



Public Services Committee

Uncorrected oral evidence: One-off public evidence session in follow-up to the Government's letter on the Procurement Green Paper

Wednesday 9 June 2021

4 pm

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Members present: Baroness Armstrong of Hill Top (The Chair); Lord Bichard; Lord Bourne of Aberystwyth; Lord Davies of Gower; Lord Filkin; Lord Hunt of Kings Heath; Baroness Pinnock; Baroness Pitkeathley; Baroness Tyler of Enfield; Baroness Wyld; Lord Young of Cookham.

Evidence Session No. 2

Virtual Proceeding

Questions 6 - 10

Witnesses

I: Rachel Silcock, Strategic Commissioning Manager, Plymouth City Council; Mike Barker, Strategic Director of Communications and Reform, Oldham Council; Martin Wilson, Chief Operating Officer, Newcastle Hospitals NHS Foundation Trust.

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Examination of witnesses

Rachel Silcock, Mike Barker and Martin Wilson.

The Chair: Good afternoon and welcome to the three witnesses in our second evidence session in this special look at commissioning. I am delighted that we have witnesses from both Oldham and Plymouth. You have both been mentioned in the previous session as examples of good practice. I hope that is not too threatening for you. We also have a representative of the health service in Newcastle. I always like to welcome people from the north-east. We have Rachel Wilcock from Plymouth and Mike Barker from Oldham—both local authorities—and Martin Wilson from Newcastle Hospitals NHS Foundation Trust.

Welcome to all of you. If when you get your first question you can say a couple of things about yourself, people will be able to align what you say with how you appear on the screen. That is always helpful.

The first questioner for the second session is Lord Filkin.

Q6 Lord Filkin: Welcome to the panel and thank you very much for your time. In essence, we are starting again with the question that we put to the previous panel, exploring the obstacles to effective integrated value-focused commissioning. It would be good if each of you could summarise what you think have been those obstacles in your experience and, to the extent that you have been able, have you overcome them and how you have overcome them. In other words, what are the problems, and can we learn from you how to overcome them? Could we start off in the south-west with Rachel?

Rachel Silcock: I am a strategic commissioning manager at Plymouth City Council. My area of commissioning is well-being and preventive services, working strongly with public health. I work very closely with the voluntary community and social enterprise sectors.

There are several barriers to effective integrated social value commissioning. Over the previous few years local authorities have had reducing resources. That has a double impact. One is that we do not necessarily have the ability to make the longer-term commitments we would like to make, but there is also lack of staff capacity. One of the things we really need to do in terms of effective commissioning is to have time and resources. To work in an integrated way is time consuming.

In Plymouth, we have been working in an integrated fashion, certainly with the NHS. Over the past few years we have had a pooled budget with the local CCG; we have a partially integrated commissioning team in that we have a joint director of commissioning with the CCG, and we work very collaboratively with them, but in some ways there is a different commissioning culture in local authorities and the NHS. Local authorities are very much rooted in place. We are very embedded in our communities and work closely with them. Often, the NHS does not have that kind of local knowledge and understanding of the voluntary sector

and that experience. That is where we can bring that experience to the partnership.

Relationships and trust are absolutely fundamental. It takes time to build that. You need to build trust. In order for different partners—for example, the CCG and the local authority—almost to delegate decision-making to each other and share decision-making you have to have trust.

To give an example of the amount of time you need to put into effective social value commissioning, we spent many years developing a partnership, which we call Complex Lives, with our voluntary sector around homelessness and substance misuse. We did a lot of work with communities and people with lived experience through a process of conversation that we call appreciative inquiry. That collaboration eventually led to an alliance commissioning process. That alliance now includes the local authority as a partner, so the master-servant relationship of commissioner and provider does not exist.

We now have a collaboration with the local authority sitting on the alliance with those voluntary sector organisations and the health provider. I think it is about the time it takes, because that took a lot of time, resource and capacity. You have to be committed to that kind of way of working. As I say, the barrier is resources that we come up against as local authorities all the time. I will let other people come in now and I can come back later.

Lord Filkin: Thank you, Rachel. We might come back to some of those points. Mike, from Oldham's experience what have been the barriers to effective commissioning? Have you been able to overcome them and, if so, how?

