



HOUSE OF LORDS

Select Committee on Public Services

Oral evidence: Public services: lessons from coronavirus

Wednesday 3 June 2020

3 pm

[Watch the meeting](#)

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

Evidence Session No. 1

Heard in Public

Questions 1 - 9

Witnesses

I: Nick Davies, Programme Director, Institute for Government; Richard Sloggett, Senior Fellow and Health & Social Care Lead, Policy Exchange; Professor Nick Pearce, Director, Institute for Policy Research, University of Bath.

Examination of witnesses

Nick Davies, Richard Sloggett and Professor Nick Pearce.

Q1 The Chair: Good afternoon, everyone. This is the first public evidence session of this Committee. At the beginning of the year when the Committee was established, nobody thought that we would be taken over, as it were, and that the whole of public services, what they were doing and how they were performing would be dominated by Covid-19. Inevitably, for our first inquiry, we have had to take account of what is happening to our public services during this pandemic. We want to look at what we are learning about our public services during this pandemic, what is working well and what is not working, and then in future inquiries we will be able to look at how we take those lessons forward.

Inevitably, because this is a virtual session, things will be a bit clunky, and I apologise to you all for that, my Committee members too, because it means that for this first session we have allocated questions in a totally arbitrary way. We have had to square it with the broadcasting authorities and they have had to have a list of the questions and so on. For witnesses as well as for Members this is a bit of a weird experience, so we ask you to bear with us through this as we learn and become more expert at using the technology and at sharing our time together.

I thank all the witnesses for coming. We have ended up with a male first session and a female second session, but perhaps that is okay. I want to get going, because inevitably time is a real constraint in these sessions; we cannot run over because of the demands of broadcasting the session.

I am Hilary Armstrong and I am the Chair of the Committee. We have a very good and lively set of questioners. As I say, they are not being given the freedom they normally would be. None the less, I know that they are all capable of going off script and I am anxious that I am constraining their normal activity today.

I am very pleased to welcome Nick Davies, Richard Sloggett and Nick Pearce to our first evidence panel. I will ask you to introduce yourselves and then we will go straight into questions.

Nick Davies: I am a programme director at the Institute for Government.

Richard Sloggett: Good afternoon, everyone. I am a senior fellow in health and social care policy at the think tank Policy Exchange.

Professor Nick Pearce: Good afternoon, everyone. I am a professor of public policy at the University of Bath.

Q2 The Chair: Welcome to you all. May I remind Members that if they have an interest, they should declare it when they first speak? Apart from that, I will go first into the questioning. What have been the main areas of public service success and failure during the Covid-19 outbreak, and how could these lessons help us to shape a future programme for reform?

Professor Nick Pearce: Some of the big successes have been in the volume services provided by HMRC and DWP—the job retention scheme, which is a very innovative policy that has reached over 8 million workers, and the Self-Employment Income Support Scheme. Those have been delivered very effectively by HMRC. DWP handled a huge increase in universal credit claims after the lockdown started, and 90% of those claims have been paid in full and on time. The big digitally based services that had been put in place before the crisis have performed well in reaching large volumes of the British population in the crisis.

Local government has also performed well in very difficult circumstances, having experienced large cuts to its budgets before the crisis. It has been working with the voluntary sector, distributing emergency food supplies, doing its public health work of course and working more broadly with communities. We have seen some successes, including with the rough sleepers programme, which has managed to get rough sleepers into accommodation.

Where the failings have been, as seems quite obvious from the last few months, is in care homes, where we have had a huge number of deaths. We are not unique in that; other countries in Europe—Spain, Sweden and elsewhere—have also seen large numbers of deaths in their care homes. But the failure to have a proper testing infrastructure in place in the community and for care homes, the discharge of patients from hospitals into care homes without testing, the lack of PPE, and familiar divisions between health and social care that go back to 1948 when the NHS was created have played themselves out in this crisis and made the case for reform ever more strongly.

When we look into the lockdown, we will see that the problem we inherited from some of the institutional changes that took place under the health reforms in 2012 and the lack of a robust community health testing and tracing infrastructure are some very obvious failures. I am sure that those will get looked at in any public inquiry, but at the heart of them is the question of the relationship between the NHS, local government and social care.

Richard Sloggett: I very much concur with Nick Pearce on the challenges that you have seen in social care. Policy Exchange has published a series of reports over the last 12 months calling for urgent and very much overdue long-term reform to social care funding. What you have seen play out through the pandemic is 30-plus years of neglect by policymakers to fix this challenge, and unfortunately it has played out in a very negative and in some ways predictable way.

