Health and Social Care Committee

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

Tuesday 9 March 2021

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Watch the meeting

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

Questions 65 - 130

Witnesses

I: Sir Simon Stevens, Chief Executive, NHS England; and Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement.

Examination of witnesses

Witnesses: Sir Simon Stevens and Amanda Pritchard.

Q65 **Chair:** Good morning. Welcome to the House of Commons Health and Social Care Committee's second evidence session on the Government's proposed new NHS reforms—the White Paper they have published recently. Last week, we heard from health policy experts. Next week, we will be hearing from the Secretary of State himself. Today, we are very pleased to have with us the chief executive of the NHS, Sir Simon Stevens, and the deputy chief executive and chief operating officer, Amanda Pritchard. You are very welcome. Thank you for joining us. As ever, we start by asking you to pass on to your staff our gratitude as a Committee, and indeed the gratitude of all MPs, for the incredible hard work that has been happening over the last year, and which we know is continuing. We may say it repetitively, but it really is heartfelt.

We will come to the White Paper the Government have published shortly, but I would like to start, if I may, Sir Simon, with a few questions about last week's Budget. The NHS long-term plan you put together, after you and I negotiated the extra funding in 2018, showed NHS salaries budgeted to increase by 2.1% this year. Were you told of the Government's decision to recommend changing that to 1% and, if so, what reasons were you given?

Sir Simon Stevens: As you say, at the time we published the long-term plan, and shortly thereafter, in 2019, we laid out the underpinning financial assumptions. Obviously, that was approaching two years ago, so things have changed, but, as you say, at the time the working assumption was that there would be available 2.1% for the costs of the "Agenda for Change" pay group in 2021-22, together with the overhang from the 2021 elements of the multi-year "Agenda for Change" pay deal.

Q66 **Chair:** I understand that you do not normally get involved in pay negotiations, which are a matter for the Government to negotiate with the unions. Do you understand and support the Government's approach on this occasion, or do you have sympathy for NHS frontline workers who feel very aggrieved about it?

Sir Simon Stevens: Ultimately, of course, in a publicly funded democratically accountable health service, the Government of the day get to decide what NHS pay should be, but you would expect me as the head of the health service to want to see properly rewarded NHS staff, particularly given everything that the service has been through, and that they have been through, over the course of the last year. I think the right way to resolve this is the path the Government have set out, which is to ask the independent pay review body to look at all the evidence in the round—the evidence from the Government side and the evidence from the staff side—and make independently a fair recommendation, so that NHS staff get the pay and reward they deserve.

Q67 **Chair:** If that recommendation was more than 1%, you would support the Government accepting that recommendation.

Sir Simon Stevens: The purpose of having an independent review body is that it can consider the different evidence put forward by different groups through that process, and make a recommendation. Ultimately, of course, the Government get to decide whether to accept the recommendation, but we are in a process where the review body needs to be able to do its work without fear or favour, and put forward that recommendation, and its justification for so doing.

Q68 **Chair:** That is very clear, thank you. Last year, the Chancellor said the NHS would get whatever resources it needs to deal with Covid-19. Last week, after the Budget, the OBR said that the spending plans make no explicit provision for virus-related costs beyond 2021-22. In other words, when you are talking about April next year, there is nothing on test and trace, nothing on an annual vaccine programme, nothing for the surgery backlog. Have you been given the money you need for the year after next?

Sir Simon Stevens: Are you talking specifically about next year?

Chair: Let's talk about the next two years. We have the next financial year, which starts next month, and the year after that.

Sir Simon Stevens: For the year we are about to go into, beginning on 1 April, we have the previously agreed NHS long-term funding settlement. Over and above that, in the November spending review, the

Chancellor provided additional funding to make a start on catching up on the backlogs of care that have arisen as a result of Covid, including waiting list operations and new needs that have arisen for mental health services.

In addition, during the course of the past year, as you say, the NHS has been provided with the extra costs of looking after Covid patients and all the indirect consequences for Covid care. Given that the majority of Covid-hospitalised patients we have been looking after were admitted since that November spending review, and we have obviously had an incredibly tough December, January and February across the health service, there are going to be continuing Covid-related needs and costs spilling into the new financial year. The expectation is that the NHS will receive additional funding to cover those unavoidable Covid costs, certainly into the first half of the year, which I think, by the way, is the approach the Chancellor has already set out for Test and Trace, where it has been allocated additional funding for next year, and for the broader support package across the economy—the furlough scheme, for example.

Q69 **Chair:** You say the expectation is that the NHS will be given more money for the coming year, but you have not actually had it allocated. Isn't it a bit surprising that it was not allocated in the Budget, given that that was only last week, and the new financial year starts very soon?

Sir Simon Stevens: There is obviously an urgent need now to give funding certainty to hospitals and to local frontline services. As you say, the beginning of the financial year is hoving into view, so we expect that that will be resolved very shortly. Given the uncertainties, an alternative approach would be the one that has been used successfully throughout parts of last year, whereby the Secretary of State provides ministerial direction to give flexibility for those elements of cost that are not fully predictable. Either is viable, and I expect that we will satisfactorily resolve that very shortly.

Q70 **Chair:** Chris Hopson from NHS Providers said yesterday that the gap at the moment is around £8 billion this coming year. Does that number ring true to you?

Sir Simon Stevens: I think that is an extrapolation of the 2020-21 extra Covid costs. Those are all in the public domain. That is an extrapolation of what those costs might look like for the first half of next year. As I say, there is significant uncertainty as to precisely what they will look like, but that is the sort of ballpark that has been incurred over the previous six months.

Chair: Thank you.

Q71 **Paul Bristow:** Good morning, Sir Simon. You just said in response to the Chair's question that there is an expectation that the NHS will get the extra money it needs to deal with Covid pressures, and so on. In November 2020, in the comprehensive spending review, £1 billion was given to the NHS to deal with the backlog. Is that enough as it stands now?

Sir Simon Stevens: I think we are dealing with two slightly separate things. One is the extra operations that will be needed to deal with the backlog, as you rightly say, Mr Bristow, and that obviously is a start on that. There are then the additional costs that hospitals and other parts of the health service are incurring because of the ongoing need to manage infection control, the Covid operating environment and so on. It is those costs that the Chair was talking about rather than the additional catch-up costs for routine operations.

Q72 **Paul Bristow:** Going back to the catch-up costs for routine operations, with the £1 billion that was given in October 2020, as we have had a second round of lockdowns and NHS pressures, do we have enough money to deal with the backlog in the short term and the medium term? Is that £1 billion enough?

Sir Simon Stevens: The £1 billion is a very important start to enable hospitals to begin to make the inroads into the set of waiting list operations that are required. I have to say that there is quite a lot of uncertainty as to precisely what the size and shape of the waiting lists will be by the time we get to the end of 2021-22 and beyond. I have seen some predictions, for example, that, in what is now three weeks' time, the waiting list in England might be 10 million people. I can categorically predict that that is not going to be the case. We do not know precisely what the size and shape of it will be. What the Government have rightly done is allocate funding to enable hospitals to make an important start on that, and, as the year develops and we have an autumn spending review, there will be an opportunity to take stock, and the Government will be able to make decisions in the round.

Chair: Barbara Keeley wants to ask a question on nurses' pay.

Q73 **Barbara Keeley:** Good morning, Sir Simon. May I take you back to what you said about NHS pay increases? You talked about the standard process, "Agenda for Change", and, of course, we had an agreement, and Parliament budgeted for and legislated for that 2.1% increase. Clearly, this is not a standard year in any way. Has there been consideration of paying a bonus to NHS staff for their remarkable support during the pandemic, and now in the vaccine roll-out? What has become clear over the last number of days is that there is very substantial public support for financial recognition of the wonderful job NHS staff have done, going over and above. Would that help with staff morale and is it something we should be looking at?

Sir Simon Stevens: It needs to be seen in the context of the overall judgments that the Government will make on NHS pay in the round. I agree with you that, coming out of the past year, and everything that NHS staff have been through, proper recognition of that is entirely right, and goes with the grain of what the public would want to see, none of which is to ignore the broader economic context facing the country. Those are ultimately judgments that Government have to make, but as head of the NHS I want to make sure that our staff get proper reward, and not only support through that mechanism; fundamentally, staff want

to see a broader range of measures, including further increases in the workforce to deal with some of the intense workforce pressures that have been experienced across the health service.

Q74 **Barbara Keeley:** I understand that, but would a one-off bonus, recognising the wonderful job that has been done and how people have gone above and beyond, be appropriate, as well as the standard processes?

