want to know a bit more about that. I would want, if I could, to talk to those individuals so that they could perhaps learn a little more from the impact of all this on people. I am not saying that it should happen in all circumstances, but in order for the family to have a true understanding of it. It does not necessarily mean they need to know the names in that sort of case that you mentioned, but I do not think it should be automatically assumed that they will be excluded from that information.

Dr Whitford: But in what way—

The Chair: I know it is fascinating, but we had better go to Mr Norris.

Q216 Alex Norris: Thank you, Chair, and good afternoon, Sir Robert.

We have spoken quite a bit in these proceedings about the relationship between the integrated care board and the integrated care partnership, the fact that the board has to pay “due regard” to the integrated partnership's plan, and what that due regard means. You talked about that in your written evidence, and you suggested mechanisms for resolving the situation—or at least making account for a situation where the board sets aside the ICP's plan. Could you talk a little more about that?

Sir Robert Francis: The first requirement is that there needs to be clarity about what happens in those circumstances, which I am not sure we see in the current legislation or in the guidance that NHS England has produced, which I briefly read. Our suggestion is that there should be a provision inserted into the Bill that, if there is a disagreement, and the board decides to do something that is contrary to the views put forward by the partnership, it should then be obliged to set out their reasons for that. In other words, there should be transparency, which enables accountability, if it is necessary, to be more easily handled.

That would be the major thing we would require, but there also needs to be a better understanding, as far as the public is concerned, about the relationship between the two. I have heard what has been said today, and I must say that I am not clear that the partnership is a sub-committee of the board. That is because the Bill explicitly says that the creation of the partnership is a joint matter between the board—I think, or the NHS—and the local authority. It strikes me that that is not clear.

That is important because, if there is a disagreement, local people are entitled to know why. It would be good if they could also be persuaded that whatever is happening

is actually the right thing for them, but they are certainly entitled to be part of the discussion. For that to happen, there need to be reasons given. Another thing that might send a shiver through some spines is that if there is an obligation to give reasons, it might be easier for those who object to the course being taken to challenge it.

Q217 Alex Norris: Do you envisage, when setting out those reasons for disagreement, that they would be publicly available?

Sir Robert Francis: Yes.

Q218 Alex Norris: Thank you.

We will move on to something else that you said in your written evidence. On Tuesday, we had a very good conversation about data, but the whole thing was about quantitative data. In your written evidence, you talk about qualitative data, and it is very easy for us, as Members of Parliament, to conceive of the importance of that, as it is something that we routinely draw on. With your insight from leading Healthwatch, how can we develop systems that properly trap that, use that and prioritise that just as much as the quantitative data?

Sir Robert Francis: Technically, these days, that is no problem at all. You will not expect me to explain that to you, but the qualitative data—comments from the friends and family test, or similar things—is easily mined these days. You can develop a view of the sentiment that comes through it, and you can then dig down more closely into specifics if you need to. That information is extremely valuable to Healthwatch in determining what people think about a particular subject or services, and we feel that there should be a recognition that that data, in that form, should be capable of being shared with a statutory body like Healthwatch, and possibly others.

We also think that—I am sure others might agree—while quantitative data is extremely important, it is informed by qualitative data. The personal impact—good or bad—of things that happen in the service are best described by the people who have received that service. If you just look at figures—I am afraid that this was a problem at Mid Staffs—you lose a great deal, and the trigger for change and improvement is lost.

Q219 Edward Argar: I will try to be brief in the five minutes that we have left. Sir Robert, I have two questions: one with your Healthwatch hat on; and one in your personal capacity—and also as an eminent lawyer.

We sought with this Bill to be permissive rather than prescriptive; behaviours, and how things work on the ground, are often as, if not more, important than the framework. Notwithstanding your on-the-record comments about Healthwatch participation in ICB levels as a formal member, what else would you draw out as opportunities within the framework to build on patient participation and accountability to those who pay for, and use, the service? Are there other opportunities, that, with a small tweak either in guidance or in the Bill, we could seize more effectively?