One of the benefits that we may well see now is renewed cross-party calls for that reform. However, in the short-term we have also noticed a real sense of fear and anxiety among the public about the safety of social care services. Our latest polling found there has been a collapse of confidence in people sending relatives to care homes. Some 33% of people are now less likely to send their relatives into a care home as a

result of the coverage of the pandemic, which creates some significant longer-term challenges.

On the NHS side, the narrative about the NHS is very interesting, because broadly the narrative is that it has held up pretty well and the impact has been far worse in social care, which on the surface is definitely true, but some pretty fundamental challenges have been stored up for the NHS over the coming months and years ahead. We have deferred a set of care that was due to be delivered but will now have to be delivered at some later point, arguably at increased cost and in a system that is under increased strain.

I have mapped out the different health needs of the country on the back of the pandemic, and you can see five categories of healthcare need emerging. The first is Covid-19 patients themselves. The second is patients with long-term conditions who had conditions before the pandemic. The third is patients who were due to have an operation and have had that operation deferred. The fourth is patients who have had care missed, so they may have had a cancer not diagnosed. The fifth is something that I think will be with us for a long time, which is the wider societal and health impacts of this pandemic, whether that be through unemployment, bereavement, or other things. The care home and social care impacts are most acute and with us right now, but we have a big build-up in our healthcare system that will need some very creative and innovative solutions to address it, for many years to come.

Nick Davies: I agree broadly with what both the other panellists have said. To pick up a couple of successes, first, services that are used to responding to crises, particularly hospitals, the police and prisons, have been able quite successfully to use existing centralised command structures to manage the first wave. Whether that is NHS England instructing trusts for example to prioritise good care capacity, clear space, or stand down community services, et cetera, or the existing gold command structures in the police and prisons, those have generally worked pretty well.

More generally, front-line staff have shown a huge willingness to work differently and to respond quickly, be that through repurposing hospital wards, building whole new hospitals to substantially increase ICU capacity, or local authorities redeploying staff between services to meet critical needs from youth justice or early years teams to child protection and children's homes, for example.

On the question of the failures, we have seen the impact of a long-term underinvestment in buildings and equipment in particular. I will pick out a few services. In prisons, the state of toilets, showers, telephones and video equipment is incredibly poor and has made it much harder to isolate prisoners and maintain social distancing. In courts, although there has been a digital reform programme, it has been slower than expected, and, in general, the court estate is in very bad repair, with inadequate toilet and handwashing facilities. Even in hospitals it is clearly harder to re-organise and use older decrepit hospitals than it is newer ones.

Secondly, in some cases we have seen an overly centralised response, which has excluded local expertise and ingenuity, whether that is PPE, testing and tracing or the free school meal vouchers that were set up through a national system.

Finally, strategically, the decision to focus on ensuring that the NHS, particularly hospitals, were not overwhelmed has come at the expense of a consideration of excess deaths more generally. We have also seen, as is historically the case and as Richard noted, a focus on hospitals at the expense of other parts of the wider health and social care system. Social carers have not had the same access to PPE or testing, for example.

The Chair: Thank you very much. You have given us a good basis to move on. Not all of you may want to answer every question and Members may want to direct questions, but we will see. May I ask Lord Bichard to ask the next question?

Q3 **Lord Bichard:** Have public attitudes to public services, and public expectations of public services, changed? If so, in what way? Will that have an impact on any longer-term proposals for reform of public services?

Professor Nick Pearce: One of the interesting things about this crisis is that, because it is a public health crisis that potentially impacts everybody, although it has in fact impacted very differentially across our society there has been a normative universalism at work whereby everybody is treated as having health needs or requiring public health protection.

That has meant that in the discourse about rough sleepers, for example, we have been able to move very rapidly to get rough sleepers housed, because they have been treated as human beings with health needs first. Ditto with the social security system. Because the crisis has hit everybody and has affected so many people's jobs and incomes, the discourse about strivers and skivers is very hard to maintain in these circumstances.

It is a matter of wanting to provide support where it is required. Ditto with migrants and others, too—people who are undocumented or otherwise at risk because they do not have status. Again, there has been more of a move towards ensuring that they are protected.

There has been an interesting shift in public attitudes by virtue of the nature of the crisis. That distinguishes it from some previous crises. AIDS in the 1980s, for example, reinforced discrimination rather than overcame it. The question is whether any of these things will be maintained as we go into the next phase of recovery and what it means for wider attitudes. A lack of trust in public health messaging, a sense that you cannot use services, or that services are worse because of this backlog that has been talked about, may be a problem.

