HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Integrated care: organisations, partnerships and systems, HC 650

Tuesday 27 February 2018

Ordered by the House of Commons to be published on 27 February 2018.

Watch the meeting

Members present: Dr Sarah Wollaston (Chair); Mr Ben Bradshaw; Dr Lisa Cameron; Rosie Cooper; Diana Johnson; Johnny Mercer; Andrew Selous; Martin Vickers; and Dr Paul Williams.

Questions 1 - 156

Witnesses

I: Dr Colin Hutchinson, Chair, Doctors for the NHS; Dr Tony O'Sullivan, Co-Chair, Keep Our NHS Public; Professor Allyson Pollock, Professor of Public Health and Director of the Institute of Health and Society, Newcastle University; and Dr Graham Winyard CBE, Former Chief Medical Officer for NHS in England.

II: Lara Carmona, Assistant Director of Policy, Public Affairs UK and International, Royal College of Nursing; Dr Chaand Nagpaul, Chair, British Medical Association; and Helga Pile, Deputy Head of Health, UNISON.

III: Imelda Redmond, National Director, Healthwatch England; Dr Charlotte Augst, Partnerships Director, The Richmond Group; Don Redding, Director of Policy, National Voices; and Kate Duxbury, Research Director, Ipsos MORI.

Written evidence from witnesses:

- Dr Colin Hutchinson
- Dr Tony O'Sullivan
- Professor Allyson Pollock
- Dr Graham Winyard
- Lara Carmona
- Dr Chaand Nagpaul
- Helga Pile
- Imelda Redmond
- Dr Charlotte Augst

- Don Redding
- Kate Duxbury

Examination of witnesses

Witnesses: Dr Colin Hutchinson, Dr Tony O'Sullivan, Professor Allyson Pollock and Dr Graham Winyard.

Q1 **Chair:** Good afternoon and welcome to our first hearing here in Westminster on accountable care organisations, integrated systems and partnerships. For the benefit of those following from outside the room, it would be helpful if you could introduce yourselves and who you are representing, but just before we start I would like to make an opening statement, if that is all right, because the Committee is aware that there are judicial review proceedings under way concerning the proposed accountable care organisation contract model. It might be helpful for me to clarify that the purpose of this hearing is not to explore the legality of that model. For those who are wondering why we are not asking questions about that, it is because that is, rightly, going to be an issue for the courts to decide. We are going to be discussing in these hearings the desirability in policy terms, and particularly how that relates to people using services, of accountable care organisations, integrated partnerships and systems as a means of delivering care. We look forward to hearing all of your views on those models.

The other thing I would do for those following from outside is to cut through some of the acronym spaghetti that we have here. There has been recently a renaming of accountable care partnerships and accountable care systems to integrated care partnerships and integrated care systems, but the accountable care organisation model has been left with its current wording because that has been the phrasing of the consultation. Obviously, all these systems, partnerships and organisations are things that we are going to be exploring, but we are also very conscious that witnesses may use the terms interchangeably. So, rather than tripping people up and correcting them, we will use the appropriate terminology as we go along when we are making the recording. I hope that has explained it.

Could we start with you, Graham Winyard, explaining who you are and who you are representing here today?

Dr Winyard: I am representing myself, although I am one of the claimants in the judicial review. I worked in the NHS in the Department of Health for my entire professional career, and that included six years as the medical director of the NHS in England in the 1990s.

Dr Hutchinson: I am Colin Hutchinson. I am also one of the claimants in the judicial review, together with Graham, but I am here representing, and am chair of, Doctors for the NHS, which is an association that originated as the NHS Consultants Association in 1976 to bring together senior doctors who believe that the public service ethos and aspiration to the highest standards of clinical care are far stronger foundations for a national health service than commercial profit. It changed its name to Doctors for the NHS in 2014, recognising that NHS doctors, other than

consultants, share those commitments. I am representing them rather than being here as a claimant in the judicial review.

Dr O'Sullivan: Good afternoon. I am Tony O'Sullivan. I am a retired consultant paediatrician. I was director of service for children's services across the hospital and the community for the Lewisham and Greenwich NHS Trust for four years. My lifetime work has been in the NHS and on integrating multidisciplinary teamwork and inter-agency teamwork as a consultant specialising in children with disability, working with children and families. As a director of service, I was thrown into campaigning by the Secretary of State himself, Jeremy Hunt, who tried to close down Lewisham Hospital in 2013, so my day job became my 24/7 job, campaigning to save the hospital. As it happens, the 400 beds that would have been lost are now needed. I am now chair of Keep Our NHS Public, which was set up in 2005. As it says in the title, we were concerned about the move towards privatisation of health services.

Q2 **Chair:** That is who you are representing today.

Dr O'Sullivan: Keep Our NHS Public, yes.

Professor Pollock: I am Professor Allyson Pollock. I am a professor of public health working at Newcastle University. I am here in my academic capacity, but I also have an honorary consultant contract with Public Health England North East. I have worked in the NHS for over 20 years on public health matters.

Q3 **Chair:** Thank you very much. One thing we would like to get to the bottom of here is that we hear all sorts of conflicting views, and we heard a very clear message as we went on our visit last week and in much of the evidence, that integrated care partnerships and integrated care systems have a huge amount to offer. Obviously, your action—those of you who are part of the judicial review—is specifically against accountable care organisations. Could you try to clarify for the Committee whether there are aspects of this about systems and partnerships that you agree with? What would you like to see maintained from these systems and partnerships, perhaps starting with you, Dr Winyard?

Dr Winyard: No one can be against integration, and I would applaud the work that is going on at the moment within the current legal framework. The NHS is in a real mess organisationally: it is fragmented and it is over-commercialised. I think there is a general acceptance that that needs to be changed. My plea—and I hope your report is going to be a watershed—is that this needs legislation to change. The situation we are in is the cumulative product of successive Acts of Parliament that started in 1990—and I set this out in a table in my evidence—and it has progressed to a more and more pure form of the market, the contractor-provider split. I think nearly everyone now agrees that the benefits that that might have produced are now heavily outweighed by the disadvantages. The ACO is an attempted workaround to tackle some very real problems. I think it is dangerous and that is why I am one of

the people who has brought the challenge, but the problems are very real. I just make a plea: it needs you, Parliament, to change the legislation and get us out of this tangle.

Q4 **Chair:** Would you accept the view, though, that primary legislation is very difficult, particularly in a hung Parliament, and, therefore, that if the health system itself sees this integrated working—these integrated care partnerships and integrated care systems as a workaround to address some of the problems that you have highlighted, Dr Winyard—that is something that you would like to see continue?

Dr Winyard: I would accept it is difficult, but it cannot be impossible, surely, for an organisation that is as important to the public as the NHS is. One cannot say, "It is in a mess and we cannot do anything about it." The particularly dangerous thing about ACOs as a workaround is that they will be established, as you know, by commercial contracts that will be there for 10 or 15 years. Simon Stevens said to the Public Accounts Committee that we are trying these things out, pushing at the limits, and if you want to catch up later on, Parliament, that is all well and good, but it will not be—

Q5 **Chair:** We are going to come on specifically to ACOs in a minute, but the question was about the integrated care systems and partnerships that do not require the contractors. Is that something you welcome and you would like to see developed?

Dr Winyard: I welcome integration, yes, of course.

Q6 **Chair:** Can I come on to you, Dr Hutchinson?

Dr Hutchinson: I spent the last 10 years of my career trying to stop the wheels coming off the services that I was managing. Many members of Doctors for the NHS agree with my view that any of these systems are an inadequate and inappropriate response to the major challenges facing the NHS, which include the failure of levels—you have rehearsed these many times probably in this Committee—of funding to keep up with the growth in overall population—

Q7 **Chair:** Can I stop you there, because you will probably have seen the work that the Committee has already done on that? We accept the system challenges around funding and workforce. My question is, given that that is where we are, this was about a response for people to be able to adapt as best they could for patients within the existing funding envelope. The Committee has done a great deal of work on the issue of funding, so I do not know that we—

Dr Hutchinson: It is not just funding, though. It is a way to make the workforce feel valued, to reduce the wastage from the reduced morale. Putting together one overstretched and underfunded service with another overstretched and underfunded service and saying, "There you are. Now get on with it," is an inadequate response from the Government.

Q8 **Chair:** Thank you. Tony, would you like to come in?

Dr O'Sullivan: I have spent my whole professional life trying to build up well-co-ordinated integrated care for the patient and for the family at the point of delivery. That is very different from top-down integration of management systems and organisations. There is a huge difference there. We have just had one major reorganisation of the NHS, which has been disastrous, and I think most people here would probably agree with that. This is another major reorganisation at a time when the NHS is very weak because of all the other factors. The proposal is to integrate a free-at the-point-of-use health service with a social care service that is not free at the point of use but that is means-tested and paid for in many instances, including for my own mother when she had dementia. You cannot just push those together in a top-down way. Integration takes years of working together as professionals and as managers willing do that. To bring co-operation to the table takes years of co-operation across disciplines and agencies. We did that. It took me 20 years in Lewisham, for example, to work around disabled young people leaving school or around autism. It can be done, and these terms were not invented by Simon Stevens or by Jeremy Hunt.

Good healthcare, good social workers and good teachers have been working in an integrated fashion for all their professional lives. It was not invented by the five year forward view—not at all. What we are doing is a top-down and damaging total reorganisation. In fact, to me, the integrated work that was mushrooming around the country post Victoria Climbié, when there was legislation that said to agencies, "Thou shalt co-operate," did not require organisational fusion, especially not with an organisation set outside the NHS, that is beyond FOIs and beyond all the other public scrutiny measures. That is the danger. It is top-down. The integration is integration of management systems, of financial purses and of organisations, and, to me, it is at the expense of the integration of true delivery of co-ordinated care that has been going on and did not need Simon Stevens or Jeremy Hunt to tell us to do it.