Mike Barker: Thank you very much for today. I am strategic director of commissioning for Oldham's health and care system, so I hold a senior-level executive post in a local authority and the equivalent senior-level executive post in the clinical commissioning group. I have a single joint accountable officer for the local authority. I am the chief executive of both organisations.

Some of our barriers and obstacles are very much wrapped up in that type of approach. We have broadly managed to be able to pool budgets. I largely look over £500 million-worth of pooled funding across health and social care. We have brought together teams from a commissioning point of view underneath that structure and integrated the decision-making process into a single place where we have elected members of the local authority along with practising GPs of the clinical commissioning group and professional managers, all working together to identify need and understand what needs to happen in communities.

We have overcome certain things that exist. I would not underestimate the cultural and leadership challenge of two very different types of organisations, but we have invested quite heavily in organisational development. We work with people such as the King's Fund and bring in

leaders, whether from the voluntary sector, community sector, faith sector, GPs and social workers, into spaces and have real conversations about what it takes to be effective together to work for the benefit of Oldham as a place and the people of Oldham as individuals and communities.

It all sounds really rosy, but it is not quite that rosy because major challenges come with that. How we allocate the funds and spend them is still an issue. Straightaway, the NHS has a different VAT exemption rule from local authorities, so there is some complexity about how we use some of our cash. However, for the structural bits we have tried to do as much as we can from a development point of view. We are now starting to think about the next stage of that journey. I will stop at that point, because I am sure you are dying to ask a further question, Lord Filkin.

Lord Filkin: That is impressive and very interesting. The issues you have identified are clearly of considerable complexity, but they are fundamentally about ambition and culture, are they not? I have not heard in what you have said anything about what I would describe crudely as national-level public policy that needs to change so that you liberalise such a process. It sounds as if, as ever, in localities or in the NHS we need more heroes or heroines, and they are always in short supply. Let me sharpen that. Is there anything in public policy at national level that ought to change that would make this more commonplace and less exceptional?

Mike Barker: I was particularly fascinated by the earlier session on the difference between procurement and commissioning. There is a need to think about those two things as separate legislative processes. I also think there is something really significant nationally about VAT regulations and rules and the overall regulatory framework that exists for different parts of local systems. The Care Quality Commission, for example, inherently does not treat both local authorities and health services in the same way and in effect causes some major issues about how they are able to work together.

From a procurement point of view, I am very much in a space where the state of leadership and scale of ambition of leadership really does matter. I think you can find ways around most things within the rules, but there has to be an appetite to do it. There is a very big difference between the flat NHS structure and a very hierarchical local government tier that needs to be worked through and understood properly by all parts of that community.

I largely think that working in a devolved system has brought some fairly significant benefits. Greater Manchester is a devolved health and care system. I am more in favour of the new White Paper on health and social care, notwithstanding the Bill is yet to be published, because it is a very permissive paper. There are some very good strong points in it that I hope will come through in the legislation in the way they are written in the White Paper.

Lord Filkin: That is positive. Martin, would you share that? Do not answer that. Focus, if you would, on the exam question: what have you seen as the obstacles, and how have you been able to overcome them?

Martin Wilson: I am the chief operating officer at Newcastle hospitals, but I am also chair of something called Collaborative Newcastle, which is our place-based partnership between the NHS, the council, voluntary and community sector and the universities about how we are trying to improve health, wealth and well-being across the city of Newcastle.

I am very fortunate to find myself working individually in an organisation that is rated as outstanding by the Care Quality Commission, but how could we possibly be proud of that position when people in Newcastle die on average two years earlier than the England average and our healthy life expectancy is five years less?

Our Collaborative Newcastle programme and joint venture is very much because we recognise that healthcare services are not sufficient to deliver health; indeed, they are only 20% of population health. We have to focus as much on homes, jobs and trends if we are to attack our core business, which is improving the health of our local population. For us, the real awakening has been that kind of leadership commitment that it is only by social value and joint working with partners that we will transform it. That has unlocked it. That has been the change in the Newcastle system over the past two to three years.