Sir Robert Francis: I suspect that there is something around reporting, particularly with the oversight of quality, inequalities and matters of that nature, which would be of assistance. I agree that flexibility of engagement is really important, and Healthwatch claims no monopoly over this. I see it taking place in guidance. If the

emphasis is to change culture to one where the service is being responsive to people's needs, as opposed to providing them with what the service thinks they need, there could be greater emphasis in the Bill on ensuring there is a strategic plan for engagement. There could be more emphasis on how the ICS is going to engage with local people and communities, and an actual requirement that it provides comprehensible information to the community about how people should be able to communicate with it. I know they sound like matters of detail, but if there is an obligation to make such things clear, it does not prevent flexibility, but it does oblige organisations to actually do it—and mean it. There will be lots of other ideas, I am sure.

Q220 Edward Argar: That is useful, and builds on your written evidence. What do you think in a personal capacity? This builds on Dr Whitford's questions and acknowledges Keith Conradi's preference that the safe space be not qualified. If one accepts that it is qualified in respect of aspects of the judiciary—he acknowledged in those circumstances that he would accept that—would you consider that a High Court judge is probably the most appropriate person to make such a judgement on whether something should be taken out of the safe space and made available to a coroner?

Sir Robert Francis: In relation to a decision of whether information should be capable of being used in legal proceedings, there is no better qualified person than a High Court judge—so, absolutely. My advocating that there should be some qualification in relation to the family does not mean, in any way, that I suggest they should then be able to use that for litigation or other purposes. Indeed, some of the conditions you might impose on them in order for them to get the information are that they do not do those sort of things. There will be areas where it can be said that it is too sensitive for that. Of course, there may need to be a balancing of people's rights of privacy. It is really about ensuring that families feel that they are not being excluded or that something is being hidden from them. We need to build trust. I do not think that that decision needs to be taken by a High Court judge, because it is not about legal proceedings; it is about something really quite private.

Edward Argar: That is extremely helpful, thank you very much.

The Chair: Thank you, Sir Robert.

Examination of Witnesses

Stephen Chandler and Gerry Nosowska gave evidence.

4.29 pm

Q221 The Chair: We now come to our final witness session of the day. We will be joined by Stephen Chandler, who is the president of the Association of Directors of Adult Social Services. We will also be joined remotely by Gerry Nosowska, who is the chair of the British Association of Social Workers. We have until 5.15 pm for this session. I remind Members, because one of our witnesses is joining remotely, to be clear about who they are directing their questions to. May I ask both witnesses to introduce themselves for the record?

Stephen Chandler: Good afternoon, everyone. I am Stephen Chandler. As you said, I am currently the president of the Association of Directors of Adult Social Services. ADASS is a small charity that represents directors such as myself. My day job is director of adult services in Oxfordshire—up and down the country. It is probably important to say by way of context that I have only worked in the public sector. I left school and started my training as a nurse. The first 20 years of my career were in the NHS. I reached trust board level via a route of joint commissioning. The second half of my career is in local government, so in a way I am living proof of integration, if there was one.

Gerry Nosowska: I am Gerry Nosowska, and I am the chair of the British Association of Social Workers, which is the professional body for social work in the United Kingdom. We have around 22,000 members. I am here to represent the voice of social work, and our experts by experience who have worked with us.

Q222 Edward Timpson: May I start with you, Stephen? This may start to build on your dual professional career in both local government and the national health service. The Bill tries to ensure that much of the important data that flows between the two, and other services within the health and social care system, is more effectively and efficiently used for the benefit of patients and their outcomes, so how could a new provider dataset best meet the needs of local authorities in particular in meeting their Care Act duties?

Stephen Chandler: It is a really good question. We see the importance of bringing that collective data together in one place at every level in the stratified system. If you take the integrated care system, at the macro level it is really important for population-based planning. My local integrated care system covers Buckinghamshire, Oxfordshire and Berkshire—colloquially, BOB—and for some conditions dealing with it at that footprint is really important. Having data, for example, around cancer care and some of the specialist mental health services is really important.

