Health and Social Care Committee

Oral evidence: Department's White Paper on Health and Social Care, HC 1274

Tuesday 2 March 2021

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Watch the meeting

Members present: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Barbara Keeley; Taiwo Owatemi; Laura Trott.

Questions 1 - 64

Witnesses

I: Richard Murray, Chief Executive, The King's Fund; Hugh Alderwick, Head of Policy, The Health Foundation; and Nigel Edwards, Chief Executive, The Nuffield Trust.

II: Danny Mortimer, Chief Executive, NHS Confederation; Sarah Pickup, Deputy Chief Executive, Local Government Association; Sir Robert Francis, Chair, Healthwatch England; and Chris Hopson, Chief Executive, NHS Providers.

Examination of witnesses

Witnesses: Richard Murray, Hugh Alderwick and Nigel Edwards.

Q1 **Chair:** Good morning. Welcome to the Health and Social Care Select Committee. Our evidence session this morning is on the Government's White Paper on NHS reform, which is likely to lead to a brand new health and care Bill expected to be introduced to the House of Commons at the start of the next parliamentary session. As everyone knows, me perhaps more than many people, it is a very risky business making structural changes to the NHS. The Covid-19 pandemic has brought into sharp relief the things that are working well and the things that are working less well in the current system. It is a very important area. We will be looking at the short-term lessons for the NHS and the long-term challenge of delivering integrated care as part of our three evidence sessions.

This morning, we have a group of experts. Next week, we will have Sir Simon Stevens, and the week after that we will have the Health Secretary Matt Hancock. Our intention is to produce a report ahead of the

Second Reading debate in the House of Commons. We have two panels this morning. In the second panel, we will hear from Chris Hopson, the chief executive of NHS Providers; Danny Mortimer, the chief executive of the NHS Confederation, which represents NHS organisations; Sir Robert Francis, who did the Mid Staffs inquiry and is the chair of Healthwatch England; and Sarah Pickup, who is the deputy chief executive of the Local Government Association, and very knowledgeable on social care issues.

First this morning, I give a warm welcome to our opening panel. They are regular visitors to the Select Committee: Richard Murray, the chief executive of the King's Fund, Hugh Alderwick, head of policy at the Health Foundation, and Nigel Edwards, the chief executive of the Nuffield Trust. Thank you all very much for joining us.

I want to start, if I may, with a question to Richard Murray about the core change proposed by the Government, which is the replacement of clinical commissioning groups set up in the Lansley reforms with integrated care systems as the core statutory plumbing of the NHS, the part of the NHS that will get all the money for every area in the country, and decide how to distribute it.

Richard, when the Lansley reforms were introduced in 2012, your predecessor Chris Ham led the charge against them, saying that we needed structures that allowed joined-up integrated care rather than more competition. These reforms would put integrated care systems on a statutory footing and remove many of the competition requirements. Are you broadly happy that they address the concerns that have been expressed by the King's Fund and many others over recent years?

Richard Murray: They are certainly moving in the right direction. It is best to think about these changes as a way to enable better integrated care. They cannot by themselves force it. That lies in a change in behaviours, and in the way that people work together, across both the health service and local government, and other partners in the voluntary sector. This is certainly a structure that makes it easier for areas to work together in that way. There will be some disruption that will come through from it, and, as I say, you cannot rely on legislation alone to deliver all the gains that you are looking for from integration; not least because much of the heavy lifting on integration is not done at ICS level but at place level, often on a local government footprint, and that is not really in this legislation. There is a lot outside it that needs to be done as well.

Q2 **Chair:** One of the criticisms that you often hear inside the system about what is happening with ICSs at the moment is that they can only go at the pace of the slowest party, the least willing person, because they have no statutory powers. Will this legislation help deal with that issue at least?

Richard Murray: It will certainly help to make some of the relationships easier, in the sense of giving foundation trusts the power to delegate more of their authority and more of their control. It gives a structure for areas that are struggling with how to set themselves up, and how to work

with local government, but I do not think you can force people to integrate care. I do not think that what we have seen through Covid was Government ordering all parts of the country to work together better. It was the fact that at local level people saw the need, and saw a way through some of the difficulties in working together, and that is what changed it. I see these as helping. I do not think on their own they would help some of the parts of the country that have struggled to integrate care to suddenly make a tremendous leap. You just cannot order people in that way. I think they will make it easier.

Q3 **Chair:** Let me bring in Hugh Alderwick. The Health Foundation has traditionally done a lot of work on the quality and safety of care. When care is not joined up it creates a lot of problems for patients. Putting that perspective on it, what is your view of the reforms?

Hugh Alderwick: I echo a lot of the points Richard made. I have three reflections on integrated care systems, which, as you say, are one core part. The emphasis on collaboration between the NHS, local government and other partners is clearly right, and largely follows the direction the system is already heading in. It builds on what has been done and is being done despite the legislation. As you pointed out, it has long been recognised that changes are needed to the Health and Social Care Act to help integrated care happen.

The flip side, which Richard touched on, is that the benefits of the kind of integration on offer in the White Paper, which is really about structures and formal rules, risk being way overstated. Formal duties to collaborate and mergers of functions do not necessarily produce collaboration in practice. Integration that can potentially improve some aspects of quality depends on culture, management, sufficient resources, trust, and time to develop new care models much more than on structures and rules. Even then, I think the benefits risk being overstated by some because, as we know, adult social care and public health, which the NHS is supposed to be integrating with, remain chronically underfunded.

Secondly, there are still lots of questions about what ICSs are and what they will do. On the one hand, they are a big opportunity to improve some of the pretty murky accountabilities at local level, and to provide more clarity about who is in charge, but at the moment it is not clear how much power ICSs will have over providers, for instance. We now look like we have two ICSs, one NHS ICS and a local government partnership ICS that involves local government and others. What is the relationship between those two? Is there a risk that the NHS dominates?

The third thing, as Richard pointed out, is that it is another NHS reorganisation, so there are the obvious risks that go with that of disruption and distraction. Creating agencies is much easier on paper than it is in practice. Experience from the long history of NHS reorganisations can tell us that moving agencies around, changing who is in charge and setting up new governance can distract from service improvements. That is a big risk and will need a close eye kept on it when we think about the implementation of the proposals.

Q4 **Chair:** Let me ask Nigel Edwards about that risk in particular. You have talked many times about the importance of integrating the care that we give people, but right after the pandemic when people are exhausted and pretty bruised, even if the general direction of these reforms is right, is there any validity in the criticism that the timing is not right?

Nigel Edwards: It might be worth saying that this change is probably the culmination of or perhaps a waypoint in a process that has been going on since the formation of what were then called sustainability and transformation partnerships—STPs—about four or five years ago. Other witnesses have made the point that integration is quite a slow relationship-based process, so the legislation is a waypoint. The actual implementation of it, I guess, will probably be some time after the legislation is passed. In many ways, the legislation will formalise arrangements that people already largely have in place. Probably there is not a big-bang change.

I know NHS England is very aware of our, the King's Fund's and others' concerns, as Hugh mentioned, about the potential for a cascade of reorganisation as people look for jobs, and people at senior levels move around. It has to be said that most reorganisations in the NHS do not affect frontline staff very much. One of the paradoxes is that reorganisation is supposed to fundamentally change the NHS, but most frontline staff get on with what they are doing and are relatively unaffected. I am reasonably optimistic that, although the timing looks a little risky, many of those risks are mitigated by the fact that a lot of the change has already happened and some of the impacts will not be seen for some significant time anyway.

Chair: Thank you.

Q5 **Taiwo Owatemi:** I am interested to know what the risks are of placing the functions of CCGs within ICSs. Richard, would you mind explaining?

Richard Murray: I didn't quite hear that—the risks of placing CCG functions into ICSs?

Chair: Yes, that's right.

Richard Murray: We do not want ICSs to be just big CCGs. That was not really the point. If that is what happens, all we will have done, as Nigel said, is move some of the deck chairs around for some of the senior staff, but not much more than that. We want ICSs to be different. They are supposed to be able to work more closely with NHS providers and other providers. Some of the divisions created by the split of purchasers and providers do not disappear, but they are less stark than they were. We want the closer working between the NHS, local government, the voluntary sector and other parts of the private sector that the partnership board can help create.

A lot of that comes at place level, at a geographical level below the level of an ICS. ICSs are so big. One of the things we have to watch for is that, as all of the attention switches to ICSs on their very large footprints, we

do not lose sight of the fact that, for frontline staff and for patients, often what matters is what goes on locally at place level. There is a bit of a risk that as you merge CCGs, which were sometimes closer to local government colleagues, you lose that. As ICSs form, we will need to see that they keep some function and can devolve spending and budgets down to the more local level to work with GPs and to work with communities.

Q6 **Taiwo Owatemi:** Thank you. Hugh, what are your views on that?

Hugh Alderwick: I agree with much of what Richard said. I think there are three risks. One is lack of clarity about what they are supposed to do. As Richard says, we do not want ICSs just to be a bigger commissioner. The original idea behind STPs, which became ICSs, was that commissioners, providers in the NHS and local government could come together to plan services collectively and make the best use of resources. If this turns into a bigger commissioner, or a body that is not quite sure what its role in the system is, there is a challenge about its effectiveness.

It is also about how they relate to the new provider collaboratives that NHS England wants to establish, which are groups of providers that will get together. What is the relationship between providers that are getting together and the ICS? Who really holds the power? At the moment, it is difficult to draw a diagram of how it is all going to work and how the different boards will relate to each other. Even the best civil servants in DH would find it difficult to draw the relationships between those bodies.

We also have existing partnership boards and health and wellbeing boards; there is a proliferation of boards. Which partnership board is in charge? I think that relates to the second risk. There are two ICSs in the draft proposal, which makes sense to ensure local government involvement, but the risk is that the NHS ICS becomes much more about integrating NHS services and local government, and other partners in the community get sidelined, and it becomes an NHS-dominated thing. Again, that would undermine the original objectives.

