HOUSE OF LORDS

Integration of Primary and Community Care Committee

Uncorrected oral evidence: Integration of primary and community care

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Members present: Baroness Pitkeathley (The Chair); Lord Altrincham; Baroness Armstrong of Hill Top; Baroness Barker; Baroness Finlay of Llandaff; Lord Kakkar; Baroness Osamor; Baroness Redfern; Baroness Shephard of Northwold; Baroness Tyler of Enfield; Lord Watts; Baroness Wyld.

Evidence Session No. 20 Heard in Public Questions 198 - 205

Witnesses

I: Councillor Tim Oliver, Leader, Surrey County Council; Dawn Wakeling, Co-Priority Lead for Sustainable Personalised Health & Care Systems, Association of Directors of Adult Social Services, and Executive Director of Communities, Adults and Health, London Borough of Barnet; Simon Williams, Director of Adult Social Care Improvement, Local Government Association.

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Examination of witnesses

Councillor Tim Oliver, Dawn Wakeling and Simon Williams.

Q198 **The Chair:** Good afternoon and welcome to the Integration of Primary and Community Care Committee. We are pleased to have with us online Councillor Tim Oliver, leader of Surrey County Council. With us in the room is Dawn Wakeling, co-priority lead for sustainable personalised health and care systems at ADAS and executive director of communities, adults and health at the London Borough of Barnet. That is a large title you have there, Ms Wakeling. Simon Williams is director of adult social care improvement with the LGA. Welcome to everybody.

As you know, we will take it in turns to ask you questions and some of my colleagues will come in with supplementary questions, always with an eye, I am afraid, on the clock.

To what extent are new integrated care systems and primary care networks facilitating the effective involvement and contributions of local government? Can we also include the voluntary and community sector and social care? I know that gives a wide range, but those things are important to the committee. As you are online, Councillor Oliver, can we start with your answer?

Councillor Tim Oliver: Yes. Thank you very much. Apologies for not being with you in person. It is a very mixed picture across the country. There were a number of first-wave ICSs, and those are at a great state of maturity than the others. Not only am I the leader of Surrey County Council but I am the chair of Surrey Heartlands Integrated Care Partnership, having been the chair of the ICS before last July, so I have been able to see first-hand how things have worked locally.

The challenge in part is how the ICSs were set up. They are predominantly focused on the work of the integrated care boards. As we know, the clinical interventions that the ICPs are particularly focused on are only 20% of those wider determinants. The challenge has been getting the integrated care partnerships to have equal status and equal contribution, because it is the ICPs bring along local government, the VCSE and social care generally.

The Chair: Thanks very much. Ms Wakeling, what is your view on that?

Dawn Wakeling: I am in danger of repeating what my colleague said. It is variable and it is quite early to say. I am also the chair of the London Association of Directors of Adult Social Services. Our view is that it is working at its best when it focuses in at the place and community level. That can be even smaller than a primary care

network; some primary care networks might serve 70,000 to 100,000 people. When it is rooted in place, you can develop that truly shared agenda and those trusting relationships that make that equal voice work.

I know the committee is keen to hear examples, so I will give a small example from my day job. In Barnet, we have secured funding from all our health colleagues, and the local authority, to pump prime voluntary and community sector new initiatives. In the last three years, we have grant funded 47 different new community projects by about £900,000. That has been possible because we have looked at our place, our communities and our neighbourhoods. In my experience, when it becomes really big—there are 44 integrated care systems in England—it is harder to create that truly shared agenda that will bring on board your local, voluntary and community organisations, which are deeply rooted in serving local communities. Place, however you define it, needs to be something that people can identify with and relate to, and then it can work really well.

The Chair: Does that mean that there should be a formal requirement, or are the formal requirements of the ICBs getting in the way of that focus on place?

Dawn Wakeling: It is notable, if you look at the legislation and what is statutory, that ICBs and ICPs are statutory but the footprint will be very different. I work in an integrated care partnership that covers five London boroughs, but I have colleagues who are in one upper-tier local authority and work across three ICSs. The place-based partnership element of an integrated care system is in guidance, but it does not exist on a statutory footing. I hesitate to suggest primary legislation in this place, but if Place Partnerships ~~if they~~ had more teeth that would drive the agenda.