Sir Simon Stevens: I think there is a discussion to be had in the round about whether that or other underlying action is the right approach. Obviously, we can see the attractions of that, but it might not be the only answer.

Barbara Keeley: Perhaps both. Thank you.

Chair: Neale Hanvey is himself a cancer nurse.

Q75 **Neale Hanvey:** Good morning, Sir Simon. One of the anxieties that has come into the inboxes of many MPs over the course of the pandemic has been around cancer treatment. I know there was a cancer recovery plan put in place prior to the significant spike over the winter months. That is due to run out shortly. Could you give us some advice on how it will be managed going forward in terms of recovering both misdiagnoses and delayed treatments, and how cancer charities can be supported to help improve the situation for cancer patients across the UK?

Sir Simon Stevens: Thank you very much, Mr Hanvey. You are quite right about that. Our starting point has to be continuing to encourage patients who think they might have a cancer lump, or who have a concern about their health, to come forward and get checked out. That is the single biggest thing that will help, at the front door of the health service, if you like. There are some encouraging signs on that. We saw more people being referred for cancer checks in December than a year ago, in the prior December, as a result of that campaign. We are working very closely with patients charities to ensure that the message continues to be heard.

Obviously, when people are referred, it is important that they quickly get their diagnostics, so we are expanding access to diagnostic services. In the spending review, another £325 million of capital investment was allocated to enable us to deal with the need for more CT scanning, MRI scanning and other types of quick diagnostics. When it comes through to the flow of treatment, we have seen protected cancer surgery hubs, and chemotherapy now back above its usual levels. We have been expanding access to precision radiotherapy. There will clearly be a lot more to do in the cancer programme during the course of the coming year, and that will be one of the top operational priorities of the health service.

Q76 **Neale Hanvey:** Does the cancer plan end date need to be revised? Do you need more resources to make all of that happen, because it is a big job?

Sir Simon Stevens: We are going to be refreshing the cancer recovery plan for 2021-22 in the way you describe.

Q77 **Chair:** Sir Simon, I would like to move on to the Government's White Paper now. I want to start with one of the main criticisms of the White Paper, which is not the content but the timing. The Health Foundation told us last week: "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." Do you think now, right in the middle of a global health pandemic, is the right moment for some pretty big structural reforms?

Sir Simon Stevens: Yes, as the NHS we would ask that Parliament gives attention to this matter during the course of the coming year. The reason is that it is not coming from a standing start. It is almost the concluding stage of an evolution that has been under way across the health service for at least the last seven or eight years. It began back in 2014 with the NHS five-year forward view, where we looked very objectively at the fact that with an ageing population with multiple health needs, a way of organising the health service that was all about individual treatment at fragmented providers, with different groups all in competition with each other, was not the way to future-proof the health service. Rather than starting with the legislation, we started with changing the reality, or beginning to change the reality, of frontline care.

We have been embarked on that journey since 2014, with different areas of the country coming together to make it a reality. In 2018, we brought forward proposals, which were discussed with the predecessor Health Committee, that endorsed the approach we were taking. In June 2018, the Prime Minister asked us to come forward with detailed legislative proposals, which we did. In January 2019, the long-term plan set out those recommendations. In June 2019, the Health Committee held an inquiry alongside our own engagement. On 26 September, a big coalition of stakeholders across the health service wrote to the Government backing the proposals we were putting forward, including the Academy of Medical Royal Colleges, the Local Government Association, NHS Providers, the Richmond Group of Charities, the Patients Association, the Royal College of GPs, the King's Fund, the Royal College of Nursing and so forth.

What we are saying is that the health service has done nine tenths of what we are able to do, but the final tenth requires changes to the 2012 Act, to get rid of some of the fragmentation, to get rid of the funding silos; and to enable more partnership working across the health service, which the pandemic has revealed is so necessary. That is why we are asking Parliament to consider a Bill that would do that, to take effect from April 2022.

Q78 **Chair:** Potentially, we have that Bill, which is the final 10%, but there are a lot of other things in the proposals as well. Is there anything in the White Paper that was published that you do not agree with or that makes you uncomfortable?

Sir Simon Stevens: Some 85% of the content of the White Paper comes out of the proposals that we, the health service, have consulted on and are requesting. Over and above that, there are a few bonus prizes in the White Paper. There are some areas that go beyond our initial proposals, and there are some other topics that, rightly, Government and Parliament would consider but which do not fall in the bailiwick of the national health service itself. Making it easier to prevent children having bad teeth through fluoridation is a proposal in the White Paper. That did not come out of the NHS consultation specifically. That is not to say we do not support it. It is just that we cannot say it came directly from the NHS proposals themselves.

Q79 **Chair:** You are the perfect diplomat, and I really could have taken you with me to the Foreign Office. I am just trying to understand whether there is anything in the proposals you do not like or would like to see changed?

Sir Simon Stevens: The thrust of what is in the White Paper has our support. There will be detail on particular aspects that of course will need to be worked through, but we are in a very constructive dialogue with Government on those, and no doubt through parliamentary passage a lot of those questions will be discussed as well. I put my name to the release for the White Paper proposals because they go with the grain of what people across the health service want to see.

Q80 **Chair:** Let's go into some of those details. My colleagues have lots of questions on them. The main change is putting the new integrated care systems on to a statutory footing. Effectively, they replace the CCGs. Could I ask you about some of the details of that change? First, do you agree that the new ICSs should be geographically coterminous with local authority areas to make health and social care integration easier?

Sir Simon Stevens: Generally yes, that should be the default, and I think that is where we will get to. It implies a change in some of the geographies. As you know, Chair, in your part of the country, the Frimley integrated care system does not have a one-to-one correspondence with the geography of Surrey County Council, for example. There are some cross-boundary questions to resolve in Essex. As a working principle, it seems very sensible. It does not need to be prescribed in legislation. Generally speaking, we are looking for a permissive framework that enables sensible local judgments to be made. Perhaps you would allow me to bring in Amanda Pritchard at this point. Amanda has been leading a lot of the development work on integrated care systems, and she may want to say a word on that point.

Amanda Pritchard: I strongly echo what Simon has said. I think that is right. Generally, the coterminosity that we have seen, particularly through the last year, makes sense, with the strength of the relationship between local government and the NHS, and we are clearly looking to build on that in the proposals that have come forward in the White Paper. There is a bit to work through, and certainly if we could continue to hold on to this as the permissive framework, with a set of principles that then

guide local decision making, it gives people the space locally to make sure that they have an outcome, whether it is on boundaries or on a whole number of other things, that really works for the local population and for the local situation.

Q81 **Chair:** One of the other questions is how the public will know whether their local NHS, the local ICS, is doing a good job or not. Last week, the Secretary of State told the Commons that the CQC would have a crucial role in that. If we move to Ofsted ratings, as the CQC does for hospitals, for example, how do we make sure that the system works well and happens in a light touch way, and does not lead to a huge amount of additional bureaucracy?

Sir Simon Stevens: One of the important developments of the CQC inspection regime over the last several years has been the ability to do thematic reviews, looking across providers in a geography, to look from the patient's eye perspective as to how well joined up different services are. Rather than just inspecting the GP practices, the community nurses, the hospital services and mental health entirely separately, not to mention the interaction with social care, those thematic reviews, which look end to end at the journey a patient might be taking through the service, are hugely important.

For integrated care systems, having that focus across individual providers in the ICS will be of great value. To the extent that the CQC looks at the ICSs' own performance, it will be very important that it is reviewing against the mandate goals and the long-term plan deliverables that have been set, so that there is complete accountable alignment through the service. To the extent that there are recommendations that the CQC would be making on safety grounds in terms of reconfigurations, if, with the new step-in powers the Secretary of State is proposing, those are not being supported, there needs to be a very transparent way for publicly recognising where decisions are being taken, if they are not being taken by the individual provider, or by the ICS.

Chair: We will come back to the Secretary of State's role later, but I want to bring in Laura Trott on accountability.

Q82 **Laura Trott:** Sir Simon, in our evidence session last week, the King's Fund was very clear that the most successful NHS reorganisations are around demonstrable improvements in patient care. Can you tell us how patient care is going to change as a result of the changes that are proposed in the White Paper?

Sir Simon Stevens: Yes, I agree with the King's Fund on that point. There needs to be a degree of, shall we say, humility about the role that legislation itself plays in improvement across the health service, which I think was the point that they and others were making. The bulk of the change that comes about in healthcare is as a result of the brilliant innovation and work of clinicians, with their managers supporting them, the interaction with patients, and the ability to take seriously what

communities are saying needs to change about care. That is where the magic actually happens.