The third risk is at place level, as Richard rightly identified—local authorities, neighbourhoods. That is where the action is with integrating services, particularly integrating health and social care and primary care services. There could be an absence of an NHS leader there. A lot of the documents produced by NHS England seem to suggest that primary care networks, which are groups of GPs, might play that role, but they are much smaller, they are early in their development, and changing their functions now risks derailing the progress they have made. Which is the body at a place level that will hold the delegated budgets for care? That is not very clear at the moment. The risks are lack of clarity, NHS domination and a question over what happens at a place level, and how that is strengthened.

Q7 **Taiwo Owatemi:** Nigel, how do you think some of the risks can be mitigated?

Nigel Edwards: As Hugh has just said, quite a lot of things are not clear. I suspect that people will have to discover the answer to some of these questions as they go along. They will probably be different in different places. One of the strengths of the White Paper is that it does something some previous reorganisations of the NHS have not done, which is to recognise that it serves very diverse areas with very different characteristics, and different geographies. The downside of that is that it makes it very difficult to specify an answer about how to deal with the issues and mitigate the risks. One of the mitigations will be a degree of patience as local systems work their way through it.

A second issue will be getting to the bottom of the question of where the primary care voice is in these systems. It needs to be very strong at place level. It is not clear how it relates to the ICS, and that will need to be worked through. We should probably avoid trying to specify the answer to all the questions, but make sure that we put in place a process that allows people to learn and develop some of those answers, and to be ready to intervene and help where things are not going right. I am afraid I cannot give you a prospective, "This is how you are going solve it", other than that.

Q8 **Dr Evans:** Ten years on from the last big reorganisation, it is not often we have the think-tanks here to be able to blue-sky think about what should be coming ahead. What I am particularly interested in is the triple aim within the NHS. For those watching at home, the triple aim is better health and wellbeing for the population; quality health services and wellbeing for the individual; and sustainable use of NHS resources, as a triad. That is really important as a basis, but I would be grateful for your comments on whether you think that is even attainable within the legislation at the current place we are in, and what structure the legislation brings to help try to reinforce that. Nigel, could you answer that question first and give us your thoughts?

Nigel Edwards: You will probably see from the Local Government Association response that there is an interesting debate about where responsibility for the entire health of the population sits. There has been a bit of ambiguity, with the NHS feeling that maybe it needs to take the lead on everything. I think there is a very clear role for local government to have a big leadership role in developing population health. As Hugh alluded to, there is a slightly confusing system of multiple committees that allows a focus on population health in one place without allowing people to be diverted and sucked into the rabbit hole of thinking about NHS services. The two obviously need to come together at some point.

The machinery to do the population health aspects of the triple aim is in place. The question is about the driver of efficiency. We have moved away from the use of more market-based mechanisms for driving efficiency, using a tariff and prices, although there will still be those mechanisms for planned elective care. The question of what the engine for change for improving efficiency will be is not so clear, and thought will need to be given to that.

On the question of quality of care, the ICS machinery allows for a degree of standardisation, mutual accountability and self-scrutiny, and if they put in the systems—sometimes called learning systems—they will be able to use the fact that there will be, hopefully, as a consequence of the changes, much better data about the nature of both the population and services within an area. That is a cultural thing, and it is hard to legislate for. We still have, and I think there is an ongoing debate about its appropriateness, a fairly rigorous performance management system in the NHS that could substitute for the drivers on both quality and efficiency, and of course the CQC is still there. There is quite a lot of machinery. As Hugh was saying, how it all joins together is not quite so clear. We will need to watch for whether we have lost some of the spark that can drive some of the efficiency and productivity improvements we will undoubtedly need to see over the next few years.

Q9 **Dr Evans:** Thank you, Nigel. Richard, do you have thoughts on this?

Richard Murray: I would start by noting that the system as it is now is pretty unclear. We have evolved a large number of work-arounds. The way things are done in Cornwall is not the same as they are done in Harrogate. Although this might not give a single blueprint about how the triple aim will be delivered, it is clearer than the system we have left. I think the goal was to try to bring a little more consistency in those structures, without squashing everybody into the same cookie-cutter shape across the whole country, as we have done in the past, I am afraid, and we know that does not work. That is a tension between a little more consistency around governance and accountability while retaining some of the local flexibility.

I think the triple aim is helpful in guiding the system. It may be a caricature of some foundation trusts in the past that they cared about the quality of care they delivered to their patients, but things about the wider population and their health were not really their business, and what happened to the finances of their commissioner and what happened to the finances of the people they competed against, even if it was in different sectors, again was none of their business. This helpfully tries to reset the tone for the system.

What I would not lose is that it is a piece about the wiring of the system. There are deep workforce shortages. Social care faces very severe long-term challenges to the way it is funded and the way it is delivered. This is a toolbox that might help to deal with some of those issues, but on its own it is not an answer to some of the challenges, particularly some of those that have come through Covid. There is something that is trying to lean against the tendency towards an NHS view of the world—that the NHS part of ICS will just wander off and do its own thing. If you think about the triple aims and apply them to some of the critical issues like inequalities in mental health or how you support child health, these are issues that the NHS cannot address on its own. It would recognise them as priorities and bring together local government and other parts of the system, and try to work through what it means to do the triple aim.

Q10 **Dr Evans:** Richard and Nigel, that is really helpful because both of you picked up on population aspects. The paper particularly targets obesity and fluoride in water; those two have been singled out. There is a mechanism for other directions that the Secretary of State could decide in public health. What are your thoughts with regards to that?

It is interesting, Richard, that you picked up on mental health. For me, mental wellbeing seems not to be in there, when we have given so much credibility to bringing parity with physical health. Is that just because of the emphasis at the moment and the problems? Do you think the framework allows us to tackle mental wellbeing as a population issue? If so, who should that responsibility fall to? Richard, would you like to come back on that?

Richard Murray: The structure that has been set out should make it easier for issues like that to be focused on at a population level, if the partnership board really does its business and brings the NHS side of the house along with it. The NHS clearly cannot do things about housing or transport. Loads of other levers, including access to green space, sit with local authorities. It has the ability to focus on some of the bigger population issues better than its predecessor. We have to note that public health is not there. There are separate proposals coming on public health. There is a bit of an anxiety that we are settling the NHS and, perhaps partly, the local government role, but somewhere off in the wings something else will come on wider public health, and that would pick up some of the wider wellbeing issues.

There is a risk. It is almost inevitable that you have to have an NHS body. You cannot give control over NHS spending either to local government or to the voluntary sector without changing the very fundamentals of the way our public sector works, so there is a risk that the NHS will disappear off into its own world. The real risk in that comes from aggressive performance management, particularly on waiting times. If we really mean mental health, and wider wellbeing, and supporting children, particularly given what has gone on through Covid, we have to remember that when the NHS gets asked to try to deal with some of the waiting time issues that have built up. We need to do something about waiting times, but if it becomes a very narrow message, "Do whatever you can to reduce acute sector waiting times," I am afraid some of those issues such as mental health will fall by the wayside, as they have before.

Q11 **Dr Evans:** That is really helpful, Richard. I have a final question to Nigel around this topic. Richard hinted about the financial implications. The paper talks about imposing capital spending limits on foundation trusts with regard to managing resources. I can see pros and cons of doing such a thing. How do we incentivise the system, provide it with the money, but at the same time reprimand, for want of a better word, those who are struggling or have poor performance? How do you see the relationship going? In healthcare it is very difficult, as in education. Would you be able to address that side, Nigel?

Nigel Edwards: For background, the previous settlement meant that the Department of Health, now the DHSC, was responsible for capital spending for the entire vote, but was unable to control the foundation trust components. In a sense, this brings back capital controls. I suspect the other reason for it is that it provides a lever, albeit rather a nuclear one, over recalcitrant foundation trusts.

What it potentially also allows is for the ICSs to do something that started with the STPs, which is to take a better approach to the planning of resources, the planning of capital, and, indeed, the workforce. I see it as part of that suite of changes. Some of the missing components are probably a bit of investment in people and skills to do that planning. A lot of it is currently outsourced to management consultants.

If you have to rely on tools to discipline people to get them back in line, which I think is the underlying bit of your question, you have probably already failed as a system. The intervention point probably ought to be before that, with the NHS England and NHS Improvement regions keeping a close eye on ICSs, and watching out for where relationship problems are developing, and trying to avoid the need to use rather big sticks like the capital controls to bring people back into line.

Q12 **Dr Evans:** Do you think the new framework provides that early intervention enough?

Nigel Edwards: I think it should, yes. As Richard was saying, the legislation only provides a framework, and, therefore, it is only as good as the people who are operating within it, and how they discharge their role. There is enough of that framework at the ICS level.

There is a tricky question in that there are some providers that sit across multiple ICSs but do not have a particular share in any one of them. Mental health trusts particularly may well sit in more than one, as may some of the big specialist trusts. How they are brought into line has never been an easy question. Getting alignment on what the strategy is and what the goals are, and having a system to have a proper dialogue about that, is probably the mechanism, rather than trying to construct too many statutory levers that can be used to compel people in the right direction.

Chair: We have lots to get on to and we want to talk about social care and workforce issues in much more detail. On this issue, let me bring in Laura Trott for a final question.

Q13 **Laura Trott:** I want to ask about accountability, building on Luke's last question. We have talked a lot this morning about the very broad powers the ICSs will have. We have seen recently what happens when CCGs fail. Is there an improved accountability mechanism that we can bring in for ICSs to help guard against that? That question is for Richard in the first instance.

Richard Murray: It is a really tough question. An improved accountability structure? Certainly, a bit more national clarity about

where the rules and accountabilities lie will help. Tidying up some of the work-arounds that have emerged since 2012 will help. The merger issue between finally getting NHS England and NHS Improvement into one organisation also helps.

In the NHS, though, the risk in the past has been that many chief executives/leaders feel incredibly accountable to NHS England, or to whoever is in the system above them. That power of performance management and the power to end your career is quite dramatic. The problem has been with their accountability to their communities and to other partners such as local authorities. I hope we could see a bit less accountability upwards and a bit more accountability outwards. Again, the partnership boards might give some element of that—what happens, what powers can we give to the partnership structure—so that they can try to deliver some degree of accountability over the NHS and, indeed, possibly on the other side as well. The NHS is sometimes portrayed as the villain of the piece, but of course that is often not the case.

