PARLIAMENTARY DEBATES

HOUSE OF COMMONS
OFFICIAL REPORT
GENERAL COMMITTEES

Public Bill Committee

HEALTH AND CARE BILL

Third Sitting

Thursday 9 September 2021

(Morning)

CONTENTS

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Monday 13 September 2021

The Committee consisted of the following Members:

Chairs: Steve McCabe, † Mrs Sheryll Murray

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

Huw Yardley, Sarah Ioannou, *Committee Clerks*

† attended the Committee

Witnesses

Sara Gorton, Head of Health, UNISON

Dr Chaand Nagpaul CBE, Chair of Council, British Medical Association

Professor Martin Marshall CBE, Chair of Council, Royal College of General Practitioners

Pat Cullen, General Secretary and Chief Executive, Royal College of Nursing

Professor Helen Stokes-Lampard, Chair, Academy of Medical Royal Colleges

Public Bill Committee

Thursday 9 September 2021

(Morning)

[Mrs Sheryll Murray *in the Chair*]

Health and Care Bill

11.30 am

The Chair: Before we begin, I have a few reminders. Please switch electronic devices to silent. Tea and coffee are not allowed during sittings of the Committee. I encourage Members to wear masks when they are not speaking, in line with the current Government guidance and that of the House of Commons Commission. Please also give each other and members of staff space when seated and when entering and leaving the room.

Members should send their speaking notes by email to hansardnotes@parliament.uk. Similarly, officials in the Gallery should communicate only electronically with Ministers. If everyone is agreed, we will go into private sitting to discuss lines of questioning.

11.31 am

The Committee deliberated in private.

Examination of Witnesses

Sara Gorton and Dr Chaand Nagpaul gave evidence.

11.32 am

The Chair: All our witnesses are appearing in person. It is helpful if Members direct their questions to specific witnesses.

Before calling the first panel of witnesses, I first remind all Members that questions should be limited to matters within the scope of the Bill and that we must stick to the timings in the programme order the Committee has agreed. For the first panel, we have until 12.15 pm.

Secondly, do any members of the Committee wish to declare any relevant interests in connection with the Bill?

Dr James Davies (Vale of Clwyd) (Con): Chair, I am still a member of the British Medical Association.

Dr Philippa Whitford (Central Ayrshire) (SNP): I remain a member of the BMA.

Mary Kelly Foy (City of Durham) (Lab): I am a member of Unison.

The Chair: Welcome Sara and Chaand. Will you kindly introduce yourselves, please?

Sara Gorton: Good morning. I am Sara—it is pronounced as if it is spelled with an h at the end. I am head of health at the trade union Unison.

Dr Chaand Nagpaul: My name is Dr Chaand Nagpaul. I am a GP in north London. I have been a GP for more than 30 years. I am chair of the BMA UK council. We represent doctors across the UK—more than 160,000. I represent all doctors of all types, working in hospitals, public health, general practice—you name it.

The Chair: Thank you. Will Members indicate whether they have any questions?

Q112 Edward Timpson (Eddisbury) (Con): Good morning, both. My name is Edward Timpson. I am the Member of Parliament for Eddisbury in Cheshire. This question is for both of you, but I will start with Sara. You were a signatory who supported NHS England's original proposals for legislative change back in 2019, I think. How much in the Bill before us reflects what you signed? What do the changes proposed bring for your members and to the health and care system, based on the proposals that you were in favour of back in 2019? That is probably something you will be able to answer as well, Dr Chaand Nagpaul, but Sara first.

Sara Gorton: I hope you have had our Bill submission, which makes clear the areas where we feel the new Bill needs some amending. You are right that Unison was a signatory, along with the BMA and other colleagues, to the letter in 2019, so it is a matter of concern that, after all this time and with such broad consensus, we are still awaiting the legislation.

The Select Committee process that followed that letter clearly identified that the changes that have been added would be contentious, so that is adding further delay. There are a variety of elements that stray outside the clear consensus that was set out in the 2019 proposals. However, we are committed to seeing an end to a system that holds lots of unnecessary cost implications for the NHS. There is an urgent need to stabilise and give clarity of employment, particularly for the 27,000-plus people who are currently in a state of flux, moving between the clinical commissioning groups and the proposed new ICSs.

There are some clear areas where we would like to talk to you about amending, improving and strengthening what is in the legislation at the moment. There is very, very clear support for following through on the commitments in that 2019 letter, to strip away the unnecessary procurement and competition regime.

Dr Chaand Nagpaul: The BMA was very opposed, and I believe rightly so, to the changes in 2012. We felt they introduced unnecessary competition in the NHS that did not work, has not worked, was not good for the taxpayer, fragmented the service and increased private sector involvement, which we can talk about later. We were very supportive of any changes that would reverse that legislation and have a duty of collaboration. In fact, I led a piece of work at the BMA called "Caring, supportive, collaborative: a future vision for the NHS", where we spelled out the sort of arrangements we believe would be right, in keeping with the principles of the national health service, and be right for patients, right for the workforce and right for the taxpayer.

In principle, the idea that the Government were relooking at or reversing the 2012 Act was something we supported. In one way, you could say that the repealing of section 75 is an element that we are supportive of. However, in doing so there are not sufficient safeguards and we believe there are many consequences that would actually do the reverse, in particular with regards to a lack of

assuredness around national health service providers being supported, in terms of the continuation—we can talk about this later—of unequal arrangements for the private sector provision of care compared to the NHS, and in terms of the lack of clinical engagement that would ensue. Of course, we are getting rid of a whole tier of local commissioning organisations, CCGs, and moving them at a more distant level, called ICSs. We are very concerned about that.

We are also concerned about some of the Secretary of State's powers and the balance between political accountability and political influence. There is a range of issues here that we think need to be addressed.

The other thing I should say is that we are in the midst of a pandemic. It is by no means over. It is hard to grasp the scale of the backlog of care. These changes have occurred when the profession has not been able to engage. I have not had the time to properly be involved in the input. With the BMA I have, but my colleagues have not. We believe that this is the wrong Bill at the wrong time. We should really address what the NHS needs and get the right Bill at the right time, in due course.

Q113 Edward Timpson: May I have one follow-up question, Mrs Murray? Picking up on your answers and accepting that you will have some aspects of the Bill that you will want to challenge and some amendments that you will want to put forward, the general thrust of the Bill, which is moving from a competition to a collaboration approach, is one that you both welcome. In that endeavour, and touching on some of the issues around procurement and the section 75 regulations governing NHS procurement, what benefits do you see in the changes to the role of the Competition and Markets Authority, which will change the current procurement regime? You touched on some of your concerns, but what are some of the potential benefits?

Sara Gorton: When we set out our support along with other parties in 2019, we saw huge benefits from not wasting unnecessary time, process, money and oversight on unnecessary competition, particularly where no provider other than the NHS was capable of providing the service. We support the removal of the role, as set out in that consensus letter, and that has travelled through to the legislation.

Where we think this could be more robust is the so-called provider selection regime that backs up exactly how the process will be carried out. We think that needs to be extended to make it absolutely explicit that the NHS is the preferred provider where there is an NHS service, that there need to be limits placed on roll-over without scrutiny from external providers and that that provision should be extended to cover non-clinical services. I think that earlier in the week you heard from employers how important the whole-team—the one-team—approach had been during the pandemic and how crucial that had been to tackling the spread of the virus and the work that the NHS had done. We think that principle should be extended and placed in the provider selection regime as well.