The first thing that I did this morning was to chair a call looking at urgent care activity in our local system, and it was really important for the staff from the community trust and social care, as well as the acute staff, to be looking at a single view of the citizen—the patient—in that instance. We have done a lot of work to get there already. Again, this is about building on some good foundations, but it is critical for practitioners to do their job to have that data there, flowing readily, as well as for us in the planning and commissioning sense.

Q223 Edward Timpson: Gerry, I do not know whether that is something that you, from a social work perspective, would like to comment on.

Gerry Nosowska: Yes, please. The link between health and social care data is obviously essential, because health care impacts on people's lives and social lives, and social determinants impact on health. Joining those things up will help us to have a much more holistic picture, which is what social workers are interested in. For social workers, what we really want to understand are the trends, the gaps, and the barriers to wellbeing. In practice, having that data and that understanding—ideally a really local understanding—is important.

We would want to see social workers and experts by experience input into the kind of data that is collected, with an understanding in particular of under-met or unmet need, so that we can become more preventative, which is another aim of integration, and we have information about people who might fall outside of statutory responsibilities—self-funders, for example. We know that there is a real need to understand much more about the pressures on carers. This is an opportunity to think about how we can build more fairness locally through understanding the inconsistencies in people's experiences and outcomes. We also have a need to understand the impact of digital developments on people—how to ensure equity as we move into a wider range of working. Another hope would be that, ultimately, our health and social care leaders will be able to be more proactive using the data, because very often it feels like we are on the back foot.

Q224 Karin Smyth: I, too, did joint commissioning roles in Oxfordshire at one point—so, only the best.

Every project that I have seen or witnessed on integration—joint commissioning; joint collaboration—has fallen apart in the end because of accountability for the money. A finance director in a local authority has to account for its budgets, and the finance director and accountable officer of a health authority ultimately has to account for their budgets. If agreement cannot be held at that point, those projects fall apart.

We heard earlier that we still do not know any detail on the tariff or money flows as a result of changes in the Bill—changes that will come into place in April. We also have the better care fund outwith the Bill, and this week's announcement of a major change in funding is also outwith it. I wonder, with your ADASS hat on, how can you now help the Government to get around the problem for organisations regarding accountability for the money so that they do not fail?

Stephen Chandler: Again, that is a really good question. To be honest, a real challenge for those of us working in both health and social care is that uncertainty and delay in knowing the financial envelope we are working with. The announcements this week help to provide some clarity of what the future funding arrangement is likely to look like but, of course—from a local government point of view—until the spending review confirms the final settlement later this year, we will not know.

Some practical examples of how to mitigate or manage some of that uncertainty clearly come down to how much you are able to put together—and feel confident to put together. I suspect it was probably there in your day in Oxfordshire, but Oxfordshire has a large pooled budget arrangement—some of it completely risk-shared, but some of it not. That reflects the confidence and experience we have in using that money together. If I were not here providing testimony to you, I would be chairing a joint commissioning executive. In Oxfordshire, across health and social care, we have responsibility for more than £500 million in health and social care expenditure.

We are talking about continuing to build on some really good relationships and experiences that have existed but, rather than allowing them to evolve because individuals—either at a system level or a personal level—believe it is the right thing, it becomes policy and direction. I think that the success for us has to be

looking at where systems have been able to resolve some of those challenges. I am still working with my CCG colleagues in Oxfordshire around what we believe the better care fund will look like, having signed the agreement at the beginning of the year. That is about us becoming much more involved and therefore much more confident in each other.

You will appreciate that ADASS members are constantly providing reassurance and at times caution to our elected members on how far we could and should go in relation to sharing and using our resources. Some of the developments in the Bill around the establishment of integrated care partnerships fully provide a vehicle for some of that greater transparency and greater opportunity to look at the problem, the challenge and the opportunity from a place, and then from a system, point of view.

Q225 Karin Smyth: But, clearly, accountability is with the ICB and not with the partnership. We have heard that very clearly from NHS England.

Stephen Chandler: Yes, indeed. Without giving away too much personal information, my wife and I have a joint account. We each have our own accounts. She is not here, so I will say that I think I have the authority on the joint account, but if she was here she would probably say that she has.