Those sorts of phenomena come into play, and as we reach the autumn we will see the needs of young people in particular come to the fore. When you get school leavers entering a labour market with fewer jobs,

graduates leaving universities, children who have not had a full education, and so on, I think there will be a shift towards thinking about how we ensure that public services meet all those kinds of needs, and we may get a change in public attitudes.

Most people would say that the value we place on health and social care in particular has been enhanced by this crisis, and that we have placed a new premium on the labour of the workers in those services and in other essential public services in the private sector and low-wage sectors. What is important coming out of this crisis is how that affects our attitudes to low pay and low skill and the importance of better wages, and terms and conditions, particularly in social care.

Nick Davies: May I make two points: one on public attitudes to how much we spend on public services, and the other on how we access them?

First, on spending, ultimately there is a trade-off between the amount we spend and the quality of service we receive. There are limits to the efficiencies that can be achieved, particularly in relational services dealing with complex needs, where staff account for the vast majority of the costs. Public opinion has been shifting for some time towards greater willingness to pay more tax to improve public services, particularly the NHS. That trend is likely to continue, although it may depend, for example, on how deep an upcoming recession is, if there is one, and what impact that has on disposable income.

Clearly, reforms are always easier if there is more money to spend, and in some cases, it is a prerequisite. A couple of weeks ago it was reported that the Government were 90% of the way towards agreeing reform of social care before the crisis hit; they just had to work out the funding. How you pay for social care reform, be that improving the quality of care, providing free personal care or capping costs so that people do not lose their homes, has always been the hardest bit.

Clearly, there will be people remotely accessing services, in particular GP appointments, who did not before and who will find that it is more convenient to their life. Whether it is the telephone in particular, or video, GPs surgeries have generally been a bit slow to use that technology, but there has been growth over time. Similarly, although less widespread, some parents may have appreciated the remote lessons their children have received. We have also heard of some children's social workers who have found that it has been quite easy to talk to older teenagers via video-calling facilities to check in on them. I think there will be a greater demand for that type of remote access in future as well.

Richard Sloggett: On digital access, which I think has been a real success in health and social care, there is a real need to evaluate the impact of that from an equalities perspective, because it will definitely be very positive for certain groups who are more technologically enabled and have the ability to do that, but for particular groups, and for people with particular health conditions, it may be more difficult.

In our latest research we have called for a proper evaluation of the digital health impacts of the pandemic, where positive lessons can be learned to lock in the right benefits so that we can try to maintain that equity of access. Nick Davies is absolutely right about access. From a healthcare perspective, we will have real challenges in the capacity of the system with this backlog, and the ability of the system to work at a lower capacity. How we prioritise and manage that access for the public will be very difficult. Some difficult messages will have to be communicated to the public about waiting lists and access to services, and that prioritisation exercise is very difficult.

Q4 Lord Bourne of Aberystwyth: Thank you to the witnesses for their contributions. We have perhaps touched on this a little with some of the comments on digital, but to what extent have we seen innovation and new ways of working that we can keep hold of in the delivery of public services as a result of coronavirus? Could you give some examples of where you have seen it working very well?

Richard Sloggett: In the health and social care space some quite clear and direct patient engagement tools have been rolled out, whether that is the expansion of 111 or the move to GP appointments and outpatient appointments on line, and an obvious and quite rapid transformation of the way public services are delivered to those on the front line. That has been a good example of service innovation, from a technological perspective.

The Government are also trying to move forward on their own devices and technology. On the healthcare side, there are the plans for a contact tracing app to be rolled out as part of the test and trace programme to respond to the pandemic.

One thing that has been very interesting from a health and care perspective—again, it has come out of necessity—is the public-private connectivity and partnership that we have seen to ensure that we maintain standards of care for as many patients as possible. There are some really good examples of cancer care, for example, from Plymouth and Southampton, where the private sector has come in to provide additional capacity to ensure that cancer patients are able to continue to access services. That collaboration not only within the public sector but between the public and private sector has been really positive, and it has been going on at a local and regional level to ensure that population health needs are maintained. There is a technological angle, and that public-private connectivity, which has broadly been very helpful.

Professor Nick Pearce: I echo some of that. There has been data sharing and collaboration between local authorities and others on the data they have and on what has happened during the crisis. We have seen this digital innovation in court services and other organisations. However, for some of that, in particular in the ramping up of testing capability, the Government have just moved back to a more familiar model of public service delivery of recent years, which is to contract with the big providers—Serco, Deloitte, G4S and others.

That model of public sector delivery, where you have these very large companies that do not specialise in any particular area of public service delivery but none the less specialise in government contracts servicing the state across a range of services, has returned. Of course, it was under a lot of pressure with local authority insourcing before the crisis, with the collapse of Carillion and others.