Professor Pollock: I am puzzled as to why these new structures and systems are needed when we have had a major reorganisation with the Health and Social Care Act, and especially when we are talking about a major reorganisation being pushed through without primary legislation. For me, the proper way to proceed with integration would be to work out first, legislatively, how you are going to resolve the different funding and population bases for health and social care.

As part of that, we have a current statutory integration regime—section 75 partnerships arrangements. We need to understand how they help or hinder integration and then, if necessary, amend the primary or secondary legislation. It is puzzling as to why NHS England has not gone about things in this way. We do not know why NHS England is not using the statute, why it is not good enough. Why are the statutory section 75 arrangements not good enough? It has "developed evidence to support

discussions with the Department of Health about changes to the section 75 arrangements in order to enable the pooling of budgets for all services delivered by an ACO provider." The DH has said that it is to keep the section 75 regulations and related legislation under review because it has been told by a number of local areas that they would like to see changes to these statutory partnership arrangements, which are all about facilitating integration. We are being kept in the dark as to what these problems are with the section 75 arrangements, so it would be very helpful to know what the obstacles are to using these, because they were put in place in 1999 to facilitate partnerships.

Q9 **Chair:** But would you welcome what is happening on the ground in many areas where organisations are coming together to try to work in partnerships?

Professor Pollock: Everybody welcomes integration, but that is not how these partnerships are being formed. They are being formed, in many ways, often through contracting. These partnerships have to take into account that there are very different funding and population bases for care. This is a real problem because I and you, Sarah, I know, welcome the notion of area-based and strategic planning, but local authorities serve an area. They serve all residents in an area. CCGs do not. They are list based.

What we are now seeing in these new arrangements that are taking place is competition between providers for practice lists, so the Department of Health is funding NHS trusts to establish GP practices and GPs are federating. This competition for practices is because of the dissolving of practice boundaries. This means now that the CCG area and the residents in that area will no longer, increasingly, reflect the CCG population, so it is going to be very hard to know how CCGs are going to plan and commission services when they have hundreds or tens of thousands of patients who are not in their area—their contract within their CCG area—and when, equally, there are many tens of thousands of residents no longer eligible for services through the CCG where they are resident.

These provider-driven decisions about CCG populations and resource allocation are very worrying indeed. We have to take the big picture; everybody on the ground is working hard because they want to make the best of a very bad and chaotic deal, but we have to have some sunlight as to what is really going on. That is why we need to take the big picture.

Q10 **Chair:** You have set out very clearly in your written evidence how you think we should return to a more logical way of commissioning over populations. To pick up on your point about competition, we have been hearing that accountable care partnerships are working together to rather than being in competition, so is it not exactly the opposite of what you are saying, that these are designed to have a co-operative approach rather than to be in direct competition with each other?

Professor Pollock: I would ask you where the evidence for that is, because CCGs have a duty to arrange. They are contracting for services, and providers are bidding and tendering: as you know, Virgin has £1 billion-worth and these are being challenged. Now we see CCGs going to court to challenge some of the decisions that are being made.

Q11 **Chair:** That is partly what integrated care partnership are trying to do, to do the opposite of what you say. That is what we are being told—that they want to try to row back from the endless contracting rounds and competition to genuinely provide in a more logical way over a whole population.

Professor Pollock: The question is: how can they do that legally when the Health and Social Care Act 2012 has completed the commissioner-provider split? How can providers come together and not compete? That is the question—

Q12 **Chair:** My question to you, Allyson, if I may, is that if this does prove to be a way of getting around that constant wasteful contracting, would you welcome it? If this does prove an effective workaround for integrated care partnerships and integrated care systems to get back to a much more logical way of providing care, based on co-operation rather than competition, would that be something you would welcome?

Professor Pollock: I do not see how they can work around the primary legislation, under which we have an external market. We have CCGs with a duty to arrange, to contract and bid. If you are talking about simply bundling up services and awarding giant contracts, which is what the plan is for ACOs, where you have billions of pounds of contracts for 10 to 15 years, then you have real issues about how the commissioning and the public accountability are going to work, but you are still doing it through a giant contract.

Q13 **Chair:** I understand that that is your concern, but if it does prove to be a mechanism, that they can actually co-operate more than compete, is that something you would welcome?

Professor Pollock: I do not see how providers can co-operate rather than compete.

Chair: That is not my question, with respect.

Professor Pollock: That merging together.

Chair: I was saying that if it proves to be that they can, is that something—that principle of trying to work co-operatively—you would welcome?

Professor Pollock: I do not understand how they can do that outside the legislation.

Chair: I will pass on to Ben.

Q14 **Mr Bradshaw:** There is some common ground here. We are all pro-integration. We all think that the Lansley Bill was an absolute disaster. What I cannot quite understand is why, when health and social care professionals at a local level are voluntarily coming together in these collaborative partnerships, you are trying to stop them.

Dr Winyard: I do not think we are. Certainly, the judicial review is about stopping a very specific semi-permanent way of doing that. People coming together is great.

Q15 **Mr Bradshaw:** The JR is specifically and narrowly about the particular contracting model of the ACO; is that right?

Dr Winyard: Yes.

Q16 **Mr Bradshaw:** Given that in the light of this Committee's inquiry and the NHS consultation, as far as I am aware, there are no ACOs currently planned—and as to the only one that was planned by Dudley they have already said that the NHS was its preferred provider any way—why are you still bothering to go ahead with your JR, at huge expense, I would imagine?

Dr Winyard: I would say: why doesn't NHS England come completely clean and say, "We accept that we cannot do this legally without primary legislation"? I am sorry we are getting into the substance of the JR. The reason we took it on was that we felt the NHS was being taken over an abyss really. That is overstating it slightly, but a huge range of, or most, decisions about health and social care were being passed to some new entity that could be a special-purpose vehicle that is something used for money laundering, whose accountability, in spite of it being called accountable, is completely opaque, and those arrangements were going to be signed up for 10 to 15 years before you or the public had a chance to even comment. That is why we have—

Q17 **Mr Bradshaw:** The Chair has already explained why primary legislation is almost inevitably not going to happen in this Parliament, because of the parliamentary arithmetic. Are you not tilting at windmills by objecting to something that, as far as the evidence we have heard on the ground and from NHS England is concerned, is not going to happen, because it is not being proposed? You do not object to what is happening on the ground with every model apart from ACOs. Let us get that clear, that you are perfectly happy with all the other models of integration that are going on at the moment, or is there a difference between you and Allyson?

Dr Winyard: Yes.

Q18 **Mr Bradshaw:** Allyson objects to all of them and you only object to the ACOs.

Dr Winyard: I am particularly concerned about the ACO pinning down an arrangement in a permanent form. I share a lot of Colin and Tony's concerns, having seen, going on for 35 years, that changing the organisational superstructure is not what achieves integration on the

ground. It is about different sorts of health professionals and carers working together. You can make that easier or you can make it more difficult via the superstructure, but that is what is really important—the interprofessional working—and it does irritate for it to be implied that this is suddenly a new thing just discovered recently that needs magic acronyms to make it work.

Q19 **Mr Bradshaw:** Allyson, how do you respond to the advocates of these various models of integration, such as Chris Ham, the very respected representative from the King's Fund, and even people we have met on the ground as part of this inquiry, who do see this as a way of working around the disastrous Lansley Act and enabling them to collaborate in the way that everybody here seems to want to see happen?

Professor Pollock: Everything follows from the law. Are Chris Ham and others proposing that they act unlawfully—they just do what they think is convenient because for them they think it is the way forward? Surely the law is very important and everything should follow the law.

Q20 **Mr Bradshaw:** Indeed, we put that to some lawyers on our recent visit, who said that they had received legal advice that the voluntary agreements to co-operate that they are entering into—not a legal fusion that one of you referred to—are perfectly lawful. Are you happy with those sorts of voluntary agreements of integration?

Professor Pollock: If providers want to work together, there is nothing to stop them from working together, but the issue is—

Q21 **Mr Bradshaw:** This is providers and commissioners working together.

Professor Pollock: I do not see how the commissioners can do that. It would be very interesting to see that legal advice, and I hope you will publish it, because if you are saying that a duty to arrange no longer means having to go out to contract, when the contract has been the main vehicle, and if you are now telling me and everybody else that five years after the Act was passed CCGs did not need to go out to do commercial contracting or all the tendering or the bidding, then this is very welcome news indeed. It needs to be published and put out there right away so that we are not wasting any more money—all the billions that are being spent—on management consultants and lawyers drawing up contracts.

Q22 **Mr Bradshaw:** You are not at all concerned, are you, that by dancing on the pin of a legal argument here you could be deterring health and social care professionals on the ground arranging productive voluntary arrangements to deliver better integrated care, which is what we saw happening?

Professor Pollock: I would be very interested to understand more about what you saw happening. I do not want to comment on things that I have not seen. I would like more detail on what you actually saw happening and what the nature of these arrangements were, but why are the

Government proposing a national consultation if you are saying these organisations are non-existent and are not going to come into existence?

Q23 **Mr Bradshaw:** It is the NHS England consultation that came as a result of us launching this inquiry.

Professor Pollock: Could you answer my question about—

Q24 **Mr Bradshaw:** I am not the Government. It is a question for the Government, not me. The other advocates of these integrated models are not just people such as Chris Ham but people we have spoken to on the ground, trying to deliver a service for their local population. First, it helps them overcome the purchase-provider split, which has already been referred to, and, secondly, it makes it less likely that they are going to be private contracting. Finally—and we saw evidence of this—it has had a positive impact on things like delayed discharge, waiting times and so forth. How would you respond to all of that?

Dr O'Sullivan: What I struggle with is your trust in statements that ACOs are not going to happen and that the integrated care systems are going to solve the problems.

Q25 **Mr Bradshaw:** You used the two in the same sentence. Do you accept that there is a difference, as we have clearly identified here in the panel, between ACOs and the other integrated care systems?