The point I am trying to make is that a lot of this works on the formal agreement, but as much of it also works on the trust and confidence you build in those relationships. However, you cannot take away the facts, as you said. Equally, my elected members are very clear with me that I am responsible for ensuring that Oxfordshire County Council's resources are being managed and used in the way that they have approved.

Q226 Dr James Davies: Stephen Chandler, what are the principles that underlie the successful discharge of a patient from hospital, and does this Bill support that?

Stephen Chandler: The principles that underpin successful discharge are, quite simply, a person-centred, strength-based approach to enabling that individual to get back, preferably and ideally, to their own home, in a timely manner, with the level of support that they need to continue the recovery that will have started in the hospital but will not have finished in the hospital.

Where we have got that process right—I think the discharge to assess arrangements have really helped us in this—is by clarifying that the destination for discharge, for the majority of patients, has to be home. It is pathway 1—“Home First”, as it is often described—with the appropriate reablement support to maximise the recovery. That is good for the patient; it is good for us in local government, because it reduces the level of ongoing care needs in many cases; and it is good for the NHS, in that it frees up acute hospital beds. Those are the principles.

The way you successfully do that is by ensuring that the focus is on the patient and getting the patient—the citizen—to their home, not on the organisational form and who is responsible for it; in fairness, we all are. Discharge to assess has helped us to clarify “Home First” or pathway 1, and it has provided for some of those systems where one of the stumbling blocks was the resources to make that happen.

The challenge we have, though, is that we have introduced “Home First” at a system level nationally at a time when demand, linked to covid and the unintended consequences of covid, has really impacted. I reference my first meeting this morning, looking at acute pressures in Oxfordshire. We pride ourselves on getting people home, and “Home First”, but when I was chairing that call I heard myself saying, “We need to move people into some interim beds”, because I needed to create capacity in the acute system. I am hearing that coming through from director colleagues up and down the country; we are making less than ideal decisions for people because of just how much demand there is in the system. Let us be very clear: good discharge is discharge home, to your bed, with the support to enable you to maximise your recovery.

Q227 Dr Davies: Gerry, do you have any comments to add?

Gerry Nosowska: Yes, please. I completely agree with Stephen on the principles behind discharge to assess, and we have good experience within social work of it working when there is clear shared responsibility and the person is kept at the centre of it. We also have evidence from our members of the potential for rapid discharge to assess, without real advocacy and potentially without the involvement of social work, to lead to some undermining of people's rights around potentially being placed in a more restrictive environment and potentially struggling to have access to their family. It is partly about resourcing, but it is also about the ethos of human rights and people's right to be heard and to have choice, and then having the practical backing to follow things up well.

I think that people with experience of social care and health want to have a really clear and transparent process. For that to happen well, we still need some safeguards around that transition. It is a complex moment in people's lives, and I would want to see social work involvement in the guidance around that. But we also need to be thinking, if we want people to have more of their care closer to home, about how we rebalance resources—this relates to the previous question—by making sure that there are incentives for the resource to be put into community and local support and not just into the most urgent matters.

Stephen Chandler: Could I come back in? One thing that I omitted—it was remiss of me—was that we also need to never forget the importance of the support for carers, particularly around hospital discharge. All too often we are focusing on the individual in the hospital bed and the need to get them out, but we also need to ensure that we are not overlooking or not giving due regard to the role of the carer in that. If I could ask you to do anything, it would be this. Can you just ensure that the emphasis on the role of carers and how all of this is going to help the role of carers is brought through? Without carers, the health and care system would disintegrate rapidly.

Q228 Chris Skidmore: What confidence do you have in the discharge to assess model? Obviously, there have been pilots since 2016, but a lot of this was accelerated through the pandemic. That may be a good thing, but it might also be a bad thing, in that we have now to look at data in a very short timeframe. I served on the Health Committee over a decade ago, and during those discussions

[Chris Skidmore]

around tables like this, we used to talk about the Liverpool care pathway and how that was a good model to be following, until it unwound spectacularly and its local delivery was not as was thought in Committees like this. I wanted to ask what your view is on discharge to assess. You have mentioned carers and ensuring that we take into account the need for carers to be able to cope with any rapid discharges. Are there any other concerns that you might have about the model that should be taken into account?