We will need to think about how far we want to ensure that we have resilience in our infrastructures, particularly in health and other public services, which does not rely on volume contracts with large public sector providers from the private sector in that way so that we can build up capabilities within local authorities, the NHS and elsewhere to be able to meet a pandemic of this kind in the future. That is a very big and important question.

For me, some of the interesting innovations come at local government level in relationship to local communities. This has been a crisis where communities have had to change their behaviour and do things differently, but where they have also stepped up to provide services to those around them. Mutual aid groups have flourished. There is a lot of civic commitment on display. Local government has done very well to connect into those forms of voluntary and mutual commitment, to connect into the voluntary and community sector in local areas, and to create hubs for doing that and to create networks for the dispersal of emergency food supplies and other forms of support.

The connection between local authorities and the voluntary and community sector at that local level for services for the vulnerable, for the disadvantaged, for community collective endeavour has been very impressive, and I hope it will lead to a longer-term recalibration of the role of those service sectors in relationship to local government.

Nick Davies: I would like to pick up on that procurement point in particular, because it is a really important one. We need to recognise that the Government have found themselves in a difficult position in some cases. They have needed to move very quickly in uncertain circumstances. There is a trade-off in how you do the procurement processes. At a national level, call-off contracts from existing frameworks were used to deliver those services, but often those frameworks were not very appropriate, either because of the size of the contracts that had been expected from those frameworks or because of the types of service expected to be delivered.

The national free school meal voucher scheme, for example, which is costing the best part of a quarter of a billion pounds, is from a framework for employment benefits that happened to have a childcare voucher element to it, and the value of the contract is 20 times the turnover of the organisation now delivering it. In one way, that is better, because there had at least been some scrutiny through procurement to get on to the framework.

That may be preferable to doing a short-term emergency non-competitive procedure now, but clearly there are problems, and in many cases it might have been better, as Nick was suggesting, to give more responsibility, if there was more capability and capacity, at a local level to make those decisions. In Scotland, Wales and Northern Ireland, for example, there has been a much greater role for local authorities in decisions on free school meals, and they have also had the ability to provide cash to families rather than doing it through voucher schemes.

The Chair: We will keep with the Welsh members of the Committee. Lord Davies.

Q5 **Lord Davies of Gower:** It is a very trying time for organisations. My question is: how well have public services been able to co-operate in order to respond to people's needs during the Covid-19 outbreak? I realise that you may have addressed some of this in the previous answer, but specifically can you give any examples of where co-operation has been successful and, perhaps, examples of where it has been less successful?

Nick Davies: In general, local resilience forums have worked quite well in a lot of areas. In some cases, planning for a no-deal Brexit has helped because local resilience forums, which in some cases had not done much for a few years, were reactivated for no-deal planning and preparing for disorder and food supply shocks, so some of those relationships were fresher than they might otherwise have been.

However, the legislation setting up local resilience forums was written before academy trusts or police and crime commissioners existed, so they are not explicitly named as members to be involved in discussions, and while some local resilience forums have involved them, not all of them have.

As I said earlier, I do not think central government has worked as well as it should have done with local authorities, consulting them late or sometimes not at all, treating them as an afterthought rather than a critical partner, or, in many cases, as the part of government that might be best placed to lead the response.

Richard Sloggett: I would very much agree with that. There has been a really interesting tension in a fast-moving situation about what you recentralise and what you decentralise, and where accountability and delivery sits. This pandemic has exposed the real challenges when you are moving at national level, at pace, trying to engage effectively locally while maintaining the levels of accountability. There are some really important lessons to learn from this.

The Lansley reforms that were mentioned by Nick Pearce earlier have had a significant impact on the response. The Government were planning to bring forward healthcare legislation later this year, although of course that may well be delayed, and I think one of the learnings from this is that that legislation needs to tidy up some of the ways of working. The

collaboration we have seen is a journey in healthcare towards integrated care systems at a regional level, to do commissioning at scale rather than on a more localised basis.

That model feels like it has had some momentum on the back of the pandemic through the partnerships we have seen, but that creates an accountability challenge in that entities at a regional level are not on the statute book. With the Lansley reforms being in statute and some of the response being outside the normal ways of working, we have found that there is a challenge to do with accountability, and we have found out how you get the funding flows and delivery and reporting mechanisms right. Health and social care has been very difficult as a result of the situation we found ourselves in.