We need more accountability outwards and a little less upwards. We have an incredibly nationally dominated system that has a lot of accountability upwards, but I think we need more towards patients, the public and other stakeholders who are also working on health and care.

Q14 **Laura Trott:** That is a very interesting point. Nigel, is there anything further from you on that?

Nigel Edwards: I agree with that analysis. Internationally, we are an outlier in that sense particularly. There is no shortage of vertical accountability.

Over the last few years, the systems to try to identify organisations that are running into trouble have been reasonably well developed. There is a risk of being too ready to intervene centrally. We learned in the 2006-07 financial crisis that it is very important that local leaders of systems feel that they are responsible and there is not someone doing the job for them. I am not sure that lack of accountability is the problem with the current system. There is an interesting question at the top of the system about the new powers for the Secretary of State that are proposed in the White Paper, but I suspect we may well come on to those.

Q15 **Chair:** Thank you very much. We will indeed. I want to talk about social care though. Let me ask Hugh, because we have not heard from you for a while. There was not a great deal in the White Paper on social care, beyond a pledge to bring forward more proposals later this year. Is that a missed opportunity, given the concerns in the social care sector that they are always having their issues put on the back burner in favour of sorting out NHS issues first?

Hugh Alderwick: It absolutely is, Jeremy. The White Paper is pretty silent on reform of social care in England. There are some limited policy measures in it which, without additional funding, look a little perverse in places. It is such a long way from adding up to comprehensive reform.

We all know that the current system is a threadbare safety net. It struggles to provide effective support to lots of vulnerable people and their families. There is ongoing political failure, to be frank, which the Government appear to be choosing to prolong. We have been promised reform lots of times; it has been ducked lots of times. Without adequate funding for social care, without thinking comprehensively about the workforce and other challenges facing the system, the rest of the objectives in the White Paper around the NHS on improving population health will be very, very difficult to meet.

The NHS is clearly only one small part of what keeps us healthy. If social care and public health are underfunded, what is the NHS integrating with? Yes, this is a clear missed opportunity. The case for reform is so strong. What is missing is political will. It is extraordinary that it is not being done, particularly after what has happened over the last year. I cannot put it in stronger terms.

Q16 **Chair:** I will bring in my colleague Barbara Keeley on this, but I have a quick question to Richard from the King's Fund. The NHS had its 10-year plan two years ago. Do we need something similar for the social care system that allows for a long-term view and long-term planning on things such as the workforce issues that bedevil the social care system even more than the NHS?

Richard Murray: That would be the gold standard, and a huge landmark victory for any Government who could bring it off. You are right that it needs to be more long term. That is because any major funding reform is going to take a while to get through the Commons and a while to enact across the country, so you need something in the interim. A 10-year plan gives the ability to take the long-term view over workforce. We saw the weaknesses in the social care workforce exposed in the worst possible way through Covid, despite the incredible efforts of many of the staff.

There needs to be a short-term bridge between the short-term pressures the system is under into the medium term, and into the longer term when the funding solution could, hopefully, be in place and working. That kind of long-term view could then be brought alongside the NHS. There is a good case for making that public health as well. The more you go into the long term, the more chance you have to influence some of the very basic reasons why we are unwell. Trying to connect all three would be amazing, but I would absolutely accept your offer, Jeremy, of a 10-year social care piece. That has to be the highest priority.

Chair: Sadly, it is not my offer. I am not in a position to make these offers, but it is certainly my suggestion.

Q17 **Barbara Keeley:** Nigel, you have not given us your view yet on social care with respect to the Bill. You highlighted the duty of the CQC to assess local authorities' delivery of social care, and argue for bolstering the role of the CQC in relating to the provider market. Do you want to speak more broadly about that, and could you tell us what you think are the benefits of extending the CQC's role in that way? There is a view that

it could be tinkering without additional funding or a plan for reform.

Nigel Edwards: Certainly, more oversight and tinkering, as you put it, would probably be unhelpful anyway, but in the absence of proper reform it will not solve the fundamental problem.

We are concerned about the state of the provider sector in the social care system. As you know, it is very fragmented, and often quite financially precarious. It has major workforce problems, and there are significant quality problems. A lot of the emphasis in social care has been on older people, but these problems are also true for younger adults. In some cases, they are even worse.

Our feeling is that local authorities are not well placed to do this at the moment, and are certainly without the resources and skills to do it, so there is an issue. The CQC already has a role, and keeps an eye on the financial state of the larger providers particularly. This followed the Southern Cross problems of a few years ago, which you may remember. There is an infrastructure that could be built on, and it is important that someone is watching that market. We are not convinced that the White Paper proposals, as they are currently put, solve that particular problem.

On your wider question on social care, I do not have much to add to what my colleagues have said, other than the point that a lot of the policy attention has focused on the funding settlement. It is massively important, but my experience of work on universal health coverage in other countries is that, if you only fix the funding system and do not fix the provider system, you have not solved the problem at all. In fact, you may produce some pretty perverse and unintended consequences as a result.

Q18 **Barbara Keeley:** The Secretary of State will have a power to intervene where the CQC finds a local authority is failing to meet its duties. Could you comment on what form that intervention should take? Should the criteria for intervention be set independently? Again, given the funding situation of local authorities, it seems a massively incomplete new power.

Nigel Edwards: Our feeling is that in many cases local authorities are effectively being set up to fail. The general principle with intervention powers is what you have just put your finger on, to be honest. There needs to be absolute clarity about what the criteria are, and transparency about how they are then applied and exercised. That will be a very important part. I am back to a similar point that I was making earlier; if you are intervening, you have already failed. Yes, it is quite helpful to have—I guess as a last resort—an intervention power, but we would like a rather more fundamental change in the nature of the funding and the social care system that obviates the need for intervention. Having the Secretary of State sucked into it regularly would be a real mark of failure, I think.

Q19 **Barbara Keeley:** Do you see the power of the Secretary of State to make payments directly to adult social care providers as facilitating integrated care any more than the other powers?

Nigel Edwards: Again, it seems something of a sticking plaster. Someone perhaps ought to check whether payments of that sort are going to be possible for commercial providers. It is helpful to be able to rescue, I guess, but, absent a proper funding solution, again it feels like a sticking plaster when we need major surgery.

Q20 **Barbara Keeley:** Richard or Hugh, do you want to add to that?

Richard Murray: The ability to fund social care providers directly may be a helpful emergency measure should Covid come again, or if we get another pandemic or some other financial crisis, but it is not an answer, and I doubt it is meant to be an answer, to the underlying funding problem.

As regards the ability to intervene on local authorities, I do not wish to draw too many times on analogies with the NHS, but when NHS providers all began to get into financial difficulty, the intervention regime was used in spades. Half of them were in special measures. All of them were having their accounts qualified. It did not really do any good because, fundamentally, the problem was not one of bad management; it was being asked to do things they could not do. I am sure there will be occasional examples when the ability to intervene with local authorities may be helpful, but it is not an answer to the question of social care, and I do not think it is an answer to the question of integration either.

Q21 **Barbara Keeley:** Do you have any thoughts about the role of the CQC, and the suggestion of the CQC regulating the provider market? Clearly, it is not being managed. We know how fragile it is, and it is not being managed at the moment.

Richard Murray: Either for local authorities or for the CQC, it is incredibly difficult to do more than identify cases where there is poor management and do what they can on that, and provide information to the public about the quality of the services around them. Sometimes, through the things that they publish, they can help with learning, but they cannot fundamentally alter the pay for people who work in social care. They cannot commission new training. They cannot alter the balance between public and private sector funding or for those that get no funding at all. They are leaning on a piece of string; they are trying to use regulatory levers for something that is not a regulatory issue.

Q22 **Barbara Keeley:** Hugh, do you want to add to that?

Hugh Alderwick: I agree with much of what Richard said. There is clearly a role for stronger national support for learning improvement in the sector, but not for intervention and stronger national oversight when a lot of the problems are systemic, about funding and pay in the system. It would be better for the Department to focus on intervention in Government to release the funding to support the system effectively, rather than looking at top-down performance management for a system that is being set up to fail at the moment. I agree with both Nigel and Richard.

Q23 **Chair:** I want to move on to another incredibly important area: workforce and long-term workforce planning. You all said in response to the last question that you cannot necessarily solve problems at a stroke with new legislation. None the less, Richard Murray from the King's Fund, you describe the workforce planning side of the White Paper as very disappointing. In fact, you said the duty for the Government to publish a document on workforce planning every five years was "wholly inadequate." When it comes to workforce planning, what, in your view, is missing?

Richard Murray: We need a workforce plan that combines measures you would take in the shorter term to support employers to improve retention, and to improve people's skills in the workforce we already have, linking to the longer term as regards new training and increases of supply in the workforce, and, potentially, new professional groups that could fill need both from shortages and from new ways of delivering care.

We have struggled, particularly since 2012, in that it was never clear where that sat. NHS England was a commissioner and, for the most part, stood aside from workforce issues. Health Education England would do some of the longer-term thinking about the commissioning of training in the long term. NHS Improvement, or Monitor at the start, had no workforce responsibility and slowly moved into it because nature abhors a vacuum. That tries to deal with the health side.

Meanwhile on social care, we have spoken to parts of the NHS which, on occasion, I am afraid, were targeting nursing homes to recruit nurses. We thought, "You'll be really sorry if you succeed and you push your nursing homes out of business." We need a wider health and care approach to the workforce that balances both the short term and the long term, and recognises that there is a bit of a gap and too many powers spread across too many different parts of the system.

I am glad that there would be a report once every five years, but that is not the effort and the importance we need for the issue right now. We saw through Covid, over and over and over again, that it is the workforce who matter. You can buy as many ventilators as you want, but if you do not have intensive care nurses to work them, it does not help. It is the workforce.

Q24 **Chair:** One of the issues that has come up in many of our other Select Committee inquiries is the timescales involved—seven years to train a doctor and three years to train a nurse—and the need for long-term planning when you are estimating how many doctors and nurses you are going to need in 10, 15, 20 years' time. Anita Charlesworth told the Committee last week that there ought to be a legal obligation on Health Education England, or some NHS body, to publish independent estimates of those long-term needs every year, revising them and continually updating them, but they need to be independent forecasts, so that we can really check whether we are training enough doctors and nurses. Does that have merit in the view of the King's Fund?