Dr O'Sullivan: There is a legal difference and there is a statement by NHS England and Simon Stevens that he intends integrated care systems to become ACOs. I do not understand where you suddenly have said that is the end of the story. First, if ACOs occur, we are setting up bodies outside the NHS with a huge amount of money in their budget and the ability to control the health service from thereon in, in a fragmented sense. The mistrust comes from a number of directions. One is that this explicitly, again from Simon Stevens's mouth, was a financially driven initiative—how they could possibly save £22 billion of projected need by 2020, and it is going to be £26 billion now by 2021, and the Government were saying, "We will not give you that money."

Q26 **Mr Bradshaw:** Can you answer my question? How do you respond to those who say this helps them overcome the purchaser-provider split, that it helps in providing integration, it helps work around the disastrous Lansley Bill and also helps them deal with issues such as—and we have seen evidence of this, with huge improvements—delayed discharge?

Dr O'Sullivan: What has helped them? You are saying "it" has helped. What is it? Actually, I have been part of this myself. Before I retired, I was in meetings with other professionals and agencies talking about how you could co-operate to give better care for children across the community, hospital and mental health spectrum, and of course that is valuable and is something that can produce good ideas, but we did not need a new total reorganisation of the NHS to do that. There are

instances where co-operative proposals were stopped dead in their tracks by what has gone on.

Integrated care systems, in terms of thinking together, short of reorganising organisations, is something that professionals have done for ever, but there is no evidence—the National Audit Office Report a year ago said this, and this was the challenge to the Government—that integrating health and social care per se gives better outcomes. It does not mean that co-operation is not a good thing. If you are a family, a child or an adult with learning disability, of course you need co-ordinated care across the systems, but you are not being, I would say, open enough with us if you think that ACOs are just off the agenda all of a sudden and that reorganising organisations into new bundles with contracts is off the agenda. If it is off the agenda, then we can go back to a completely public, clinical set of health services and we do not need to worry about privatisation.

Q27 **Mr Bradshaw:** We seem to be jumping all over the place. I was asking a simple question: how do you respond to the advocates of voluntary collaborative working together at local level, which we have seen have delivered real results for their patients?

Dr O'Sullivan: I am not jumping about. I am saying that your question was a little disingenuous because of course co-operation is good and it can give good results, but the context at the moment is a desert of funding and a dearth of evidence that community-based care, for example, which is the vehicle for success, is going to be possible without investment in it.

Q28 **Mr Bradshaw:** We agree with you on investment, as the Chair has made absolutely clear. We are trying to get to the bottom of these attempts to work collaboratively at local level, which, as we have all acknowledged, the Lansley Bill makes very difficult. People are trying to do it for the benefit of their patients.

Dr O'Sullivan: Local working is fine.

Chair: Several members want to come in, so, Colin, can you be brief?

Dr Hutchinson: I was going to tell Mr Bradshaw about one difficulty with the kind of collaborative work that you are talking about. We have been told time and again that this is about dissolving the boundaries between health and social care. At my local authority health and wellbeing board, the medical side of the collaborative agrees that there are situations where the definition of what is classified as healthcare and what is classified as social care could become very important, such as the use of intermediate care beds, including the care B&B type of model that has been suggested. Are those health or are they social care? The use of rehabilitation services, particularly if they are delivered in patients' homes, raises the possibility of hotel charges for non-direct medical care for patients staying in hospital. If you are dissolving those boundaries, it does need to be defined, otherwise people will receive unexpected bills at

the end of their treatment. It requires an awful lot more definition and it cannot be left to every single area to make up its own rules.

Chair: I have several members who want to come in—Johnny, Rosie and Andrew.

Q29 **Johnny Mercer:** Dr Hutchinson, you said it is not about money but about making our staff feel like they are valued. What more can the Government do in that respect? Do you not think one reason they are not getting valued is that there is a persistent degradation in the conversations around the NHS?

Dr Hutchinson: No. The problem is that we all know what good care looks like and that, if we find that barriers are being put in the way of delivering care to our patients on a daily basis such that it becomes like wading through treacle, that is what demoralises people. You know what you should be doing, and the system stops you from doing it because we have insufficient staff, insufficient hospital beds—all the resource issues that we have talked about. My wife is a community matron, a district nurse. We have half the number of district nurses now that we had at the beginning of the century and yet we are saying we can look after far more people who are seriously ill, in their own home.

Q30 **Chair:** To be fair, the nursing workforce is something we have just completed an inquiry into. We are not suggesting this is an alternative to dealing with some of the other key issues around funding and workforce. We are trying to establish, given where we are, whether this is a mechanism for working—

Dr Hutchinson: Using the models will not produce a single extra district nurse to do that work.

Q31 **Johnny Mercer:** My point is that in Plymouth they have already pooled their health and social care funding and it is beginning to deliver real benefits on delayed transfers of care and things like that. Yet the impression I get—as Ben has said, and I am only asking because you have not really answered the question—is that this group here is pushing in the other direction, against that, and it is hard to understand the evidence base that makes you want to do that.

Professor Pollock: The best evidence base comes from the NAO, which has said that neither the Department of Health and Social Care nor the Department for Communities and Local Government—as it was—have yet established a robust evidence base to show that integration leads to better outcomes for patients.

Q32 **Johnny Mercer:** You think integration is the wrong direction.

Professor Pollock: They have not tested it at scale.

Q33 **Johnny Mercer:** The sort of integration such as we are doing in Plymouth is the wrong direction for patients.

Professor Pollock: I have not seen your Plymouth study and I would be very interested to see what the basis of integration is—how you have actually got round the different funding and population bases and how you have put in the criteria for what is NHS care, what is social care and what is the funding base and who is delivering care. I have not seen any of that and I have not seen any of the evidence to support that. You are talking about something that none of us on this panel can comment on.

Q34 **Johnny Mercer:** I think Mr Bradshaw is alluding to the fact that there are a number of local authorities that have done this and seen better outcomes.

Professor Pollock: Bring them forward. The NAO has said there is no compelling evidence of better outcomes, but bring them forward and we look forward to seeing them.

Q35 **Rosie Cooper:** I do not think there is anybody who does not want to see better care for patients by working together, integration and all of that. However, in my area the CCG chose to go out to procurement, gave a contract, took it from a hospital and gave it to Virgin under the guise of being forced to do this. How would you react to the view that now we are at a point at which we are an à la carte Parliament and we have an à la carte NHS, where you can pick and choose which laws and rules you would like to adhere to this week? My big question is: here is the end on which we all agree; does the end justify the means?

Professor Pollock: I do not know what end we are going to. What is the end that you would like to see?

Q36 **Rosie Cooper:** Everybody wants to see better care and everyone on both sides is making statements saying it will be better if we all integrate, but there is no legal basis, in my view, for those decisions to be taken. Every time we use the word "workaround," I, with my good old Scouse framework, say "a fiddle," and if we were bankers we would probably be in front of a judge. Everybody is using the word "workaround," but actually it means getting around the rules and we are all complicit in the fact that we are saying we are not sticking to the rules—we are going to get round them. I have a fundamental problem with that because I think the big gap here is the word "trust." I can show that in Liverpool, in LCH and in the prisons, trust has been eroded. If you get a benign organisation, then these guys are great. If you get a bad organisation, where do we go? Does the end justify the means?

Professor Pollock: Absolutely. I am afraid that it does not because everything follows from the law. If you are finding that everything is as chaotic and untrustworthy as you say, then we need the primary legislation to end the internal market, to re-establish area-based bodies, which continue their needs assessment. I am very puzzled. I think we are at the wrong level when we talk about integration. We still have contracting and we still have commercial contracting, and these contracts are being let untendered all the time and people are changing their

badges all the time. You are absolutely right. What has been lost is control and trust—Government control and the trust of patients, the public and staff in the system. We need to revisit the legislation.

Dr Winyard: I have a plea along those lines. I do not think this is a party-political issue because the mess we are in is a cumulative product of Acts passed by both parties and it is not just about privatisation; it is about commercialisation. We are tearing the country apart in pursuit of parliamentary sovereignty, and surely you cannot sit there and tell us that there is nothing you can do to sort it out, to help the NHS by getting together and passing some primary legislation to restore simplicity. I am old enough to have worked for a single organisation taking most decisions about healthcare. It was called a district health authority. It was accountable, it was set up in statute, we did not use lawyers and we did not use management consultants. We did not need incentivising. Why do people need incentivising to do their job? We just got on with it.

Q37 **Chair:** We need to get briefer answers, as we have a lot to get through. Your view is that we need primary legislation.

Dr Winyard: Yes, please.

Q38 **Andrew Selous:** I have a counterpoint. From our visit last week to South Yorkshire and Nottinghamshire, we had a very clear message that things move at the speed of trust and many senior people across the NHS were saying, "Please don't tie us down with legislation at the moment." The issue I really want to draw to your attention is what we saw in the example of the primary care home model. I do not know if you are aware of Larwood House in Worksop—it is an organisation I suggest you get to know—but there we saw the most amazing degree of collaboration in a surgery where every patient's needs were dealt with that day. You had pharmacists, district nurses and paramedics working alongside an excellent GP team, achieving superlative outcomes as part of the foundation plank, if you like, of the STPs. That was happening without contracts and it was happening on the basis of collaboration, good will, positive outcomes and a happy and contented workforce.

Just as a counterpoint to you, the evidence we have seen on the ground is that this is starting to happen without a legal basis because it makes sense. It was driven forward by a visionary GP, but this was part of the STP: the senior STP leaders were there and it is their foundation block. I am encouraged by what I saw on the ground of good co-operative care happening without law. I am interested in your response to that.

Dr Winyard: You have every right to be, you should be and that is great. The point I would make, having been on the other side, is that, if you are in the Department of Health and you want to go in a particular direction, you find enthusiasts, you sign them up to your project, you say they are pilots, and then you take people to see them and say, "Look, there is all this great stuff going on under the flag of what we have invented". But great stuff would probably be going on anyway because across the NHS

there are natural leaders who achieve good things and the centre is very good at finding and badging them appropriately.