Professor Nick Pearce: The point I made earlier about the relationship between local government and the voluntary and community sector has been really important. People touched earlier on what the NHS was able to do to ensure that it got the capabilities and capacities in place. There was a lot of collaboration within the NHS, even if some of the collaboration with local government, as we have just discussed, was not as strong.

One of the interesting issues for researchers in the coming months will be to look at some of the outcomes from the pandemic in excess deaths, or other measures of public service performance, and see where co-operation between health and social care was strong and whether that had an independent effect on those kinds of outcomes.

In Scotland, where there has been a longer-term tradition of a funding settlement for health and social care and more integration, there has been a much higher number of deaths proportionately in its care homes than in England and Wales. The research will have to tease that out very carefully.

Q6 Lord Filkin: I have a question about public services and digital skills and systems. Did the public sector have appropriate skills and systems? What are the lessons from this for the future?

Richard Sloggett: On skills, we have touched already on the expertise in the public sector—I will come at this from a national perspective—expertise in-house and what can be brought in on a short-term basis. We have seen quite a lot of bringing in of outside skills and expertise from large companies to support the direct pandemic response. There are companies supporting the development of the contact tracing app, for example, and companies involved in the creation of an NHS data store, which is designed to collect the data on how the NHS is performing and its capacity in order to plan more effectively. That has not been done in the past. There has been a willingness to bring outside contractors and support into the system on a short-term basis.

On a longer term, more sustainable basis, there is a real gap in the expertise and ability of the public sector on digital. The Government

Digital Service is an excellent example of how to do that correctly. All public bodies need to look strongly at the training and education they are offering and the skills and expertise they need. The pandemic, as was said, has given a real acceleration to the use of digital to provide services, and that needs to be reflected in the way people are recruited and trained into different public sector and government agencies.

Professor Nick Pearce: Going back to one of my earlier answers, the services that had moved to digital by default some years ago—the DWP, HMRC and others—were much better placed to provide the kind of volume services that were required to deal with applications. We might think about what would have been the case if people had been queuing outside job centres, unable to access their support online.

That has been an obvious factor in the crisis. Local government, certainly the leading edge of local government, has also had a lot more investment in digital capabilities, data collection, the use of data, and the understanding of data, but perhaps not as much as we would want in the use of digital platforms for engaging with communities, in digital democratic systems, and in systems where people can register their concerns, voices, issues, where they can deliberate online.

We have seen a lot of innovation in that across the rest of Europe, with participatory budgeting and these sorts of things. That has been slower to take off in the UK and is happening now more. I think the crisis has also given that a shove, because local authorities have had to find new ways of engaging with their local communities, so the infrastructures that need to be put in place to make that happen have started to come on stream more.

Nick Davies: There have been some good examples, but in general there has been underinvestment in digital technology. Going through a few services, there has been a big expansion in the use of remote consultation in GP services, but the vast majority of that has been via telephone rather than video. Clearly, we have had telephone technology for some time, and we probably should have been using it a bit more already.

Virtually no prisons have in-cell video facilities. Indeed, there may be only a single video feed to court in an entire prison. In criminal courts, there has been a big digitisation programme in recent years, but wi-fi can be patchy, file sharing does not always work, and video facilities are limited, although it is also worth noting that there are legitimate concerns about the openness and fairness of remote trials. We would certainly urge caution about rapidly expanding video technology in courts.

In schools, there was not a huge amount of remote learning equipment at the beginning of the crisis. ICT expenditure has fallen in recent years in schools, for example. In adult social care there has been a lack of investment in remote working equipment and technology, both in care homes and home care. That is less about the ethos and more because doing so requires investing time, effort and money, which is very difficult

to do when you are operating on the razor-thin margins that most adult social care providers are.

Lord Hogan-Howe: I will adapt this supplementary question a bit, because some of the issues have been addressed a little earlier.

You have named four or five really good examples of the advances that have been made in the use of technology. The broad question is: how do we prevent backsliding where things that appear to have worked ought to carry on? Taking one example, the medical profession and the use of video assessments, the other half of that is how you ensure that organisations such as the Prison Service make better-enabled use of the internet, with all the risk that carries. I have been a critic in the past of the amount of communication within and without prisons, but it provides a great opportunity, including to record what is communicated.

There are two sides to the question: how we ensure that we capitalise on developments, and how we enable organisations such as the Prison Service to make better use of it.

Professor Nick Pearce: If we have to maintain social distancing for some time, and there is no rapid development of a vaccine or treatments that make that less necessary, clearly we will have to adapt services to use new technologies on a much more consistent mainstream basis. For many services, that will be less difficult for those working from home. That kind of shift will be consolidated more readily than perhaps other areas, although of course there are services where staff need to get in front of people—children's services, social services—and it is important in that regard.