Richard Murray: If you particularly link it to funding, the challenge with the training of the workforce over many years is that the body responsible for it, whether it is Health Education England or the Department before that, is constrained by HM Treasury to come up with numbers that look quite low in order to keep the bill down on training, and to keep the future forecasts of the workforce down, because that directly backs into public spending. Of course, we only find out when the future finally arrives that we do not have enough workforce groups.

That long-term view, if we could find a way of doing it, would be useful. We have from the OBR long-term forecasts of spending now. It provides them and it is independent. You could ask HEE to convert that into workforce numbers. The bit we need to keep, though, is that it is quite a strategic role. The temptation would be to convert the current workforce and just make it bigger. Sometimes you want a different workforce. You might want doctors, but you might also want physician associates or nursing associates; you might need a different kind of workforce. The workforce body on its own needs to make sure that it has links to NHS England, and to the Department and the other players as well.

Q25 **Chair:** Let me bring in Nigel. What would your argument be to Treasury officials? They say that because we are always going to employ everyone we train, if you make a long-term commitment to train more doctors and nurses, you are, effectively, making a long-term commitment to expand the NHS and care budget beyond the spending review period, and the Treasury can never sign up to that.

Nigel Edwards: I have some sympathy with that view, except that not all doctors and nurses end up working for the NHS. They work in life sciences or the social care sector, for example. They are very employable in a number of other sectors of the economy. We are creating human capital, and that is perhaps the way the Treasury should look at it.

The other point that never seems to be considered is that, if you think a surplus is expensive, you should try having a shortage. Markets will operate, and we have seen huge growth, for example, in locum usage in shortage specialties, at very high expense. I am not sure I have actually seen a proper cost-benefit analysis of what would have happened if we had had a bit of a surplus. In international comparisons, England would have tens of thousands more doctors than it does currently if we were France or Germany, perhaps even more than tens. A bit of a surplus also has knock-on effects for improving quality and efficiency, because if you are appointing to a job, it is good to have more than one applicant.

Q26 **Chair:** Let me bring in Hugh on a slightly different but related point. We all know about the absolutely brilliant contribution made to the NHS and care system by foreign-born doctors and nurses over the last year. We would have fallen over without their help. Over the last decades, this has sometimes meant that we are recruiting doctors and nurses from very poor countries that need those doctors and nurses at home. Do you think that the NHS and care system should aim broadly to be self-sufficient—in other words, training the numbers of doctors and nurses that we are

actually going to need in the future?

Hugh Alderwick: It needs both. If we look, for instance, at the Government's target of employing 50,000 extra nurses by the end of the Parliament, it will clearly need sustained investment and policy action on domestic supply, but also co-ordinated ethical recruitment from overseas. We benefit enormously from overseas staff. The question is about the balance, particularly as Nigel set out. The experience of the last year, not just in terms of staff but in NHS capacity, is that we have to plan for over-supply.

There is no way that in the short term or medium term we can train our way domestically out of our huge chronic workforce challenges. We have to look at boosting domestic recruitment and the actions needed to retain staff once they are in the NHS, particularly given levels of bullying and discrimination. We also have to look at ethical effective international recruitment. There has to be both to fill the gaps we have.

Q27 **Chair:** Is one of the ways we could address those issues by lifting the cap on the number of graduates that medical schools are allowed to train?

Hugh Alderwick: The challenge at the moment is that we do not have decent projections about what we need over the longer term. We have to look not just at things like whether there should be a cap and whether there should be clarification of roles in the legislation around who is doing workforce projections; we have to stop biting off different pieces of the workforce policy puzzle and try to look at it as a whole. I think there are four chunks.

First are actual projections that we can stand behind, to say what we need as regards staff over the short and medium term. That needs to go hand in hand with planning new care models. It needs NHS England involved and others involved, and it cannot be done without, secondly, a long-term funding settlement from Government. Thirdly, it has to be about health and social care together. Looking at one particular policy intervention without a strategy for the health and social care workforce as a whole is taking us down the wrong track and could have unintended consequences.

Q28 **Rosie Cooper:** I would like to join up some workforce and governance issues, if I may, and ask whether there will be open competition for all ICS jobs, including chief execs and chairs. I understand that embryo partnership organisations seem to have made permanent appointments. Are you picking up any concern from CCG employees who may find that they have limited opportunities because of the mismatch in going from one body to the other? To whom are ICSs directly accountable? I am very concerned that if it is just the Secretary of State, it will be almost as unworkable, and as useless, as NHSE being the commissioning body for CCGs. Perhaps Nigel could start with that, please.

Nigel Edwards: I have not picked up anxiety. I am probably not moving in quite the right circles necessarily to be able to answer the first part of your question. The ICSs I have worked with now have, as you say, fairly

stable leadership teams. Quite a few of them have almost completed the process of folding the CCG into the ICS, although there are a few places around the country where that process is still not completed.

On the accountability point, my understanding is that they will be accountable through the regions of what is now NHS England/Improvement to the chief executive of the NHS. Eventually, of course they are accountable to the Secretary of State under the way that the legislation is proposed to be set up, but the accountability system that we currently have probably still applies, with some additional powers, in that CCGs could not be directed by NHS England unless they were in a failing regime.

I understand that under the new regime there are more powers of direction. Richard's caveat about the potentially overbearing nature and upward direction of the performance management system is perhaps more of an anxiety than a lack of accountability, but I cannot shed much more light on the first part of your question. As far as I can see at the moment, most senior staff seem to be settled. The more middle and junior staff have been given a guarantee of keeping their jobs. Tasks are still there to be done mostly, so, hopefully, the level of disruption that is implied by the question can be contained, but it remains an anxiety, I think.

Q29 **Rosie Cooper:** Absolutely. In Cheshire and Mersey, to my knowledge, those mergers have taken place, and we now have permanent appointments being made and CCGs still as they were. There are a number of CCGs in the area. Richard, would you be able to shed any light on some of this?

Richard Murray: My understanding from the document NHS England published that was the precursor to the White Paper is that CCG staff, away from the most senior leadership, had a guarantee of employment, not forever, but at least for the next few years, and that senior staff, particularly the accounting officers, did not. I think that is still the case.

Where you have a settled leadership in your ICS, which may be the same as the CCG, that is before the legislation changes and unsettles them again. NHS England, with the Department, will have to set out what the appointment process is, both for the accounting officers on the NHS body and the chairs and non-executives who are there as well. How do these people get appointed, and to whom are they responsible? That is what we are waiting for next. I do not want to spread anxiety, but if that NHS England document from December still stands, people who think that they are in secure employment now in senior roles at the top of CCGs and ICSs may need to think again.

Q30 **Rosie Cooper:** Do you think, Richard, that we have been clear to executives of CCGs, who have not applied for volatile partnership jobs because nobody knew where they were going, that they may now find that unless the ICS jobs are advertised as new organisations—indeed, chairs and chief execs may have been appointed when the competition

was not great—those people will be seen to keep permanent jobs in the move towards ICSs? It is just not fair.

Richard Murray: Rosie, I think what you are correctly pointing to is that there is an objective both from the Department and from NHS England to keep the level of disruption as low as possible. In point of fact, when you are changing organisations, there is a limit to how far you can do that. Some of the real pain of reorganisations in the past—I have lived through some of them; I have been in them and I have done them to other people—is that you get trapped by HR rules, and there is not much room for manoeuvre.

We need to see exactly how NHS England and the Department plan to fill those roles, for the people who think they are in them at the moment, although in some senses they cannot be because the ICS does not exist, so, even if you are the ICS lead you must have a host employer that is somebody else. That will be a job to unravel. It is also what you do about the leaders of CCGs, some of whom may only very recently have been appointed, because CCGs have been merging. What role do they get? This has been a problem in reorganisations in the past.

Traditionally, quite a few of them pop up in the Department in temporary roles. People try to find homes for some and do not find them for others; it is messy. The good thing is that they are trying to protect the bulk of staff from going through that. That really is different from what we have seen in the past, when it came as a great cascade across all grades, and everybody was involved. This time, they are trying to limit some of the pain. Remember that ICSs are incredibly important bodies. They will control huge amounts of public spending, and the public and MPs will want to know how those people are appointed.

Chair: Thank you very much indeed. That brings us to the end of our first panel this morning. A very big thank you to our three panellists—Richard, Nigel and Hugh—for very insightful answers on very important topics. I think what I am sensing is broad support for the direction of travel, concern about some of the details, and real concerns about some of the things that are not mentioned in the Bill that need attention, such as social care and workforce. We are now going to move on to the second panel and we will test out some of that as well. We thank all three of you for joining us this morning.

Examination of witnesses

Witnesses: Danny Mortimer, Sarah Pickup, Sir Robert Francis and Chris Hopson.

Q31 **Chair:** A very warm welcome to our second set of witnesses this morning, which includes Chris Hopson from NHS Providers and his familiar fireplace, which we have seen on many occasions in these virtual Select Committee sessions. Sir Robert Francis is of course very well known for his inquiry into Mid Staffs, which has had such a huge impact on improving the focus on safety and quality in the NHS. He is now responsible for Healthwatch as its chair. Danny Mortimer is chief

executive of the NHS Confederation, an organisation that represents NHS bodies. He is temporarily away from NHS Employers where, as chief executive, he had very close involvement in NHS workforce issues. A very warm welcome to you as well, Danny.

For the record, Sir Robert is also a member of the advisory board of Patient Safety Watch, which is a charity that I set up and am a trustee of. A very warm welcome to everyone. Thank you for joining us this morning.

I would like to start, if I may, with Sir Robert. You will have heard the evidence that we have just had about the idea of integrated care systems being generally welcomed, but there are quite a few questions about accountability and how we are going to know how well they are doing. Richard Murray from the King's Fund talked about the need for more accountability outwards to patients and not upwards to NHS England and Ministers.

You are on the board of the CQC, where that problem has been addressed for hospitals, GP surgeries and care homes by having the Ofsted rating system. Do you think that having Ofsted ratings for the new integrated care systems done by the CQC might be a way of providing that outward accountability?