Simon Williams: I agree that it is variable. Our belief in the LGA is that there is a collective will from ICSs to work with local government in an integrated way. There are probably three key factors that drive the variability. The number one factor is history, because although ICSs are new, locally people were getting on in their previous guises for years, so they are all building on history in one way or another. Secondly, it depends on complexity, because there are greater levels of geographical complexity in some places than others. The third factor is relationships: what is the level of relationship that they are building on? As Dr Amanda Doyle said in the previous session, that is so important. Our feeling is that collectively everyone is trying to make it work, everyone is trying

to look at ways of reconciling the ICS and the place level, but those three factors may be driving the variability that we see.

The Chair: That is very interesting. Thank you.

Q199 **Baroness Wyld:** My question is about data sharing. I do not know how much of the previous session you heard, but we had quite a long session on data sharing across primary care and community care. Would you talk to us from the point of view of social care and how well, or not, you think data sharing works across social care and with other services? Where do you find barriers? You will have heard that we talked about technological barriers but also cultural barriers. Where there are barriers, how much of that is a result of the technology and the degree of digitalisation, and are there other issues that you would like to raise?

Simon Williams: From my experience, I would say that the biggest barriers are cultural rather than technical. I do not underplay the technical, but in my experience if people really want to create a seamless service for people, they find a way of doing it. That is my experience as a DASS, like Dawn, for 11 years in London. That is the thing, because if we are really determined to join this up for people, we find a way of joining up our information in a safe and appropriate way. If we are not determined, we just come to a halt on all the governance and technical barriers. I would say that is the single biggest thing.

Secondly, seeing this in a person-centred way is enormously helpful. I know that people cannot sit in their homes and hold their own health and care records any more, but there is no reason why they should not see what is held in their own records. I know there have been various attempts to do that. Another really important test is whether people know what is being recorded about them and whether they feel in control about where their information goes. As a previous witness said, it would be reassuring to me, as a patient or unpaid carer, if I knew who was using my information and what it was being used for.

So, yes, there are technical barriers to getting all these systems to talk to each other, but in social care there are four main patient information systems. It is not like there are 150 of them. We generally use four, so I do not believe it is impossible to find ways of technically achieving join-up between those systems and what the NHS does. That is what I would single out.

Baroness Wyld: Thank you. I might come back to you for that, as we are against the clock. Ms Wakeling, would you agree with that?

Dawn Wakeling: It is doable. In my day job, we have a shared care record. It can be done. Primary care, community health, secondary care and now social care share information. We are at the level of sharing fairly basic information. It takes money, skills, time and all the associated data-sharing agreements. It absolutely can be done, but it is not cheap and it is not quick. ~~That is for local authority social care information.~~

It would be even more helpful if we could start to think about how we could share information with other providers dealing with housing, community, safety, for example, if you want to join up and prevent things. When it becomes very complex, you will want to think about the social care provider sector. That is hundreds or even thousands of different organisations, some of which might be small businesses, some of which will be national organisations with different infrastructures and different IT skills.

The thing to aim for is getting that single view that supports better support for people. There are good examples of care homes doing remote monitoring and sharing that information with GPs through systems like WHZAN. Some of that small-scale stuff is happening, but how could you do it at scale?

Baroness Wyld: Where it is not working, are you picking up any cultural nervousness? Are people nervous about sharing data and the risk to them?

Dawn Wakeling: I think that is why the projects take time, skills and resources, because you need to make it safe. You need the people whose data it is to feel that it is safe, and professionals need to trust the system, but certainly in my day job people are finding it incredibly useful.

Baroness Wyld: Thank you very much.

Councillor Tim Oliver: I agree with the other two witnesses. It is not only trust from individuals but trust across organisations that seems to be a problem. There are different vocabularies, different coding, different data standards and so on. There are two aspects. One is the culture, which should be easily addressable. The second is lack of capital investment in systems—that is less of an issue—and the ongoing maintenance revenue costs of running those systems.

In Surrey, we have addressed that by setting up the Surrey Office of Data Analytics—SODA—which includes data from the health system from local government and from the health system voluntary sector. The University of Surrey is supporting that. It is

chaired by the chief constable, so there is an independent driver of that data warehouse. We have a joint analytics and insights team and a joint director across the county council, the ICS and so on.