A lot of it is down to personal leadership. There are a number of technical problems that make our lives harder, such as different funding arrangements and the unfairness you have discussed before, but having that shared common purpose about why we need to work together and the belief that that will make a genuine difference is enabling us to unlock many things.

You asked a very specific question about legislation. While in the White Paper it is very encouraging to see in a permissive sense that we are moving to a sense of collaboration, that is very discretely defined as only for healthcare. Unfortunately, harking back to my previous point, we do not think about just healthcare. I have to focus across the city on health, wealth and well-being. It needs to be health, care and other services if we are going to make that difference.

Lord Filkin: That is fascinating, and it is very hard to disagree with that. In the previous session we talked about how nice it would be to have two Bills. Of course it would be nice to have two, but the Bill we have is a procurement Bill at present, and we may have to wait quite a long time to get a commissioning Bill. How do we make the procurement Bill learn some of the lessons from the health and social care White Paper and think more intelligently about commissioning? Where do you think is the leverage into that? Mike, will you have a go first?

Mike Barker: I find it quite interesting that there is no mention of collaboration in the procurement Bill at all. That is part of the issue. I can

see some really positive things in the procurement Bill as it currently stands. It is slimmed down; it provides a greater level of flexibility than exists currently; it does not always have to be the cheapest, which I think is a big step forward.

However, it is not really encouraging collaboration in the way the health and care proposals are coming out. I still think, though, on the health and care proposals that there has to be some caution. Of course, it removes the Competition and Markets Authority from the health and care landscape. However, it does not say what it is to be replaced by or what procurement aspects will come next. For me, that is still largely one of the unanswered questions of the White Paper. We are certainly looking with interest at what will replace those matters. We are not terribly clear. I still think there will be some kind of provider selection regime. It is just a question of what that looks like going forward. However, the move to collaboration definitely has to be welcomed and should be moved into both Bills.

Lord Filkin: Excellent. Martin and Rachel, do you want to make some very quick points before I pass back to the Chair?

Martin Wilson: I would reinforce the distinction for us between procurement—I think you talked in the previous hearing about crockery—as opposed to people-based services. They are fundamentally different things. We much prefer to talk about not the difference between procurement and commissioning but the difference between procurement and co-production, because I think that the sense of commissioning is an antiquated one. There is much more of an art about co-production.

Lord Filkin: Excellent, thank you. And Rachel?

Rachel Silcock: I have been involved in commissioning for the past 13 years and it has developed as a profession in that time. It is not about procurement so much now; it is about leadership and management of resources across a whole system and how we curate those resources to produce something that is needed by people in the area.

We need much more freedom to be able to do things like invest. During Covid, we were able to invest in things that we knew would work very quickly in collaboration with the voluntary sector to produce results. We need freedom to be able to make investments in things that we know will work in terms of partnerships with the voluntary sector. Procurement is obviously part of it, but we need to move away from that as a central focus and look much more towards how we marshal our resources as a system.

Lord Filkin: Thank you, Rachel, and thank you all three.

Q7 **Baroness Pinnock:** Hello there. Before I ask my question I ought to say that I am a councillor in Kirklees and have been particularly interested in the answers to the questions in this session. Thank you very much.

Lord Filkin has explored one part of the question that I was going to ask

about collaboration. How might the two Bills that are coming—the procurement Bill and health and social care Bill—encourage a social value-focused approach to commissioning? During all our conversations about procurement and commissioning we have been pointed towards the importance of adding in the social value aspect of commissioning and procurement. It would be really helpful for us to understand how best you think that could be achieved. Would Mike from Oldham like to start? It would be good if you could.

Mike Barker: You are not a million miles away from us in Kirklees.

Baroness Pinnock: I am not and I am speaking from home, so if you shout loud enough I can hear you.

Mike Barker: You might do. Perhaps I can tackle the question in a slightly different way. I think there are a lot of permissive things in the Bills as they currently stand. One of the things we recognise—Martin alluded to this—is that you cannot affect economic well-being without impacting health and well-being. Both are connected. One of the things we have been quite proud of achieving in Oldham is that we have used an innovation partnership. I think we were one of the first in the country to do so. That has brought about a significant difference in how we have not just procured but commissioned.