Sir Robert Francis: First, I agree with the previous panellists that accountability is necessary and that it is very unclear in relation to how the integrated systems work. I should say that I and Healthwatch England welcome the direction of travel, but, from a public and a patient point of view, it remains very unclear what an ICS is, what it does and how it will relate to social care and matters of that nature. First, there is a job to be done explaining to the public how their NHS and social care will work in the future.

Quite rightly, there is not an over-degree of prescription about how they are going to work. They will work differently, and they are currently working differently, in different parts of the country. It is important that the public and the patient voice is involved, and that can happen in two ways.

The first suggestion, which I welcome, is that there should be some form of oversight, probably by the Care Quality Commission, of the system. The value of that has already been demonstrated by the system reviews that the Secretary of State commissions from time to time, as indeed you did, Chair, when you were there. As far as a rating is concerned, we need to consider who the audience is for that rating. There can be two audiences. One is the taxpayer and those that represent the taxpayer. Are we getting what we are paying for?

One thing that has not featured very much in the conversation so far has been the performance of systems in relation to providing quality and safety of care to patients, and the reflection of their needs. There are conversations that need to go on between patients and the system. In that sense, a rating that summarises the performance of an organisation

to the public is a form of accountability. It does not affect patient choice in quite the same way as a provider rating does, but it may be a way of explaining to the public how their system is doing.

Q32 **Chair:** Thank you. You mentioned that the Secretary of State currently has the power to ask the CQC to do system reviews. If they have that power already, does it need to become a regular part of the CQC's work or could you just stick with what we have at the moment?

Sir Robert Francis: The importance is how the CQC chooses where to go when it is acting independently, who it looks at and what it says. If it is continually being directed to go to places that the Secretary of State chooses, that may not have quite the authority or credibility of an independent judgment made on the same basis. As the CQC moves more towards an intelligence/insight-led format, there is the chance that it can act as a warning when things are going wrong, as opposed to getting there, as a previous panellist suggested, when it is too late. In other words, if you have regulatory intervention, you already have a failure.

Mention was made of the market oversight system, which I have to say would need very considerable development to go wider than it is at the moment, and would need to be resourced. I think there is a role that the CQC plays now in relation to responding to concerns, going and having a look, if you will, and then reporting on what it finds. The ability to do that would potentially be a powerful assurance to the public that the ICS, instead of being a rather nebulous organisation that may be doing this or that, is doing a job, and someone is actually looking to see whether that job is being done safely and meeting local patients' needs.

Q33 **Chair:** Let me bring in Chris Hopson on that point. Do you agree with Sir Robert's views on that, and do you have any other general comments about the proposed reforms?

Chris Hopson: In terms of ICSs, I think the accountability question is very important. For us, it is a classic illustration of the huge amount of detailed work that still needs to be done. When we asked the question of some officials working on the Bill last week, the immediate response was that of course accountability was to NHS England and Improvement. Our view is that we need a much more sophisticated model of accountability than that.

For example, we are putting £100 billion of public money through ICSs. That is 11% of total UK public expenditure, so my assumption would be that ICSs would have to be responsible to Parliament, through the Department and through NHS England and Improvement. We are asking ICSs to produce plans that their local providers are, effectively, seeking to deliver. I would assume that in that planning process the ICS has to have an element of accountability to, and close co-operation with, the providers who are to deliver those plans.

We have said that we want ICSs to deliver the right service, commission the right services and deliver improvements in healthcare for their local populations. There presumably must be an element of accountability to

those local populations. If that is right, and we think it is, it immediately raises the question of what the governance needs to look like in order to take account of that range of different accountabilities. All of that still needs to be worked through in a level of detail that we have not got to yet.

On the question about regulation and oversight of ICSs, I think we would all agree that ICSs need an appropriate degree of transparency on how well they are doing. I could not agree more with Robert that service quality and patient safety, as well as improvements in population health, are really important.

It is important to remember that we have providers actually providing the detailed services. If we are to measure ICSs for one thing, we have to ensure that it is appropriately aligned with how we are measuring the providers in the system. As to who does that, exactly as Robert says, the CQC has played a valuable role in those system reviews. It makes sense to regularise them, as you have already implied, but we should not forget that NHSEI also have an important role. They already have an existing ICS assessment regime in place. They have also been helpfully developing a system-led improvement approach.

We agree with you, Chair, that an important quick piece of work needs to be done to design a proportionate and aligned regulatory and oversight approach to ICSs, which looks at how well they are doing on whole population health, patient quality and safety and some other things, such as use of resources. When that piece of work is done, we can see what needs to be put in the Bill, and whether ratings or other things are the appropriate mechanism for delivering that oversight and assurance.

Chair: Thank you. I want to come back to other issues, particularly an operational independence issue that I know you will have views on. On transparency, I want to bring in my colleagues Paul Bristow and Laura Trott.

Q34 **Paul Bristow:** I am particularly concerned about how we learn the lessons from the previous system. On bureaucracy, for example, what provisions do you think should be in the Bill to ensure that the existing bureaucratic burdens encountered by various NHS institutions at the moment are not replaced by new burdens on the ICS body and the ICS health and care partnership?

Chris Hopson: We have a worry there, if I am honest. What we appear to have now is a system in which we are going to have primary care networks, and we are going to have trusts and foundation trusts that the paper is very clear will continue to deliver secondary care services.

We talk quite rightly about the importance of places. We are saying that we want providers to work together in provider collaboratives. We are now going to put ICSs on a statutory footing, but with a two-part governance structure: a health and care partnership and an ICS NHS board. We also have NHS England and Improvement, both at national and regional level.

One of our observations would be—we have said this to the Department very clearly—that we will need to be very clear about what the accountabilities of each of those bodies are. Some of them will not have formal governance around them. How will all of that work together? There is a danger that, if you have that many players on the pitch, there is an opportunity for duplication and overlap. To pull out one very specific example, we are asking trusts and foundation trusts to be responsible for the delivery of care services, and for the management and successful use of probably £90 billion of the £130 billion that we spend in the NHS, but we are also asking ICSs to have responsibility for overall system performance, which you might regard as the aggregation of the work that each of the providers in that system does.

We need to be sure about exactly how we are going to define those accountabilities and responsibilities. I look at Sir Robert: one of the things he was absolutely clear about in his report on Mid Staffordshire was that one of the anchor points in the NHS was the fact that the trust was always responsible for everything that it did in the care that was provided. He then went on to say that it was unclear who was meant to be holding trusts to account. Was it a bit of the CQC? Was it a bit of Parliament? Was it a bit of, at that point, Monitor and potentially the CCG as well?

The bit that is really important is that, given the level of risk that the NHS is responsible for and given the amount of money and the number of people for whom trusts and foundation trusts are involved in care delivery, we need to be absolutely precise about who is responsible and accountable for what. That is why I say that there is still an awful lot of detail to work through. Nobody has yet set out clearly exactly how the different accountabilities for the different bits of the system will work going forward.

Q35 **Paul Bristow:** Danny, from the NHS Confederation, do you want to comment?

Danny Mortimer: Thanks very much. I do. The first thing to say is that we have seen some very different ways of working over recent years, with some sharing of accountability. The collaboration that Chris touched on is desirable and is intended by the Act. It is described by our members as being of enormous benefit over recent years, not least during the pandemic.

The previous Act envisaged a system of hundreds, if not thousands, of separate organisations working together. I do not think the accountability in that process was terribly clear either. The Chair touched upon that in terms of the need to find some sensible way of providing oversight to systems as a whole. We have had situations where you may have individual organisations getting strong ratings from the CQC, but the experience of the population as a whole has not been where we would want it to be.

We need to take these steps, and I think we can work them through. What our members describe to us as their biggest area of concern, and the biggest opportunity in implementing the Act, is that we now have a very centralised and very performance management-driven system. I think you touched on this in your question. The level of oversight and interaction that there is now between our regulators and those providing health services in particular has reached a point where it needs serious rethinking. ICSs absolutely need to be held to account in the way that the Chair and Sir Robert talked about, but they also need some freedom to set local priorities related to the health needs of their population. Those will vary around the country. The centralised system that we have seen develop over the last 10 years needs to be revisited and rethought in light of these reforms.

The opportunity to do that is in the guidance that will be developed. The conversations that we have had over recent months with both NHS England and the CQC have given us some assurance that those organisations recognise that they need to revisit and change their ways of working. It is very prominent in the new strategy that the CQC are currently consulting on, and, as I have said, we have had some very good exchanges with Sir Simon and his team at NHS England on how they will revisit their approach to managing the NHS in light of the Act and its implementation.

Q36 **Paul Bristow:** Thank you; that is very helpful. NHS organisations are likely to dominate the membership of ICS bodies. What steps do you think should be taken to ensure that all members have equal input into collaboration across the ICS? Maybe Sarah could start.

Sarah Pickup: Thank you very much. There is a lot of discussion about the mechanics of the operation of the NHS body. We were very pleased to work with the NHS and the Department to say that we cannot manage partnerships of equals managing population health through the board of a statutory NHS body, and therefore the health and care partnerships are crucial. If what we are about is improving population health, which must be what we are about overall, those partnerships are absolutely critical.

There is a risk, as an earlier contributor said, of so much focus going on to the NHS body that we neglect those partnerships. We neglect them at our peril. They build on what is already there by way of health and wellbeing boards and system-level partnerships that were operating well in some places. There is primacy of place built into the White Paper, in annexe B, which should not be forgotten. Most of the integration and most of the partnerships should still take place at more local level, with flexibility about exactly what the footprint is within systems.

What is really important is that, yes, the NHS board needs to be established properly and all the mechanics need to be working, and, as I understand it, local government will have a place on that board, which we are pleased about; but the constitution of the partnerships needs to be jointly agreed between local government and the NHS and to bring in other partners like the community and voluntary sector, and the patient

and public voice. It is in those places where we should be using the existing mechanics of things like section 75 agreements to pull budgets and push forward on the delivery of the long-term plan in relation to prevention, community services and helping people to stay healthy and well. Those partnerships need to be expected to succeed.

We have talked a lot about accountability in the NHS and how what is decreed at the top flows down and happens. We need to expect, enable and empower the partnerships, and the place-based partnerships within them—the health and wellbeing boards and others—to succeed. What is expected and what is empowered should be done. If the NHS turns a blind eye to the partnerships and is tokenistically involved in them, they will not succeed. They have to be seen with equal importance.