The point of legislation is simply to provide an enabling framework for that to occur. We are saying that we have got about as far as we can with, if I can be indelicate, the work-arounds to the 2012 Act that ever since I became NHS chief executive we have been seeking to drive through the health service, and now we need the clarity that comes with a change in the law. Specifically, Ms Trott, the first thing we are looking to do is overcome the funding silos that the current law creates in a local area. What I mean by that is that the local clinical commissioning groups have responsibility for planning and funding most community health services and local hospital services, but when it comes, legally at least, to GP services, which are hyper-local, and at the other end of the range specialist services, they are not overseen locally; statutorily, they are overseen nationally by NHS England.

One of the things I have done, I might say with the support of the Chair when he was Health Secretary, is pass back and devolve responsibility for those decisions locally, so that people can take a holistic view. In my judgment, it makes no sense to think about the way GP practice nursing works independent of the way community nursing itself works, even though at the moment those are completely separate funding silos. Bringing together the whole ability to plan and fund for a population is what the Act, if passed, would formalise.

Secondly, it would bring together a wider group of stakeholders to help make those planning judgments, not just groups of GPs on CCG governing bodies but other providers, patient groups and local authorities. Thirdly, because of some of the changes we are recommending in the procurement regime, it would free up a lot of time and wasted effort from some of the transactional purchasing arrangements, which tend to reinforce the fragmentation of care that we have otherwise seen. We would like those changes, which in practice the NHS has been seeking to bring about, now formalised through the statutory framework, so that it is all transparent and accountable to you.

Q83 **Laura Trott:** I understand there are clear administrative inefficiencies that are going to be addressed, but it is very important that we are very clear about the tangible outcomes and improvements for patients as a result of this. Could you give us a bit more detail of what we are expecting in that area?

Sir Simon Stevens: First and foremost, what it will do is make it easier for frontline GPs, hospital nurses, clinicians and therapists, with their patients, to join up services in a way that makes sense locally. It is not saying that passing an Act of Parliament can guarantee that that is what occurs. As I say, the humility we need about the role of legislation is to recognise that it can be a necessary but not a sufficient condition. It will help with that, but implementing the NHS long-term plan in the round is what will be required in order to get that kind of join-up of services, as

well as the other gains we want to see on cancer care, maternity services, mental health and so on.

Q84 **Laura Trott:** Cancer care was one of the examples the King's Fund gave. They said the reorganisations that have taken place around cancer care and cardio care have been very effective in improving patient outcomes. When we are trying to explain this, and explain the impact it is going to have for patients, I think it is very important that we focus on that. Amanda, you are nodding. Is there anything you wanted to add on that point?

Amanda Pritchard: For me, one thing that is really striking about the conversations we have had across the NHS, and more widely with partners, is exactly the point you have made about what this can help us do for patients. That is what has galvanised the support that we have heard. Simon is right; legislation is only one piece of the jigsaw. For some parts of the country that have been on this journey, and been very serious about integration, for some time, it removes the remaining barriers for them, to make it as easy as possible. For other places, it is much more about putting some of the foundations in place. The root of it, around integrated care at PCN level, is about population health management. It is the ability to understand the local needs of your population, and design services that bring together primary care, community, acute, mental health, and partners, to best meet the needs of the population, and scaling up to ICS.

The sorts of things we are talking about now are running single waiting lists across an integrated care system, so, rather than being reliant just on the resources of an individual hospital, you are looking at being able to prioritise care for those who most need it, across a much wider geography, whether that is through things like, as Simon said, cancer hubs, or surgical hubs, or indeed some of the more specialist services that at the moment we know we need to organise in a way that meets everybody's needs. That is the fundamental thing that is driving the enthusiasm, certainly between health and wider colleagues, for the ability to make it the default way we work in future.

Q85 **Chair:** Chris Ham, the former chief executive of the King's Fund, said that one of the problems with the NHS is that we have a lot of accountability upwards but not enough accountability outwards to patients. Following up Laura's point, one of the things that a properly designed CQC inspection regime could do is make sure the new ICSs are focused on the things patients notice—how long they have to wait for their care, the safety and quality of care, all those things. I want to probe that with Simon. I think what you are saying is that we also have to ensure that the ICSs are not torn in the opposite direction by some internal metrics and that therefore what the CQC looks at is what everyone is asking it to look at. Is that basically what you are saying?

Sir Simon Stevens: Yes, it is.

Chair: Thank you. That is very clear. Let me move on to James Davies.

Q86 **Dr Davies:** Continuing the theme of patient experience initially, Sir Simon, when the Bill is published, do you believe that it should continue to allow patients to have the choice as to where they receive their care, both within the ICS and outside it?

Sir Simon Stevens: Yes, I do.

Q87 **Dr Davies:** Excellent, and you think that that will be forthcoming.

Sir Simon Stevens: At the risk of repeating myself for a third time, yes, I do.

Q88 **Dr Davies:** In terms of the composition of the boards, clearly those who are appointed can drive the direction and success of the board. Do you think that guidance should be issued as to those appointments, whether executive members or others?

Sir Simon Stevens: I think that will make sense. Equally, we do not want to be too prescriptive, certainly not on the face of the Bill, as to precisely what that composition should be. As I said a moment ago, the starting point is that lots of different parts of the country are already working in this new way and have figured out the right kinds of judgments for their local area.

This is a diverse country with a different set of arrangements, challenges and partners in different parts of the country, so trying to be completely vanilla, one size fits all, on some of those governance questions would cut across what is already working well now in parts of the country. A permissive framework with the ability, through regulation, for NHS England to set some guidance, and at least ensure there are the right guarantees in place locally, is the way to proceed. Again, I might bring in Amanda because she has been doing a lot of the thinking on this.

Amanda Pritchard: I think that is quite right. We tried to suggest in our recommendations to Government the absolute minimum that you would expect to see around the governance table, both in the ICS body and in the relationship with the health and care partnership. We would absolutely expect to give people, within that permissive framework, some guidance. One of the things we are clear about, as you would expect, is the importance of clinical leadership through the whole of the NHS. That is as true for PCNs or individual organisations as it will be for ICSs. We are keen to steer away from being overly prescriptive about exactly what that is going to look like at local level because, as you say, there are some examples where things are working incredibly well now, and we do not want to stop people getting on and building on that success. There will be a place for guidance to make sure that we have a minimum expectation set out.

Q89 **Dr Davies:** In terms of the standard of those appointed, should there be a reformed UK-wide fit and proper person register, so that perhaps where an individual has been somewhat less than successful on one ICS board, for instance, they do not then pop up elsewhere in the country?

Sir Simon Stevens: I would say yes to that. Again, Amanda in her capacity as chief executive of NHS Improvement oversees the current regime in respect of that and the Kark proposals, so I am sure Amanda will want to come in as well.

Amanda Pritchard: We welcome the strengthening of the proposals around that. I know this Committee and the Government have been very thoughtful about it, and we are very supportive.

Q90 **Rosie Cooper:** Might I make a comment on the fit and proper persons test? What I would say to both Simon and Amanda is that we have been talking about it for two years. We are still getting absolutely nowhere with it. Indeed, today, CQC has not managed to take on board the cases from Mid-Leicestershire, I think it is.

We also have the case, which Simon will know about, where, after my question to the Prime Minister and a Deloitte inquiry, NHS England required the resignation of both the chair and the chief executive of Liverpool CCG, and both of them popped up again. One of them straightaway almost became the finance director of Dudley. No amount of looking at it from a fit and proper persons test point of view worked. We need to do a lot more than talk about it. How do you think we can move on and get it done?

Sir Simon Stevens: Again, let me bring in Amanda. I do not disagree with what you have just said, Rosie. In the case of the University Hospitals of Leicester situation, we referred those individuals to the CQC and, in the case of the former CFO, to the accounting professional regulatory body as well, and we would expect them to fully weigh what action is required. We obviously need to discuss with the CQC whether, were any of those individuals to seek to re-emerge, it would trigger a fit and proper person process at that point, while Parliament decides through the legislation whether there is a backstop arrangement that could be put in place that is not available to us right now. Amanda, do you want to add anything?

Amanda Pritchard: I think that is exactly right. Across the whole health service, there is a whole range of different experience and expertise in a different number of roles in leadership positions, and part of what we are trying to do, clearly, is make sure at one end of the spectrum that we have the right support in place, particularly for people who are newly appointed, or who have taken on particular challenges, so that we set them up for success in an appropriately professional and supportive way. I think what Simon is saying, and what you are quite rightly asking about, is the other end of the spectrum where things have gone very wrong. We need to know that we have appropriate and adequate mechanisms in place to intervene at that point as well. I think we are entirely in agreement on this.