Whether we embed those changes in the Prison Service and so on in the future will depend in large part on the wider government response to the crisis, what the Chancellor chooses to do after the immediate crisis response, and what his Autumn Budget lays out for public services. There does not appear to be the same sort of appetite for an austerity response to this crisis as there was in the great financial crisis, but there will still be significant pressures on public spending.

Whether some of these issues about technology, digital skills and investment in services can be maintained will depend on whether those investments come through the spending review to the different departments and into different services. The capital budget, how it is spent, and the staffing needs required to use new technologies to maintain and consolidate some of the changes will be very important, and as we shift into the autumn those questions will come to the fore.

Richard Sloggett: I completely agree with all that. I wanted to add quickly that you definitely get lock-in from the lockdown by evaluation. You have to undertake some kind of evaluation of the services that have changed, build the evidence and lock that change, which leads into exactly what Nick Pearce has said—conversations about how you resource that and structure it and fund it moving forward.

The other thing about technology is procurement and having flexibility in your procurement structures, often with longer-term contracts. Trying to use different contracting models that are more about outcomes or that are outcome-led is always a challenge and should also be considered.

In the short term, evaluation of what has worked and what has not is definitely a good way to start to move from lockdown to lock-in.

Lord Hunt of Kings Heath: May I follow up on this whole question of technological innovation? You have given a number of examples at central and local government level—the DWP, HMRC and the health service and social care—where you have seen some great examples of innovation.

I want to pose two questions. In some of the sectors where it has been much more difficult, there has been a lack of investment. How can that be overcome, given the financial pressures in the future? Secondly, are there any examples of where this innovation has been used to help the integration of services—in other words, services have not just operated in silos but have used technology as a way of integrating their effort?

Nick Davies: On how the lack of investment can be overcome, I think it is worth noting that we have not just spent less on capital than we might have wanted to; we have also spent less than was planned. For example, most departments have significantly underspent their capital budgets since 2015, for a variety of reasons. In some cases, notably in the justice sector, that is because the MoJ was allowed to move money from its capital budget to its resource budget to help meet day-to-day spending pressures.

Partly it is about ensuring that there is a suitable funding envelope for the whole service. Clearly, there will be other pressures on those services. Particularly in justice, the fact that the Government have committed to 20,000 additional police officers will have downstream implications for demand in the criminal courts and prisons, and will require fairly substantial spending in prisons if we are to house additional prisoners safely while allowing them to undertake rehabilitative activity.

On integration, I would add that we are talking quite a lot about what central government can do. It is also worth noting that a lot of the most interesting innovations will be happening at the local level. There will be positive deviants who are acting well within difficult constraints. Learning communities have already been established by front-line professionals. There is a role for us all in listening to those and trying to understand the barriers they are facing to greater implementation of those technologies.

The Chair: That is very interesting. Do either of the other witnesses have anything to say on this?

Richard Sloggett: I want to come in from a health and social care perspective. We need to look again at the NHS budget versus the other contingent budgets. The learning from the 2015 spending review and the

NHS long-term plan settlement is that there has probably been too much focus on the NHS budget as a ring-fenced budget, with the contingent budgets of public health, social care, capital and staff not necessarily moving in the same direction. You need to look at those budgets as a working set rather than as a set of islands and a set of silos, given the different ways in which they connect.

The other thing on technology is that a lot of what has been done at pace has been done at cost. It has been delivered on very short-term at-cost levels that will not be sustainable for the suppliers in the long term. The big question is how you then move off that model into a more sustainable long-term set of contracts and lock some of this technology in.

Professor Nick Pearce: I would add one thing that we have not really discussed yet: the biopolitics of the Covid pandemic. As individuals, we will have more data collected on us. We will have to submit data via apps or other mechanisms. When we go to airports, the security procedures will be different depending on whether we get immunity certificates, and all this sort of stuff.

There is a whole landscape of what data is collected by public services on individuals, how that data is shared, how it relates to private sector data collection, and the big tech companies and others who are supplying the technologies that make these things possible. You see that around the world, particularly in Asia, but it is a debate that is about to kick off much more in the UK as we come into the recovery period in the next year to 18 months. The protocols for data collection, privacy questions, how data is shared across public services, and the role of public versus private in the supply of those services will be very important questions that will come increasingly to the fore.

Q7 Baroness Pinnock: I declare my interest as a serving councillor on Kirklees Council in West Yorkshire. Thinking about the years preceding this crisis, did the pressures that arose on the workforce, resources and capacity affect the ability of public services to respond effectively to the crisis?