Stephen Chandler: You are right: discharge to assess and, indeed, the “Home First” model of three pathways is not new. It has been around and used up and down the country for a decade or so now, so there are some well established services that you can draw some really good data from. Before I was in Oxfordshire, I was in Somerset, and we did a lot of work in the Somerset system to develop “Home First”, because our delays were really poor. We saw significant improvement in the outcomes for patients in the first instance. We then saw significant improvements in the flow from the acute hospitals, and I would say we also saw some significant benefits to the local authority in relation to the commitment it had to individuals on an ongoing basis.

I have been out of that system for over two years, but the work that it has done since then to take that even further is phenomenal, and I would encourage you to talk to some of the health and social care professionals in that system. One of the hallmarks of the system is that it does not rely solely on health and social care professionals. It has brought what it refers to as community agents and village agents into the hospital to help with discharge. It has got the voluntary sector as an equal partner. It is helping the individuals beyond the health and care needs that they have in leaving hospital.

I personally believe that discharge to assess is a robust and positive model, and I am hearing nothing to the contrary from director colleagues. What I am hearing from director colleagues, though, is real anxiety about conclusions that might be being drawn from the very point you made, which is that we have tried to evaluate discharge to assess in a very short period of time, and at a time when demand and pressure on the service has been at its most acute. Remember that it is not just the physical demand on those services that we have been experiencing; we have been working on an assumption that there is likely, at any point, to be an immediate surge in the demand for acute services, so we have been working to try to ensure that there is always capacity behind us should a further wave—either a local or a national wave—occur. We have been, up and down the country, operating systems at a pace that I have never seen before, as a result of covid. I would be cautious about drawing out any strong opinions around discharge to assess from an evaluation that was done during that covid period. For me, it is the only model that really helps people leave hospital in a timely manner.

I do not know about any of you, but as I get older and hospital admission becomes more likely, I want that hospital admission to deal with the acute need that requires it, but I want to go back home as quickly as I possibly can and to be able to continue to regain the independence I had. I do not want to become reliant on the local authority for all my support, which is why that reablement support at discharge is so critical.

Gerry probably wants to add to this, but the multidisciplinary approach that has a social worker and the local authority at its heart, building upon not just the professional expertise we bring but the relationships with our communities, our voluntary sector and our social care providers, is critical to that success.

Chris Skidmore: Thank you.

The Chair: Do you want to add anything, Ms Nosowska?

Gerry Nosowska: Yes, please. The issue with getting out of hospital is not about getting out of hospital; it is about getting your life back and getting back to your normal life. We know that reablement can be a really important part of that. The persistence, co-ordination and attention to the impact of a transition from hospital to home is something that social workers can really help with, and I do not think we should underestimate how potentially complex that can be. It is not just a question of somebody going back home and picking up where they left off.

Having really good support rapidly following up is absolutely essential. We have concerns about evidence of either inappropriate support or lack of support, support that has not been there or follow-up that has not happened. I would want us to be careful about checks and balances here.

Q229 Dr Whitford: May I start with you, Gerry? Do you think the provisions in the Bill will bring about genuine integration of health and social care, which is something that has been talked about through quite a lot of my lifetime in the NHS? If you could only change one thing in the Bill to get the best outcome from it, what would it be?

Gerry Nosowska: I think that this can achieve some strengthening of integration if it is not just a reorganisation that sucks in energy and resource, but a change that is absolutely about relationship, trust and understanding of local services, and it leads to a flow of resources and attention to that idea of home and community. There is potential, absolutely, but we have seen efforts to build integration before. What makes them work, certainly from a frontline point of view, is parity of esteem, trust, understanding and recognition of expertise, and relational time together.

One question I have is about how the integrated care partnership and the board have the appropriate input, the right people in there and the right people engaged, so that those relationships can really build, bearing in mind that we might be talking about quite a large area. We also have to make sure that from the point of view of the person who needs help or care, it is about their local community and neighbourhood. If I were going to change something, I would want to make sure that there was lived experience and social work expertise at the heart of those integrated structures.