Dr Chaand Nagpaul: We absolutely agree that repealing section 75 is something the BMA has called for since 2012. It has been a nonsense that every single contract up to this point has to be put out to tender: huge amounts of waste of taxpayers' money and of time. As a GP, we were not even able to provide our own phlebotomy services without it going through a process, so in that sense, that is a good thing. However, just repealing section 75 without complementing it with the right tools to ensure collaboration will not work. In fact, the current arrangements repeal section 75 but do not provide any safeguards, or rather structural processes, that will, in our view, allow the NHS to work as a collaborative system.

The example I will give is that we believe the NHS should be the preferred provider of care wherever it is capable and wherever it is available to do so. There is so much evidence. People say: "Does it matter who provides?" Well, it does matter, and all the evidence in the last few years has shown repeated examples. Some of you will remember Circle taking over Hinchingbrooke Hospital. It is very easy for the private sector to say: "You know what? We will really run the NHS efficiently. We will use all the market skills we have." The NHS does not work like that. We forget at our peril the added value, the accountability, the loyalty and the good will that the NHS provides. We really do.

We only have to look back at the last year. Compare the vaccination programme run by the NHS and delivered by NHS staff to Test and Trace. Even with Test and Trace, compare the £400 million that Public Health England had to the billions that went to the private sector, and local public health teams reached 97% of contacts compared to 60% for the others. I am saying that it does matter. Your local acute trust is not there on a 10-year contract, willing to walk away after two years. It is there for your population; it cannot walk away. I think that given those things, we need to make sure the NHS is the preferred provider.

The Chair: Could I just ask you to keep your answers to within the scope of the Bill, please? Also, I ask if we could perhaps have more succinct answers. I still have several people who want to ask questions and we do not have a lot of time to get them in. I intend to call the Front Bench spokespeople at about 10 minutes to 12. I now move to the hon. Member for Arfon (Hywel Williams), but if we could keep to the confines of the Bill, that would be good.

Q114 Hywel Williams (Arfon) (PC): This question is specifically for Sara. You said in your response to the Bill that you agree with the Select Committee recommendation for an annual report on workforce shortages. The workforce move, specifically between England and Wales, very freely and the Governments of Wales, Scotland and Northern Ireland have their own appreciation of workforce shortages and how to respond. For example, after a long campaign, we now have a medical school being set up in Bangor in my constituency. Anyway, the point of my question is how do you see the Governments in those parts of the United Kingdom being able to feed into the process without ceding their power to decide for themselves? How do you see it going?

Sara Gorton: This is a matter of no small significance to organisations such as my own that have membership across the UK. That ability to understand and translate the statistics that we get from one environment in the UK to another, and understand how that feeds through and get a whole picture of it, is really difficult at the

moment. That is not just for the basic nuts and bolts of who is in the workforce at the moment, doing what job—the training plans, the workforce planning, and other aspects of workforce are really difficult to compare.

The short answer is that we would like to be involved in the interpretation, assuming that we do get that amendment through and the workforce reporting is on a more frequent basis than five years. We would like to be involved in the conversation about what that looks like, and how it can answer some of the issues that you have raised about feeding into a UK-wide perspective as well.

Q115 Hywel Williams: You see that in Wales, acting through the Welsh Government, so would you be seeking direct access regarding Welsh issues to the Government here in Westminster?

Sara Gorton: That is not something we have considered in the passage of the legislation so far, but we are certainly willing to talk about it in future.

Q116 Hywel Williams: Lastly—if I may, Chair, very briefly—a great number of people from Wales receive treatment in England, mainly from north Wales. They go to Merseyside and Manchester, and sometimes to London as well, so I am sure you would be in favour of the health bodies in those areas taking due regard of not only the health needs of their own population, but those of the population that comes in from Wales.

Sara Gorton: There are all sorts of workforce aspects that are very relevant to the England and Wales environment. The joint systems we have for pay and pensions, and workforce planning as well, all need to be factored in, but lots of work on the detail of the workforce reporting is needed.

Hywel Williams: Thank you.

Q117 Dr James Davies: I am interested in Unison's position on the social care aspects of the Bill, and in particular the CQC inspection that is proposed, and also the data collection powers, please.

Sara Gorton: That is not an area of the Bill that we focused on. Our main focus is on extending the provisions of the provider selection regime—the procurement. I can do some more work and send in something.

Q118 Dr Davies: That is fine. In that case, I will turn to Dr Chaand about a fit and proper persons register for those on NHS boards, or wishing to be on NHS boards. Do you have any views on that, and how legislation might expand?

Dr Chaand Nagpaul: I can tell you, just from the personal experience of being a GP over 30 years and speaking to doctors and representing doctors, that clinical engagement is vital. None of us can have any workplace that functions well until those who work within it feel engaged—feel that their voice is heard and their experience is understood. One of my biggest concerns about the current arrangements is that at the moment, for example, we have clinical commissioning groups. We have had seven GPs in my local area representing me and my colleagues. That is going to whittle down to no one, except one primary care doctor—we think—on an ICS board, which will be more remote, so we are diluting that local accountability. We vote for those doctors who sit on the CCG boards; we will not have any voting, so you are reducing the numbers who are influencing.

The second point is that we believe that those who sit on ICS boards should be facing the reality of the clinicians they represent. In the medical profession, we have two statutory bodies—the local medical committees and the local negotiating committees—that represent hospital doctors and GPs, and we believe that they should be there because of their motive: they will be clinicians representing clinicians, as opposed to what sometimes happens, which is doctors becoming managers. We know that that just disconnects, and if you have a disconnect, you will not be able to deliver your aims as a health service.

The other notable omission in the Bill, we believe, is the lack of public health presence. There is no place for a public health doctor. Again, I know that it is not in the scope of the Bill, but I think we have to learn from the past year. Public health is vital.

The Chair: We should stick to within the scope of the Bill.

Dr Chaand Nagpaul: The scope of the Bill should include a public health doctor who is independent, who should be an advocate. Those of you who were present in the 1990s will know that is exactly what we had. An independent public health voice on ICS boards can provide proper independent advice on population health. These are meant to be population commissioning bodies, in the interests of the public. Those are the things that we think should be changed.

Dr Davies: Thank you.

The Chair: Would anybody else like to ask a question from the Back Benches before I move to the Front-Bench spokespeople? Okay, that means that the SNP and Labour spokespeople have around 10 minutes. If they could keep it between nine and 10 minutes, that would be appreciated. I call Dr Philippa Whitford.

Q119 Dr Whitford: Thank you very much, Mrs Murray.

I will ask each of you the same question. Obviously, the aim of the Committee is to improve the Bill and bring in voices. Sara, if you could amend only one part of the Bill, what would it be, and what change do you think would improve it to the greatest degree? I know that you may have three or four—your submissions are here—but what do you want us to do that would have the biggest impact in improving what actually happens to health and social care?

Sara Gorton: I am going to choose something that I think none of the other people you hear from, except staff representative bodies, will pick up on. We would like to see the principle set out in the NHS constitution: to involve staff in decision making about how the service that they work in is set up and run, and in decisions that could affect the way they work. That principle is very clear in the NHS constitution; at the moment, with the system set up the way it is, that is transacted through the relationships that staff have with their employers at a provider level. If the system proposed in the Bill comes in, one of the risks is that

that may be undercut by decisions made at ICS level. I think trade unions and staff would feel as though they had a stake and would be reassured that they had involvement in future decisions with workforce implications made by those new bits of the system if that pledge were placed in the legislation and were the underpinning principle.

Dr Whitford: Thank you very much. Certainly, for some of the projects in Scotland around quality improvement or patient safety, the involvement of staff has actually made that work. Dr Nagpaul, I am pinning you down to one area and one change that you think will make a big difference.