Nick Davies: Yes, definitely. I do not think there is any doubt that public services would have been able to respond more effectively if they had had more funding over the past decade. I would pick out three points.

First, they would have been performing better as the crisis hit. Whether we are talking about hospitals meeting waiting-time targets for A&E or elective procedures, the ability of people to get a GP appointment, access to publicly funded social care, the number of police charges, or violence and self-harm rates in prisons, there has been a decline in performance in a lot of key public services.

Secondly, services would have had more staff, which would give them greater ability to deploy them flexibly. That will be particularly important as we start to ease the lockdown. In schools or prisons, for example, where they have been able to operate on more of a skeleton staff in

lockdown conditions, clearly it is harder to do that once we unlock, so they need more staff.

Thirdly, as I have said previously, the public sector estate would be in much better condition, which would have allowed us to respond more effectively.

Professor Nick Pearce: I agree with that. In the study of so-called critical junctures of crises like this, the antecedent conditions are as important as what happens in the crisis, as is what politicians and other actors make of the opportunities for reform arising out of the crisis. The fact that we had 10 years of public sector cuts before the crisis, which fell particularly on local authorities, undoubtedly impacted on our preparedness to meet the pandemic. That is clear in particular areas, such as testing capability, the centralisation of those in Public Health England, the closure of public health laboratories that we used to have many years ago, and so on.

That has had to be radically confronted during the last few weeks. In care services, something like a third of care staff in England and Wales turn over each year. There is a huge volume of turnover in the social care workforce, and of course it is a very low-paid sector that has relied heavily on migrants, people coming from the European Union. Those pressures on budgets in local government and other services, the pressure on staff, whether it is numbers as Nick says, their turnover or wages, undoubtedly affected our ability to respond to a crisis that has hit those services in particular very hard.

One of the issues for us going forward is how this crisis is defined. Is it defined as a crisis that has impacted on our public services and shown us that we need to invest more in certain services and their staff and to change the wage structure in these kinds of services, or is it deemed to be simply a failure of scientific advice or political decisions and so on? As we know from the great financial crisis, how you define a crisis in many ways affects how you respond to it. Committees such as yours, which will publish reports on the crisis, will help us to frame many of the reforms that we will need to undertake.

Q8 Baroness Pitkeathley: Richard, you might want to come in first on this question, because I want to ask about prevention, particularly perhaps in the field of public health. Some might say that preventive services have been very much curtailed in recent years because of austerity and cuts to the budgets of local authorities and the voluntary sector. Clearly, they have not been a priority during the crisis, because we are focusing on crisis services. Looking to the future, what role should prevention play in any reform of public services?

Richard Sloggett: It is an excellent question, and it is about one of the long-term structural changes and shifts that we really need to see. In the midst of this crisis, we are talking about short-term fixes, but in the long term we have to try to move away from a system that pays to deliver certain things in a certain way to preventing them in the first place. In

the healthcare space, the NHS plan seeks to move money from secondary care and hospitals into primary care, but the crisis, as Nick Davies and others have said, has seen hospitals prioritised over those GP and primary care appointments. Long term, we have to try to look at public services delivering preventive interventions that prevent downstream extreme costs rather than just tariff and activity-based services, letting people get into more and more difficulty.

Structurally, how you do that is very difficult. It is about how you pay for something that might never happen and how you measure that. It is about what that model looks like. It is not one that many services are particularly comfortable with. There have been some good examples of high-level programmes that make that invest-to-save case.

We need to put prevention front and centre of a longer-term trajectory in our health and social care services. It seems from media reports that the Prime Minister may be prepared to take action on obesity as a result of his own experience of the crisis and the wider seriousness of that particular public health issue. That would be immensely welcome. There is a prevention Green Paper, published by the last Government right at the end of their tenure, that is sitting awaiting a response. In there are a lot of very good ideas for how you can start to make this shift from a healthcare service that treats at the point of need to one that is more preventive and early led. Ultimately, it will come back to resources and taking a longer-term view rather than a short-term one. It is exactly where we need to be.

My final comment on this is that the Public Health England report yesterday is further evidence of the need for real action here. The inequalities in healthcare that are seen through this crisis require a very different model of response, and prevention needs to be at the heart of that.

Nick Davies: I agree with everything Richard said. I also think that we need to be up front about the fact that while early intervention or preventive services are likely to lead to a better experience for those using services and probably better long-term outcomes, in the short term at least it is unlikely to deliver cashable savings. It may well do in the longer term, but we need to be up front about the fact that it is not going to save money immediately. To do that you need to reduce demand sufficiently so that you can sustainably reduce the number of people employed by public services. That is difficult to do, because there is usually a substantial amount of unmet demand.