Q91 **Rosie Cooper:** Forgive me, Amanda, we might be in agreement, but we are not making progress, but anyway we need to move on.

Can I look at some of the governance and structures? As Simon says, we

are in the concluding stage of this process, and we need to plan and fund for a whole population. Totally accepting that, let's do a bit of detail. For example, where does it leave my constituents in West Lancashire? The hospital is functionally in Cheshire and Merseyside, but Ormskirk is actually in Lancashire, so we already suffer really poor issues because of Greater Manchester and the closing down of their powers. For my constituents who live on the border and perhaps have a GP in Greater Manchester but live in West Lancs, when it comes to getting physiotherapy and cross-border stuff like that, it is really difficult.

In that kind of situation, where do my constituents' voices get heard? Technically, they will be part of the Lancashire ICS but their services will come from Liverpool. That is a really poor situation. We have talked about shared waiting lists. In that case, where do my constituents' voices get heard about their treatment? Where is their choice? Are they set to be done unto by two different ICSs?

Sir Simon Stevens: I do not think the situation is going to be changed in that respect. There is no magic answer, just as there has not been since the health service was set up in 1948, to tell the truth. In a sense, you will have two avenues to pursue on behalf of your constituents. You will have the geographical body, the integrated care system, where those constituents are living. That is no different from the days when it was a primary care trust or a health authority. There would have been a geographical body where your constituents were living. If your constituents are getting care somewhere outside that geography, which will be the case for many services, you also have the route to go direct to that provider. To tell the truth, there is nothing about the legislation that changes that double avenue, which has been in place since 1948.

Q92 **Rosie Cooper:** Simon, it does. Where will my constituents' representation be for acute services when the ICS they will be in geographically will be Lancashire, which is not going to provide their acute services? I do not want to waste time.

Sir Simon Stevens: It would be no different if it was Lancashire health authority or one of the CCGs or PCTs in Lancashire. That has always been the case. If you live in a place and your hospital is somewhere else, you have a double opportunity to influence.

Q93 **Rosie Cooper:** No, that is absolutely not right, Simon. We fall between two stools, which is why, as you know, Southport and Ormskirk has been a very difficult case since its inception, but it has been a particular problem of mine since I became an MP there. The area is so small that it does not mean a great deal to either of the big centres of population. Perhaps we can continue this outside because it is really important. I have talked to Liverpool, and their partnership board could be 30-plus people. What is the difference in not just the number and aim but the power structure between the NHS body and the partnership board as you envisage it in the Bill?

Sir Simon Stevens: That is an excellent point to draw out. If we want aligned accountability across the national health service, ultimately, the

public money that Parliament votes for the NHS flows through the Secretary of State to NHS England, through to the ICSs, and they have to have the ability, with an accounting officer, to discharge the budgetary responsibilities that have been set by Parliament, and that is what the NHS ICS will have the legal responsibility to do. However, you also, of course, want to involve a much wider group of people, not just local GPs as on a CCG governing body, in the shaping of what the health needs are, how to tackle inequalities, and how to do the join-up with our social care and other services. The partnership board is the place where that takes place.

We changed our mind on this. I will be perfectly frank about it. We had an engagement process. We put forward a proposal. People came back and said, "Have you thought about the following?", and we listened and we changed our mind. It was Local Government Association colleagues who came back and said you cannot have local councils, as it were, bound by budgetary decisions of the NHS body, because of the direct local electoral accountability that local authorities have; equally, local authorities want to be part of the process. We have the double opportunity of the clarity of the NHS body and the partnership board bringing in the local councils and others. That provides the right mechanism to square the circle. We changed our proposals in the light of listening to what people told us.

Amanda Pritchard: I totally agree. May I say a word about the boundary issue and place, and what that means? That is a different matter from democratic accountability and how that works.

We should acknowledge that there are, as you say, always issues around boundaries, and it can be a source of friction. It does not always work. It is almost impossible to design something that does not have some boundaries somewhere. The bit that is not in legislation, and rightly is not, but is important in the reality on the ground, is going to be how PCNs work around their neighbourhoods. We have an opportunity with the firming up of the focus on integration around place. An awful lot of the energy and the money is going to be spent at the place level, and that is going to be about local services for local people, the ICS we are talking about today.

We should also acknowledge that networks exist that are much bigger than single ICSs, and need to be, particularly around specialist services. To take cancer as an example, we have 22 cancer alliances versus 42 STPs/ICSs. That is partly in recognition of the fact that we need collectively to make sure that patients have access to the right specialist services, which might not be provided within the bounds of an ICS. There are a whole number of different types of networks and combinations of places where people will need to work together, and make the best sense of something that is right for individuals.

In terms of the exact point on accountability, and how the different groups are going to work, as Simon says, as a result of going out as part of our public consultation, we heard clear feedback that people wanted a

both/and model, both the specificity of a line of statutory accountability through an ICS body, which of course gives us huge opportunity to do the integration within health services that we would acknowledge has been, as Simon said earlier, split into silos a bit too much in the past; and the absolute importance, which we heard strongly from local government colleagues in particular, of the need for wider partnership, and we agree entirely. It is particularly important to hear the voice of the population, of the voluntary sector and of other partners as part of wider engagement in the partnership. Again, we have heard multiple different ways people would like to bring that to life in their own areas, and many examples where it is already working quite well in the way that we would envisage it, hopefully, being described in legislation.

Q94 **Rosie Cooper:** I am not saying there won't be problems with boundaries. I am saying we need to know how you are going to solve them.

May I ask a final question about data? Shared care records have boundaries. To maintain confidence in data sharing within the NHS for direct care, will patients have the ability to dissent from the new shared care records? If so, what will the mechanism be? It is getting harder to object to having your records shared. You cannot withdraw your permission by individual organisation because hospitals do not know you are going to become a patient, and it all becomes very complex. Why isn't it, and why can't it be, a shared care record?

Chair: Simon and Amanda, perhaps you could write to us with the answer, because it is a pretty detailed question. It would be very helpful to know that. If that is all right, Rosie, I will ask for a written answer on that one.

Sir Simon Stevens: I am happy to. There are two completely complementary principles. The first is that patients of course have a right to protect the confidentiality of their medical data. The second, however, is that there are significant benefits to patients of making sure that when you are being looked after, including in an emergency situation, the nurse or doctor or paramedic looking after you knows about your background health conditions, so that you can get the right care there and then. That is the circle to be squared. We will certainly come back to you on that. I know Matt Hancock is working very directly on it because there are proposals in the White Paper specifically on that point.

Q95 **Dr Evans:** Sir Simon Stevens, in January, the last time you came and gave evidence to us, I asked about red tape and bureaucracy. I would like to follow up with some questions on that. In your answer, you split it into two sides, the patient frontline side and the administrative side. I am keen to go down the administrative side in light of the White Paper and what has been put in place. You pointed out that 2p in every pound was spent on administration, and in Germany and France it was 5p or 6p. Does that mean we have the level right in the UK?

Sir Simon Stevens: Luke, you mean the level of spending on administration.

Dr Evans: The cost of administration.

Sir Simon Stevens: As you rightly remind us, our administrative costs are low, but what we are suggesting is that some of the requirements that are placed on the health service nevertheless generate wasted administrative effort, and it would be good to be able to dispense with that legally induced bureaucracy, in particular the requirement to competitively tender many aspects of care that we get no benefit from whatsoever. It would be good to be able to drop that requirement.

Q96 **Dr Evans:** That is the element that comes out in the White Paper of reducing bureaucracy. Could you explain where we have come from and where we are going in the White Paper as regards competition?

Sir Simon Stevens: To pick up the prompt, particularly starting with the procurement point, the combined effect of section 75 of the 2012 Act and the public contract regulations 2015 is that we frequently find ourselves running competitive tendering processes where there is a presumption that those services will be tendered out if the value is more than £663,000. That can lead to some pretty spurious processes where you tender out some community nursing but not some other parts of nursing, and you fragment.

We frankly went through the farcical situation of having to put out OJEU procurement documents for the nation's specialist cancer services, cardiovascular tertiary services and so forth because they were obviously more than £663,000-worth, yet the reality is who is actually going to come and be the replacement for the Royal Marsden or Guy's and St Thomas' or Central Manchester foundation trust and so on? There is a lot of spurious activity generated off the back of those things, and it means that parts of care get fragmented, and that is what we want to dispense with.