Dr Chaand Nagpaul: The area would be around collaboration. We would want the section 75 regulations to be amended to make the NHS the preferred provider where it is able to do that. As part of that, there would be legislative changes on the duties of foundation trusts and other NHS providers to collaborate. We believe that at the moment, the changes for section 75 do not tally with any such duty, and we find that providers are focused on their own budgets and balance sheets, so you are talking about collaboration but not enabling it. We would want both those changes.

Q120 Dr Whitford: Obviously, because of the duty of balancing budgets, one of the frictions within the system is going to be where an area that is managing its budget has to collaborate with a service—perhaps in social care—that is not. Clearly, the aim of the Bill is to bring about integration.

Dr Chaand Nagpaul: Can I come back on that? At the moment, we are seeing foundation trusts thinking about their budgets, community providers thinking about theirs, and general practice as well. There is not even collaboration between the community and the hospital. No foundation trust currently has the ability to say, for example, "We will go beyond our budget and invest in the community—it may actually reduce our hospital admissions." At the moment there is no structure of processes to enable collaboration even within the NHS.

Q121 Dr Whitford: Do you not think that creating the overarching ICB is meant to look at that budget in a more holistic way?

Dr Chaand Nagpaul: It is only looking at it—like sitting around the table. We have had a lot of these arrangements in the past. Until you actually change the duty of a foundation trust to collaborate, so that its board meetings are no longer focused purely on its own balance sheet but actually look at the good of the local community as a statutory change, we do not think this will work. It will just be aspirational.

Q122 Dr Whitford: My second and final question to you both is about the healthcare safety investigations body. I was on the pre-legislative scrutiny Committee for it and I know there will be a lot of support for it across the House. However, on Tuesday we heard Keith Conradi's concerns about disclosure of safe space material. As a representative of the BMA, what is your view about that part of the Bill—part 4—and the degree to which it protects or weakens safe space, and how do you think it will affect staff engagement with the process?

Dr Chaand Nagpaul: We are supportive of the concept of the HSIB. We know that the NHS is riddled with a fear culture and a targeting of individuals for systemic failures. Based upon the aviation industry, it is absolutely right to have arrangements whereby you can learn from serious incidents, and healthcare staff, doctors and patients have a safe place where they are free, without fear, to contribute and learn from such incidents.

What is important—this is something we learned from a previous episode involving a doctor called Doctor Bawa-Garba, where there were a lot of issues around her information being disclosed—is that safe places should be safe places. They should be legally privileged. That will allow us to make the NHS safer, because I think that openness will allow us to address the systemic issues that actually make up the majority of medical errors in our health service.

Q123 Dr Whitford: And yourself, Sara?

Sara Gorton: The HSSIB is not an area that we have covered and focused on in our response, but like the BMA we are strongly supportive of attempts to drive a just and learning culture across the NHS. We have participated, through the social partnership forum in the NHS, in trying to spread that culture, and we are strongly supportive of the Freedom To Speak Up Guardian programme that is in operation in the NHS in England and its interaction with staff and their representative bodies.

Q124 Dr Whitford: But you would support, as Dr Nagpaul says, the idea that safe space should be protected?

Sara Gorton: Yes, indeed—certainly no opposition to that.

Dr Whitford: Thank you very much.

The Chair: Thank you very much. I now turn to Justin Madders, the shadow spokesman.

Q125 Justin Madders (Ellesmere Port and Neston) (Lab): Thank you, Mrs Murray. Good morning to the witnesses and thank you for coming today. Dr Nagpaul, you talked earlier about unequal arrangements for private sector provision. Could you expand a little on what you mean by that?

Dr Chaand Nagpaul: Yes. If you repeal section 75 but do not allow the NHS to be a preferred provider, we believe that opens the door for contracts to be handed out to the private sector and undermines the NHS.

Although it may fall out of scope, the point is that there is every reason for the NHS to be a preferred provider. The point I am making is that the NHS really is effective and cost-effective, and allows for a population approach from providers that have accountability to local populations.

The other problem we have at the moment, unless you put in legislation to make the NHS the preferred provider, is that at the moment a lot of contracts are going out to the private sector and are affecting workforce training. In some areas, cataract operations have been moved en bloc into the private sector, meaning that ophthalmology trainees are not even seeing them, and

the providers that are providing cataract operations are being paid the same sum of money but not providing the full service.

Another problem we have at the moment is cherry-picking. It has been there since 2012 and nothing in this Bill is legislatively addressing that. It means that you pay the same amount to a hospital—I am a GP and there is a list of exclusion criteria for any patient who has co-morbidities or complex conditions, so I cannot refer them there—but when something goes wrong in the middle of the night or on a weekend, they end up in the A&E of our local hospital.

That is why we believe it is really important that the Bill is amended to make the NHS the preferred provider; that is what we are referring to. We believe it will allow for a much more co-ordinated, accountable, locally focused and population-approach health service.

Q126 Justin Madders: We will see what we can do about that. In your written submission, you raised concerns about private providers sitting on ICS boards. Could you just say a little more about what your concerns are there?

Dr Chaand Nagpaul: If we have a Bill that is designed to support the NHS, we just feel that it does not make sense to then allow a private provider to sit on a commissioning board. We believe that there is an inherent conflict of interest. It is really important to understand that there is a difference between the private provider and the NHS. The private provider is ultimately driven by its financial motives, and to be sitting on a board influencing the spend of money where it may have an interest is a conflict of interest. That does not apply to the NHS. A doctor from a hospital does not have any financial gain to be made. I come back to the fact that we need to support the NHS, not as an ideological principle, but because it actually works.

Q127 Justin Madders: That is very clear, thank you. To play devil's advocate, can you think of any positive reason why there would be a need for private companies?

Dr Chaand Nagpaul: No, I do not. If the NHS cannot provide a service—if it does not have the capacity—and there is a private sector contract, the private provider needs to be held to account to deliver. As I say, I think the same rules should be applied, so that if there is a complication, they need to be accountable for that complication, rather than the patient going back to the NHS, which picks up the pieces. There is a need to hold private providers to account where they are contracted to provide care, but we do not approve of them sitting on the commissioning board, which is about the use of public resources in the interests of local populations. That should be a commissioning decision, and commissioners who are accountable to the NHS and providers of the NHS should be sitting as part of that arrangement.

Q128 Justin Madders: Thank you. In your submission, you also referred to concerns about some of the Secretary of State's powers proposed in the Bill. Could you say a little more about what those concerns are, please?

Dr Chaand Nagpaul: Sure. One is the NHS mandate, which spells out how the NHS functions. At the moment, the powers allow the Secretary of State to amend the mandate. We would like that to be affirmative. We would like it to be approved by Parliament, and therefore Parliament would vote to agree changes to the mandate. That is one area.

The other concern is about the local reconfigurations. We know how politically sensitive these things can be. We would not want the Secretary of State to have disproportionate powers in those arrangements, which will often be more susceptible to political influence. We think that those need to be safeguarded by mandated clinician involvement, so that we make the right decisions about local services. It is a counterbalance: we want a health service that has local clinician leadership, but on the other hand the Secretary of State can intervene. We think that is an amendment that needs to be made.

Q129 Justin Madders: Thank you. Ms Gorton, good afternoon—it is afternoon now. You obviously represent a huge range of employees within the NHS. What role do you see ICBs having in direct negotiations and consultation with the workforce?

Sara Gorton: There are a couple of points to raise here. First, we would like to see in the legislation confirmation of what we have been given assurances of in guidance and conversation—that there is no intention for any new parts of the system to undermine the existing collective arrangements and that, for the workforce I represent, the collective agenda for change agreement would apply for their staff. There is a very clear amendment that could be supported to ensure the new bodies are listed as what are called annex 1 employers in the relevant terms and conditions documents. That is one aspect.