To get to that point we have had to focus on co-production, using an agile start-up methodology to deliver a new service that is fundamentally focused on changing our health and care landscape and economy. We recognise that people who turn up in GP practices often do not do so because they have a sore ankle or a cough and cold; some of them quite often turn up because they are socially isolated and lonely, or they have not had a proper meal in a few days and want some help and signposting as to how they get there. Simply turning them away because they do not have a medical need is not the answer.

We have very much built a new way of working that starts to bring the voluntary community and faith sector into statutory-based service provision to develop what we would describe as things like focused care or social prescribing-type services.

There is a very good benefit in looking at service specifications as part of a procurement process with very strict outcomes and specific financial targets that have to be met, but they are often very prohibitive for small enterprises that are community based and socially focused. Here is how we have focused a contracting mechanism to get that in and working. I do not think that has been easy. A lot of it has been about bravery from local leaders, relationships and bringing people in a system together on a vision to achieve things.

I could go on all afternoon about the concept of an innovation contract, but I will leave it to other partners who I am sure have their versions of that as well.

Baroness Pinnock: Many thanks. I wonder whether Martin from the

NHS could throw a different light or perception on this question.

Martin Wilson: I declare an interest that I was once a civil servant and I am not a big fan of legislation as a consequence. What we are talking about here is trying to change our behaviour as public servants to do the right thing. There are two ways that could help. One of them is recognising that to have the kind of impact we want requires longevity and confidence about funding, but also confidence that you are doing the right thing. The NHS has a tendency to incentivise people to do activity that is going to generate income and do all that stuff, but it has not made the long-term impact that it needs to have. I think that taking a longer view of what drives it will lead to different outcomes.

The second point is the one Rachel alluded to earlier. The idea of what is sometimes called the master-servant relationship, or the purchaser-provider relationship, makes for a relationship in any setting where there is unequal power and supposedly one person has the answer and another person is holding themselves to account. Given the kind of complexity about service provision that we are talking about here, nobody has the answer. What we need to do is create a space where people can sit alongside each other, learn and experiment and have that kind of impact together. If the legislation can create that focus on joint learning, it probably speaks to that idea about innovation that has just been alluded to.

Baroness Pinnock: Rachel, what is your perspective?

Rachel Silcock: The issue with social value is that it is seen as a kind of add-on to procurement. It is like saying, "While you're doing your procurement, don't forget you have to have a bit of social value". It is not about that. The whole purpose of what we are doing is to create social value. Fundamentally, commissioning for social care and care services is about social value.

Building on what my two colleagues have just said, you need to listen to your communities and understand what is important to them. It is important to take that bottom-up approach. We developed a system of health and well-being hubs with our communities. We spent a good year or so listening to communities about their feelings on health and well-being and what they would like to see happen in their communities. We worked with voluntary sector partners to create those hubs.

As Mike said, we did not write a specification, in the sense that we had an outline of one, but it was a very iterative process and we developed it with those partners. We did not start off by going out to competitive procurement, although we did do that eventually. We seed-funded a model, which we called a prototype. It was a bit like piloting. We tried it out, learned from it, changed it and tried it again. It is about being able to do that kind of developmental process. That is how you create social value. I do not think that running a competitive procurement that has some social value aspect to it is really the way to go. I think the focus of

the legislation, if anything, needs to change that completely and almost turn it on its head.

Baroness Pinnock: I wonder if it will. To explore it a bit further, one of the fascinating aspects of the earlier discussions we had on all this during the Covid crisis was that groups were saying that they felt empowered just to put aside some of the restrictions they felt the current guidance and legislation had around them and, in order to deal with the pandemic, they simply did what they felt was the most productive way forward. It was such a fresh and innovative approach. How do you think central government could encourage, even embed, such changes? Would it be through guidance or legislation? What would help?

Rachel Silcock: From what people are saying, listening to earlier speakers, legislation does allow quite a lot of these freedoms, although perhaps during Covid things were able to be done a lot more quickly because we all had to do that. To an extent it contradicts a bit what I said at the start about the need to take a lot of time over these things so that we listen to people. Legislation probably does allow a lot of these freedoms. What we probably need is better guidance. It is about leadership being committed to this way of working, but maybe we just need stronger guidance for local authorities to understand because they are quite often risk averse. We need to understand the reality of the risk.