Q97 **Dr Evans:** I am really keen to point that out. It is a prime example. Can you give us a feel for what that means for either money saving or time saving? Have you done projections in the NHS of what it would look like practically?

Sir Simon Stevens: We have certainly spoken repeatedly down the years to frontline staff, to our colleagues, to NHS leaders who have to operate that system. That is one of the clear points they have put to us. Until now, our hands have been tied by virtue of a combination of domestic and EU legislation. Now the Bill gives us the opportunity to step beyond that.

Q98 **Dr Evans:** May I pick up some points on procurement with Amanda, if that is okay? Sir Simon has mentioned it to Laura, and now in these points as well, particularly around goods. The Institute for Government talks about the NHS supply chain looking to account for about 80% of procurement by 2022. Is that still the case? Again, how does the legislation free up the procurement? Procurement has been in the news a lot during the pandemic. What difference can the public, and indeed those who work in the service, expect to see?

Amanda Pritchard: The proposed legislation is much more about services than goods. As Simon says, it is designed more around services that are tendered out that can be, and often are, very small parts of community services, although we have examples of huge specialist services having to go through the same process. The legislation makes it easier to avoid having to go through multiple competitive tenders. As Simon said, we have countless examples, because of the way the law is currently described, where people have gone for very short term, very inflexible contracts that have had to be relet almost year on year, which means, in practice, a big overhead of time and cost, but we also lose the opportunity to think about continuity, and we often lose good leadership on the back of that. It works against integration of care at local level, and that is the main thing we are trying to fix.

The primary benefit will be for the local physiotherapy service, the local podiatry service, or the local speech and language service. That is the opportunity now, with a proper framework in place, not just to roll things over without due process around looking at value for money, quality and patient feedback and, clearly, an expectation of continuous improvement as part of that, but to allow a different process that does not require the same sort of formalised procurement arrangement.

Q99 **Dr Evans:** That is really helpful. I would like to take this a little wider because the Bill talks about reciprocal healthcare. We have had Brexit now. Sir Simon, what do you see as the benefits and drawbacks of the reciprocal arrangements put in place? How much of a problem is it, and what will this solve?

Sir Simon Stevens: I think that is primarily a question, if I might say so, Luke, for Matt Hancock when he is with you next week. There is a DHSC and Government judgment on reciprocal healthcare. Clearly, there have been benefits in British citizens being able to get healthcare outwith their travel insurance when they are travelling, and vice versa, but it has been quite a complicated regime hitherto, it would be fair to say. There are transitional arrangements, but those, ultimately, will be judgments for the Government rather than for the NHS.

Q100 **Dr Evans:** If we invert it, though, because it says that no healthcare system should be out of pocket, what is the scale of the problem for the NHS currently, and what would it look like, with the new changes, for the NHS itself, because it is a two-way street?

Sir Simon Stevens: I am happy on your behalf to ask the Department to come back to you on that, based on the estimates it has drawn up.

Q101 **Dr Evans:** The final question I have on this side is moving to the public health aspect. You picked up on fluoride. One of the things I noticed is that food standards are being put on a legislative footing. How will that affect the NHS, and why does that need to be put in place in the first place?

Sir Simon Stevens: Those are standards for hospital catering, for food. The underlying argument, which is of long standing, is that nutrition is

vital for people's health and recovery, so ensuring that proper standards are in place across hospitals is obviously a good thing to do. If that is going to be the case, we need to make sure that hospital food has the right resourcing. The Hospital Caterers Association is doing a fantastic job. We have had the review with Prue Leith recently, building on other reviews as well. There is a real appetite on the part of hospital caterers—no pun intended—to drive change and improvement in that area. The Government have said they believe it would be useful to have the ability to set some of those standards statutorily.

Q102 **Dr Evans:** Sir Simon, do you think that should extend to the care sector, and care homes and residential homes?

Sir Simon Stevens: It is an interesting question. What is sauce for the goose is sauce for the gander, but there is a slight risk that one gets into statutorily trying to regulate lots of different input elements in the way care is provided, whereas, if you are looking at a rounded view as to what counts as high-quality care in a care home, then, perhaps channelling your Chair, the CQC has a responsibility to do that, as well as the publication of transparent information and the choices that people are able to make.

I do not think you can second-guess every aspect of what high-quality care looks like by trying to pass an Act of Parliament. That will just gum up the ability of people to do the right thing and innovate. That is the spirit that we have seen across the health service and the care sector over the pandemic and the last year. It is that can do spirit, frankly, with more initiative and autonomy devolved to the frontline of care, that we want to see, rather than more centralised second-guessing and command structures.

Q103 **Dean Russell:** Sir Simon, may I add my huge thanks to all NHS and social care staff over the past year? They have done a tremendous job.

My questions come from the perspective of digital, virtual and technology. I want to start off by asking whether you feel that the CQC can fulfil a role over the coming years in looking at regulation around the use of technology within the NHS, and if it does already.

Sir Simon Stevens: That is quite a profound question. We are clearly seeing a big transition in the way that a lot of care is provided. We saw that with the move towards online and telephone-based appointments to supplement face to face over the course of the last year, interestingly not just in this country but around the world. That is the effect that Covid has had on the provision of health services.

The question was already in view as a result of some of the changed GP services that were beginning to occur around the country, and the CQC had to decide what its regulatory stance was going to be. Digital medicine and digital health will obviously be a bigger part of what healthcare looks like in the future. Yes, the CQC clearly needs to think that question through.

That is not to say, however, that a regulated approach to trying to drive change will be the fuel in the tank that is going to bring about more modern forms of healthcare. It is not going to be driven by the CQC. It is going to be driven by what patients and clinicians can see makes sense.

Q104 **Dean Russell:** On that point, in my local trust—the West Herts hospitals trust—they have done a fabulous job of creating virtual wards during Covid. They have helped many patients in the work that they have done by enabling them to be at home but still be monitored and safe. I believe that even an app was used to help take certain readings throughout the day and to check on them. What are the plans for expanding that sort of virtual ward and the use of digital to enable the patient experience to be improved over the coming months and years?

Sir Simon Stevens: Dean, you are quite right. In fact, I have been to Watford hospital to see the work that has been led there. They are one of the early adopters of home-based monitoring for Covid patients. The clinicians who have driven that change there are now helping to drive it nationally across the country. It is a fantastic example of innovation at Watford, and we are going to see much more of it in other areas, such as the monitoring of heart conditions at home. Our NHS digital unit is, over the course of the next year, going to be taking the example of Covid monitoring and deploying that in cardiovascular monitoring. The same is true for a number of other conditions as well.

Amanda Pritchard: I entirely agree with your point on this. There is huge clinical enthusiasm about going further. We are thinking about things like virtual wards and home monitoring. For me, it is another fantastic example of why integration can be so powerful. It is really bringing together primary care and their expertise with the experts that we have in secondary care around specific conditions. The patients themselves are much more able to be in control of their own care. Of course, the digital wraparound is the thing that enables it. We have had some good conversations with the CQC already about how they bring that invaluable patient safety and patient experience lens to it and help us to make sure that we have the governance in place to do it well across the whole country.

Q105 **Dean Russell:** Sir Simon, could I stretch that a little bit further? One of the things I have been fortunate enough to see at first hand is the role of volunteering within the NHS. Over the past year, there has been an ability to cut red tape so that St John Ambulance can help out on wards through to the ability to mobilise volunteers on the ground, identifying where there are gaps in volunteers in terms of time and even helping on wards. Is that something that you anticipate will increase over the coming years, both the technology to support volunteering and the drive to increase volunteers?

Sir Simon Stevens: Yes, I think so. Again, as you rightly say, Dean, we have seen fantastic examples of that over the course of the last year, both in the national volunteer response and in local communities

mobilising. The current dramatic example is the NHS Covid vaccination programme.

If you have been to any of your local vaccination services or centres, you will have seen that, as well as the brilliant work that GPs, nurses and other NHS staff are doing, the force multipliers are the volunteers. There is a huge community mobilisation across the country. That speaks to the fact that part of the success with uptake is that it is not just a medical exercise. It is also reaching into communities, with community leaders, and engaging people, whether that is in mosques, sports halls or rugby clubs. Today, I am pleased to say, patients will now be vaccinated in Poets' Corner in Westminster Abbey.

Q106 **Dean Russell:** I have been fortunate to be a vaccination volunteer myself and have seen the huge amount of operational effort that goes on behind the scenes. I do not think it is quite realised how much goes on to make sure that the whole process runs smoothly, from the length of the queues, when there need to be queues, through to the process post vaccination, with St John Ambulance being involved in that.