The other aspect is the role that the provider selection regime can play—sorry, not the provider selection regime; what are called the people responsibilities, which are set out in some of the guidance materials that have only been recently published to support the legislation. They set out 10 areas relating to workforce over which the new bodies may have scope. We would like to see those areas of scope clearly defined within the legislation. That is why what I said earlier about the commitment to involve staff through the constitution promise is so important. We want to ensure that, if decisions are made at system level that undercut the role that staff have in making decisions within providers—if there are overarching decisions made about workforce—staff have an opportunity, through their representatives, to understand what the impact might be and to influence that conversation.

Q130 Justin Madders: Thank you. That is very helpful. You have probably seen quite a lot of media coverage today about the possible salaries of the chief executives of the ICBs—up to £270,000. What do your members, who have had 10 years of pay restraint, feel about those kind of figures being bandied about?

Sara Gorton: We are supposed to stick to polite language in here, aren't we? You can all probably imagine what most of our members feel. Sticking within the scope of the Bill, as we have been asked to, the relevant segue is to go back to the extension of the provider selection regime to the non-clinical services. We are strongly supportive of the measures that have been put in place to ensure that service sustainability and social value are taken into account. Clearly, however, extending

those provisions to non-clinical services would create a culture of in-sourcing, of valuing all members of the healthcare team equally, and place those on an equal footing.

Q131 Justin Madders: Moving on to the proposals in the Bill regarding professional regulation, do you see any risk or have any concerns about that, as it is set out?

Sara Gorton: As you have hopefully seen in our briefing, we are calling for that to be either explained in much more detail in the guidance, or dropped from the legislation. We are already seeing concerns from regulated occupations that this could lead to a sort of "regulation-lite" scenario, and there are concerns that, without it being clear exactly what the proposals would entail, this could be a hostage to fortune. We would very much like to see some clarity on that, or have it taken out at this stage.

Q132 Justin Madders: I will ask the same question that I asked Dr Nagpaul about the involvement of private providers on ICBs. Is there, in your mind, any possible argument as to why it might be a good idea?

Sara Gorton: What we are more concerned about is the potential risk that, if involved in the ICBs and in the partnerships, they could exert influence over the exploratory stage of discussions, which could tilt the balance their way. That seems out of kilter when we do not have clarity that staff of the NHS will have the opportunity to be involved at the same sort of level. We are very keen to ensure that we support amendments making any of the processes, and the way that the boards meet, more transparent, and, clearly, subject to the freedom of information process.

Q133 Justin Madders: Just one final question: at the moment, do you feel that there are enough avenues for trade union staff representation to feed into the boards?

Sara Gorton: At the moment, there is no explicit route through. What is set out in the published guidance documents is that the route for trade unions to be involved will be through the regional structures of NHS England and NHS Improvement. That is at a distance, and potentially after decisions have been made. Putting in a clear link, through that staff pledge in the NHS constitution and having that underpinning in the legislation, would really make clear the principle of staff involvement and engagement at the earliest stage of decisions.

Justin Madders: Thank you very much.

Q134 The Minister for Health (Edward Argar): Sara and Chand, welcome. I will try to get through three questions, but, if I run out of time, I will settle for two. We heard from a significant number of witnesses on Tuesday; you will have seen or read what they said. The overwhelming majority said that now was the right time to do this. Sara, I noticed that, in your evidence, notwithstanding the challenges you posed about some of the content that you would disagree with, you highlighted that this was due in 2019, on the basis of the original consultation, and asked why it had taken so long.

To both of you, do you think that now is the right time? I know that Chand has answered that, but this second part might apply to him: if it is not, when is the right time?

Sara Gorton: We were strong opponents of the 2012 legislation, so, in our view, the right time to do this would have been to not put that legislation through. However, we have been waiting for this batch of changes for some time. It has been evident, from 2013-14, and certainly since the "Five Year Forward View" was published, that what we were doing was having a structural workaround with people tacitly agreeing to almost ignore legislation. That is just not acceptable in the system.

Certainly, for my members who have been moved into new arm's length bodies, moved around those bodies, and are now subject to another change, they want the security of knowing who is going to be employing them this time next year. In our view, the changes, both to the competition and procurement regime, and to clarifying how the new bodies will operate and what powers they will have, cannot wait. There are lots of other aspects that, as you can see from our briefing, we suggest could wait for future debate.

Dr Chaand Nagpaul: I want to be clear: we do not support the status quo. There is a pressing need to repeal much of the 2012 Act. However, I cannot overestimate how much the pandemic has affected us. We have not been able to be engaged, so it has to be asked: why do we need the Bill at this moment in time, when we are all absolutely overwhelmed? We know that any reorganisation of the health service means that people get distracted from their core work. The process of reorganisation takes human resource time. We have not been able to engage with this as we should, so we do not think that this is the right time.

The right time would be decided by two factors: first, when we are through the worst of what we are going through at the moment, and secondly, when the legitimate concerns we have are addressed, and there are the amendments that we would like to see. This Bill can shape the future of our health service. Get the right Bill, at the right time.

Q135 Edward Argar: I have read your evidence very carefully, and your views on the 2012 Act are clear. To put in context what sort of changes—not withstanding your evidence—the BMA is and is not supportive of, which of the 1999, 2001, 2003, and 2006 Acts did the BMA come out fully in support of?

Dr Chaand Nagpaul: I am afraid I will have to let you know later, as I do not, off the top of my head, know exactly what those Bills contained.

Q136 Edward Argar: Thank you. Feel free to write to the Committee. This is my final question, so that we finish on time. This relates directly to the BMA's evidence, but Sarah may want to come in on this afterwards. You both touched on the procurement regulations in section 75 of the 2012 legislation; why are saying that NHS, or public sector, provision should be the default, rather than whatever provision provides the best outcome for patients? You highlighted the very clear view that NHS and public sector provision is the most cost-effective and the most clinically effective; it would therefore succeed anyway if the question is what delivers the best outcomes. Why preset that default?

Dr Chaand Nagpaul: First, the rules at the moment do not factor in that the NHS provides, in addition to the service, a complete, full body of care for patients.

The same money would go on a hip replacement in the private sector. Secondly, there is the training element that I mentioned earlier. Thirdly, no acute NHS trust can walk away after two years—it is there to provide care to its population—but Serco was able to walk away after two years. We have many examples of private companies that have ended their GP contracts. Serco left an out-of-hours contract in Cornwall; that does not happen in the NHS. My local hospital has been there for as long as I can remember—it cannot walk away. The NHS provides accountability and duty, but more importantly, it is actually cost-effective. The staff have national terms and conditions; they provide huge amounts of good will and work above their contracts. It just makes sense to be resourcing our NHS.

Every time you take a contract away from the NHS, it is defunding the local system. We want taxpayers' money to bolster an NHS that is co-ordinated, because we also want changes in the legislative requirements for foundation trusts and other NHS bodies to collaborate.

Q137 Edward Argar: In the minute left, Sarah, is there anything you wanted to add?

Sara Gorton: What the legislation sets out is a proposal for system working. Therefore, having something that disrupts that system is potentially counterproductive. I strongly support putting the NHS first—the NHS default—into the provider selection regime that is listed in clause 68.

The Chair: Thank you very much. We are making excellent time.

Justin Madders: On a point of order, Mrs Murray. On the Minister's question to the BMA witness about previous Acts that the BMA may have endorsed, that would clearly be out of scope as evidence. I would not want Dr Nagpaul to waste time researching an answer that the Committee could not take into account.

Edward Argar: Further to that point of order, Mrs Murray. Would it help if I set out the context in which I believe that question relates directly to the content of the Bill? Much of what is discussed in the Bill relates to previous legislation that has grown up over time; understanding which pieces of legislation the BMA supports will help us to better understand the evidence it has put forward on this legislation, and its context.