That has cut through a lot of the cultural issues, but, even then, getting all that data into a single format in a way that is usable and reportable is challenging. We also have the Surrey Care Record. Until you get all the organisations to agree that there are benefits in sharing data, and that they must do that because it informs the joint strategic needs assessment, which is key to identifying the areas where interventions will help on deprivation and addressing population health management.

Baroness Wyld: Thank you. How do you know that those initiatives have cut across the cultural issues? What are your proof points? If you have the evidence for that, do you think that ought to be rolled out more widely? Maybe that is something that the LGA could pick up.

Councillor Tim Oliver: To your first question on how we get all the systems to work together, in Surrey we have split it into 29 towns, which have a population of broadly 30,000 to 50,000. The ICSs will only work if you truly adopt a subsidiarity approach. As Dawn said, you need to push it down to that lowest level. We use the data from SODA and the public health team, and we have tracked which of the 20 top areas are low or super-output areas and so on. We have hard data on what is happening in the communities, and, equally, data on what those interventions and support have achieved.

Q200 **Lord Altrincham:** My question is on local government. How can local government play a greater role in local health services? What needs to change for co-ordination and integration to be made easier? Perhaps you could comment on mental health services; we have had submissions already on this area.

Councillor Tim Oliver: Carrying on from what I was saying before, the subsidiarity point is hugely important. Improving health population cannot really be done at an ICS level. We need to identify what place looks like—place will mean different things to different people—but a manageable size of community would be the first thing.

The chief executive of Surrey Heartlands is Claire Fuller, so we were closely involved in the work she did on the stocktake, which is about how you drive that integrated deliverable approach. That is why we landed on the town's footprint as the way forward. The

local authority can have a key role in social prescribing and various initiatives, such as Growing Health Together.

On mental health, in Surrey we ring-fenced 1% of the council tax last year, which in Surry is about £8 million. The health system and Community Foundation for Surrey also put in some money. We created a ring-fenced pot of money of £12 million or so, which has been used to support specific initiatives, specific pilots and projects in mental health, largely towards children. That was an example of where the systems came together, created this pot and then identified what good work was going on. It focused predominantly on looking at prevention and how we can move that support up stream.

Dawn Wakeling: Local governments already play a significant role in local health services, and the whole ICS system has facilitated that. In my own professional association, there are a significant number of directors of adult social services who are leading place partnerships and are ~~executively placed~~placed Place Executives, and there are council chief executives who are leading place partnerships. We are playing that strategic role.

We are also commissioning health services through public health and providing a whole range of work to tackle health inequalities and create prevention at scale. All that stuff is happening. There are multiple integrated teams in place, such as integrated teams in mental health and in learning disabilities for older people.

On the question of a greater role, it is important that there is that shared agenda. The colleague online said that 20% of your health outcomes are to do with what you get from the NHS and 80% are to do with whether you have a job, a good home and friends. All those are things that local government is working on all the time. That is really important.

On the question of a greater role working together, we need a shared agenda. As a jobbing DASS and as a spokesperson for ADASS, I have to say that social care is very underfunded at the moment and that the focus in policy is on hospital discharge and elective recovery waiting times, all of which are very important, but we also need to focus on prevention and early intervention, and think longer term as well as shorter term. We can do things quite quickly to reduce cardiovascular disease risk through early intervention programmes. We also need to be thinking about the longer-term lifestyle changes that will help to prevent a lot of people in their 30s, 40s and 50s going on to develop multiple long-term conditions. Those we can do in partnership, because local government has a lot of the levers, but, of course, local

government is struggling with funding and resources, just like the NHS.

Simon Williams: I will not repeat all of that, but will add. First, we would be bound to say that sorting out the funding for social care must be a first step. The LGA's estimate for the underfunding of social care as of last year was £13 billion. Last year, the autumn budget made some welcome inroads into that, but unfortunately, with headwinds of inflation, has not been as much of an inroad as we would have liked. That remains a challenge for all of us.

Secondly, it is about using the role of local elected members for local accountability. They are in touch with their local communities and can add value in connecting health and social care systems back into their local communities. The health and well-being boards and health overview and scrutiny committees have been around for a while and we very much want them to become a key feature in the ICS landscape as well.

Thirdly, local authorities already play a major role, given their knowledge of local communities at a very local level. Their knowledge of the local voluntary community sector, and all the added value and informal support and the like, can be brought in. Without it, we will never get the full benefit of integration.