So I absolutely agree, but we need to go into it with our eyes open about what we are likely to get out of it.

Professor Nick Pearce: I declare an interest as chair of trustees of the Early Intervention Foundation. There is voluminous and incredibly powerful evidence on the importance of early intervention. I am sure this Committee is aware of it. As Nick says, the key issue is how in spending review processes you can unlock resources to go into early intervention

and prevention, which again will be a big challenge for the Chancellor in the forthcoming spending review, where a lot of effort and thought have to be focused.

I would add one other point, which we have not discussed much, about the urban environment. There are changes all around us now in the use of our cities, in particular the movement away from cars towards walking and cycling, with the restrictions on public transport. We need to give a lot more thought to the upstream issues of urban planning and the built environment and what they mean for public health, climate change preparedness and for our resilience to future pandemics.

Those kinds of questions are not straightforwardly resource questions or about investing in services. They are about the decisions we take and the interests we prioritise in planning how we think about the urban environment, and so on.

Q9 **Baroness Tyler of Enfield:** I start by declaring an interest. I am a board member on Social Work England and recently stepped down as chair of the Making Every Adult Matter coalition of charities.

My question pulls together a number of threads that we have already touched on. In the pandemic, we have seen a rapid expansion in the role of central government, the central state if you like, but in recent years there has also been a growing interest in what you might call place-based approaches to public service delivery that are much more rooted in their communities. How far should any future public service reform programme take account of both these developments, and can tensions be reconciled?

Professor Nick Pearce: It is certainly true that since 2010 there has been less of a focus on the central state, with delivery targets and performance management indicators. The work that Lord Bichard and others did on Total Place prefigured that. In academic study, there has been a lot more focus on systems and local collaborations and how they produce outcomes, and a move away from some of the new public management processes that were taken in the past.

There were definitely trends here that were accentuating the shift towards more place-based policy-making and the integration of public services at a local level. Some of that has obviously stalled in recent years. We have seen less of the devolution agenda in the last few years than we have perhaps preceding those years, where we had the creation of new combined authorities and so on. Of course, in this crisis the NHS has been at the forefront and it is still a very centralised command-and-control system, as we have heard in this discussion. Those tensions will not go away. Whether we will learn from this crisis the importance of local collaboration and investment in local government and its relationship with the NHS on things like social care will be one of the key determinants as to whether we can move forward.

One point I would make in closing, in particular on social care, is that it is not for the want of Green Papers and White Papers. We have 20 or 30 of

those. It is not for the want of policy wonks working on the question. It is a political economy question. If you want to invest in social care, there are questions about who pays for it and what taxes they pay, and the way those get crystallised in decision-making is what has held up reform of social care.

There are veto players in this; there are particular electoral coalitions that have defeated reform attempts in the past. We have to give attention not just to how public services relate to each other, the structure of services and so on, but to how they are paid for and the politics of reform, as much as the architecture of it.

Richard Sloggett: All I would add to that is the idea of balance. It is really important that in responding to the crisis where things have been taken up to a national and central level that they are re-devolved when the crisis has passed. There is a real role in population health for place-based solutions. Primary care networks, for example, are groups of 30,000 to 50,000 people led by GPs but with other professionals—physios, nurses and others—playing a major role, and that kind of model must be here to stay for a while. In a crisis and moving things centrally, we should not lose sight of the importance of place in the future of public service commissioning.

Nick Davies: It is first worth noting that the number of civil servants has been growing every quarter since the EU referendum. While many of the largest increases in staff have been in departments affected by Brexit, there have also been some big public service-related increases, whether that is the DfE taking on staff to manage the increased number of academies or the MoJ hiring lots of extra prison officers, although not as many as they had fired in the years previously. That has not been matched at local level, where there has been a massive reduction in the spending power of local authorities over the last decade.

As others have said, any future programme of public service reform needs to recognise the interdependences between different services and the limited returns from funding national services, while at the same time impoverishing more local services, and recognising that many of the wicked issues facing government require seamlessly knitting together or co-ordinating the support provided by different arms of the state.

That is inevitably much easier to do locally by taking a place-based approach in response to local need. That is why, as Richard said, we should not be overcentralising. In many cases, central government policy teams would be better off trying to identify the best practice in local government and the barriers that prevent them doing more and seeking to remove those, rather than developing and directing reforms from Whitehall.

The Chair: I want to say thank you to all three of you. You have given us a lot to think about and I am sure it will be helpful. We will also be drawing on your ideas as we are going through. Thank you very much indeed.