The Chair: Mr Madders, I think that the Minister has taken on board your point of order and paid attention to it. Thank you, Minister.

As there are no further questions, because we are out of time, I thank our witnesses very much for their evidence. We will move on to the next panel.

Examination of Witnesses

Professor Martin Marshall, Pat Cullen and Professor Helen Stokes-Lampard gave evidence.

12.17 pm

The Chair: We will now hear from Professor Martin Marshall, the chair of the Council of the Royal College of General Practitioners; Pat Cullen, the general secretary and chief executive of the Royal College of Nursing; and Professor Helen Stokes-Lampard, the chair of the Academy of Medical Royal Colleges—all of whom are appearing in person. Starting with Pat Cullen, could I ask you to introduce yourselves for the record?

Pat Cullen: I am Pat Cullen. Thank you for inviting me along. I am the recently appointed chief executive and general secretary of the Royal College of Nursing. We are a trade union and a professional organisation, and we represent more than 480,000 nurses.

Professor Helen Stokes-Lampard: Hi! I am Professor Helen Stokes-Lampard, and I am chair of the Academy of Medical Royal Colleges. The Academy is the umbrella body for all the medical royal colleges in the UK and Ireland; we also cover the independent medical faculties.

Professor Martin Marshall: Good afternoon, everybody. I am Martin Marshall, chair of the Royal College of General Practitioners and a practising GP in Newham in east London.

The Chair: Thank you. We have until 1 pm for this session, so I propose the same timings as for the last one. I call on Back-Bench Members to indicate if they have any questions.

Q138 Dr James Davies: Good afternoon and welcome. I would like to ask all three panellists about the workforce projection elements of the Bill and the adequacy of those, starting with Pat.

Pat Cullen: We have yet to submit our evidence in relation to the Bill—we are currently doing that. It is very clear to us and our members that the Bill does not go far enough on accountability for the workforce. We are very clear that the workforce shortages in nursing are not addressed properly through the Bill.

The Chair: Could you speak up a little bit, please? We are finding it quite difficult to hear you.

Pat Cullen: That is not normal, mind you, for a woman from Northern Ireland! I will try again. Principally, our response to the Bill is that the accountability issues do not go far enough in the Bill. We are asking for the Secretary of State for Health and Social Care to not only clearly have full accountability and responsibility for the assessment of workforce planning, but ensure accountability for the delivery of the workforce. It is not just about the assessment. We are all clear about and know about—it has been played out well—the shortages of nursing staff. We had 40,000 vacancies heading into the pandemic. We make up 26% of the workforce. Everywhere you see a patient, you see a nurse, and we need nurses. That is the only way to provide the best care for our patients. We say that the legislator at the highest level must have that accountability and responsibility for the assessment and the delivery of the workforce shortages in nursing.

Professor Helen Stokes-Lampard: The Academy of Medical Royal Colleges has worked very closely with the Government on the development of the Bill, and we have been very grateful for the opportunity to collaborate so far. We have been largely supportive of the direction of travel, but the workforce, in clause 33 particularly, is the one area where we probably still have the greatest concern. We feel that it needs to go further. That builds

on exactly what Pat has said. Along with other organisations such as the RCN, we have co-signed an amendment that goes further on that.

We feel that workforce planning needs to be very transparent and collaborative across multiple organisations and agencies, but ultimately owned by the Secretary of State for Health and Social Care. It needs to take on board both the projected supply of workforce already in the pipeline and projected demand. We anticipate that the line representing workforce supply going upwards, and the line representing the demand for need and care climbing even more steeply. There is a gap between them that, at the moment, we cannot quantify. It needs to be quantified and made transparent. Even if the state does not feel it can fund for that gap, we should not be afraid of knowledge. Without knowledge, we run into the risk of repeating historical cycles of boom and bust when it comes to workforce planning. That would be our big plea to you: try to strengthen that, and please do not fear knowledge—it will help us in the end.

Professor Martin Marshall: The Royal College of General Practitioners, as members of the Academy, are completely in line with Helen's position. There is a marked workforce crisis relating to general practitioners and other health professionals who work in general practice. Without an adequate workforce, it will be very difficult to deliver any of the ambitions of the Bill, so we are absolutely in favour of a much stronger emphasis on workforce. I think workforce planning is an oxymoron and has been for many years in the NHS. This is an opportunity to do something about it.

Q139 Chris Skidmore (Kingswood) (Con): I have two questions. On clause 33, which we have just spoken about, what would be the best compromise when it comes to planning for a workforce strategy? The Bill suggests five years, and that the Secretary of State should direct Health Education England and NHS England to produce this report. Would you suggest a more frequent process? If so, how frequent should it be? What organisations should be involved with workforce planning, and how would you see that operating?

Professor Helen Stokes-Lampard: We have thought about this seriously—what would be a sensible interval? Having discussed this extensively with colleagues right across the health and care landscape, we have come to the conclusion that two-yearly feels about right. Annually just feels too intense, and it would be too labour-intensive to get meaningful data out in that period; you would run the risk of fatigue in the system. If we go much longer than two years, we run the risk of fundamental change coming into the system—another pandemic or some other national thing happening that needs to be factored in, and of which we need to be made aware. We have come down on two years, and that is the proposal that we put forward.

Every time, the work needs to look five, 10 and 20 years ahead. We need that longer-term projection. It takes so long to train doctors—that is the agency that I represent—from their entry to medical school to consultant independent practice that you need to have that time lag built into the system. That way, you can look at the totality of the workforce and ensure that you have the right interim solutions for the needs of the population.

Q140 Chris Skidmore: Do the other organisations agree with that assessment?

Pat Cullen: Yes, we would certainly agree. We believe that annual plans are too short-term for the reasons that Helen has laid out—training nurses takes three years, and when you think about the added training for clinical specialist nurses and other advanced nurses in practice, it absolutely needs to be at least two years.

Professor Martin Marshall: We agree that two years is the right interval. I think the request of HEE to produce a high-level framework is a good start—that is correct—but it is just a start, and a high-level framework does not help workforce planning on the ground. It is right that most workforce planning should happen at a local level, but some elements need to be managed nationally. Basically, this is such an important issue for the NHS that it needs to be absolutely top priority in the Bill.

Professor Helen Stokes-Lampard: I am conscious that I did not answer the second part of your question about who should be involved. We propose that this be led by Health Education England, but it has to be done in collaboration with NHS England. We cannot look at the needs of the population without involving them. There are other bodies, too. For doctors in particular, we would argue that the Medical Schools Council and the GMC have to be involved. I am sure Pat will have similar views.

In terms of population needs, we need to look at the Office for Budget Responsibility and use the resources of the Office for National Statistics. We need to go widely on this; it is not about saying, "That is one person's problem to sort, and then the Secretary of State signs it off." This is a truly collaborative effort, and we need to legislate for and enable collaboration in the greatest possible sense.

Q141 Chris Skidmore: On clause 19 and the duties on the ICBs and ICSs, particularly, in your case, around education, training and research, do you have any thoughts about who might be able to help those ICCs with their duties, and about the role of universities, which are not mentioned in the Bill? How can we integrate not just health and social care, which are the focus of the Bill, but education and training, and what needs to take place for that integration to happen?

Professor Martin Marshall: Universities have an enormous amount to offer. If we look at the way that universities have operated in academic health science networks in the current structures, in many parts they have played a really significant role. I absolutely think that ICSs give us an opportunity to bring universities into the debate.

Education is particularly important here. If the Bill is to achieve its potential of better population health, there are some massive training leads for all the workforce, and universities clearly need to be involved in that process.