Finally, it is about the whole local authority, as Dawn was saying. Housing comes up again and again as something that has a big impact, both on health outcomes and on how well systems are able to perform. Another example is further education. We know that for young people with lifelong disabilities transitioning to adulthood, their experience of being able to move into further education and employment is critical. Local authorities can play a key role in facilitating that.

Q201 **Baroness Armstrong of Hill Top:** I am really impressed at how positive and optimistic you are, because a lot of our witnesses have not been as confident about the relationship between local government and the NHS, and local government, the voluntary sector and the NHS. All three have to come together when we are talking about social care and the role of those in the community who need care.

My question was about the barriers. You have said something on that. What you have not done is talk much about how you see, if you do see, the very different structures, workforces and remuneration of those workforces in the different sectors being a barrier to true integration. In a previous session somebody said that if the NHS is in the room, it always thinks that it is in charge.

That was a reflection of what you, Simon, said about culture, but it was also a reflection of salaries, roles and so on. That was a long introduction to this question: what barriers are you experiencing to real integration in different parts of the country?

Simon Williams: It comes back to the first question about variability and what I said about history and relationships. I am sure there is that predisposition, given that the NHS is a very big organisation full of highly educated, clever people—not that we are not clever in local government, but we do not have as many handles after our name. So, yes, we recognise that there is that predisposition, but in my experience in my current role in the LGA and more locally—I have also had a couple of roles in the NHS—what changes that is simply folk working together trying to achieve something together.

If we all sit in a room and just talk about the problems and the difficulties, and there are lots of them, there are a lot of things that we are not going to change anytime soon, like remuneration. If we are in a room talking about something practical, such as how we are going to change a service or a set of outcomes for a group of people, my own experience is that that of itself gets us used to working together as equals or realising that we bring different things to the party.

The long-stay hospital closure programme, which I led a bit in Derbyshire a few years ago, was a really good example. It started as something that felt like it was coming down nationally from the top of the NHS, but we quickly realised that unless we engaged councils at a district and a county level, and housing associations and the voluntary sector, we simply would not be able to achieve that objective.

Baroness Armstrong of Hill Top: Can I bring you back to something practical? I did some work with an organisation in the north-east of the country. We were providing work coaches, but on a minimum wage. None of the NHS workers were on anything as low as the minimum wage. Keeping that strand of work going in the programme was extremely difficult, because the workforce saw the differences, felt they were contributing in an equal way but were not getting any of the recognition or the remuneration that the others were getting.

Simon Williams: We agree. That is why both ADASS and the LGA have called for parity of pay with the direct front-line workforce with agenda for change grade band 3.

Baroness Armstrong of Hill Top: It is looking at agenda for

change.

Simon Williams: We believe that that needs to be sorted out.

Dawn Wakeling: I agree about the workforce. Being a front-line care worker is an incredibly skilled and challenging job and it deserves recognition and remuneration. I know that for many local authorities whenin commissioning that is challenging to achieve.

On barriers, one of the practical things is knowledge and understanding of each other's roles and responsibilities at the microgranular level, because there are hundreds of thousands of people working in our systems and not everybody knows everything. We still need to make sure every day that a GP understands the whole breadth of what social care can do, that a social worker understands that in a GP practice there will now be a wide range of roles—physiotherapists, OTs, physician assistants, frailty nurses—and that people understand the diversity of what the voluntary sector can offer.

Often people are sent to the wrong place or come to social care, for example, saying, "My doctor says I need to go into a home", when there are actually many more options available for that person. What is incredibly hard to achieve but sounds relatively simple is keeping up that comprehensive knowledge of what other parts of the system can do. That is why link roles, which my colleague online mentioned, between social providerssuch as social prescribers, for example, are important, but that is incredibly hard to achieve.

The other barrier is access criteria. Apologies that we did not pick up your mental health question, but one of the challenges with mental health services is how you get into them and different access criteria. You can self-refer to social services, but you cannot necessarily self-refer to secondary mental health services; you have to go through the GP. All those practical things about how you get into services create problems. The other obvious one is that NHS services are free, but local authority social care is not free for everybody, and a lot of people are just buying their own care directly, which creates another set of barriers.

Councillor Tim Oliver: I would say that workforce inequality, pay, conditions and perception are a very real issue. One small way in which we have started to tackle that is to create a joint training academy. Anybody can come into that academy and go through the system, maybe into social care or into the NHS or back again, and so on. Of course, you then need to equalise the terms and

conditions, which is challenging from a financial perspective but is needed to get equal recognition.