Q39 **Andrew Selous:** This was part of the local sustainability and transformation plan. The head of it in that area accompanied us to that GP surgery.

Dr Winyard: It was the GP who—

Dr O'Sullivan: It could have been at any time in the last 20 years before STPs because I, too, have been involved in great co-operations between social care, education, mental health, GPs and so on, and it did not require these things. So, when you are saying those things are happening without any formal changes, that is great. So why are you—

Q40 **Andrew Selous:** What kick-started it was an initiative from the top to try to break down silos and get decent place-based integrated care, and it is almost as if they had to have permission and support to do this with great local leadership.

Dr O'Sullivan: Legally, they did not need permission.

Q41 **Chair:** The nub of what we are trying to get to is that, yes, I accept that these things have always happened in places around the country—there are great examples of good working practice—but the trouble for the NHS is that that is often not rolled out and experience is not shared. Do you see that there is anything in integrated care partnerships and systems that could help to roll out best practice and share this kind of good working, or do you not see it has any role in that?

Dr O'Sullivan: The willingness of organisations to work together—and going right down to individual professionals—has always been there. There is a public service ethos that makes that happen because people want to do it, whether you are a GP, a physiotherapist or a social worker. A set of discussions has started to take place, but it is disingenuous to deny the fact that these things have been put in place because of the top-down plan to go on a journey, which includes, I am afraid—we have not really discussed this—the assumption of a growing degree of privatisation, to an end form of ACOs that are independent bodies outside the NHS, so you have fragmented the NHS.

The degree of co-operation—this is a separate point—with local authorities is extraordinarily variable, and a lot of the time Simon Stevens is claiming local authority buy-in when, actually, there has not been any political buy-in from councils, they have not been involved and you have full-time, almost, civil servants taking part in a process that is deemed, "This must happen." There is a deep mistrust because, since 2010 and beyond, there has been a slow drift, escalating, towards privatisation, and the privatisation of management organisations is explicit down there in the model contracts. It needs a lot more than Mr Bradshaw saying it is not going to happen for me to believe it is not going to happen.

Q42 **Mr Bradshaw:** I was not saying it is not going to happen.

Dr O'Sullivan: Thank you, so we are right to be worried then.

Q43 **Mr Bradshaw:** What is not clear from the panel is whether you oppose all sorts of integration, whether you do want primary legislation, you do not want primary legislation or whether you just oppose those ACOs, for the reasons that one or two of you have outlined.

Dr O'Sullivan: I hope we have made that clear. Examples are child protection, childhood disability, adult learning disability and adult mental health: all of those require co-ordinated care. Perhaps "co-ordinated care" is a better term, because when "integration" is in the title, you are talking about integrated care organisations or systems.

Q44 **Chair:** The point is that there is a conflation, as we have heard. You have the judicial review going on into accountable care organisations, but then, apart from that, you have systems and partnerships, and we are trying to tease out whether you would at least welcome the partnerships and systems model of trying to roll out best practice, as you have said this happened anyway.

Professor Pollock: Simon Stevens himself has said that STPs are intended to evolve into ACSs and from there into ACOs, so let us not just stop the thought processes at systems. That is disingenuous.

Q45 **Chair:** My point, Allyson, is that, if we leave out the organisation bit, would you welcome partnerships and systems? I am trying to tease out the difference between them.

Professor Pollock: I really do not understand that question because for me, as a public health physician, with my training, everything comes from the law. You put a system into place, you know what population you are serving, you know what their funding base is and what the—

Chair: You have made that point.

Professor Pollock: These partnerships are nebulous because the reality at the moment is that you have CCGs contracting and you have over 130 providers as well as the trusts and foundation trusts competing for contracts in the marketplace at a cost of millions of pounds. How these partnerships are organising themselves outside the duty to arrange and contract is a question I would ask you. How is that actually happening?

Chair: Okay, thank you. Paul.

Q46 **Dr Williams:** I think most of us would like to see more prevention taking place. It is very clear that the NHS is largely a reactive service. Do you think there is any way that these partnerships or even organisations could potentially act as a vehicle to encourage investment in prevention?

Dr Hutchinson: It depends on what kind of prevention you are talking about. The problem with most of the STPs has been that they have talked about unhealthy behaviour as being an individual form of behaviour,

whether it is drinking too much, smoking, obesity or lack of exercise. So, the responsibility is there on the individual, whereas the work from the Black report in 1980 and the Marmot review in 2010 stresses the importance of the social determinants of health—that those risky behaviours are a result of much larger pressures in people's lives, whether it is financial instability, a lack of suitable workplace environment or poor housing. Those are totally ignored in the STPs, so all the onus is focused on the individual, which leads those of us with a suspicious mind to think that you are getting the separation like the deserving poor and the undeserving poor. We are already seeing it with people who smoke being denied surgery for joint replacements.

Chair: We are going to need briefer answers, I am afraid, because we have a lot to get through.

Dr Hutchinson: I am saying that the preventive health side of things is quite limited in the STPs that I have looked at.

Q47 **Diana Johnson:** I want to ask you about the focus that you have on primary legislation and how that will solve all the problems we are looking at today. I have been interested in some of the comments you have been making—particularly the clinicians—saying that you cannot push together in a top-down way, that we do not want a top-down reorganisation. Can you explain why you think primary legislation will force everybody to behave in the way that is happening now, as we saw in South Yorkshire just last week? We saw that working together, from the bottom up, which I think particularly, Dr O'Sullivan, you talked about happening when you were in practice. Explain that to me, as someone who has been in Parliament for a little while. I know that Parliament can pass all sorts of laws, but whether they have the impact that you want on the services that are being provided is a different matter. Is it not better if things are working well now? Is that not a good thing? What is so great about the primary legislation and where are the risks? That is the other point about primary legislation.

Dr O'Sullivan: Who are you asking?

Diana Johnson: Anyone who wants to answer.

Dr O'Sullivan: I will answer briefly and then I will let others in. The elephant in the room is the lack of trust around the direction and degree of privatisation in clinical care. You are shaking your head. I am not sure why you are shaking your head because 7.7% of clinical services are—

Q48 **Mr Bradshaw:** It is because you are not answering the question. My colleague asked, based on the evidence we heard last week where people are working together voluntarily to provide better integration and service for their patients, why you want to put primary legislation on top of that. They were saying it is better without primary legislation because it is building trust and they are working co-operatively together. You want to impose a system on them. That was the question my colleague asked and

you are just not answering it.

Dr O'Sullivan: The one thing I am talking about is that primary legislation puts down in law that the NHS, however it is co-operating with social care or other agencies, will not be put out to tender in 44 or 50 bite-sized chunks. That primary legislation I would welcome.

Professor Pollock: I think this is a false binary. It is perfectly possible to have legislation that allows for proposals to be worked out on the ground, and indeed Scotland did it over health and social care. They passed an Act of Parliament and it was worked out bottom up from the ground. Indeed, what we have drafted—and Peter Roderick is behind me—on the NHS Bill does exactly that. "Bottom-up" is really misleading because we have to remember that Parliament votes for the funding, and it comes through and we also have law, but it is perfectly possible to do both and to do so within the legal frameworks—the legislation.

Dr Hutchinson: It has been said that in a hung Parliament it is difficult to get legislation through, but this is an English measure and, in so far as English MPs go, there is no hung Parliament.

Q49 **Chair:** As Ben said, we are not here to answer questions—we are here to ask you questions. The point is that the reality is that it is very difficult to get primary legislation through. Also, the question was whether it is necessarily desirable to have primary legislation. Are there risks, I guess was the—

Dr Hutchinson: For the benefit of clarity—

Professor Pollock: If the Health and Social Care Committee cannot push for primary legislation, no one else can, and I really hope—

Q50 **Chair:** We were asking your views on that. We have heard a clear view from Dr Winyard that he thinks primary legislation would be sensible, but we are asking you the question: do you see there could be risks, to summarise it?

Professor Pollock: It would depend on which primary legislation. The primary legislation I would advocate, if we were talking about ACOs, is that you would have them constituted as public bodies, area-based health boards serving contiguous geographic areas, restoring the duty to provide and making sure that the resources follow all the residents living in an area and not just practice lists, because, as you know, the resources do not cover unregistered patients, and you would have planning as well. That is what I would see.

Chair: That is the point you have made. Did you have any other questions?

Diana Johnson: No. It is okay.

Q51 **Dr Williams:** My understanding of what you are saying is that we need primary legislation to protect the kind of things that we have seen

because what we largely saw was a group of NHS organisations working together. If we had gone to a different part of the country where there had already been significant fragmentation, it may have been more difficult for those kinds of things to happen because people would have been serving different masters. I think what you are saying is that the legislation would put some boundaries around this and it would be enabling legislation rather than legislation that stops things from happening.

Professor Pollock: It would stop contracting and allow integration, needs assessment and service delivery.

Dr Winyard: Building on that, it does not have to be legislation that says, "You will all do this now," but it would say to the places that, in the current lexicon, are ready to become ACOs, "Here you are. What you can do is set up a health and care authority. There is the template—a public body—and this is the accountability." They, I suspect, would say, "Yes, please," and we would not have to do any of this contracting now either. It has huge potential benefits.

Chair: I know that Rosie is next and then I will come to you, Martin.

Q52 **Rosie Cooper:** We have moved on a bit. What action do you think the Government and national bodies could take to allay your concerns about the accountability of organisations holding an ACO contract and—you have partially answered this question so far—to what extent do you think the worries about ACOs are short-term worries and not impactful over time? That is the difference, almost, between Ben and me, because the end result of improved patient care is where we all want to go. However we get to good care is great. How do you think those concerns could be allayed?