Paul Bristow: That was very helpful, Sarah; thank you very much.

Chair: I want to interrupt, Paul, if I may, because I forgot to introduce Sarah Pickup at the start of this session. She is deputy chief executive of the Local Government Association and a regular contributor to this Committee. She is a great expert on social care, so we are delighted to have her with us.

Paul, do you have any more questions?

Q37 **Paul Bristow:** I do. Sir Robert, are you satisfied with the composition of the boards of the new ICS bodies?

Sir Robert Francis: I am not sure I have seen the full composition, but the gap I see—if it is a gap—is in patient and public engagement. It seems to me that we have a reasonably recognised structure for that now at local place level. We have a pretty recognised working structure at national level for it, but it has not been fully fleshed out yet. I think it is capable of being fleshed out at ICS level.

It seems to me that if you want integrated care, which is what the public want, by the way—they want seamless care—they need to be involved and their needs listened to at ICS level. As Sarah says, they need to be part of the partnership working. Our bit as Healthwatch would be that we need a similar arrangement at ICS level to the one we currently have at local level in order for the public to say what they need to be taken into account, and to be a channel through which the ICS can explain to the public what it is actually doing.

I would advocate that as a means forward. That does not mean that the public need to take responsibility or be personally accountable for what happens, by the way, but they need to be there. I think transparency is really important. The public will expect all the partners to work together. If this, as has been suggested, becomes a conversation about the NHS within the NHS, we will not have the true integration that is the aim, difficult though that aim is.

What worries me a bit is that there has not been much of an explanation as to how the relationship between the NHS board and the partnership board will actually work. Of course, it may work in different ways in

different places, but I have heard it suggested that in some places a partnership board may be the dominant body. I have heard that they may have identical membership in some places. Those sorts of questions need ironing out because, from a public point of view, if someone moves from Doncaster to Cornwall, it would be good if they found that what they think of as the NHS is working in a roughly similar way, albeit with special responsiveness towards local need.

Q38 **Laura Trott:** I want to pick up some of the discussions we were having earlier around accountability and patient choice to talk about the specifics in the White Paper around patient choice. Do you think they are strong enough?

Chris Hopson: There has been a long history, embodied in the NHS constitution, that people should have the ability to choose which provider they use. The Government have made it clear that they want that choice to carry on.

Patient choice is done in a number of different ways. It can be done at an individual level, as I have just described, but there has also been a regime in which clinical commissioning groups can have a procurement exercise to identify which provider should be delivering services. One of the helpful proposals in the paper, in our view, is about the fact that that has turned into, in a sense, enforcement and requirement to do regular procurement for certain services and has been very debilitating, particularly in the community services sector, where our members have said they are on an incredibly disruptive regular cycle every two or three years of having to spend huge amounts of effort having competitions, often with private sector providers who tend to bid low. They find themselves spending huge amounts of management time on processes that they believe are not necessary.

One of the things that we would flag to you that we think is helpful is that there is a new approach to procurement outlined in the process. There is consultation going on about exactly how the provider selection regime would work going forward, but that sits alongside the basic right of an individual to decide which particular provider they want to use. For us, that is a happy mix of the two.

Q39 **Laura Trott:** Yes, that makes sense. Sir Robert, what are your views on the patient choice provisions in the White Paper?

Sir Robert Francis: It is important that patient choice continues to be recognised as it is, as Chris said. What worries us a little is what happens at the boundaries of ICSs and the extent to which the patient has the choice to go somewhere that is not within their ICS. That is one issue that needs looking at because it can become a little complicated, it seems to me.

Although I think it is extremely necessary, I wonder how the ICSs will build into their strategies the idea that the patient has the right to choose; in other words, there should not be dictation from the top as to where the patient goes. That is part of the listening that ICSs need to do

as to what their patients need and want and, in particular, their ability to reach out to the seldom heard communities such as the economically deprived, ethnic minorities and so on. At the moment, they sometimes have no choice and no service. That needs to be looked at as well.

Whatever the rules say, it requires real dialogue, and continuing dialogue, with the people who need services in order to cater for what they want to happen. Of course, they do not dictate what can happen, but if you do not actually provide the service that people want and would choose, you are not providing a service at all.

Q40 **Laura Trott:** Sir Robert, I want to ask you a specific question about the difference between the patient choice that is available and parental choice over where and what treatment their children get. There has always been a bit of a gulf. Is this something you think should be looked at as part of the White Paper?

Sir Robert Francis: It depends on the area you are talking about. The potential conflict between the patient's choice and parental choice can be quite acute. There are laws that deal with that. If, in general terms, you are talking about parental choice in relation to how their children are treated—

Q41 **Laura Trott:** And where as well.

Sir Robert Francis: And where?

Laura Trott: Yes.

Sir Robert Francis: It is really important. The place of treatment is something that, far too often, it seems to me, in the past in the NHS has been arranged for the convenience of the service rather than the service being arranged for the convenience of the patients. That is true for parents; it is true for children; it is true for adults; and it is true, perhaps particularly, in the disability sector, where horrendous stories are told about people being put miles away from home. All those things need to be taken into account.

It is an area where an ICS is potentially a better solution. First, there are fewer of them than there are of providers and CCGs and so on. Secondly, a more holistic view can be taken of where it is appropriate for people to go. A system that ignores what people want to happen and what is good for them is not a system that is doing its job at all.

Laura Trott: Thank you.

Q42 **Chair:** I want to move on to workforce issues, which we discussed in the earlier session. Before that, I have a question on operational independence for Chris Hopson.

The Lansley reforms were very controversial, but many people would say that the one bit of those reforms that has proved a success is giving operational independence to NHS England. Do you worry that some of the provisions allowing the Secretary of State to intervene could undermine that progress?

Chris Hopson: It is impossible to tell at this point because we do not know what is proposed. If the power of direction became a very general power to direct any activity undertaken by NHS England, with no consultation before use of that power and no transparency on when and how the power was used, I think we would all agree that it would be very difficult. If, on the other hand, it was a very tightly defined power to direct in very specific areas that were central to the Secretary of State's parliamentary accountability, and there was appropriate consultation on how the power was used and transparency around it, that would be very different.

I think we would all agree, wouldn't we, that it cannot be right for a Secretary of State to have power to direct money to flow to certain areas of the country? It is better to have an independent formula. It cannot be right for a Secretary of State to be able to stop on their own initiative a very carefully and well worked up local reconfiguration plan because he or she is coming under inappropriate pressure from, let's say, a fellow Cabinet Minister or a Speaker of the House of Commons.

It would be inappropriate for a Secretary of State to direct that whole services should be, effectively, farmed out to the private sector. It would be wrong for the Secretary of State to have the power to hire and fire NHS chairs and chief executives. It would also be inappropriate for them to have the power to give in to very extensive lobbying by single-condition pressure groups to overturn NICE's guidance on how drugs should be used.

There are clearly a number of areas where the NHS's operational independence is absolutely fundamental, but we cannot really assess how much that is under threat until we see the detail of the power that is being proposed. That is why we are being deliberately silent on that until we see what the detailed proposal is.

Q43 **Chair:** There is one area where they have been very specific about the power that they are going to give the Secretary of State. That is to reconstitute the powers of arm's length bodies without having to go back to Parliament. That is a very specific power that the Secretary of State will be taking for himself or herself in this White Paper. What do you think about that?

Chris Hopson: Again, it would depend on how it is defined. I do not think anybody would have a massive problem if the Secretary of State wanted to move a single, tightly defined function that everybody agreed made sense to be moved, for example, between the MHRA and NHS England or wherever. Having a bit more flexibility to do that seems to us perfectly sensible. However, if you take that power to its logical extreme, as some are suggesting, which is, for example, the ability of the Secretary of State to abolish NHS England without coming back to Parliament, that clearly cannot be right.

I am sorry not to be specific, Chair, but it really depends on—as so much in this Bill does—the real detail of what will actually be in the clauses.

That is why we are engaged, and we think it is incredibly important that the Department engages, in a sensible and detailed debate with the sector before it brings the Bill to Parliament.

To make one final point, the Department will say, quite rightly, that a fair bit of the Bill was discussed in detail and agreed with the NHS in 2019, but there are significant new areas—this is exactly one of them—where, to be frank, the issues were not discussed at the time. It is very important, if we are not to have formal pre-legislative scrutiny, as I understand we are not, that the Department should develop its proposals in deep and significant collaboration with the sector so that we do not have what we had with the Lansley reforms, which was the sector holding up its hands in horror and saying, "No, we simply don't agree with this."

Q44 **Chair:** Thank you. Let me move on to the workforce. I would like to bring in Danny Mortimer. You and I worked together very closely when you ran NHS Employers, and I know that you have thought long and hard about the issues around workforce planning. We heard from the three think-tanks in the earlier session that the Bill is a missed opportunity to sort out long-term workforce planning issues. Do you think they have a point?

Danny Mortimer: Yes, but I also think there is an opportunity for the role of ICSs in addressing that, Chair. What we have not had are properly costed and properly resourced long-term plans for the workforce, for health and social care. That is another opportunity that needs to be picked up as well.

The role of ICSs gives the opportunity to devolve some of the work that is currently vested in Health Education England and NHS England around the workforce plan—the people plan that has been developed for England. I think ICSs, with their ability to relate workforce needs in the longer term to the needs of their population and the needs of their services, can become an engine for producing the plan.

I echo the comments that I heard colleagues make earlier about the fact that the plan needs to be developed in a way that is rooted in the need of patients, and is not conditioned and restrained by the short-term view of the Treasury in terms of the resource that is currently available. It needs to speak to the long-term needs of patients and populations.

It needs to build in innovation. I think the ICSs are the best place to identify potential innovation in how our people work, and speak to the longer term. There have been steps over the years to invest in the workforce. There was the medical school expansion and the commitments made after the last election on funding degree-level study, but they have not been done in the context of a whole plan. There is a real opportunity for ICSs to provide leadership in doing that and aggregating it nationally.