On general barriers to integration, I chaired the integration place workstream in the Hewitt review, and there is a lot of commonality in what people across the system were saying. Part of the challenge is that the ICSs work to the NHS agenda, and a recognition that top-down approach will not work when you are looking at genuine partnership working. There have been recommendations and the Government's response to that review in a reduced number of targets.

Reinforcing the point about subsidiarity, local areas know their area and population best, so they are best placed to address them. The cultural issue is that local government has seen a reduction in financing over probably the last 10 years and has had to adjust its services to deliver a balanced budget. The NHS, perhaps until this year, has had the luxury of not having to balance a budget, but that has put all sorts of pressures on things like continuing health care and where that sits and so on, and there is no democratic accountability.

Local government and the health service have come from a very different space. I think you said that you were surprised at the optimism. In my view, the ICSs are absolutely the right structure. It is the first time there has been a requirement for all the partners to come together. There is a challenge for the voluntary sector, which does not have a designated seat on the integrated care board and so does not feel that it has a loud enough voice in the system, and there is a long-term sustainable funding issue for the voluntary sector. Local government and the health system are very dependent on the voluntary sector for its support, and if that is not addressed it could become a barrier.

There are lots of positive things here. Some of it is people and personalities rather than structure, but it is important that everybody continues to be aligned on the agenda. Prevention is a key, although greater preventive activity and earlier intervention will result in more activity and more cost pressure on the systems, but that is definitely where we need to go. I do not think that any of the barriers are insurmountable, but they need to be recognised and addressed.

Q202 **Baroness Barker:** Would it be accurate to say that each local authority faces the same health care issues, but that what varies is the relative incidents of different conditions? Does that happen because of demography, employment, housing or factors such as that? Is that a fair statement? If it is right, what is the role of

integration in dealing with what are essentially universal problems?

Simon Williams: Different local authorities face different challenges. The first challenge is, very simply, the nature of the population. It is a fact that in some local authorities, their populations might be poorer or older, or whatever it may be. The population mix is different, and because of the correlation of that with health outcomes, that of itself presents a particular health challenge. So we would say that, yes, there is a difference in the health care challenges that are faced, depending on the population, basically.

The second area is access to health care. What varies across the piece is how people get into the social care system, which is often measured by waiting times or complexity in finding your way to where you need to be. Again, we see variation in waits for health care and in some aspects of social care, and that is also something that we are keen to address. So the short answer to your question is yes, there is variation.

How do we address that? On the first point about population, that is the value of a joint strategic needs assessment—it is a whole-population assessment that looks at the particular characteristics and, therefore, at what form of public health intervention or prevention as well as service delivery will best meet the needs of that population.

With regard to the access question, that is particularly where we need to work together primarily with our health partners but also with the voluntary community sector to be able to design better ways of making that work.

Dawn Wakeling: The other thing that creates a difference is historic levels of investment in services and funding formulas. You will see stark differences across different parts of London and across the country in the level of investment into primary care, mental health services, community health services and ~~probably~~ even social care. Those things have a real impact. You will have different services in different places and a different quantum of services. You can have very low levels of community health services in one London borough and very high levels next door, and those things inevitably affect access and peoples' health outcomes.

Councillor Tim Oliver: The levels of deprivation vary enormously across the country and within geographies and local authorities. As we just heard, the joint strategic needs assessment is key to understanding what is going on in that community. It varies between rural and urban and so on, but it also depends on what

assets you have in that locality—whether you have hospitals, universities, community centres and so on.

On the question about the role of integration in addressing those differences, the key thing is getting all the key stakeholder partners together. That can make a difference. We saw just recently the huge pressure on police forces in dealing with individuals with mental health, which is distracting them from their core activity. You need the police, the health system, the voluntary sector and probably businesses; everybody who contributes to that community can help to address the issue.

We discussed some of the wider determinants, and part of that is about public health and peoples' behaviour, encouraging them to walk and cycle more, and those sorts of things. It is absolutely about the quality of housing, which has a massive impact on health outcomes. Even in my own county here, between adjoining wards there is an 11-year difference in life expectancy, which is simply unacceptable. Together, as systems, we have to address that. It is not easy and could not be done overnight, but the key part of the conversation about the future of ICSs is to get them to focus on exactly those issues: addressing inequality of opportunity and inequality of life expectancy. As a partnering group hopefully that is achievable.