Professor Helen Stokes-Lampard: To supplement what Martin has said, we have not criticised what the Bill says at the moment. For us, this is where the Bill is an enabler, and we hope it is a greater enabler that what we have currently. In that sense, the logical thing to do next is greater collaboration. The challenge with legislation is that although it can remove barriers and enable, it does not actually change culture. We need to engage with the individuals who are establishing this and ensure that the frontline educators and clinicians are on board with it to make it a reality.

Clearly, I support what Martin said about the vital need for education right across the piece. I think you will find that the universities are very much up for that and keen. It has been difficult to expand training places across nursing and medicine in short order, but it is something the universities are really stepping up to do. I think we would all argue that we want to go further and faster to deliver the best possible care for the public.

The Chair: Thank you very much. We have about 10 minutes, and three people have indicated that they want to ask questions, so if we could direct our questions to one person and keep questions and answers brief, that would be very helpful, because I would like to include everybody.

Q142 Hywel Williams: I have a question for Pat. You have indicated some concern about the new powers regarding professional regulators and the fact that there may be changes, including the dismissal of regulators and that sort of thing, through secondary legislation. Given that those bodies are UK-wide, do you think that the Senedd, the Welsh Government in Cardiff, and the other Governments should have some input into those sorts of decisions about professional regulators?

Pat Cullen: We have had some thoughts about this across the countries—and we can learn from all of the countries, really. Of course, you will know from my accent that I come from Northern Ireland, and our regulator is a four-country regulator. In relation to the standards that are referred to within the Bill, I think our royal college will play an important role in terms of working with our regulator to look at some of the devolved responsibilities and the role that we can play in setting standards for our profession, and assisting and supporting our regulator in the setting of those standards right across the country, and obviously the other countries as well.

More recently, we have just brought out our nursing workforce standards, which apply across the four countries, and we had significant engagement in those right across the four countries. If you look at those standards being aligned in the new Bill and reading across to the new Bill, working across with our regulator and having more powers devolved to a royal college will enhance the regulator's response to standards and the applicability of those standards, and their implementation across the countries.

The Chair: Thank you very much, Mr Williams. I now turn to Edward Timpson.

Q143 Edward Timpson: Thank you very much, Mrs Murray. This is directed to Martin. Perhaps unsurprisingly, there is a lot of demand on representation or membership of the integrated care boards, and I think we heard evidence earlier that in my own area of Cheshire and Merseyside, if everyone who wanted to sit around the table was sitting around the table, there would have to be 63 seats, which is clearly unwieldy and unworkable. Specifically thinking about the organisations that you represent, when it comes to clinical representation, moving from the CCGs to the ICS, what do you think should be specified about clinical representation on these new ICBs?

Professor Martin Marshall: We have pushed very hard for clinical representation on the board, and I think that the acknowledgement that a primary care representative is required is absolutely right. Of course, one representative is not going to change the world, but there is something symbolic about it, and there is something about having a primary care voice that is really important. The nature of that primary care voice is interesting, because of course, general practice is a multi-disciplinary specialty, and we work very closely with our nursing colleagues, our pharmacy colleagues and a whole range of different clinical disciplines. I think that in most localities, it is likely that a GP will be the representative of primary care, most obviously because general practice has a long track record of being involved in the management of the NHS, and the onus will then be on that general practitioner to represent all of the primary care voices. As a college, just last week we had a very productive workshop involving all the different specialties in primary care, and a strong sense of consensus that we must and will work together to drive this forward.

I have a particular focus on the primary care voice—I guess that is my job; Helen might refer to other clinical voices—but it is particularly important for primary care, for the simple reason that in primary care, we deal with about 90% of the presentations that come to the NHS every day. We live in, and are closest to, the communities that we serve. We are trained to address the broader determinants of health. We are trained as doctors, as GPs, for example, but we are trained to understand the social determinants of health and health inequalities. Everything that is important about this Bill is stuff that general practice is expert in, so we feel the general practice voice is really important.

One of our biggest concerns—not so much with the legislation, but the way that this is likely to play out on the ground—is that the general practice voice threatens to be diminished as a consequence of the change in legislation around CCGs. If you look at what the boards will look like, we know that the acute trusts will still have their governance arrangements and their budgets. CCGs are going to disappear. We are not necessarily saying that that is the wrong thing, but it means that a lot of the experienced clinical leaders in CCGs risk getting lost, and we know that that is not happening in some of the ICSs around the country, but it is happening in others. The CCG staff are just being transferred into the ICSs, but there is a real risk that the leaders who have been around for a decade or two decades, who understand the nature of organisational change and understand what the Bill is trying to achieve, will get lost. We know from the evidence that the most successful integrated care organisations around the world are the ones that are primary care led, so if primary care does not have a dominant voice, the ICSs are much less likely to achieve their potential.

The Chair: Thank you.

Q144 Karin Smyth (Bristol South) (Lab): It is as though we have rehearsed, because that was my question. I was a GP manager leader in my area before coming to Parliament, and GPs have been at the forefront of developing CCGs, as you said, which followed on from the great desire of Governments to move the gatekeeper up the food chain, shall we say, in order to provide clinical leadership and—to be crude—control costs.

I would like to ask this to everybody. Personally, I think this issue of clinical representation is a backwards step in this Bill. You may or may not want to say

whether you think that is true, but given that you have said that successful organisations are primary care-led, and none of these organisations will be clinically-led, let alone primary care-led, that is not rectifiable in the Bill through an amendment, I suspect. How will we ensure that these organisations are successful from a clinical leadership perspective, given the current state of the legislation, or would you be putting forward suggestions for amendments? I am sorry, but I do not think I have time to ask all three of you. Currently, CCGs are GP-led, so—

The Chair: We have about three minutes, so could you keep your answers to one minute each?

Professor Martin Marshall: I speak very rapidly.

"How?" is an interesting question. Can it be done in legislation? I think there have to be some legislative levers to ensure that this happens properly on the ground. There are some examples—one in Surrey and one in Gloucestershire—where there is already a very strong commitment to a robust primary care voice, so there is something about shining a light on those examples, which others can learn from. That is not a legislative responsibility, but it is a really important one. There is certainly something about holding localities to account and understanding what is happening on the ground at regular intervals, in terms of whether those voices are present and whether they are being heard.

Professor Helen Stokes-Lampard: I would strongly advocate that everyone takes a look at the very excellent document that NHS England put out just a few days ago, which is about implementation guidance for ICSs on clinical leadership. I have to say that whoever put it together absolutely nailed it, in terms of what to do and how. There is a how-to guide there. I had no input into it, so I feel I can shamelessly give you that, because there are a lot of answers in there.

The legislation as it stands on clinical leadership does not prevent any of those things, as I understand it. That goes back to my other point about ensuring that the legislation removes barriers and is a facilitative enabler of these things. Clearly, my colleagues have more specific things about it. I just want to draw to your attention to the fact that it says that clinicians who get involved in leadership need to be supported, protected and resourced to do so, because unfortunately clinician time is expensive. That comes back to the original conversation about workforce, but we have to factor it in. The evidence is quite clear that better clinical input in all disciplines helps systems run better and be safer. It is more cost-effective, but that needs support factored in from the outside.

Pat Cullen: You will not be surprised to hear me say that the Bill does not go far enough, and we will be looking for an amendment. There absolutely needs to be a director of nursing at the top table if you are to prevent what has happened and what has gone before, where the financial balancing of books significantly impacts the decisions of that table. The only way to ensure patient safety and quality of care, and that the workforce that we deserve and need for our patients are paramount and the centre of those discussions, is to have our clinical leaders at the top table. That must be a director of nursing, not only to bring evidence on the clinical care that needs to be delivered to the table to shape each strategic decision, but to hold that person to account for our workforce and ensure that the workforce is available to provide care for our patients.