Professor Pollock: Above all, we need primary legislation and we need to reinstate the NHS using something along the lines of our Bill. In the immediate short term, we should stop CCG mergers, STPs, get real advice on the duty to arrange and contracting, as you are doing, and take a long hard look at what is happening. I think there are now really very major problems emerging as a result of the commercial contracting, with increasing atomisation of care and the atomisation of patient risks as well— individual risks. What we will see if ACOs come to pass, and Simon Stevens has said he intends STPs to evolve into ACSs and then into ACOs, is that more and more of the risks and costs of care will be shunted to providers and to patients. Our real concern is about what also happens to commissioning functions.

Q53 **Rosie Cooper:** How will that real accountability be able to be seen by the man in the street? How would he see that accountability?

Professor Pollock: For a start, people in Scotland, for example, understand direct service accountability. They have health boards, they have abolished the internal market and they have reintegrated everything. It is a much simpler, more straightforward system with no

commercial contracting. Here, we now have GP providers and trusts competing for patients for practice lists, which are the currency, and patients do not even realise that, if they change practice and move out of their own CCG area, the whole budget is moving with them and that can destabilise not only their own access to care in their local area but everybody else's as well. Patients do not realise what is actually happening in England. They are very worried and they are alarmed, and public accountability is diminishing, if not removed completely, judging by the number of judicial reviews that are going on up and down, and in every area of, the country. That is a direct result of having lost direct public accountability and community health councils.

Q54 **Rosie Cooper:** How do you think the private sector is going to react to this?

Professor Pollock: If I were the private sector, I would be packing my bags.

Q55 **Rosie Cooper:** Do you think they will challenge some of the decisions?

Professor Pollock: Which decisions are you talking about?

Q56 **Rosie Cooper:** Do you think the private sector will challenge the decisions—the workarounds?

Professor Pollock: In what sense—if they are lawful or unlawful?

Q57 **Rosie Cooper:** I mean limiting their business and being able to operate under the current law.

Dr O'Sullivan: We have seen it very recently, have we not, in Surrey, where the six CCGs decided to give a children's contract back to the NHS social enterprise alliance and Virgin Care challenged that and were given a buy-off of £2 million to avoid going to court? The answer is they clearly will challenge at every step of the way. That is their legal entitlement at the moment: such is the law. That is one of the explicit reasons why there should be an attempt to change that law.

Q58 **Rosie Cooper:** If there are organisations in areas that already have private contractors—for example, West Lancs has Virgin Care doing quite a few bits—how would we do these workarounds if they do not want to play?

Professor Pollock: If the contract comes to an end, it comes to an end.

Q59 **Rosie Cooper:** No. While the contract is going on, how do you get them to be part of the integrated service if they do not wish to?

Professor Pollock: It is a question for the politicians.

Chair: I am conscious of time because we have three panels.

Q60 **Mr Bradshaw:** The sorry example of Virgin Care challenging legally, and the general concern of the private sector about these integrated systems

that are happening on the ground, might suggest that they are rather a good thing.

Dr O'Sullivan: What is a good thing?

Q61 **Mr Bradshaw:** Might the fact that Virgin Care is challenging these legally and that the private sector have told us they are very concerned about the direction of travel, as a result of these integrated systems on the ground, suggest that these integrated systems are quite a good thing?

Dr O'Sullivan: Not at all. They challenged a specific contract. They did not challenge an integrated care system. I was just saying that the evidence is that they certainly will challenge to the best of their ability and the best of their funds, which are greater than those of local CCGs.

Q62 **Martin Vickers:** This is more of a comment than a question because this is my first meeting of this Committee, so I have not had the benefit of the previous exchanges with witnesses or the visits that my colleagues have been on. After less than two hours on the Committee I am already in despair because we are so hung up about structures and so on. To me, privatisation, for example, means what happened with British Telecom or something: you sell it off lock, stock and barrel, and you sell shares and so on. That is not going to happen in the National Health Service because no serious politician would even contemplate putting it forward.

What I presume, Dr O'Sullivan, you are talking about is obviously a commercial contract to provide a specific service. To me, if that specific service can be provided still free at the point of need to the patient and more efficiently, that has to be an advantage. Outcomes are what we should be looking at. When we talk about integration—and this is not a panacea—in one of my local authority areas, the chief executive is also the chief executive of the CCG, which must logically allow at least at management level for a more integrated view of the service and how it needs to be provided.

My plea would be, first, if Dr O'Sullivan could confirm that his version of privatisation is as I perceive, and whether he thinks, or indeed any of the panel members think, that the joint operations of local authorities and CCGs will help deliver the health and social care agenda.

Dr O'Sullivan: It is not my definition of privatisation. It is the World Health Organisation's definition of privatisation, which includes selling off lock, stock and barrel. It also includes outsourcing and control of the finances and the infrastructure of a public service, where those are going into the private sector. For example, Carillion running the soft services for a PFI is privatisation; a PFI of actual buildings is privatisation. There is a range beyond your very strict, narrow definition of privatisation.

Q63 **Martin Vickers:** I think it would be more useful if we had a strict definition rather than—

Dr O'Sullivan: There is a definition.

Q64 **Martin Vickers:** We will worry our constituents by talking about something that is not actually on anyone's agenda.

Dr O'Sullivan: It is where the public service and the servants who are providing that public service are no longer wholly responsible to the public, Parliament and the National Health Service, but they are more employed by a private company. The private company's duty is to the shareholder, and the transaction between giving a service and needing that service, as a patient, changes.

Chair: Thank you for providing your definition, Tony.

Q65 **Johnny Mercer:** What are the grounds that you have to support claims that the NHS is being privatised along American lines?

Dr O'Sullivan: Some 7.7% of CCG budgets are now private contracts. PFI payments—

Q66 **Johnny Mercer:** I am sorry—7.7% of the whole budget is out with private contracts. That is not privatisation, as we have just discussed, is it?

Dr O'Sullivan: As we have just discussed, it is, by World Health Organisation—

Q67 **Johnny Mercer:** Let me make it clear that your average person on the street, who would probably be watching this with their head in their hands thinking, "This is why we have so many problems with the NHS," would not consider that to be privatisation. Also, they would not have a problem with outsourcing that care to private companies, if it was 7.7%, if we got a better standard of care and outcomes for our constituents who pay for this health service.

Professor Pollock: Perhaps I can come back here for both your questions. I would really be interested to know of any country in the world that delivers a universal healthcare service through a market and through private healthcare, because there is not one, and the WHO has already made many—

Q68 **Johnny Mercer:** I am so sorry, but the way these Committees work best is that we ask the questions and then we get the answers.

Professor Pollock: The second thing is—

Q69 **Johnny Mercer:** No, wait. There are opportunities for you to speak on other platforms, but there have been a number of questions that have not been answered here. What I have asked for is evidence of the Americanisation or the privatisation of the NHS, as the average person in the street would understand it, and there isn't any.

Professor Pollock: It is a direction of travel. There is plenty of evidence.

Q70 **Johnny Mercer:** I accept it is a direction of travel, but the privatisation is not there.

Professor Pollock: You accept the direction of travel. That is very good.

Q71 **Johnny Mercer:** Okay, so you have answered my question that there is no evidence; thank you very much.

Professor Pollock: You have answered your own question—not mine.

Q72 **Johnny Mercer:** What could the Government and arm's length bodies do? If ACOs are going to come down the line, and the evidence is there that this is going to provide a better outcome for patients, which is the only driver for people like me who do not know or profess to know the ins and outs of the NHS, because, ultimately, we are driven by outcomes for patients—if they are going to happen—what could the Government do to allay your fears that these are not going to be a vehicle for privatisation?

Dr Hutchinson: They could constitute them as public bodies, with the underpinning legislation.

Q73 **Johnny Mercer:** That is through primary legislation, which we have just heard that most healthcare professionals do not want.

Dr Hutchinson: I do not think most healthcare professionals have been asked.

Johnny Mercer: Chair, that is all I have; thank you.

Professor Pollock: May I draw your attention to a *BMJ* article and this *BMJ* figure that they have published on the big questions about ACOs? It might help you if you had a look at this.

Johnny Mercer: I will look at that; thank you.

Q74 **Chair:** Can I raise one thing, because I get a lot of correspondence, as you can imagine, about this subject? One thing that sometimes gets conflated when we talk about the Americanisation of healthcare in some of this campaign literature is that people are led to believe that "Americanisation" means they are going to have to start paying for their care. Is that what you are seriously concerned about? Can we try to unpick whether that is a serious concern?

Dr Winyard: There must be a serious possibility of that if you recognise that ACOs are bringing together healthcare, which is free, and social care, which is means-tested, and that we all know the actual boundary between those two is very fuzzy.

Q75 **Chair:** But we also know that there is primary legislation that prevents people being charged for their NHS care. The trouble is that the public are being led to believe that, somehow, they are going to get a bill when you talk about Americanisation, but actually there is primary legislation that prevents you charging for healthcare. Do you accept that?

Dr Winyard: Yes, but Simon Stevens is proposing to put responsibility for both health and social care together in one organisation, which is going to be incentivised to make profits, and within that organisation we

know absolutely nothing that would stop them being able, as Colin was giving you an example, to say this is actually social care and a bit of—

Q76 **Chair:** But people already have means-testing for social care. Would you accept, Graham, that there is primary legislation that sets out that you cannot extend charging for healthcare, but we have always had a degree of means-testing for social care?

Dr Winyard: Sure, but healthcare is defined by the fact that it is provided by a healthcare provider. There is lots of hands-on activity, particularly with the elderly, for example, that could be and is done by home helps or nursing assistants. If it is done by people provided through the local authority, it is social care and it is paid for; if it is done by people provided by the health authority, it is not. These are being brought together in this one organisation.