Related to that, I proposed the idea of, effectively, an NHS cadets scheme in a report last year with some colleagues, to encourage more young people to volunteer at local hospitals. Is that something you think could be explored in the future?

Sir Simon Stevens: Yes, I think it could be. The use of the word "cadet" has certain resonances that we have to be thoughtful about. There have been nursing cadet programmes. The Royal College of Nursing, the Prince of Wales and others have been involved in some of those kinds of discussions in the past, but the idea behind the idea is absolutely right.

Q107 **Neale Hanvey:** Thank you both for your detailed responses this morning. It has been very interesting indeed. I want to talk about a couple of fundamental principles of the White Paper around the reduction of bureaucracy and how that will improve services. As a follow-on to the Chair's comments around timing, I would like to raise the issue of sequencing, particularly with regard to what has become very clear is the interdependency between the success of the NHS and the provision of robust social care services, particularly at a time of crisis. I think that was one of the earlier lessons from the pandemic.

Is this the wrong sequence? Is the White Paper coming at a time before meaningful reform of social care, rather than after that? Does it not demand that we pay attention to social care to make sure that the work of the ICSs, which will quite clearly interface with that environment, will be with a reformed care provision, rather than before that happens? Do you see some of that work happening in tandem and, if so, how is it going to be paid for, first of all? Secondly, how is it going to be managed strategically and nationally? That is a general question.

The other bits—

Chair: Shall we let Sir Simon answer that one first, Neale?

Neale Hanvey: Yes. The other bits I am interested in are more around contracting and the like. It is really that whole context.

Sir Simon Stevens: That is a very fair question. Our pragmatic answer is twofold. First of all, of course we support the need for proper reform of a well-funded adult social care system. Like the Committee, we have been making the case for that for some time. Everything we have seen over the last year has only reinforced the fact that health and social care are two sides of the same coin.

However, having said that, we also pragmatically think it is perfectly desirable to get on with making the changes that are set out in the White Paper, and to have them in place, subject to Parliament, with Royal Assent, so that April 2022 can be their start point. There is nothing that prejudges the social care reform package from those proposals. If anything, they provide a better docking mechanism for a reformed adult social care system than exists at the moment. Our argument would be both/and, but in the meantime don't wait.

Q108 **Neale Hanvey:** One of the key attractive elements of this type of programme is the innovation that came out of the pandemic, capturing that and being able to make sure that it translates into standard practice. All of those arguments make sense.

However, going back to that same principle, if investment is not being made or driven as forcefully in social care, how do you ensure that innovation is actually delivered? For me, it is bound up in some of the peculiarities of the NHS England system around tariffs, competitive tendering and the whole bureaucratic process that people like me, who have worked on the frontline, think is nonsense because it creates jobs to shift money around that would be much better just given to the frontline. How do you feel about that?

Sir Simon Stevens: I think that is right. One of the proposals is that there should be much more flexibility in the way the tariff is structured. We are also asking that the procurement regime that applies to any publicly funded health services, even if they are being procured by local authorities, is adjusted to take them off the competitive tendering treadmill that we have been through.

As you know, local authorities are responsible for funding and commissioning health visitor services, sexual health services and various others, many of which are delivered by NHS providers. We think it is important that there should be a shared procurement regime that exists across both, where you are talking about health services.

Q109 **Neale Hanvey:** My final question is around the disbursement of funds and supporting services. They are two different ends of a similar issue. When you were talking about the end-to-end service provision that is commissioned by an ICS, and said that within that care pathway there will be different providers, what is the mechanism to ensure that each element of the pathway is given sufficient support to ensure that there is not a narrow aperture at any point that creates a difficulty in the

pathway, or that one provider is disadvantaged to the extent that the whole pathway collapses?

I think Amanda has already touched on protecting super-specialism, particularly in tertiary services that will not be replicated everywhere but where there may be a national service or regional services of super-specialism. How is that going to be protected?

Sir Simon Stevens: I will take the second question, and perhaps Amanda will talk about the first question on the way different providers work together.

On your second question, we are quite clear that there will need to continue to be some specialist and super-specialist services that are nationally or regionally commissioned. Yesterday, I announced that NHS England has negotiated and reached agreement with what has been labelled the world's most expensive drug. The list price was £1.8 million per patient treatment. We have been negotiating hard behind the scenes for a confidential discount to deliver good value for taxpayers. That treatment will be made available for potentially 80 or more babies a year for gene therapy for spinal muscular atrophy. That is the sort of thing that you certainly would not expect an individual ICS or group of ICSs to continue to lead.

I think our specialised commissioning team at NHS England has done a really good job, with the independence to be able to drive those kinds of deals on behalf of taxpayers, as we did with Vertex for cystic fibrosis and a range of other drug procurements as well.

Q110 **Chair:** Amanda, do you want to come in on the first point?

Amanda Pritchard: Thank you. As Simon says, one of the things this gives us is the opportunity to think much more flexibly about how money flows, and particularly around how the tariff works in practice. One of the benefits of the structure that is recommended is that you have all the partners in the system around the same decision-making table. That provides some safeguard that all of those on the pathway are given due focus and appropriate resource. That is slightly different from what we have now.

There are a couple of things that are worth adding. We have recommended—this is one of the things we are talking about a lot at the moment within the NHS—that we have provider networks set up in each of the ICSs. That gives them a very specific role in looking at the whole pathway rather than just chopping it up in the way that can happen now. It particularly gives an opportunity to look at where there is unwarranted variation, and move resource around to try to address that, whether it is people or indeed money.

The point I was trying to make earlier is another one to hold on to. With specialist services, ICSs will have to work together, and we will have much larger geographical networks in place to safeguard those highly

specialist services and access to them, so that they are given a focus alongside the kind of local service provision that we have talked about.

Neale Hanvey: On that point, Amanda, this is just a reflection for you to think about. We have been doing integration in Scotland for quite a long time. It is great all being round the table talking about a pathway, but it is not quite as successful on the ground sometimes—not all the time. There are still very real challenges. I just wanted to reflect that fact.

Q111 **Chair:** That is a fair point; thank you for saying that.

We will move on to social care. We have touched on it a bit. We heard from the Local Government Association and the Health Foundation last week that the worthy aims behind the reforms in the White Paper will not be achieved without reforming the social care system at the same time. We were obviously disappointed that there was no mention of social care reform in the Budget, but the Government have confirmed that we will have that this year.

Sir Simon, what lessons are there for the social care system from the NHS 10-year plan? In particular, what are the benefits of having a 10-year horizon that goes beyond a single Parliament?

Sir Simon Stevens: There are certain inescapable facts about us as a country. We can see what our future will look like over the next five and 10 years as a consequence of demography. With an ageing population, with higher health needs and with more people living with the challenge of dementia and Alzheimer's, we can see that there will be increasing pressure on adult social care. That is layered on top of a system that is already very stressed. It is a system that is very diverse in its provider structure, as we have previously discussed.

Frankly, I do not think anybody wants more of the same in social care. We need more adult social care, but not more of the same. We need more flexibility in care models. In other words, rather than people automatically having to move house when their needs accelerate, we need the ability for supported housing and the flexibility to assign care to where people are currently living, as well as resilience in the care home sector. That is only going to work if it is backed by a workforce plan for social care, given the vacancies and the casualisation that exists across the social care workforce sector, with perhaps a quarter of people in social care on zero-hours contracts.

You have to bring all of those pieces together. It is not just the question, important though it is, of who should pay for care home residents or how to ensure that people do not have to sell their house at the point they have substantial need. It goes much broader than that. It is about increasing the overall availability of care. It is about the type of care on offer, and it is about making sure that it is sufficiently responsive to individuals and their families.

The point of a 10-year plan in the way you describe, Chair, is to bring all of those pieces together to have a comprehensive look at how the services need to change.

Q112 **Barbara Keeley:** Sir Simon, you talked about the legislation being there as a dock—I think those were the words you used—for when a social care settlement comes in. What happens to integrated care if it does not? There are some structures and levers, but if social care does not bring money to the table, does that start pulling money out of the NHS?

I have a follow-up question. If the current financial set-up in social care does not change, the power balance across the two parts will be very much weighted towards the NHS, won't it?

Sir Simon Stevens: In what way, Barbara, on your last point?

Q113 **Barbara Keeley:** If NHS bodies are providing the bulk of funding for ICSs, the direction will tend to be set by the funder. Funding tends to lead in that way. We know that local authorities are underfunded. We know that social care is underfunded. If there is no settlement or movement on that, what does that do to integrated care?