The Chair: Thank you very much. We now turn to the SNP spokesperson, Dr Philippa Whitford. You have about seven minutes.

Q145 Dr Whitford: Thank you very much, Ms Murray. I hope to try to do two questions, so can you focus your answers? If you heard the earlier session, you will know what the first one is. If there is one part of the Bill that you could change, what would it be and what would the change be? Our job over the next couple of months is to improve the Bill, so what would get the biggest bang for our buck?

Pat Cullen: No surprise, it is the accountability for workforce planning sitting and resting with the Secretary of State. I do not think any legislator or politician should have any issue with that. It is not about accountability being forced and pushed to the frontline. Of course, frontline clinical staff will have accountability and responsibility for the delivery of care, but that needs to be enshrined in legislation, and the Secretary of State needs to hold full accountability for workforce assessment and planning, and for ensuring that we have the workforce to deliver the best care for our patients. We owe that to every single nurse in the services today.

Q146 Dr Whitford: Obviously, Wales and Scotland brought in safe staffing legislation, which does not yet exist in England. Of course, workforces move around, so although this is very much a plan for the workforce in England, we do not want to get into robbing Peter to pay Paul. Do you feel that the consultation around that needs to be strengthened—things such as the foundation places for junior doctors might relate more to Helen and Martin—to ensure that the Bill actually takes account of different strategies?

Pat Cullen: Absolutely, and of course we look with envy at Wales and Scotland, although Scotland is lagging behind our Welsh colleagues in terms of safe staffing legislation. We will certainly push for safe staffing legislation to be brought forward in England as well. Of course, it is no surprise to anyone that our wonderful nurses moved to industrial action in Northern Ireland to push not for pay, but for safe nurse staffing legislation. That is what is important to every single nurse who is trying to care for their patients today.

Q147 Dr Whitford: Thanks very much. Helen, what would you pick as your one place?

Professor Helen Stokes-Lampard: My one place is the same: the workforce issue and clause 33. It is about looking at both the supply of the workforce and the needs of the population—I think it has to be both those things. The responsibility rests with the Secretary of State.

Professor Martin Marshall: I have stated mine already: the strong general practice voice is what will make a difference. That is what will turn a currently fragmented service into an integrated one, and a service that is focused on treating diseases into one focused on preventing them.

Q148 Dr Whitford: This is also, hopefully, a very short, specific one—I will start with you, Martin—on the Healthcare Safety Investigation Body, and the issue of safe space disclosure and discussion after an incident. In the Bill, coroners have access, for example, and others are lobbying for access. What is your view of how tight the safe space should actually be to get staff to really engage with it?

Professor Martin Marshall: Considerably tighter than it is at the moment. I am absolutely in support of safe spaces. A culture change needs to happen here, and legislation seems to be one of the ways of trying to promote that to get us into a much happier space than at the moment.

Q149 Dr Whitford: Do you think there is a misunderstanding of what would be covered by "safe space", in that it should really apply only to the evidence that HSIB gathers? It does not stop other bodies having access to medical records or doing their own investigations, which they do now.

Professor Martin Marshall: I am not sure I know enough about it to be able to answer that question, I am afraid.

Professor Helen Stokes-Lampard: The academy's position is that we support the proposals as they are worded—we have not suggested any amendments to them. We certainly believe that putting HSIB on a more formal footing is the right thing to do. On what Martin said about safe spaces being the right thing going forward, there may be detail and finessing in the implementation of that, but no concerns have been raised with us as an organisation representing royal colleges.

Dr Whitford: And Pat?

The Chair: Pat, before you speak, could I ask you to swivel the microphone to your left towards you a bit? We are still having difficulty hearing you.

Pat Cullen: Can you hear me now? I do not know whether it is my accent or my voice.

It is no surprise to us that the Royal College of Nursing opposes—

Dr Whitford: Could you speak a wee bit louder? I am from Northern Ireland as well and we can definitely speak loudly when we want to.

Pat Cullen: We fundamentally oppose the power of the Secretary of State to authorise disclosure, and we will be looking for amendments. We believe that we must protect whistleblowers. They must come forward. That is the only way that we can learn lessons and make sure that our services are fit for purpose, and that we learn from that, so we will be looking for amendments.

Dr Whitford: Thank you very much. Thank you, Chair.

The Chair: Thank you. I now turn to the shadow Minister, Alex Norris.

Q150 Alex Norris (Nottingham North) (Lab/Co-op): Thank you, Chair. Thank you to all three of you for joining us this afternoon, and thank you for everything your members have done for us in such difficult times in recent months. Collectively, you speak for tens of thousands of NHS staff and allied professionals, so a simple first question from me. Pat, you might go first: how do staff feel at the moment?

Pat Cullen: Where do I start? They feel exhausted, demoralised; they are tired to say the least, and they are very concerned about the future. Why is that? Because they do not have the workforce to deliver.

The Chair: Could I just remind the shadow Minister to stick within the scope of the Bill, please?

Alex Norris: On a point of order, Mrs Murray. How our staff are at the moment is within the scope of a Bill about the NHS, I would have thought.

The Chair: Okay, but can we just make sure that we stay within the scope of the Bill?

Pat Cullen: I will try and answer in relation to the Bill. All the issues that I have just spoken about in relation to that exhaustion, the tiredness and the fact that they are not able to provide the care for their patients—there are opportunities in the Bill to correct some of those things. Again, going back—I hate to harp back to it in my Northern Ireland words—but the fact is that if we ensure that accountability sits with the legislator and with the Secretary of State, to ensure that we do not find ourselves back in this place again, with 40,000 vacancies going into a pandemic or at any other emergency situation we find our nurses in, that will absolutely assist and support. However, there are opportunities for the workforce in the Bill that we do not believe are being grasped at the minute, and that is further adding to the demoralisation that they are feeling.

Professor Helen Stokes-Lampard: I will keep it succinct. I completely agree that the clinical workforce—doctors—are demoralised, and I think anxiety would be the greatest feedback that we get: anxiety and fear of the amount of risk that is being held in the system at the moment. We are in the grip of a third wave of this pandemic, which many in the media seem to have completely forgotten about. People are dying by their hundreds on a daily basis still. This is a huge challenge. It goes back to exactly the point in the Bill about workforce planning for the future, so that we never find ourselves in a similar situation again. While we cannot predict when the next pandemic will hit, we can certainly be assured that another pandemic will come. The challenges around the climate and the global problems are going to impact on our health and wellbeing hugely, and we can plan for them now if we choose to. So, fearful and anxious, but we can do something about it. We have a unique moment in time to grasp this, and this legislation is one part of that unique moment in time.

Professor Martin Marshall: You will not be surprised to hear that morale in general practice is at rock bottom. We read about it in the newspapers every day. Surveys that we have conducted of our members suggest that 60% of GPs say that their mental health has deteriorated significantly over the last year. Anxiety, depression, suicide, ideation—33% of GPs say that at least once a week they find it almost impossible—

The Chair: Order. Could we keep to referring to what is in the Bill, please?

Professor Martin Marshall: Yes, and I am going to do so. The issue here is that if you speak to GPs, because of the stats that I have just described to you, nobody is talking about the Bill.

The Chair: But we are here to talk about the Bill.

Professor Martin Marshall: And almost nobody is talking about the implications of the Bill, because I guess our job is to engage clinicians with the potential of the Bill.

The Chair: I am just saying from the Chair that we are here to talk about what is in the Bill and to take evidence on the Bill, so we should stay within the confines of what is in the Bill.

Q151 Alex Norris: With that in mind, given the quite challenging picture that all three of you describe there, do you have any anxieties that this is not the right time to have the Bill and that, with staff anxious, demoralised and tired, a reorganisation might add to those anxieties and concerns for the future?