Are we going to be challenged when we make some of these decisions? If we work really closely with our partners, we probably will not be challenged. They will understand, and we will be transparent about why we are making those decisions and will be doing it collaboratively. It is mainly about guidance on the need to understand the reality of the risks you are taking and how you can use existing legislation to do a lot of this—for example, Mike's innovation partnership and the alliance work that we have been doing. They are both legal frameworks that we have used. The speed with which we did things under Covid was incredible and very transformational. It was an amazing way of working. We all felt we were given permission to do something and we could just get on and do it, which was fantastic. I do wonder why that does not happen in the ordinary way, but normally we do have to take our time in making sure we do a consultation and collaboration. It is a tricky one and I do not necessarily have the answer.

Baroness Pinnock: I think that is the experience we heard about in our earlier discussions. Martin, would you like to reflect on that?

Martin Wilson: During the pandemic we were dealing with new things, which required us to play it differently. Going forward, it will be less about dealing with new things; we will be dealing with the same things but differently. I wonder what the role of regulation would be in that. I cannot imagine a time over the past few years when I have been regulated, or one of my organisations has been, where there has been a focus on what learning and experimentation you have undertaken; it has been much more about what you have done. If it could be about using

your collective energies and focus, the strength of your relationships and where you have done that learning, it would be a powerful driver.

Baroness Pinnock: Mike, would you like to comment?

Mike Barker: To add to that, one of the refreshing things is that, taking the example of the NHS, we changed about 180 pathways of care in the end. There was a real sense of all of us being in it together. That fundamentally removed all the red tape in the elongated process of getting people involved, going to a decision-making process before getting to the consultation process on an option, or series of options, which then has to run through all the machinery of local and central government. That was just removed. It was removed because we were obliged inherently to bring all the right people round the table to have a proper conversation about how to make this work better for you as a consumer of that service. It was transformative, undoubtedly.

We definitely have guidance and legislation that are there for good intent and the right purpose but make the process very elongated and cumbersome to get through. Things can definitely be done to slim that down and remove it. If you take as an example a walk-in centre, when you are trying to split up people up through hot and cold sites, for want of a better phrase, and repurpose it for something different, that involves a service specification, a set of targets, a set of obligations, a set of contracts, an agreement and a negotiation on the finances. All of that got removed quite quickly and easily for the benefit of getting the thing done in the right way, and, funnily enough, it worked.

Q8 **Baroness Pinnock:** That is a really good phrase on which to end. May I come in with a very quick supplementary on this point? I want to pick up something specific that Mike said about working with the voluntary sector. We received a letter from the Government in response to ours, which said that the procurement Bill will not focus on links between local government and charities. In your view, do you think the scope of the Bill needs to be broadened or new legislation introduced that does focus on that local authority commissioning regime with the voluntary sector, although I remember what Martin said about legislation? Mike, could you start on that point?

Mike Barker: I do not think the legislation does need to be broadened, to be fair. I think the biggest issue with the voluntary sector is all to do with the budget-setting rounds. The one benefit of the NHS is that it does tend to look ahead three to five years. It might not often feel that way, but we do try to look at the longer term. My experience of local authorities is that they tend to look at a shorter period.

For me, the big issue is moving away from grant funding. It is quite a divisive way of trying to sustain something. We are a nation that loves pilots. I struggle with the concept of putting something on temporary funding, testing if it works, realising it does work and then figuring out how to keep making it work because the grant has disappeared. I think our challenge with the voluntary sector is to put it on a much more,

longer-term sustainable financial platform where we are not heavily involved in difficult service specifications with very difficult targets and KPIs that will require an organisation with a very significant overhead and infrastructure. There are some more agile ways of trying to put contracts and services together in the voluntary sector, but they have to be done over a longer term. Public services and central government have to be prepared to be invested in some of the risk that comes with that, because inherently some of it will go wrong at some point in time financially, but it should be—[*Inaudible.*—]therefore.

Baroness Tyler of Enfield: Martin?

Martin Wilson: I would echo that and add that there is a tendency from NHS partners to involve the voluntary sector in service provision rather than in design. That is a silly step, because in a big hospital organisation I do not have the reach and knowledge about what local communities need and understand the way the voluntary and community sector acts. Putting them on a sustainable footing would also impact us and help in how we perform.