Q203 **Baroness Barker:** Local authorities already have some commissioning responsibilities for some aspects of public health, and you have had them for a long time. Do you have data from that that shows, in a helpful way, how having joint responsibilities improves health outcomes?

Councillor Tim Oliver: There is some data, but I am not sure that, historically, public health has focused on the same issues as are relevant or current today. Obesity in particular is one of those. There is good data on smoking cessation and those sorts of things, and outcomes for sexual health, but on other issues such as mental health and other particularly challenging issues at the moment I am not sure there would be particularly helpful, good-quality data.

Q204 **Baroness Finlay of Llandaff:** If we are going to get staff to work together better, should all the social care staff have honorary contracts with their local NHS community providers so that they can access the education, training and opportunities that are there? Would that make working easier? Would it make their ability to have a career pathway between different sectors easier?

Simon Williams: Coming back to the public health outcomes, we will go away and look at what the research says, and we will be happy to share that with the committee. From my own experience,

there are almost two levels. One is whether we can we show that working in an integrated way on public health services improves take-up. There is certainly evidence that we get more take-up of smoking cessation or whatever. Whether that leads to improved outcomes is a longer-term issue. Even 10 years on may be too soon to say, but we will be happy to look at any evidence there may be.

Coming back to terms and conditions, if our social care providers were in the room they would probably say that that level of standardisation might involve innovation in social care. One of the good things about social care is the plurality of the vision. They would say, "Actually, some people prefer zero-hours contracts", for example. Other people do not want them; they think there should be room for all sorts of contracts, depending on what staff find attractive and what actually works for the end user. We would be keen on something that gives staff a level of esteem and remuneration that is comparable with the NHS, but we would be cautious about complete standardisation in that way.

Dawn Wakeling: There is a lot that you can do about education and training that may not need an honorary contract. I will reflect on your question, because I have not thought about it before. However, we have been able to access a lot of Health Education England funding to support the front-line training of care workers, lots of training is funded by the NHS for nurses in care homes, for example, and there are people who have qualified overseas working in care homes funded to get their UK nursing registration.

An awful lot can be done without needing an honorary contract, but we are probably not doing enough and we need to do more while still reflecting that social care is not a medical service; it is about working with people in the ~~whole~~ context of their whole lives to help them achieve independence and the kind of life they want to lead. This is not a criticism of medical models; they are super helpful. But we do not want everybody to be just about diagnosis and treatment, we want people to work in the context of a whole life, and there would be a risk if everybody had the same training offer.

Q205 **Baroness Redfern:** Mine is a difficult question. What one change could the Government make to facilitate better integration of local government, social care and the health services?

The Chair: We will be strict and say that one change from each of you is what we are looking for.

Baroness Redfern: That is why it is a difficult question.

Simon Williams: The one change that the LGA could talk about is letting local leaders lead. That is not a change in legislation; that is a change in culture whereby central government trusts local partnerships and local leaders to know their populations, know the people they serve and come up with the best solutions for them.

Dawn Wakeling: I was going to say something very similar, but I would go back to the first point I made in response to your question, which is to give more direct power to local place partnerships to lead. They will operate at a much smaller geographical level than the ICSs, and the statutory power is up there.

Councillor Tim Oliver: Could I just add to a comment in answer to the previous question on the workforce challenges and education? It would be worth looking at the regulatory regime. There are certain roles that do not necessarily need to be regulated in the way they are, and you could open up a lot of the workforce if it were reviewed.

What is the one thing I would do? I would allow local government, elected members, to chair the integrated care board, because that would take away the ICSs being simply NHS-orientated. That was allowed before the Health and Care Act came in but it is no longer allowable, so I would reverse that.

The Chair: I seem to remember there was a lot of discussion about that when the Bill went through the House of Lords. I must bring the session to a close now, with thanks to all three of you for your contribution. As you know, this is a public recorded session, so you will be sent a transcript to correct any errors. We have also identified other things that we have asked for or you have volunteered, and we look forward to receiving those. Anything else that you feel you have not had the opportunity to say or that you think will be useful for the committee to know we would be more than delighted to receive from you. Thank you very much, all three of you—online and in the room—for your contribution this afternoon.