Professor Martin Marshall: There could not be a worse time for general practice to introduce the Bill, but I do not think that means it should not happen. It has to happen now. The NHS is ready for it, so it has to happen. The fact that general practice does not have the capacity or capability to engage fully with the implications of the Bill will mean that the Bill will not realise its full potential.

Professor Helen Stokes-Lampard: From my point of view, there is never an ideal time to introduce legislation and, certainly, in the midst of a global pandemic is on nobody's agenda as a good time to do anything legislatively. However, the consequences of not doing it are that the integrated care systems, which are in a really vital part of their evolution and formation, will stall and therefore are far more likely to fail. So my view and the view of the Academy of Medical Royal Colleges is that we absolutely must go ahead with this legislation in the timeframe. There is never a good time to have a baby or move house, but you still need to crack on and do these things at bad times.

Pat Cullen: Same here: never a right time. If you were to ask nurses on the ground today, carrying out patient care in frontline services, they would say that anything that might improve where things are at the minute will be a bonus. But the issue is how it plays out and whether we are listened to. The professional royal colleges do represent nurses. I am here representing 480,000 nurses today. It is really important that we get this right. There is never a right time, but it is actually a great time if we do get it right.

Q152 Alex Norris: I will just ask a final question in my last couple of minutes. Martin, notwithstanding what you said about a greater GP voice on boards, and similarly Pat regarding directors of nursing on integrated care boards, what else could we do to get the voice of the staff really heard in the plans generated by the integrated care partnerships and then executed by the boards? What mechanisms do you think are effective ways of hearing from the frontline what is happening day in, day out? Perhaps, Martin, you could go first.

Professor Martin Marshall: I cited earlier the example in Gloucestershire. It has very purposefully built a primary care subgroup of the board in order to provide that clinical expertise and that clinical sounding board to everything that goes on at board level. That seems to me to be a really good way of moving on from a single GP on the board—which will be helpful but will have limited impact—to actually making a real difference on the ground. The real change, of course, will not happen at ICS level anyway. It will happen at local level; it will happen at the place level. That is where real change in integrated care, from the patient perspective, will be enacted and will be felt.

Professor Helen Stokes-Lampard: To build on what Martin has said, there are great examples of clinical panels, which is essentially what we will be talking about. That is a model that works extremely well and which can be broadly based and covering a huge range: primary and secondary care—the whole range of specialities. But in the same way, citizen panels have become something that can be hugely helpful as well. I am very anxious that we also hear the patient voice in the decision making at community level.

There has been a covid culture of creativity. When there was less top-down insistence on following direct process at the start of the pandemic, a lot of creativity was allowed to flourish. I feel we need to capitalise on that culture of creativity. These kinds of panels are exactly the sort of output that has come and they have been hugely beneficial. And, of course, the move to greater digital working has meant that we have been able to reach people that we have not otherwise been able to get. Clinicians leaving the clinical environment to participate has become easier when they can do so remotely. There is a dividend that we should build on.

Pat Cullen: To add to that, I fundamentally believe that the patient voice must be heard in those structures beneath the board. That is how we will really influence and move forward in terms of what is required, and those voices will feed into the population needs assessment at local level. But there needs to be a nurse involved in each one of those structures that feeds right in through to the director of nursing that sits on the board, and that is how you will hold the accountability line up and down.

Alex Norris: Thanks, all three of you.

The Chair: Thank you. We now go to Minister Argar.

Q153 Edward Argar: Thank you, Mrs Murray. I will endeavour to be relatively brief, as I am conscious of time.

Welcome and thank you very much for your evidence this morning and your frank answers to the questions posed. I want to ask a question in the context of what a number of you have raised about the different voices and the extent to which they need to be represented at the different decision-making levels of the new structure. We heard from previous witnesses, for example in the context of public health voices also, about the value that they add. The principle behind this legislation is that it is permissive rather than prescriptive. Therefore it is possible to have a lot more voices; there is only a de minimis level specified as prescribed. What is your view as to whether the appropriate balance between permissive and prescriptive has been struck in the Bill? If you think

[Edward Argar]

it has not been, where do you think the balance between permissive and prescriptive has been missed? Shall we start with Pat and then work our way along?

Pat Cullen: I have said very clearly that I believe the nurse needs to be represented at the board, and that needs to be an executive director of nursing. That needs to be prescriptive; it is not good enough to have it placed within mandatory guidance, it needs to be within the Bill. That is a red line for our nurses, and it will remain a red line, and we will be putting it forward as a red line.

Professor Helen Stokes-Lampard: I am going to be slightly subtler with what I say about this. I think the legislation, as drafted at the moment, is very enabling, and the implementation of it is where the great improvement in how we deliver care will come. I do think it is permissive, and I do think that it is enabling, and I completely understand my colleague's desire to include specific words relating to nurses, GPs and whoever. What is vital for me is that the clinical voice is loud, clear, and can be influential. That is about implementation, culture and behaviour at a local level. Once we have the words for the final legislation, it is a question of how on earth we deliver it and support people to do it well, and how we learn from the best practice that is out there. That would be my—and our—view.

Professor Martin Marshall: In my 30 years as a GP, I cannot think of a single piece of legislation that has directly changed my practice on the ground. What I can see is the extent that legislation sets a tone and a culture within which clinical care is provided. I think this Bill is appropriately permissive, but, given the variation in all the challenges that we have identified, it needs to be permissive with really good oversight to ensure that the consequences of implementation do not lead to dramatic variation across the country.

Q154 Edward Argar: Thank you. I have three minutes left, so I may try a follow up. That is really helpful, and thank you again for the candour of your answers. Much as it may sometimes pain us in this place, we do recognise that legislation can be an enabler, but we cannot sit here and solve problems on the ground simply by legislation. I sat on a PCT board many years ago, and the culture and the working relationships were almost more valuable than the framework that sat around them.

Going back to Pat's evidence, but also to all of you: we have heard in our evidence today, and we heard it on Tuesday, a lot of different, vital parts of the system arguing the case for why they should be represented in a prescriptive way. Equally, we will have others arguing that a committee beyond a certain size becomes less effective. In terms of numbers, we have set a minimum. You are entirely entitled to say that you do not have a view on this, but how would you see the balance being struck between different groups making the case for representation, but, equally, having an effectively sized decision-making body? We will start with Martin, and then work backwards.

Professor Martin Marshall: I am glad to say that I do not have a view, but I do think that the boards should be small in order to be effective. They need to listen to advisory groups and sub-boards below them; it is the structures below the board level that will really make the difference.

Professor Helen Stokes-Lampard: Formally, the Academy of Medical Royal Colleges does not have a view. Personally, I have chaired boards from as few as five people, through to boards of 70 people, all of which can be hugely effective if managed well. However, the larger the board gets, the tighter the management has to be, because it is harder to get voices heard and for everyone to feel represented. Essentially, I am saying the same as Martin: smaller boards are generally more effective at getting through the agenda, but there has to be a high degree of trust in those that are actually on the board, and strong lines to sub-groups, for them to function with maximum effectiveness.

Pat Cullen: The board needs to comprise the right people. It is not about numbers; it needs to have the right people with clinical focus and patient care driving the outcomes for patients, and it needs to make sure that it does not develop a financially focused agenda. As director of nursing I have been there too many times: the table loses focus on the patient's voice and needs. There needs to be a clinical focus and the right people at the table.

Edward Argar: Thank you all very much, I have no more questions.

The Chair: Thank you very much. As there are no further questions, I thank our witnesses for their evidence. That brings us to the end of our morning session. The Committee will meet again at 2 o'clock this afternoon to take further evidence.

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

12.59 pm

Adjourned till this day at Two o'clock.