Q9 Baroness Pitkeathley: I also want to follow up on what our colleagues have been saying about the voluntary sector to our very experienced panel. I particularly want to ask about how you commission local voluntary services to help families who are not yet at the point of having statutory support.

For example, in our child vulnerability inquiry we have heard that lots of families, perhaps where there is domestic violence or addiction, have to get to crisis point before they can get any help, which is often too late. Since both Rachel and Mike have referred to things that work and we know that early intervention works before the crisis is reached, I would like to ask each of you, perhaps starting with Rachel, how you commission and work with the voluntary sector to do that kind of essential preventive work.

Rachel Silcock: I am not a commissioner with children and young people but I do work closely with my colleagues. I did speak to them about this. We have very strong partnerships with the voluntary sector in terms of children, young people and families, in particular some of the key national ones such as Barnardo's, Save the Children, but also local charities.

We very much believe in investing in early help. We are just at the beginning of a 10-year partnership working with the voluntary sector and children's social care to set up a nought to 19 offer based around family hubs. We are regarding this very much as a collaborative approach and we are following the model of an innovation partnership that Mike talked about earlier. We will be working with a key partner or partners to develop the model rather than going out to an immediate competitive procurement. We will make sure that we have families at the heart of it. We are at the beginning of that process and we are very much developing an early help system. This will be a 10-year contract ultimately. That is

something we are putting in place at the moment. If you are interested in anything else in detail I can ask my colleagues to send that information to you.

Baroness Pitkeathley: We most certainly would be. I will move to your colleagues. Mike, perhaps you could talk about what might trigger early intervention. For early intervention what would be the signals you would look for, especially with the voluntary sector?

Mike Barker: I would like to make a number of different points on this. I think that inherently you end up with places where the health service has a conversation on its own, the local authority has a conversation on its own, and the DWP has a conversation on its own, and none of that information and intelligence is generally shared from a strategic and practical planning perspective. That in itself is a problem. There are all kinds of issues about IG, which I do not think really exist; most of the time it is used as an excuse. There is something quite significant about data, intelligence and information sharing.

Secondly, you have to be prepared to get everybody in the room and have a proper discussion about resource and its allocation according to need. To do that you have to build processes that help to understand need and why things are happening.

In Oldham, we have a system board where we bring partners together and have a joined-up conversation using data that we are all party to about what we think is happening in families. There are some very significant flaws in what we are doing at the moment, but we are on that journey. We are looking in particular to find out. Can we figure out alerts that are coming from things like the housing sector that might flag up a similar type of concern from a social care perspective? Can we do some work to join up those two things? It is not perfect, but by bringing together the information into a single space and having a group of people properly engaged in a conversation about families and individuals we will start to get somewhere.

I am also not a children's commissioner. One of the things we are doing, as Rachel described earlier, is bringing our nought to 19 service into a different space, mainly because we think some of the pathways are a little bit fragmented. At times some of the services work inherently in a way that is designed to keep people separate from the issues. I offer no solutions other than the art of conversation, the sharing of the data, planning, bringing the professionals together into a single conversation space, and then empowering those professionals to be able to put solutions in place. However, I think we could do more about escalation routes for things that are starting to go off. Other than that, I have no perspective.

Baroness Pitkeathley: It is a very interesting and wise perspective. I think you are saying in particular that the flaws are there. That you can learn from them is particularly valuable. Martin, can I ask you about the voluntary sector and the early intervention-type service?

Martin Wilson: Early intervention is absolutely key to our collective success. Last week across Newcastle we went live with something called Children and Families Newcastle, which is a collective service designed over the past year with the support of the community and voluntary sector. It engages 500 local partners, including children and young people, about changing our model. In respect of many of the principles referred to by Mike about having many referrals, access points and waiting too late, we knew we needed to change that. It has absolutely galvanised our voluntary and community sector around this model. We have had very strong support for it.