Sir Simon Stevens: I see what you mean, although even a properly funded adult social care system is not going to be spending as much as the NHS in the round, so I suspect there will always be that difference, even if you have a partnerships of equals, in terms of decision makers coming round the table.

A lot of our discussion focuses on the needs of older people. That is important, but I want to take this opportunity to underline what we have talked about before. Half of adult social care spending is not for older people; it is for people with learning disabilities and autism, for people with mental health needs and for people with physical disabilities. Although the interface questions that we often debate are around frailty and ageing, given what we are also trying to do to improve the support for people with learning disability and autism, it is vitally important that social care can be there as equally resourced partners in that journey as well.

I am not sure what more I can say, other than that from the point of view of the whole of the NHS we agree with the Committee that it is important to look at both together. In the meantime, it is also important that the health service does what we can to continue to raise our game. We think that the legislation will, at least at the margin, help with that.

Q114 **Barbara Keeley:** On the question I touched on, about NHS bodies and the power relating to funding, it is likely that the NHS bodies will set the direction for services; we have experience of that in Greater Manchester. In the social care space, medicalised models are criticised for being overly simplistic. You talked about independent living and supported living, but what steps do you think the NHS can take to ensure that that dominance does not change the integrated bodies, and that we try to protect the holistic aims of social care services? There is a worry that social care could lose its way in the integrated model.

Sir Simon Stevens: That is partly just an inevitable consequence of the pluralism that is social care, I suspect. We have plural funding. Local authorities only commission some of the services that people receive

locally. That division between the publicly funded versus the self-pay part of social care has, arguably, widened in recent years.

We have a very mixed economy of social care provision, which again, as a Committee, we have talked about recently, between the large care home chains on the one hand through to small neighbourhood home-care based services on the other. I am a big fan of an organisation called Shared Lives Plus, for example, which I think you might be referring to. It lacks the kind of institutional infrastructure as a big physical provider of care but is, nevertheless, doing hugely important work across the country.

Part of it is not to expect the same unitary approach from social care that you might see from NHS bodies around the table. It just reflects the necessarily different ways in which the two sectors work.

Q115 **Barbara Keeley:** You talked about the CQC taking on a role in rating local authority provision of social care. I wonder how effective that will be if the long-term funding settlement is not delivered for social care at the time of the changes from the legislation. There was a feeling we got, when talking to the LGA last week, that it is setting local authorities up to fail, to be measured on something when the funding is not there.

Sir Simon Stevens: That is obviously a judgment for the Government and the DHSC, and falls into the 15% of the proposals that the NHS per se cannot be authoritative about. The flip side of the point you have just made would be that holding a mirror up to the reality of care and calling a spade a spade might help drive improvement and change.

Q116 **Barbara Keeley:** It might. Before we leave this topic, I want to talk about unpaid carers. The White Paper does not include a single mention of carers, even though they have rights in law under social care provision. I understand, too, that in the consultation that NHS England had on the legislation there was a total absence of the mention of carers.

We have 10 million carers. Sir Simon, I raised with you at an earlier meeting about discharge to assess failing to include mention of carers. It seems as if this keeps happening now. I know that carers organisations are deeply concerned about NHS England seeming to ignore carers in the work you are doing around the White Paper. Can you comment? What is going on?

Sir Simon Stevens: I do not think that is quite right. We obviously work very closely with Carers UK and a number of other carers organisations. The specific White Paper proposals in respect of carers are no doubt something you will want to raise with the Department. All I would say is that it is back to the question of what is legislation versus what are all the other ways in which we need to work with vitally important partners, of whom carers are front and centre. You cannot necessarily legislate for that, which is what the White Paper is all about, but that does not mean you do not need to do it.

Q117 **Barbara Keeley:** You mentioned partners, and Amanda mentioned

voluntary organisation partners. You talked just now about Shared Lives. There has clearly been consideration of those, but there are 10 million unpaid carers. Their numbers have increased something like 50% during the pandemic. There is no mention of them at all. It is not my comments on this; carers organisations have told me that they are disappointed in NHS England not mentioning carers, either when you consult on the legislation or anywhere.

It is important to consider carers when people are being discharged. There is the question of willingness and ability to care. Those are important issues. I raise it with you because organisations have raised it with me.

Sir Simon Stevens: As I say, I think we engage very directly with carers organisations and are very open to any points that they might have specifically on the Government's legislative proposals, while nevertheless, as I say, also recognising that some of the legislative content probably does not go to the heart of the legitimate concerns that carers have. There are other venues and other places where those questions have to be settled.

Can I ask you, Barbara, what it is specifically that you say carers are looking for in this legislation that is not in the proposals? That would be very useful to know, and then we can take account of it.

Q118 **Barbara Keeley:** I raised with you that on discharge from hospital it is very important that a couple of things are done. Consideration of a carer's willingness or ability to care has to be part of the discharge process. Not mentioning carers' assessments is a problem too.

When a patient is caught up in the NHS world, they are not going to necessarily think to go to a local authority or to start looking for a carer's assessment if they do not know that it does not exist. At the point when somebody becomes a carer because of what has happened to their family member, it is the NHS that has, and can play, a very important role. Not mentioning it in guidance or when you consult on legislation or in that legislation, when there are 10 million people in that position and a very large number that have become carers this year, seems absolutely curious.

Chair: Sir Simon, maybe you could write to us on that.

Sir Simon Stevens: I think Barbara, with her customary advocacy, has stated the case very strongly, but has perhaps overstated it. We are directly involving and engaging with carers organisations. As the Government frame their new and continuing healthcare and assessment processes, the points Barbara makes are absolutely spot on. We will incorporate them fully.

Barbara Keeley: Thank you.

Q119 **Chair:** Time is marching on. There are a couple more areas that I need to cover before we conclude. One of them is workforce. Sir Simon, the last time you came before us you said that there was merit in the idea of an

independent body publishing regular workforce projections. Anita Charlesworth suggested to the Committee that there could be a legal obligation on Health Education England to publish annual 10 and 20-year forecasts as a possible solution.

Do you think there could be merit in that? Does it worry you that we have such an important piece of health legislation that does not address workforce shortages?

Sir Simon Stevens: Taking those in two parts, on the first part, yes, I think some form of independent assessment in the way that you propose, Chair, has merit. To some extent, of course, the future is already set by decisions that have been made in the recent past. Last year's intake of undergraduates to medical school will be the number of new doctors in five years' time. It is just that the way the budgets for Health Education England get set is a rolling annualised process, which rather ignores the fact that those decisions have been made, for better or worse.

Yes, I think there is an opportunity to do that. As we have discussed previously, there has been a huge upsurge in interest in joining the health professions as a result of the brilliant work that young people and mature entrants have seen being done across the health service over the last year. There is a huge upsurge in applicants for nursing, for medicine and other health professionals. Capitalising on that and saying, "All right, what should we now do for the next five and 10 years on the strength of it?" has great merit.

Q120 **Chair:** A question for Amanda, if I may. Last week, we heard from Danny Mortimer of the NHS Confederation that workforce shortages actually cost the Treasury more than recruiting or training the right number of clinicians because of the premium cost of locum and agency labour. Having run St Thomas', is that an analysis you agree with?

Amanda Pritchard: I completely agree. There is a financial aspect to that, and far more. The more that the NHS is able to support permanent staff, the more that then becomes part of the cultural opportunity you have to wrap around staff, to develop them over time and to see people have long-term careers in the health service, as well as being good colleagues. As we know, it is a real benefit to patient safety when there are more people who are permanent and are used to working together as teams. Yes, I strongly agree.

Q121 **Chair:** With the background of having run one of our very biggest trusts, what would you like to see in the legislation to make sure that we actually train the right numbers of doctors and nurses for the future?

Amanda Pritchard: It would probably be to build on what Simon said. I should say, of course, that we remain hugely grateful to all the people who have offered up their time on an agency basis or a locum basis, particularly over this year. It has been completely invaluable.

My sense is really the same as that of others. When we look at the time it takes to train, in particular, the idea that we could plan the workforce on an annual basis does not make sense. The ability to move to a much

longer-term plan for the workforce, with much more surety around that and some safeguards around how it is then reported, feels eminently sensible.

Q122 **Dr Evans:** On the workforce, with regards to the training, I notice that LETBs were not recommended in NHSE's submission. Local education and training boards have been taken out and the responsibility given to Health Education England. Sir Simon, do you have an opinion as the NHS whether this is a good move, a bad move or just something completely by the bye? Do you have an approach on that?

Sir Simon Stevens: It is a sensible tidying up. We already see much closer working between Health Education England and NHS England. We expect that alignment to intensify.