Q45 **Chair:** Let me ask you about the Treasury, as you have mentioned it. I will ask you the same question that I asked Nigel Edwards. The Treasury has the view that, if you commit to training more doctors and nurses, it is a bit like building the M25. Build it and they will come. The Treasury view

is that constraining the number of doctors and nurses that we train is the best way to contain long-term growth in NHS spending. Do you think that is the right view?

Danny Mortimer: No. My direct experience, and my experience in recent years working on behalf of members, is that actually in times of shortage— and we have had shortages for many, many years—there is an additional cost for the NHS and for our colleagues in social care because of the use of premium-cost labour. There are additional costs of having to recruit at considerable scale abroad. We need, albeit over quite a significant length of time, to reach points where there is over-supply in some of our key degree-educated job markets. That will, in the longer term, help us to avoid the additional premium cost that has been such a challenge for the NHS for 10 years or more.

Chair: Thank you. Let me bring in James Davies.

Q46 **Dr Davies:** Chris Hopson, returning to the operational independence question, do you think there is an extent to which currently there are informal arrangements—for instance, opaque discussions between politicians and NHS England? Is there an argument that the White Paper proposals might increase transparency?

Chris Hopson: Transparency is really important. The Chair and I have had lots of conversations about the nature of the relationship between the Secretary of State and NHS England. The reality is that the Secretary of State has full parliamentary accountability, quite rightly, for the spending of £130 billion of public money. This is one of our major public services.

Equally, though, the 2012 Act quite deliberately gave a degree of operational independence to the NHS. Our observation, looking in from the outside, is that there is, as you would expect, a day-by-day and week-by-week dialogue between the Secretary of State and NHS England about what should happen. We have tried to bring transparency to that through the publication of a clear mandate that effectively sets out what needs to be delivered. That seems to us to be a very important mechanism.

As I was saying earlier, in relation to what is proposed, the bit that feels uncomfortable is the idea that the Secretary of State should be able to direct the chief executive of NHS England to do things that the chief executive and the leaders of NHS England feel are inappropriate without there being a degree of transparency. As you well know, James, there is a formal system in Whitehall that, if you get to the point where you need to instruct somebody to do something, you need to make it transparent. I see the argument that that can end up being a very high threshold, and therefore that means it is quite difficult to use if you are a politician, but if politicians are to have the power to direct NHS England to do things they do not want to do, there should be a degree of transparency around it. That is how it should work.

Q47 **Dr Davies:** Understood, but as the No. 1 domestic priority for many

voters, is it not right that, if the Secretary of State is essentially held to account for the operation and performance of the NHS, they should have the ability to intervene more?

Chris Hopson: This is where the terms of the debate are, which is why we have not come out and said, "No, we are opposed full stop to the idea of the Secretary of State having more powers in this area." The key is, as I have said on a couple of occasions, that the devil is in the detail. I hope you would agree that with the five areas I listed around resource allocation, use of drugs, service reconfigurations and so on, we need to be very careful about allowing single, individual politicians, who inevitably and quite understandably have party political interests, to have excessive power over exactly how the NHS operates day to day. There is a really important debate. We are very keen to join it, but we cannot do so until we see what the detail of the proposal is.

Q48 **Dr Davies:** Fair enough. Danny Mortimer, do you have any comments to add?

Danny Mortimer: Clearly, there is an element in which the Act has to tidy up some fairly complicated arrangements left over from the previous Act. The three national regulators that were established—Monitor, the Trust Development Authority and the NHS Commissioning Board—all have different lines of accountability. It is important that that is made properly clear and tidied up.

The points about transparency are important. There has to be absolute clarity. You are right that there may well be a certain opaqueness at the moment to conversations that the Secretary of State and his team have with NHS England and others. It is important that the Act sets that transparency. The NHS can also be clear about times when, particularly for population health and clinical quality reasons, it disagrees with the instruction that is given.

The most successful reconfigurations I have experienced in my career were probably the ones around cardiovascular and cancer services in particular. They are ones that have led to demonstrable benefits, improvements and outcomes for communities, but have involved services being delivered differently between organisations. On some of the anticipated interventions that there may be around reconfigurations, the experience that I have directly, and with our members, is that they are always motivated by what clinicians in particular believe is in the best interests of their patients and what they can deliver safely for their communities. There has to be transparency on any differences of opinion, and about the resource implications as well as the quality and safety implications that flow from that.

Q49 **Taiwo Owatemi:** I am particularly interested in the proposed changes to procurement. Chris, how do you think the changes will benefit health organisations in the delivery of services?

Chris Hopson: As I was saying earlier, Taiwo, one of the problems that a lot of our members have raised, particularly in the community services

sector, is that they have been completely tied up in the formal requirement, under section 75, basically to retender services on a very regular basis. It is hugely time consuming and, on occasions, awful for the staff. I came across a group of staff the other day who, I think, had been employed by three different organisations over a 10-year period. Staff are TUPE-ed across with formal undertakings, but to swap employer three times while still doing the same work seems to us far from ideal.

We think, as we said, that there is still more to do to work through exactly how the formal selection regime is to be structured. We think there is an opportunity to give an appropriate degree of discretion to ICS and NHS bodies that replace CCGs to not have to go through forced retendering for contracts that it simply does not make sense to retender.

The Chair has been clear about this. We must not ensure that the NHS somehow becomes a closed shop in which the existing providers are frozen in time forever. It seems to us that there is a happy medium, where you do not have to go through constant retendering, but you have the ability, if you wish, to look at innovative and different ways of doing things and bring in different providers. That is what we hope the new provider selection regime will enable us to do. We think these are an important set of changes in the Bill, and we support them.

Q50 **Taiwo Owatemi:** Following up on that, as you are aware, some parts of the health and social care sector have been disproportionately impacted by procurement regimes. Do you think that the new proposals will help to improve that? If so, how do you see it happening?

Chris Hopson: Yes, we think it will. As I said, people will not need to spend what they regard at the moment as far too much of their time not improving services, supporting their staff, and ensuring that they are listening carefully to what the needs of their local people are, and are not distracted from that task by going through what can be very onerous, time-consuming and, they believe, unnecessary retendering processes. You will see that the White Paper is divided into a number of different sections. I think there is a section called "Reducing bureaucracy". For us, that fits very successfully in that section because it will reduce unnecessary bureaucracy. We think it is a very good and important step.

Taiwo Owatemi: Thank you, Chris.

Q51 **Chair:** Let us move on to social care. Barbara Keeley will ask a few questions of Sarah Pickup. It is a very big priority for the Committee to make sure that we do right by social care with this new legislation. First, Sarah, can I ask how you feel, and how the social care sector feels, about the fact that the NHS has had a 10-year plan for two years, but we still do not have one for the social care sector?

Sarah Pickup: I suppose the sector is beyond distraught. It is not just two years; it is decades that we have been waiting for a solution to the social care challenge. I think this legislation is being used to pick up a couple of things that the Government see as important post pandemic in relation to social care, but what could be more important than the overall

reform of both the way it is delivered and the funding? Why is this, albeit important, change and consolidation in the NHS more important than the adult social care challenge that faces this country?

We are disappointed. We worked collaboratively in the production of the White Paper because we believe that the ICS component of it is really important to local government. It is important to local people because of the integration that is offered, but the social care reform is missing.

One of the challenges is in some of the things that have been talked about—propping up providers and so on. We do not want the same provider market in the future. We want to enable people to be supported differently. There is a lack of focus on personalisation and person-centred care in the White Paper. I get it, because it is not at that level of detail. It is quite a high level paper and guidance will be all, but we must not lose the intention of personalising care. That means integrating care and social care around people and their needs. It means that we need a properly funded social care system.

Going back to the workforce question and a new deal for the social care workforce, we are way off having a strategy and a long-term plan. We need a deal for the current workforce that pays them and rewards them well for the very difficult work they do.

Q52 **Barbara Keeley:** What do you think will be the impact on the effectiveness of ICSs of the Government not setting out a long-term plan for social care? The long-term proposals are only suggested as being brought forward "later this year."

Sarah Pickup: I think all commentators would say—I think Danny's organisation today said as part of the Health for Care coalition—that the long-term plan for health, and the aspirations for health, can only be delivered if social care and other public services like housing and public health services are developed and funded appropriately in line. Some people have called recently for public health to be transferred back to the NHS because it is not well funded in local government. That is not the right solution. The solution is to fund it properly in local government, which has done a good job with public health but without sufficient resources.

On adult social care, we know that we need to work in partnership to prevent people from going into hospital and having escalating health needs. We need to work on the prevention of escalation of long-term conditions. All of this helps the health service. It is a false economy not to sort out the social care challenge while trying to sort out the health service. It will not work.

Q53 **Barbara Keeley:** The Secretary of State will have the power to intervene where the CQC finds that a local authority is failing to meet its duties. What model of assurance do you think should be implemented to avoid the need for such interventions? Should the criteria for intervention be independently set rather than at the Government's discretion? Do you

think it should perhaps be by the CQC?

Sarah Pickup: I definitely would approach it that way round, as you said. I would start with what assurance is needed: what better transparency do we need in the system? I know that there is a concern in the Government about transparency in the adult social care system, but it is locally accountable to democratically elected councillors. We need to make sure that we do not neglect local democratic accountability, and the accountability to population and people in local places, while looking at what we need to put in place to reassure national Government.

We are in favour of working with the Care Quality Commission to design something that builds on what we already have, which is a good sector-led improvement system. It has tools that help us assess how well people are doing, and then go on to help them improve. We think that the improvement part is very much in the remit of the sector itself. We are great users of peers, which provide great support, one organisation to the next, to help with improvement. It has worked.

Intervention should always be a very last step. In fact, there are powers of intervention for local government more generally with another Secretary of State, but they are used rarely and that is as it should be.

Q54 **Barbara Keeley:** What about the fragile provider market that we have? A suggestion was made in the earlier panel that the CQC's powers should be extended to that. How do you react to that idea?

Sarah Pickup: The CQC regulate the provider market in the quality of care that they deliver. They have a market oversight role for the biggest providers that would cause a national challenge if they failed. It all stems from whether the system is properly funded or not. There is a thread of questions from why the workforce is paid at the minimum wage level through to why not all councils pay sufficient fees to care providers, and some self-funders probably pay care providers fees that are too high.