Q77 **Chair:** In fact, we have heard examples of people from frailty units who are discharged and their social care is provided and paid for by the NHS. So, do you not think we might be losing an opportunity to do just the reverse, where you pool a budget? For example, we heard that the longer somebody stays in an in-patient hospital, the more expensive their care package is. The frailty unit that we visited was pooling the budget so that they could see benefits primarily for the patient, of course, but it was saving money for both systems. Do you not worry that we could end up missing some of these potential benefits?

Dr Winyard: I would like to see us realising the benefits—

Chair: That is what we saw on our visit.

Dr Winyard: But in a way that is transparent legally in accountability terms. Not a lot has been written yet about how accountable care organisations would work, but we are told that they would take most decisions, and they would get a big pot of money from some commissioners and be told to get on with it. They would have within them both the regimes to charge for social care and to provide healthcare free, but what exactly goes on for an individual patient? The boundary could be shifted quite easily.

Q78 **Chair:** That is your concern. The literature I am getting from patients is telling them—effectively frightening them—that they are going to have to pay for their healthcare under this system. Would you accept that that is not true? I accept your point about—

Dr Winyard: I do not know about the literature, but lack of transparency leads to anxiety. There isn't public confidence in this. If we could have a bit more clarity, there might be more.

Dr Hutchinson: As I have said, the chief executive of the CCG in our area cannot say for sure how things like intermediate care beds will work, and a new generation of combined health and social care workers are being talked about in the new workforce model. Will the care that they

deliver be health; will it be social care; will it be means-tested or will it not be?

Q79 **Chair:** As I said, the example we saw was that it was being paid for by the NHS at no charge to patients, to help them get home.

Dr Hutchinson: But there is no clarity that that would be the case everywhere.

Q80 **Chair:** We could continue this for a long time, but—

Professor Pollock: Services can fall out of the NHS, and I will send you the paper we have written on it, but it is under the authorisation, under the licences of foundation trusts that have commissioned or requested, services, and we can see there are possibilities for services to fall away from the NHS. I will send you that.

Chair: Yes. Perhaps you could send me some more detail on that. I am sure we could have gone on a lot longer, but we have three panels, so I am very grateful to all of you for coming this afternoon. Thank you.

Examination of witnesses

Witnesses: Lara Carmona, Dr Chaand Nagpaul and Helga Pile.

Q81 **Chair:** Thank you very much for coming this afternoon. Could we start, for those who are following from outside the room, with you introducing yourselves and saying who you are representing today, starting with Dr Nagpaul?

Dr Nagpaul: My name is Chaand Nagpaul. I am a GP in north London and I chair the BMA Council, representing 160,000 doctors across the UK. I previously chaired the BMA GPs committee.

Helga Pile: I am Helga Pile. I am deputy head of health at UNISON. UNISON represents about 450,000 healthcare workers and about 300,000 social care workers.

Lara Carmona: I am Lara Carmona. I am the assistant director of policy and public affairs on the UK and international brief of the Royal College of Nursing. We represent about 450,000 nursing staff, which is 320,000 in England alone, just under half of whom are in the independent sector.

Chair: Thank you very much. Paul is going to open the questioning.

Q82 **Dr Williams:** Based on the current financial settlement in relation to the NHS, are STPs and integrated care systems unworkable?

Dr Nagpaul: You are asking the question in a future tense. The reality at the moment is that we are seeing huge pressures on the NHS, which I do not believe any of us would call workable in the sense we would like in a civilised nation. To cancel summarily 55,000 operations at the beginning of December does not, in my view, suggest an NHS that is working in a planned manner; to have 17,000 patients queueing up in ambulances

outside casualty units waiting to be admitted in the first week of January because there was no space in an A&E setting, so they are, is the NHS not working; I could go on to consider corridor management of patients becoming a new norm; that is the NHS not working.

You have asked a really important question. We need a funding settlement that allows us to provide the sort of care that we would all like to see for patients and that patients deserve. That, ultimately, is about money. This is not about any of us talking about money in a sterile way. It is about the fact that at the moment there are not the resources, the infrastructure or the capacity. The only way you will correct that is by putting resource in. Even the maths tells you that when we compare ourselves with other nations that provide a comprehensive service. It is not just me saying it: it is the King's Fund; it is the Nuffield Trust; and it is yourselves. Every policy expert that you now look at has recognised that we need a proper funding settlement, not what we have on offer at the moment.

Q83 **Dr Williams:** We need a proper funding statement for the ongoing running costs of the NHS.

Dr Nagpaul: Yes.

Q84 **Dr Williams:** But we also need—and part of the premise behind my question was—funding for the change that we want to make as well.

Dr Nagpaul: You are absolutely right because change does require headspace, it requires the resources for transformation, and in fact out of the £2.9 million allowed for last year under the STP transformation plans, only about 0.3 of it was used for transformation. The rest was used to plug funding deficits. We have a system now where we are not able to resource the redesign to get people working together. That is not available as a resource, and, therefore, you are absolutely right that we have a real difficulty in both service provision and redesign.

Helga Pile: One reason why the public are concerned about this issue is that the STP initiative is being seen as a means of delivering cuts to spending, and that means that many of the aims that they have that would benefit patients are not being identified and recognised. I would also draw attention specifically to capital funding because many of the plans rely heavily on ambitious capital investment for equipment, buildings and so on. Although there has been some additional funding identified for that, the tap seems to be running very slowly in terms of releasing modest amounts of that. That means that the plans cannot get off the ground, which leaves the people on the ground who want to see that happen frustrated by that situation.

Lara Carmona: As the representative body of so many nursing staff, my staff have taken the opportunity to read through every single STP, so I would like to take it down to the granular level, because it is very easy in these conversations to stay in the conceptual space. I do not think

anyone would disagree with the fact that we need more funding, but we need to be careful about our language because we are talking about an integrated approach that arguably offers the opportunity to address health and social care needs as well as public health prevention promotion. We absolutely do not have enough to do that, but when you look at the granular level, you can see that in the actual plans themselves when you look at the STPs. I do not think anyone can reasonably answer your question until each of those STPs provides us with the level of data that we need in order to ascertain whether that is even feasible. That is something I would value talking to the Committee about today—what is in the plan so far and what we can actually assess.

Q85 **Dr Williams:** Actually I was going to ask you. My next question was going to be about the evidence—what the evidence is and how reliable it is—on which the STP plans for efficiencies and for other savings are based.

Lara Carmona: If any changes are ever made solely on the basis of efficiency, we run the risk of compromising patient safety to a degree that is unacceptable and putting our workforce in conditions that are untenable. In examining what is available for each and every single one of those STPs, I am afraid—I say this with a lot of support for every single frontline professional who is out there participating in this process—the reality is that, although there are significant inroads made in some of those areas you already know about, Greater Manchester being the one that we talk about most commonly, none of those plans has the level of detail that we would expect to see in terms of transparency, particularly in workforce planning, and certainly the detail of how the efficiency savings will be made without compromising patient care.

There is some way to go still, and on the opportunity before any leadership mechanism, whether or not that is through an ACS, an ACO, an ICS and STP or any other acronym that we can use to confuse the public any further, the reality is that we need to sit down and look at the data. We need to be able to reasonably challenge any assumptions that anybody is making and have that robust conversation publicly so that we can disavow notions that are untrue, but also to speak to actual transformation opportunities that so many frontline professionals desperately want to be a part of. The chance is still here for us to take on working together. It just means that we need to throw away quite traditional relationships and hierarchies that some of us are maybe more inured to than others.

Q86 **Dr Williams:** Dr Nagpaul, did the STPs start out with a financial saving, so putting the bottom line on the spreadsheet first and then working backwards to find savings, and then work backwards further in order to try to develop programmes in order to achieve those savings? Is that your opinion?

Dr Nagpaul: Yes. We have tried to get information from doctors across England, because the BMA has that ability through its regional structures. You are absolutely right that the boardrooms of STP footprints, when you look at the papers, are all starting, and everyone is trying to get their head around how you make a saving. If you look at the papers, the actual meetings, they are not spending their time talking about how to invest in the future and create a new paradigm of healthcare delivery. They are talking about how we make cuts.

It is not just that that they are talking about. The directives that come to them, such as the capped expenditure programme, if you look at the sorts of directives you get, are very clear that you need to achieve financial balance and—maybe we can come on to this later—I also think there is a big problem about defining financial balance on a fiscal year basis. It does not allow for any planning, if that is what you are going to be judged on. Come 31 March, are you in financial balance or not? That means if it is February or January you cannot invest. It is illogical. It is a cost-driven agenda, even though they may have purported to work in a different way. When it comes down to it, that is what is driving the agenda.

The second problem we have is that they are not engaging, and, as I said, the investment in transformation is not there. I heard the previous debate, but ultimately—I really do have sympathies—there are very significant issues with the legislation, and they thwart the ability to create the sorts of collaborative arrangements that are meant to occur through STPs.

Q87 **Dr Williams:** In what way?

Dr Nagpaul: I heard the debate that we just had, but we are finding that, unfortunately, each contract that is provided is subject to a procurement that is laid down in law. As a result, there are contracts that are being awarded and outsourced. In Nottinghamshire there was a contract with Capita. It is most illogical, in my view, from a base validity point of view, to award it to an organisation that has not been able to deliver on primary care support services for general practice.

Q88 **Dr Williams:** That is the subject of another inquiry probably.

Dr Nagpaul: Absolutely, and we have seen the example in Surrey where we heard that Virgin is challenging. In these footprints, the commissioners are acutely aware of the fact that when they are looking at provision of care they have a legal system that tells them that there has to be procurement. That gets in the way because there is huge discussion on how to try to get a workaround. We need a system where you do not have to think about workarounds, where you can provide services within an NHS that is free from tendering and competition. That is also, I believe, thwarting the approach in STPs: both the lack of funding, which is driving a cost-driven agenda, unfortunately, and if you get the funding right that will take that bit away; and, secondly, there

needs to be a real system that enables collaboration without the legal threat all the time.