We are in the fortunate position that we already spend about £18 million jointly between the council and CCG in early intervention support, but we see big opportunities for the voluntary and community sector to play a bigger part in the future model of Children and Families Newcastle, in particular doing work on locality leadership, which is key for us, a community family offer, and the introduction of family partners who will support people, be much more responsive to understand their needs and help to be that bridge through to statutory services. We would be delighted to provide more information about that work particularly because of the links to positive mental health.

Baroness Pitkeathley: The committee would be very interested to get that. Can I focus on your word “galvanised”? What is it in particular that has galvanised the local voluntary and community sector apropos what you are doing?

Martin Wilson: I think it is the art of the conversation. It was the sense of collectively coming together, working as equal partners and people being honest about the contribution they could make. Our local authority is fantastic in many things, in particular looking after looked-after children. My children’s hospital is probably fantastic—well, I know it is—at doing acute care, but it is about understanding people in their communities, their assets and how we can respond and understand their services better. It is that sense of using an equal partnership around the table with no power imbalance just because of the badge of the organisation you work for.

Rachel Silcock: I will follow up on the voluntary and community sector and children and young people. Families are much more likely to disclose or talk to some of our voluntary sector partners than they are to the local authority. That is the key, is it not? People will trust and work with the NSPCC, Barnardo’s or whatever much more than they will probably with children’s social care. We have been lucky enough to have had investment from both Barnardo’s and the NSPCC in Plymouth. They are doing a lot of work on sexual abuse and exploitation of children. The extra resource they bring can be spent in a way they see fit rather than necessarily what we might think it should be spent on. It is freedom for them as well. The bringing in of extra resources by the voluntary sector is important, but also the trust of local people.

Baroness Pitkeathley: That is a very important extra point you make.

Thank you, Rachel.

- Q10 The Chair:** You have been talking about your example. Do you think you have models that can be developed in more authorities across more places than where you are? If so, what do you think needs to happen to encourage that? How do you talk about it locally? How do people locally get a sense that they are somewhere where things are being done differently in a way that will enable them to have better well-being, whatever the phrase may be, because I know that in all three areas that is a bit of a struggle? If you look at the local elections, particularly Oldham and Plymouth, that was a bit of an issue.

I am not asking you to be politicians here, but I am saying that if we want this sort of commissioning to grow we have to know what it is you would say to other areas that needs to happen. We have already talked to you about what would happen nationally, but what do you do locally to let people know what you are doing?

Mike Barker: The one thing that definitely needs to be lifted up is the breaking down of organisational boundaries and barriers. The concept of leaving your lanyard or badge at the door when you go into things and not coming at it from an organisational perspective is an extremely powerful thing that we work very hard on in Oldham. There is also something really significant about Greater Manchester as a devolved system. We have a huge infrastructure where we get together frequently and we share across 10, and we act as one when we are 10 at times when we need to. Again, it is not perfect.

If I strip that out to the NHS and local authority, I am not convinced that there is a particularly good sharing mechanism other than things like the LGA for local authorities to spread good practice. It takes an awful lot of effort.

When it comes to the NHS nationally, I have been in it for quite a long time—20 years or thereabouts—and can remember a time when we shared best practice up and down the country in the NHS. We need to try to find ways of using people such as the King's Fund, LGA and other vehicles to share some of that best practice and not be afraid to get together. I also think we need to encourage cultures where organisations are allowed to leave their baggage at the door and work around a common purpose, which in my view is about people, places and communities; I call them families. That is a difficult thing for some people to do, but it should be a competence as much as a recruitment requirement for leadership and management in public services.

The Chair: Lord Filkin and I did try very hard way back to develop means of local authorities and other public services sharing good practice through the Beacon process, but we are not going there today. Rachel?

Rachel Silcock: It is interesting. I was going to say that about Greater Manchester. I am quite jealous, because I think Manchester has made it really clear that its priorities are health. Health is the foundation of the economy and all the rest of it. That is a really clear message.

As for Plymouth—I will say something more positive in a minute—on the not so positive side, sometimes maybe we do not get across to people that we value what is important to them. Sometimes the signals you give people are that you need to get them into a job. It is important for people to get into work, but there are lots of other issues in their lives that are important, and perhaps sometimes we do not get across the message that we are listening to that. Sometimes that is a bit of a problem.