Q230 Dr Whitford: A common theme that we have heard throughout both days of discussion is about how to capture the voices and the understanding from such a broad landscape within health and social care. In Scotland, we have been working on integration since about 2013. It is clear that in some areas it is massively successful and in other areas it is struggling. A lot of it comes down to relationships, understanding and willingness to step forward together.

May I ask you the same questions, Stephen? Do you think it will improve integration? What is the one thing you would change?

Stephen Chandler: I do believe that it will improve integration. As I said earlier, anything that helps those people who have yet to be convinced that integration is a good thing or provides them with some of the roadmaps for putting integration into place is great. From a local government point of view, strengthening the role that local government has in relation to the health and wellbeing of its citizens in the way that this does is good. I look forward to the refined guidance around the roles that health and wellbeing boards will have, because when I talk to my leader, I emphasise to her the importance that that gives her, as an elected member who chairs that board.

On whether I would change anything, we risk focusing a lot on either people who are acutely unwell or the elderly. From a local government and social care point of view, we work with people across their life course, including working-age adults, many of whom often have very complex underlying health and care needs. Recognising the need to ensure that health and care systems work well for a 25-year-old with learning disabilities who is trying to achieve his potential, or to help somebody with a severe and enduring mental illness to maintain their employment and therefore their accommodation, is really important.

Unfortunately, those voices are not always as obvious in what we are doing, but they are so important. I have been quoting this a lot of late, but each and every one of us is just one accident or life-changing illness away from needing that. We all recognise that we may need healthcare to deal with it, but very few of us think that we may then need and want the support of social care. In my case, if I had an accident or a significant stroke on the way home, I would need help maintaining my family. All the things we take for granted are only possible for a lot of people through the help that local government and social care provide, but doing that together with our health colleagues offers even greater opportunities.

Q231 Dr Whitford: As you say, we often think of the frail elderly when we think of social care, but is it not the case that the need for social care among working-age and younger people—you talked about learning difficulties and disability—is a growing and under-serviced area?

Stephen Chandler: It absolutely is. If you think of a young person with a complex health need associated with a learning disability, we need to work together to ensure that we are allowing them to maximise their potential while managing the risk associated with their health needs. For somebody who is coming out of the criminal justice system, maximising their potential to reintegrate into society, get a job and get a house is only possible if we work together. That is why integration must be much more than just a focus on the frail elderly.

Q232 Dr Whitford: So is there a bit of the Bill you would want to change? If we let you write an amendment, what would you write?

Stephen Chandler: I will come back to you on that. I cannot immediately think of a part.

Q233 Justin Madders: I have a couple of questions for Gerry. Your briefing made it clear that your members had a concern about discharge to assess; a clear majority

said they did not support it, although the numbers are quite small. Would you say that is an accurate reflection of your overall membership?

Gerry Nosowska: It is a genuine concern, yes—partly because, as Stephen was saying, it was rolled out very rapidly, at scale, during an unusual and very pressured time. Social workers have often been involved in those transitions, and very well, to advocate and to ensure that the person's voice is heard and that people do not get lost somewhere in the system or forgotten, but the concerns are around the potential weakening of that social work role.

Not everybody will need that, but I advocate for a social worker being available to anybody who might need that kind of co-ordination, therapeutic support and advocacy at the point of such a major life transition. We want a review of the model, but we also have concerns about just taking out wholesale all the elements around notification of social care and everything that was in the care Act. A lot will hinge on what the statutory guidance says about this. We must make sure we do not lose people in the system, because there is always an incentive to free up a valuable resource in hospital, but our statutory job is to promote wellbeing.

Q234 Justin Madders: You mentioned the review; your briefing said that you had expected one to be undertaken back in March, and it has not been done yet. Do you know why that has happened?

Gerry Nosowska: My understanding was that the discharge to assess was due to be reviewed, but I do not know why there has been a delay on that.