Q89 **Dr Williams:** I agree with you entirely. I led a group of GPs before I came to Parliament, and it took about half an hour for the local hospital and the local GPs to decide they wanted to work together on a particular project. We then spent thousands of hours going through a procurement process. We beat the private sector and won the procurement, but there was an unnecessary bureaucracy to get to that point of collaboration. My final question, then, is what effect STPs are having on standards of care. Helga?

Helga Pile: It is very early days. It is difficult to answer that because so many of the plans are vague. They contain good aspirations, but it is not clear what that will amount to. Some of the good practice we have seen—as other witnesses have said—is the result of things that have pre-dated the STP agenda, where there are very good working relationships. In Torbay, for example, there is a long history of health and social care integration. Some of that pre-dates this agenda.

Q90 **Dr Williams:** Those are things that were happening in spite of STPs and not because of STPs.

Helga Pile: Or before STPs were the thing. It is important and useful to build on the successful examples that we know about. In terms of the concept of joining up services and joint planning across an area, it is very early days, but certainly staff are behind that as a direction of travel. It makes sense to them, having lived through the reorganisation for the 2012 Act. Again, if there is a feeling that the leadership and management of organisations are pushing towards some of the initiatives that grow from the bottom up around multidisciplinary teams, and if there is a feeling in the leadership and management of organisations that there is a genuine interest in removing some of those barriers, that is all to the good; but really the barriers to how far you can go under the legislation and how much money you can put into those initiatives get in the way of that.

Q91 **Dr Williams:** Is there any other impact on standards of care, Lara?

Lara Carmona: We, as the Royal College of Nursing, were absolutely delighted with the Committee's recent inquiry into nursing. To respond in a slightly different way to your standards of care question—I respect that the Chair has said that this Committee has done a great deal of work on both funding and workforce—standards of care in terms of outcomes, as you know, take time to generate impact in the wider population, so we will not know practically in some terms for some time, but you can see that there is absolutely no correlation between the direction of travel and the workforce on what the STPs are saying. The best example of that is the shift away from a community-based workforce and an overreliance on growth in that acute sector.

Q92 **Dr Williams:** We have already heard of the massive reduction in district

nurses.

Lara Carmona: Yes, that is right. While you could argue that standards of care cannot necessarily be measured by that, what you can see is movement in the workforce away from the direction of travel from STPs, and certainly away from the direction of travel from what people themselves describe when they talk about where they most want to be cared for—in their home and in their community setting. I would take that as an early warning sign.

Q93 **Andrew Selous:** That leads me on very nicely to the whole issue of workforce engagement. What should STPs be doing now to engage with the workforce to make a success of STPs?

Dr Nagpaul: The workforce does not go into a hospital or a GP's surgery thinking "STP." People look at their lives in terms of looking after patients within the setting they are in. We have a very serious issue, which I think is well recognised, that the workforce—and I am not just speaking about GPs or hospital doctors; it applies to all categories of NHS staff—are feeling under huge pressure and there are not enough of them. They are working in a very challenging environment and in many cases feel they cannot fulfil their professional duty of care. The problem about engagement is that while they are doing all this work most of the workforce have little time or space to be thinking about STPs, so you have a problem that we are not engaging, and we know that. The vast majority of doctors we have surveyed are not engaging. The other problem is that engagement in a system where, as I said earlier, the board papers are about making cuts is not going to be engagement in a meaningful sense.

Q94 **Andrew Selous:** I am giving you the opportunity to answer the question as to what good engagement would look like.

Dr Nagpaul: I will answer the question: what would good engagement would look like? First, it would be for healthcare staff to have a manageable workload and then to have protected time where they can go and contribute their clinical value to the changes in healthcare provision so that they are part of that change; and it is owned by doctors, nurses and others—those sorts of collaborative arrangements that start on the ground. We heard from Dr Williams that he set up a group of GPs.

The biggest problem we have is that the workforce is overstretched and does not have the headspace. Good engagement would create that headspace. There are limitations if you do not have enough staff, but, where it is possible, it should happen. For example, if I look at general practice, many GPs have asked for the ability to have backfill arrangements, protected time and so forth, and most commissioners have not had the resources to enable that to happen.

Q95 **Andrew Selous:** The clinical chair of Bedfordshire CCG is a very well respected local GP. Would you not think someone like him, though—he is actually paid as part of chairing the CCG—would have time to do this sort

of thing? Is that not satisfactory?

Dr Nagpaul: It is really important when we ask ourselves about engagement whether we are talking about engagement in a few that lead a project. True engagement is getting the grassroots involved. One thing we should learn from a previous incarnation of engagement called practice-based commissioning through the NHS Plan—I do not know how many of you remember that—was that, when we did a survey of GPs, we found that the clinical leaders responded by saying, "You know what? We are really engaged." When we asked the grassroots, we had a completely different response and they were disengaged. In fact, the scheme came to an end. The lesson from that is that the people we need to engage are those individuals who deliver care day in, day out at the coalface. We also have evidence that, when you do find that level of engagement, outcomes and performance are better.

Q96 **Andrew Selous:** Are local medical committees not involved with feeding in their views on STPs at the moment?

Dr Nagpaul: Yes, they are. I am honestly not making excuses, but most GPs are overstretched, as are hospital doctors. To engage needs a resource, it needs time, and it needs to factor in a workload where you have time to breathe, think and contribute your view. I am absolutely behind engagement and I think the NHS has always done very well when clinicians have come up with ideas. GPs, in particular, have come up with huge numbers of innovative ideas over the decades.

Q97 **Andrew Selous:** Can I ask about engagement of the nursing workforce and the healthcare ancillary workforce as well, please?

Helga Pile: Yes. One important thing is for staff to see that their representative organisations are involved. Some of the architecture around STPs, such as the local workforce action boards, have very variable involvement of staff-side representatives and are very variable in the visibility of what they are doing.

Q98 **Andrew Selous:** Have you seen some good ones that you could point us to that should be replicated or copied more widely?

Helga Pile: We have examples of an interface with the social partnership forums within the regions, where representatives from a range of staff-side unions are represented on the local workforce advisory boards, and we have some where there is absolutely nobody on them who is in any workforce capacity. There is a real range. It generates trust for staff seeing that representatives are involved around the table by some trusts. In many cases, for many staff, there are not going to be wholesale changes to what their role is, but they do not know that because nobody is saying so.

Andrew Selous: That is a good point.

Helga Pile: Sometimes, there can be a role in saying that for many staff this will not affect them at all, but others will be involved in the change.

The other thing I would like to mention is that in the five year forward view "Next Steps" document there was a somewhat inelegant reference to "de-risking service change and passporting." That is a way of saying that, to allow staff to engage really effectively, some of the things they worry about—for example, if they are going to be expected to work across boundaries between employers, portability issues, being able to maintain their terms and conditions—can be taken away by providing what is loosely termed a "passport." There are things that employers can do locally to take some of that risk away so that people can genuinely engage because they feel their employment will be facilitated; that they will still have CPD and that sort of thing.

Andrew Selous: That is very helpful.

Helga Pile: We are keen to make progress on that point.

Q99 **Andrew Selous:** Can I come on to engagement with the nursing workforce, please?

Lara Carmona: I would love to say something beautifully positive. We just completed a survey that said that from our regions across England around three quarters of nursing staff have not participated in any engagement process locally. It is important to say that good engagement in any context is difficult, and Helga and I were having this conversation before we came in. It is hard because you have to have difficult conversations. At a conceptual level, the first thing is that you have to go to where the people are, which speaks to my esteemed BMA colleague's point here. You have to go and find out where these communities are already having conversations, and, in terms of the local workforce advisory boards and any other specific changes that may be occurring, STP proposals clearly will require changes to the way people work.

Q100 **Andrew Selous:** Has the RCN talked to the nurses in the frailty assessment unit at Doncaster Royal Infirmary, because we were very impressed with what we saw there, and these are nurses at the forefront of delivering STPs?

Lara Carmona: Wonderful.

Q101 **Andrew Selous:** Have you talked to areas of good practice where STPs are rolling out?

Lara Carmona: I did a specific call-out to all 44 regions and our staff groups across England who are engaged in those local STPs mechanisms in various ways.

Q102 **Andrew Selous:** Did you hear from Doncaster Royal Infirmary?

Lara Carmona: I did not hear from them, so I look forward to hearing about that. What did come back, for the most part, was fear and

uncertainty around employment terms and conditions. If we want people to participate in active processes in which they can help improve services, we have to come to them early and often. The local workforce advisory boards are the local mechanism for that. I have a specific recommendation on STP monitoring of the dashboard functionality that they are all supposed to use. There is nothing in there on engagement. It was really interesting for my team—

Q103 **Andrew Selous:** I am going to come on to that in a second. Would you mind pausing there? I am sorry to stop you. Obviously, there are workforce plans for both doctors and nurses, which the Department of Health and Social Care has set out. Do you think they are up to the challenge of implementing integrated care systems successfully? Let us start with you, Dr Nagpaul.

Dr Nagpaul: Could you repeat the question?

Q104 **Andrew Selous:** My question is about ensuring that we have the necessary workforce successfully to implement what we might call integrated care systems. That is probably the most straightforward language. Obviously, the Department of Health and Social Care has set out its plans—25% more nurses and doctors over time. Is that going to be enough? Will that work? Do the timescales match?

Dr Nagpaul: One of the key drivers in all the integrated care approaches—not just in England but across the UK—is the movement of services out of a hospital setting into the community. We have a problem within that approach because we do not have enough GPs, and we know that, far from increasing the numbers, they are standing still, if not reducing.

Q105 **Andrew Selous:** I think half of all medical students became GPs last year, did they not, which is good?