On the positive side, we are trying to change the culture. Mike talked about workforce development in Oldham. We are trying to set up a system of workforce development where we change the culture of the local authority to be much more collaborative with the community in listening to what people say. It is a systems leadership approach and everybody can be a leader. We are not the leaders and they are not all the followers. Everybody can be a leader because everybody has their own experience and expertise. In a way, it sounds a bit cheesy, but we genuinely need to get that way of working across to local people.

In regard to people knowing what we are doing, it is difficult. With the health and well-being hubs that we have developed I think we genuinely got the message out into the communities that we were doing something positive with people and for people. We got a lot of good local press. People talk about the well-being hubs; they are really well known, partly because the voluntary sector organisations we work with feel valued. They are very proud of what they are doing. They talk about it a lot and it gets out into the community.

As to how we share what we do with other local authorities, we have talked a lot about our alliance nationally. There is a lot of publicity about that. We get local authorities contacting us every week about ours, because it was one of the first in the country. I do not know the answer to that, other than just to keep plugging away at it.

Martin Wilson: As to whether we have a specific model that can be taken elsewhere, it is the local learning that builds it rather than trying to replicate from elsewhere. First, if I was asked to describe the USP of Collaborative Newcastle, I would say it is the collective recognition that it is about health, wealth and well-being together, and all the partners can talk that language. Secondly, we put a lot of effort into joint system leadership development.

I think it speaks to Rachel's point. About three or four years ago we created a joint system leadership programme. We brought together participants, who were senior managers or clinicians from primary care, secondary care, physical and mental health services, the local authority and voluntary and community sector—we paid for the places for the voluntary and community sector—so they could learn together and develop relationships. We asked them as part of that leadership development programme to work as quads—as groups of four from four different organisations and settings on a project of their choice with only one ambition, which was to fail as big as possible. We wanted them in the safety of that group to feel that they could change the system. It has had

huge benefits for us in building a much more interconnected place and bringing new ideas that we would not otherwise have known about. That is a very tangible translation point that could be taken elsewhere.

How we get the message out to people about what we are doing is a big challenge. It is not just to local residents; it is also starting with our workforce as well. There will be lots of people in our organisations who are not yet aware of this, and that is a big and important task.

There is work going on through something called Human Learning Systems, which I am sure we would be delighted to provide some information about—Plymouth is certainly involved in it—on social movement and how we can move from this approach of new public management and its focus on metrics, markets and managers into an approach that is much more about personalised services and how we collectively learn together. We are drawing a lot of learning from our other partners in that and I am sure other organisations would say the same.

There is a risk in the NHS move to integration in that we become focused on integration happening only at the level of ICSs. This still needs to reinforce, and it is written in the White Paper, the importance of primacy of place, because it is that level of place, with the combination of political leadership, executive teams and operational teams who are focused on people they live alongside in their neighbourhoods, which drives the change, so I think it is both together.

Mike Barker: I definitely reinforce Martin's point. The ICS is Greater Manchester for us, but we have 10 places—10 local authority unitary boroughs underneath it with system boards. It is at that level and, to be fair, lower in communities and boroughs where the integration needs to start taking place.

A phrase we use quite a bit, increasingly so in Greater Manchester, is: are we after standardisation or are we after standards? I think that is quite significant. Quite often, legislation just gives you a one size fits all that does not actually really fit much. There is something quite significant about characteristics and standards that need to be in place, as opposed to simply standardising everything in a common way. That is where you get to Martin's very critical point that what matters in one local community does not necessarily matter in the local community next to it, never mind in a town 500 miles away. I finish on the point about standards and standardisation. They are not the same thing.

The Chair: That is very interesting. Thank you very much. Do any of my colleagues want a last dig at this? We have extracted a lot from you. This is an issue that will run and run, and we intend to keep an eye on it. I hope you feel that there are things you can write to us about. You have already committed to sending some stuff to us. We will be very grateful for that. We have covered some really interesting ground today.

I want to thank you for your time and commitment, and wish you well for

the future. This is an agenda that somehow we have to get right for people so that we are looking at those with particular needs in our society as people and trying to respond to that. That is what you have all been talking about this afternoon. Thanks very much indeed for coming and spending this time, and I hope we can keep in touch.