Q235 Justin Madders: Okay. But as far as you are aware, there has not been a review up to now?

Gerry Nosowska: I am not aware of a large-scale, formal review of it, no.

Justin Madders: Thank you. That is all I have, Chair.

Stephen Chandler: If I could help, I am aware that the Department of Health and Social Care has undertaken a review of some discharge to assess arrangements. It is not a national review, but I think about eight separate systems have been subject to a review. I have not seen the outcome of it, but a review of a limited capacity has taken place.

The Chair: Right. We have two Ministers now. Jo, did you want to ask something?

The Parliamentary Under-Secretary of State for Health and Social Care (Jo Churchill): No, my question was covered earlier. I had assumed that I would be called as a Back Bencher, if you see what I mean, as I am not the lead Minister on this Committee.

The Chair: I apologise for that, but I understood that we had decided to share the time between Back Benchers and Front Benchers, and I counted you among the Front Benchers. There we go. Never mind.

Q236 Jo Churchill: I will ask a supplementary. We have spoken about discharge. I have a particular interest in how we develop the system by the use of ICBs and

[Jo Churchill]

ICPs in order to highlight prevention. Very often, admission is the result of issues before, and as Stephen highlighted and Gerry alluded to, carers and families all take the weight of the stress when somebody is admitted, and when somebody is discharged and needs reablement. What does the Bill do, or what would you like to see in it, to help prevent people falling ill?

Stephen Chandler: The Bill reaffirms and formalises the requirement to plan very carefully for the population at a place level first, and then at a system level. In doing so, it sets up an integrated care partnership with a clear set of objectives, based on the population. Of course, it emphasises the importance of prevention as a way of helping people remain healthy and well for longer.

In Oxfordshire, we have set up our shadow partnership, and one of the areas we are looking at is our out-of-hospital support—particularly how we can avoid the need for hospital admissions. Again—this goes back to a point I made earlier—in doing so, we are looking at how we as a system can contribute individually, and therefore collectively, to reducing crisis and therefore the need for hospital admission. It has changed the tone of the discussion from, “Isn’t that an NHS responsibility, whether primary care or secondary care?” to, “How can we do better for our population?”.

You might say, “Well, hold on. That sounds like a very subtle change.” Let me be clear: some of these subtle changes really do make an impact. Coming back to an earlier question about resources, this also enables us to have the conversation around the prioritisation and impact of those resources. Instead of saying, “Here is the county council’s budget plan and here is the NHS’s”, we can ask how we make best use of that collective resource. The Bill helps by formalising that and providing some additional structures and focus on that.

The Bill is helpful, but it will be interesting to see how it works where, perhaps, systems have not had positive relationships or have had a more adversarial approach. I was really lucky in Somerset, because the emerging ICS there was coterminous with the local authority. It was a single provider. It was perfect in a way. I am in an ICS now where there are three different population groups. We know some ICSs have significantly more.

The opportunity is there to be grasped. This provides a fantastic focus if it can be ensured. In fairness to colleagues, the focus seems to be “start at place and work upwards”, rather than “start at system and work downwards”, in order to make really good differences to people, particularly around hospital admission avoidance. It also gives me, from a local authority point of view, greater leverage to challenge my NHS colleagues around their investment in secondary care and community care resources, because that area has, unfortunately, seen significant reductions over the years.

Q237 Jo Churchill: So you might see a positive outflow, in terms of more investment in community, in order to keep people well?

Stephen Chandler: Absolutely.

Q238 Jo Churchill: Thank you. Gerry?

Gerry Nosowska: Prevention is always undermined by the resources moving into urgent and acute needs. In practice, social workers are not able to do therapeutic,

restorative support work that they would be able to if they had the time to spend with people who need that. There is a fundamental resource issue that the Bill does not address directly, but it may help with the potential for pooling resources. Again, people in the community do not care whether it is a health or social care resource. If there is a need emerging that can be responded to, and preventive work can be done, it should happen without health and social care arguing about exactly whose purse it comes out of.