Q123 **Dr Evans:** Following up the conversation we have just had, the paper says that the Secretary of State should come in every five years to produce a report about what the workforce should look like. As someone who has trained through the system, I have seen many people moving from profession to profession within the workforce as they are training, maybe going from obs and gynae and ending up in GP. Should there be more of a road map that is held in legislation, with more flexible working, particularly around medicine and healthcare? Is that something that the Government should be looking at?

Sir Simon Stevens: Yes, but it probably does not need primary legislation.

Q124 **Chair:** We are very grateful for your time so far. The final area we want to look at is the question of operational independence. Some people are worried that the new proposals could undermine the one part of the Lansley reforms that are widely considered a success, namely the operational independence of the NHS and NHS England. Some critics have even said it is a political land grab over the NHS by Ministers. Do you think that is a fair characterisation, Sir Simon?

Sir Simon Stevens: First of all, we have a publicly funded, national health service, and one of its great strengths is the democratic accountability that flows from that. There is no argument whatsoever. That is intrinsic to having an NHS.

The second thing is that the legislative proposals envisage bringing together three separate bodies to create the new NHS England: NHS England as it currently is, together with Monitor, which is the economic regulator of foundation trusts, and the NHS Trust Development Authority, a special health authority that oversees trust providers that are not foundation trusts.

If that sounds complicated, that's because it is. What I, Amanda and colleagues have been doing for the last several years is, essentially, bringing together those three bodies in practice to provide unified leadership for the national health service. What we are now asking Parliament to consider is bringing them together de jure, not just de

facto. Because of that, of course the question has to be answered. We have three separate accountability mechanisms at the moment: one for NHS England; a different one for Monitor; and a different one for the TDA. If you are bringing three separate accountability mechanisms together, you have to answer the question, "What is the accountability mechanism for the new integrated body?" There is no argument about that whatsoever.

In practice, the reality is that there has been very close working between the NHS and the Government of the day. This is formalising some of that in a way that is transparent for everybody to see.

Q125 **Chair:** Thank you. Chris Hopson voiced concerns about one aspect of ministerial involvement, which would, essentially, allow the Secretary of State to intervene in local reconfigurations. Of course, what the Secretary of State would say is that he is accountable to Parliament for those reconfigurations, so he has to have some influence over them. What is your position on the very tricky business of ministerial involvement in local reconfigurations?

Sir Simon Stevens: The principle is already established that ultimately the Secretary of State gets to make the decision. At the moment, the mechanism is that a local proposal is put forward by the health service. If it is a substantial change, it has to be consulted on. If the local authority disagrees with it, they can formally refer it to the Secretary of State, who asks the Independent Reconfiguration Panel to advise him or her on it. Then the Secretary of State makes the decision.

It is not a new principle that ultimately the Secretary of State can make those decisions. The question is that, if it is going to happen earlier in the process, let's make sure that there is transparency about that. In particular, in a situation where, for example, there is a small service that the CQC has said is at risk of providing unsafe care—that is one of the things that is driving the proposals for change—if there is a political override on that, there needs to be transparency about why that has happened.

In general, one of the important safeguards around the use of any such powers of direction would be—not just in the case of reconfiguration, but more generally—something that Matt Hancock has undertaken, which is that the Bill will provide that such a direction will be in writing and published at the time, so that everybody can see what is going on. It will be subject to a public interest test so that the use of that power of direction is justiciable.

Q126 **Paul Bristow:** Do you think the Independent Reconfiguration Panel should be retained to arbitrate over disagreements?

Sir Simon Stevens: That is ultimately a judgment for Ministers, but Ministers may benefit from having expert clinical advice from outwith the local area, so that a group of people who have seen other proposals like it, but are not parti pris to the particular proposal under debate, can provide objective advice to the Secretary of State. The IRP has performed

an important role in that respect in the past. Ultimately, whether Ministers want to avail themselves of that advice is a matter for them.

Q127 **Paul Bristow:** That is very helpful. Coming back to something that Amanda said in a previous section, you said that the integration of primary care and secondary care would improve technology uptake and innovation, and that getting all the parties around the table would help that locally. I can see that, but how do we embed that across the system so that ICSs can learn from one another? Some say there is a "Not invented here" syndrome in the NHS. Is there a way practically, in the legislation, to address that challenge?

Amanda Pritchard: That is spot on in terms of the kind of opportunity that we have, and in fact the necessity as we think about the recovery from where we are now, post Covid. We have had some work going on and have set up a beneficial changes network that has done a lot of crowdsourcing around the hyper-local innovations that we have seen across the NHS right through to some of the much bigger things. That is being shared widely now.

It is not mandatory for people to avail themselves of that sort of rich information. It is something that we are seeking as much as possible to make sure that people are conscious of, and that it is available. It is one of the key roles that we would see not just ICSs having, but regions as well, to make sure that they share good practice and innovation. We have had such amazing examples this year of a very rapid move from innovation to practice, and that is clearly something that we will seek to build on.

Your particular question is about whether legislation can help with that. It is not something we have considered up until now. It is certainly something that, as we think about the guidance we are putting out around the role of ICSs, the role of regions more generally, and our whole approach as we think about planning guidance for the next year and the approach to recover, will be writ large in those expectations.

Chair: There are a couple of quick, final questions from Dean and Luke.

Q128 **Dean Russell:** I have a broader question, Sir Simon. We are hosting COP 26 later in the year. One of the things I have noticed—I will not say on the frontline, but in wards—when making tea and coffee for patients is the amount of plastic cups and waste that goes into the bin. I was just interested to know whether, looking long term, there is an approach to start to move away from single-use plastic and waste on that front.

Sir Simon Stevens: There absolutely is, and I shall be on to West Hertfordshire hospital straightaway, having heard your testimony now.

Q129 **Dean Russell:** I do not wish to get them into trouble. They do a great job.

Sir Simon Stevens: Well, with perhaps one exception. We are having a huge campaign against single-use plastics across the national health service. We have set ourselves the goal of becoming the world's first

carbon net neutral health system. We have mapped out practically what that will take. We are mobilising with our supply chain to enable us to put the building blocks in place, and we expect the NHS to be a showcase for what is possible in health sectors as the UK hosts COP 26 in November. We are absolutely on that.

Obviously, we have seen a big negative across all health services as a consequence of all the single-use PPE that we have had to use across the industrialised world over the last year, but we are completely committed in the way that you describe. We will be in touch with West Herts.

Dean Russell: I am sure they do a brilliant job of making sure it is all up to date.

Chair: It will be the friendliest possible communication, Sir Simon.

Sir Simon Stevens: Absolutely, but I am afraid that your local Member of Parliament has dropped you in it.

Q130 **Dr Evans:** I have an even broader question for you, Sir Simon. This is a big change that you have put forward in the White Paper. What is the biggest surprise you have had with regards to the reaction to the White Paper?

Sir Simon Stevens: I don't think there has been a surprise, to tell you the truth, Luke. We have been working so closely for a number of years with colleagues across the health service and our broader partners. Genuinely, I think this is unusual, if not unique, in having come from the NHS as a series of asks to Parliament rather than something that Parliament is perhaps imposing on the NHS.

The reality is that we, as the NHS, obviously work very closely with our partners. We worked very closely with Ministers right through this pandemic. On the idea that this is some new notion that there should be ministerial accountability in the NHS, I take you back to this time last year. We were a fortnight off from the 23 March lockdown. On 10, 11, 12 and 16 March, we were having detailed discussions with very senior Ministers about what the NHS response should be and how to free up capacity to look after the extra patients, with patient discharges and elective care. All of those were decisions agreed with Ministers. The idea that this is operating distinctly is not the practice of the matter.

My final thought would be to commend to the Committee, if you are so inclined to back us on this, Aneurin Bevan's dictum. He said that "legislation in this country…starts off by voluntary effort, it starts off by empirical experiment, it starts off by improvisation, it then establishes itself by merit, and ultimately at some stage, the State steps in and makes what was started by voluntary action and experiment a universal service."

That is the experimentation and evolution that we have been doing in the health service over the last seven years. Now we are asking you to step in and make it universal.

Chair: Thank you. What a stirring note to finish on, Sir Simon. We are most grateful for your and Amanda Pritchard's time. It has been quite a technical discussion about the plumbing of the NHS, but I think we all know how incredibly important it is to get that plumbing right for the service and the quality of care that we give patients. We are very grateful for your time. We know how busy you are with all the other things that are going on. Once again, please pass on our thanks to all NHS staff for their magnificent efforts at the moment. That concludes this morning's session. Thank you, everyone.