We do not want to perpetuate the model of care we have. Of course, there is a place for care homes and traditional domiciliary care, but people want to be more empowered to choose the way they are supported. We need more development of personal assistants and more diverse ways of helping people to design their own support. Choice, control and personalisation are things that have been through this Committee time and again. We must not forget them as we go through another set of changes.

Q55 **Barbara Keeley:** How do you feel about the power of the CQC to rate local authorities and the delivery of social care services? Do you see that driving improvement? Is there a feeling that there is going to be a scapegoating of local authorities, when in fact all the things you have just highlighted—the funding issues and the market issues—are the ones getting in the way?

Sarah Pickup: We do not yet know whether there will be a rating system. We are in discussions with CQC and DHSC about the design of

the assurance system. What is disappointing is that the thing that has been picked up as being needed at this point in time, through this legislation, is more assurance of a system that is not funded to deliver its responsibilities as set out in the Care Act. It is the wrong way round. It gives the wrong message to the sector. The only thing you can think of to do with adult social care is to look at it a bit harder to see how well it is doing.

We are hopeful that we can work on a review basis, linked to some of the system reviews that the CQC has done in the past. We co-operated and collaborated on those, and they were really helpful. We are hopeful that we will not be in a situation where there is a punitive rating arrangement. We do not think it is helpful. It is a bit like the ICS question: what exactly are you rating? Everything from public health through to housing and all the social care in between—community capacity building—is all part of the offer that councils have.

Q56 **Barbara Keeley:** Do you think it would focus the mind of the Department to include in the Bill a duty on the Secretary of State to publish a fully funded 10-year plan for social care?

Sarah Pickup: It probably would focus the mind. We would not object.

Barbara Keeley: Thanks, Sarah.

Q57 **Chair:** Let's move on to some patient safety issues. The White Paper puts the new Healthcare Safety Investigation Branch on to a statutory footing. In particular, it puts on to a statutory basis the concept of a safe space for doctors, nurses, midwives and professionals to speak confidentially to investigators without having to worry that they may be disclosed as a source. That is modelled on what happens in the airline industry.

I want to bring you in on this point, Sir Robert, given your background as an eminent clinical negligence lawyer. What is your view on safe spaces and how they need to work if it is to be a successful reform?

Sir Robert Francis: The first point is that it is vital for patient safety and the learning from accidents and incidents that there is an investigation that is able to have full access to all the information. That requires people who sometimes have made mistakes themselves to be open and honest about those. A punitive atmosphere or the threat of sanction clearly inhibits people from necessarily giving full disclosure. Some concept of a safe space is very welcome, in that people should feel free to be able to talk to the investigator without the fear that their very own words will be played back to them in some form of disciplinary proceedings or, worse, criminal prosecution.

What worries me a bit about the way in which it might be put into force is that those who are most closely affected by an incident being investigated—the patient or, sadly, often the bereaved family—have a right to know what has happened. They have a right to know what has happened in detail. While it may be, therefore, quite right that the actual identities of people who have provided information should be a matter of confidentiality, what has happened cannot be so far as the families are

concerned. If you do not have their trust that the investigation has come up with the answer, it is a system that is not going to work. If you do not satisfy as best you can those who have suffered, all the learning in the world will not produce confidence in the system.

How you square those two things is, of course, a matter of detail, but I believe it can be done. The principle, whatever anyone says to an investigator in one of those investigations, is that that in itself cannot be used to prosecute or discipline them. That is the protection. Of course, it does not mean that a similar result cannot possibly be obtained in other ways. If their identity is not disclosed in a way that means they can be pilloried in the media, that is valuable as well. It is important that the principle of openness and transparency with the families and the patient is somehow respected.

Q58 **Chair:** Thank you; that is very thoughtful. There is a reference in the Bill to the Secretary of State having the power to determine when safe spaces do and do not apply. Some people have expressed real concern about that, notably Shaun Lintern, who did a lot of campaigning around Mid Staffs. What is your view on that, Sir Robert?

Sir Robert Francis: It is important that people know where they stand in advance, rather than something being taken away retrospectively. There needs to be consistency. HSIB is being set up in order to be an independent investigator. I am not sure of the extent to which political power to change the rules, or the playing field, is necessarily beneficial. I can see, as in other areas of the Secretary of State's power, that there may be extreme examples where that might be appropriate, but it is quite difficult to envisage what they are.

Q59 **Chair:** Thank you. Chris Hopson?

Chris Hopson: Chair, you will remember that you and I had debates about this when you were working on the set-up of HSIB. There are two or three areas that we would be concerned about, a couple of which echo Robert's.

The first is that we are very nervous about the relationship between the Secretary of State and HSIB. In order for it to be an effective, independent organisation it needs to be free from the appearance of, and actual, political control. There is a very high degree of nervousness about the ability to somehow switch safe space on and off. As Robert says, people need to know where they stand.

The third bit, which Robert has not mentioned, is that, from the original Bill, when the write-around across Government occurred, there were some quite difficult negotiations with the Ministry of Justice around exactly what powers coroners' courts should have over information that was provided under safe space. We were very concerned about the clause in the original Bill, when it was introduced a couple of years ago, in which we thought there were far too wide powers for information that had been provided under safe space to be shared with coroners' courts. We think it

is important that we look at the details very carefully when they come forward, to ensure that HSIB does the job it is meant to be doing.

Chair: We are coming to a close. There are some final points that Laura Trott and Luke Evans want to ask about.

Q60 **Laura Trott:** I want to ask about the output of HSIB investigations. Sir Robert, is there more that we can do to give them teeth, to make sure that people on the ground see real change when there have been clear recommendations from reports?

Sir Robert Francis: I think it is really important, as the writer of a few reports, that, when reports are issued, there is a follow-up to ensure that the recommendations are implemented, or that, if they are not, good reasons are given why they are not or cannot be. That requires a public and transparent process. In the new world, one asks politely, where is that going to happen? Clearly, your august Committee cannot follow up every single report. It needs to be done as near the point of learning as is possible, where necessary.

Yes, I think it is important that that is baked into the system. Perhaps not just HSIB can follow up its own recommendations; perhaps the regulator can as well. Again, there needs to be accountability in the form of reports. One thing I would suggest is that, as it is often the case with accident reports and public inquiry reports that the same recommendations are made at the end of each of them, the consolidated lessons need to be kept track of. That, I am afraid, is not just a question of having one response saying, "We welcome this, and this is what we are going to do." It requires a regular process of making sure that those actions continue to be made. It is not just a matter of what I hate to hear called a "robust action plan" being looked at by the board of an organisation. It is actually something that must involve public scrutiny.

Q61 **Laura Trott:** Do you think that role at system-wide level should be done by the regulator or someone else?

Sir Robert Francis: The primary responsibility is with whichever body has the recommendation addressed to them. Who outside that has to look at it may depend on which body it is. I am sorry that is not a very specific answer. It could be the Care Quality Commission in the course of its work. We are building up quite a lot of extra jobs for the Care Quality Commission, so, if I can plead on their behalf, please do not give us jobs unless there is the resource to do them properly.

If it is a local matter, why not the overview and scrutiny board or something of that nature? You need both local and national bodies. Maybe Healthwatch has a role to play in some of the matters that affect the public, but perhaps not so much on the internal workings of an operating theatre or whatever else.

Laura Trott: Thank you, Sir Robert.

Chair: Last, but absolutely not least, Dr Luke Evans.

Q62 **Dr Evans:** I have two questions. Both are on education and professional regulation. Danny, in the White Paper, the recommendation was not put forward by NHSE, but they are removing the local education and training boards and putting them under Health Education England to allow regional structure. Do you see any concerns with that?

Danny Mortimer: As I touched on with the Chair, the opportunity is for ICSs to take much more of a leadership role, as was originally intended with the LETBs. One of the things that was a genuine intent of the Lansley Act was to give much greater local ownership of workforce planning to address exactly the kind of issues that the Chair and I talked about. That is the opportunity for ICSs.

In the conversations we have had over recent years, we see real support from NHS England and HEE for engagement with ICSs and for a recognition that a range of local partners needs to be the engine for the workforce planning discussion. In losing LETBs, which were never, in truth, given the opportunity to flourish, we need to give ICSs the equivalent role.

Q63 **Dr Evans:** My final question is for Chris on accountability. It draws in safety and personal accountability for leaders. The plan says, "there are no plans at this stage to statutorily regulate senior NHS" managers and leaders. Following the Kark review, which looked into fit people for the correct position, should there be?

Chris Hopson: That is a debate that has been ongoing for the last three or four years. There are clearly some people who feel very strongly that there ought to be. Equally, there is a wide range of leaders and managers who believe that the work they do is very different from the work that you have frontline clinicians doing, and that therefore you need to be careful about drawing them into a more formal system of professional regulation where it may be much more difficult to draw judgments around when it is appropriate, for example, to disbar people from undertaking the work that they do. This is going to be an ongoing debate.

Q64 **Dr Evans:** Does your organisation have a position on that, given that this is a chance for 10 years' reform?

Chris Hopson: The position of our organisation in response to the Kark review is that we need to be very careful about creating, for example, statutory registers of individuals, given the issues that are involved in that, and how you make judgments about fitness to practise when you are a leader and a manager.

If I am honest, Luke, there are differing views inside the sector. There are some people who believe that actually moving towards statutory regulation of leaders and managers would help in a sense, because leaders and managers have nothing to hide. Equally, there are people who feel very strongly that it is very easy to jump on people and say, "Something has gone wrong in your trust and it's your personal responsibility," when the ability to identify an individual's contribution to something going wrong is much more difficult when you are talking about

management and leadership issues, as opposed to issues of clinical practice.

Dr Evans: Many thanks. I could go on for hours.

Chair: I think we could go on for a very long time on all of these topics, because they are so important. We have had a very productive start.

I thank both sets of panellists. You have helped us frame the questions that we are going to ask Sir Simon Stevens next week and the Secretary of State the week after that. Thank you for your very insightful and thoughtful answers.

Thank you, particularly on this panel, Chris Hopson, Sarah Pickup, Danny Mortimer and Sir Robert Francis. It is much appreciated. I am sure we will see you again on the Committee before too long. For now, that concludes this morning's session.