There are some really successful examples of reablement and preventing avoidable hospital admissions. We know it is possible. Scarcity does breed competition rather than collaboration, so that is something to think about. As for what the Bill might also do, the partnership strategy ought to have a very strong preventive element to it, and that needs to be dug down into locally—into particular communities, neighbourhoods and streets. That is where you really need lived experiences. I have a question about the regard that the integrated care board would have to that, and the potential for a wonderful, collaborative partnership strategy around prevention to be disregarded because of an acute need. I was listening to Robert Francis, and I think his suggestion that there be a written explanation to a local community if that happens is very good.

Q239 Edward Argar: Just one question to both of you, if I may. First, thank you for all that you and your members have done and continue to do. I say that as a former council cabinet member for adult social care and health and public health. I know the shadow Minister will share that sentiment. When I was doing that job some years ago and I was not quite so grey, the director of adult social services with whom I worked was a lady called Marian Harrington, who had been working in adult social care for a long time. A key point that she always emphasised to me was the importance of a close working relationship between the NHS locally, social care and the local council, particularly on discharge, but also on the ongoing care of people with multiple needs who were receiving social care. She would always say to me that although the framework was important, equally important were the culture, the behaviours, and trusting relationships between organisations in the framework.

I will turn to Stephen first and then to Gerry. We have sought to be permissive rather than prescriptive in this Bill. Have we struck broadly the right balance, or are there areas where it might need to be tweaked, either in legislation or in guidance?

Stephen Chandler: Your director colleague was absolutely right. I think that you have got the balance right in relation to permissiveness. I worry that the guidance does not prescribe directly how we should develop that culture, but having worked as long as I have, I realise that you cannot prescribe how relationships are formed and how cultures work. You have to create the conditions for success. Some of those conditions are in the Bill. I have talked about some of them in relation to the pooling, the boards and the assurance methodology. What has to be absolutely clear—and I am hearing it clearly, so it is not that I have not heard it—is the importance of seeing this as a vehicle for meaningful change to people’s lives, not a restructuring of health and social care. Rather, this is a vehicle for improving

the lives of people in communities and systems, and for allowing health and social care professionals to maximise their individual abilities for that collective good. In a way, there is a duty on me as a leader in the system to create that culture and environment.

You have not gone into the area of assurance, but for me it is really important that when assurance looks at a system, it looks at the leadership and how that leadership translates the freedom, the permissiveness, but also the accountability, clearly. The feedback I am hearing from our members is, “We favour the permissive approach that is taken in this.” We would not say that the tolerance should be changed one way or the other.

Edward Argar: Gerry?

Gerry Nosowska: Apologies, I think I lost my connection for a moment, so I might repeat some of the things that Stephen said. On the balance between permissive and rigid, we have an interest in the consistency of opportunity and outcomes for members of the population. Areas face different challenges, so it is important that locally there is flexibility around how those challenges are met.

What will hold those models together are the principles of ensuring transparency around decision making; the involvement of lived experience and clinical expertise in both social care and health; and real local accountability. Certainly, more local community decision making, planning and work, and less centralisation, is much more in tune with responding to the lived needs of people and their day-to-day priorities.

Edward Argar: Thank you, Gerry and Stephen. I have no further questions, Mr McCabe.

The Chair: May I thank our witnesses for their evidence? That brings today’s oral evidence sessions to a close. The Committee will meet again on Tuesday in Committee Room 14, with Mr Peter Bone in the Chair.

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

5.14 pm

Adjourned till Tuesday 14 September at twenty-five minutes past Nine o’clock.

Written evidence reported to the House

HC47 UK Freedom From Fluoride Alliance (UKFFFA)
HC48 Alcohol Health Alliance, Collective Voice, and
NHS Addictions Provider Alliance (joint submission)
HC49 Royal College of Obstetricians and Gynaecologists
(RCOG)
HC50 Alcohol Focus Scotland
HC51 Crisis

HC52 The Health Foundation
HC53 Vision Care for Homeless People
HC54 The Richmond Group of Charities
HC55 Pam Richards
HC56 British Medical Association (BMA)
HC57 Camurus Ltd
HC58 General Medical Council (GMC)
HC59 British Association of Social Workers