Dr Nagpaul: It is great that we are seeing more doctors. I am a committed GP and I am very glad that we may see more GPs in the future, but those GPs will take 10 to 15 years to become fully-fledged doctors. So, as we are now, we have a very real issue about not having enough GPs. We also have seen a 44% drop in community nursing numbers, and we have cuts in social care. So, the community is not very well—

Q106 **Andrew Selous:** The Government have laid out their plans, so I am looking for a comment on what more the Government could or should do to provide an adequate workforce for STPs so that we will have doctors and then nurses.

Dr Nagpaul: Sure. I certainly think that doctors, nurses and other healthcare professionals want to work together and they believe in teamwork. We did a survey of GPs and asked them what would be the single greatest way of reducing their workload. They wanted more

community nurses to look after older, housebound patients, so there is a will to work together.

Q107 **Andrew Selous:** More community nurses then.

Dr Nagpaul: That would certainly support the growing number of older people, many of whom are housebound. However, while I think that integration is important, and I am not trying to come back to workforce shortages, integration is not going to solve the workforce shortages that we face. Therefore, we have to look at how care can be delivered with an inadequate workforce in the safest possible way. I will leave the others to comment, but I certainly think there are ways to try to reduce pressures. A lot of it is about enabling the workforce to work it out.

Q108 **Andrew Selous:** I am awfully sorry to stop you, but I am a little conscious of time, so if we could have slightly briefer answers it would be helpful because we have quite a few more questions to get through. Briefly now, can we have an answer on the workforce issues in terms of nursing and ancillary health staff?

Lara Carmona: You did a whole inquiry on this, so it is like a really long piece of string. Your fundamental question was: is what is set out in the current workforce strategy going to meet the need?

Q109 **Andrew Selous:** I am specifically relating this to STPs because this inquiry is on integrated care systems.

Lara Carmona: On the STPs as they stand, the current plans lack the level of granularity to make a determination as to whether they even understand the workforce that they need. That is the honest answer about the paper that is published at the moment. If you look at the national workforce strategy that Health Education England has produced for consultation—

Q110 **Andrew Selous:** Can you be a bit more granular in your answer? Dr Nagpaul suggested more community nurses, which was helpful, so can you point us to specific areas?

Dr Nagpaul: And more GPs.

Andrew Selous: Yes. I will come back to GPs in one second, if I may.

Lara Carmona: That is a huge, broad-brush question and, without looking at specific population need, one I would find hard to answer. We have seen a growth in the acute-based workforce for nursing and a significant reduction in anything that is outside the acute setting. That means health visitors, school nurses, district nurses, mental health nursing and learning disability nursing; I could go on. It is literally that everything outside the acute hospital setting has gone down significantly. The current national strategy that is out for consultation by Health Education England shows projected growth in some areas. It is not anchored, in so far as anyone is aware in the public domain, in any actual assessment of population need. Will STPs meet the need? Probably not.

Q111 **Andrew Selous:** I am going to come back very quickly for one final question, which is slightly off piste, if you will forgive me, Chair, to Dr Nagpaul on Larwood House in Worksop. I do not know if you are aware of this particular GP practice. Among other things, it deals with all its patients every day, so there is no three-to-four-week wait, and it is one of the basic building blocks of the primary care home model, which feeds up into the integrated care system. We visited last week and I was hugely impressed with it.

I have a general question to you. You have been chair of the GPs committee of the BMA. What are you doing to try to get GP practices to work in this way so that they can see all their patients every day? They have paramedics, community nurses and a pharmacy based there. They have reduced admissions to hospital, less unplanned care and so on. What are you doing to drive that? You have just been the chair of the GPs committee and are telling us about the strains, which we all recognise, but this GP practice was providing a really good integrated service. What are you doing to make sure there is more of that?

Dr Nagpaul: In actual fact, it is encouraging that most GPs want to be able to provide care in the way that you describe. They would like to have teams, as I said earlier. When we surveyed GPs, they wanted to have integrated teams that practise primary—

Q112 **Andrew Selous:** Larwood House has done it. Why can't more do it, or why aren't more doing it, and what do we need to do to help more do it?

Dr Nagpaul: I do not know the specific example, but one of the greatest limiting factors is the lack of transformation funding to enable that to happen. I will give you examples. GP practices and NHS England had announced that they would provide the resources to create such systems of collaboration. As I said earlier, this will not happen by magic. The practice you describe would have put a lot of time and energy into planning. That service would have had a lot of time and energy spent with other healthcare professionals, and their community provider, to create those systems. What we need and what we have been arguing for, and what I argued for as chair of the GPC, was to provide all areas with the funding to enable healthcare professionals, GPs and others to have the infrastructure. That infrastructure will have a range of ways—not just the human resources, but technology and so on. So, you are right, and I think it needs the pump priming and the support, and that is what will kick start it.

Q113 **Mr Bradshaw:** For the sake of clarity, let us not revisit the money and the workforce because we have been there so many times and absolutely agree with you on all of that, but on the principle of integration and working together between health and social care, this is a principle that none of your organisations opposes.

Helga Pile: We certainly do not oppose it, and it is what staff generally want to do. They see the difficulties where the interface does not work properly. They see what it means for the patients. What staff do not

accept is that integration saves money or that it should be pursued for that purpose. As a principle, that is absolutely right. We represent occupational therapists, some of whom work in health and some in local government. At the moment there are real issues to do with how they will interact with each other, and, again, we have started to see people looking at whether we will remove that. Part of that is employment conditions. If somebody is going to lose money by transferring from one sector to another, they are going to be less likely to want to do that, but again we have seen partnerships where people can be seconded, or whatever, so there are ways around this. What people do not accept is that integration will save money, at least in the short term, and it should not be pursued for that purpose.

Q114 **Mr Bradshaw:** Can I be clear from the RCN and the BMA that you also do not oppose these models of integration in principle?

Dr Nagpaul: As the BMA, one area of division we see is between GPs working in primary care and doctors working in hospital care. There is a huge amount of duplication, transactional costs and wastage, and behaviour that doctors do not want to get into, which is cost and workload shift. That integration—

Q115 **Mr Bradshaw:** Just a yes or no: you do not oppose these models of integration in principle.

Dr Nagpaul: I do not oppose the idea of working together collaboratively. That is something we support, yes.

Q116 **Mr Bradshaw:** What does the Royal College of Nursing say?

Lara Carmona: We support integrated approaches. I think it is reasonable to be sceptical about the risk of independent provision where there are suspicions of undermining existing terms and conditions, but, with that caveat, yes, we support it.

Mr Bradshaw: Great; that is lovely. Thank you for your clarity.

Q117 **Rosie Cooper:** STPs, ACSs and ACOs all depend on having staff to deliver their services, which is why you as a panel are here looking at answering questions on workforce. I wonder whether the new wheeze that is starting, where trusts are creating companies, transferring staff in to them and then re-employing them via a new company at arm's length in order to benefit from VAT loopholes or whatever, is becoming more widespread. Wrightington, Wigan and Leigh on the edge of Manchester, my area, is now considering that as well. Employees want to work for the NHS and retain their terms and conditions, so do you think that wheezes such as this, which surround the STP agenda and saving money, will dramatically affect work choices and pose a real risk to the future of the integrated organisations, however we want to describe them? Without staff, how do you deliver it?

Helga Pile: That is a really important issue for us, which we refer to in our written evidence. It runs counter to what STPs are trying to do in terms of joining up, because foundation trusts set up individual companies that they own at arm's length, which then have their own imperatives. The VAT issue is one thing, but, more fundamentally, it seems as though the driving factor is driving down terms and conditions, so new starters will not be in the NHS pension scheme and will have worse terms and conditions.

The effect on the workforce is profound. These are primarily non-clinical staff, and one of our criticisms of the workforce strategy that HE has developed is that it has virtually nothing about non-clinical staff, if that is even an acceptable term, because they are so integral to clinical outcomes. The sense of being cut adrift and of being less valued cuts across the kind of integrated team-working that we all want to see.

The long-term implications are that those people will not want to stay in the NHS; they really value NHS employment. This is a particularly important issue which we would welcome your assistance in highlighting because it runs counter. If we look at the experience of, say, hospital cleaning, when that was parcelled up and contracted out so that people were accountable to different management structures, we saw real issues with infection standards and all of that. We want to see integration that includes keeping the workforce integrated and working together. We see that as a real issue that needs to be looked at, and it has been done with very little consultation with staff.

Rosie Cooper: None.

Q118 **Chair:** Thank you. Did you want to make a point about that, Lara?

Lara Carmona: I can add one sentence. Responding to your specific point, we would not support moves by any organisations to create any structures to avoid tax or remove staff from their existing terms and conditions. Anything that would seek to create unfair or unsafe working conditions for the workforce or patients is wholly unacceptable.

Q119 **Chair:** Thank you. Chaand, do you want to add something?

Dr Nagpaul: We are absolutely behind the idea of national terms and conditions. I think the NHS should be what it is defined as—a national health service—and that includes national standards and national terms and conditions.

Q120 **Chair:** Thank you. Could I ask how great, in your opinion, is the risk of commercial providers taking over the provision of care for entire healthcare economies, which is one concern set out by those who are concerned by ACOs?

Dr Nagpaul: We have to recognise—we cannot just put aside—the legislative arrangements in England. ACOs first of all are provided, or will be contracted, on a fixed-term contract. That is completely different from

the way in which hospitals are contracted—to provide a service for a community. That is the first point.

Secondly, it is a contract that would fall under current procurement law, which means that any provider, competitively, could run that service. We cannot get round that. Therefore, you open out the provision, wholesale, of a large healthcare economy to a non-NHS provider, and that could be a commercial provider from abroad. That is an inherent problem in the creation of an ACO under current legislation. The fixed-term bit is also a problem because it has within it, as with all commercial contracts, the ability for the provider to walk away. You need not look much further than the recent past when we saw Circle, a commercial organisation, take over and run a hospital—Hinchingbrooke Hospital—only to walk away a year later. You cannot walk away.

Q121 **Chair:** That is my point; they did withdraw. We are hearing people saying that, although it is a theoretical risk, looking at the experience of Hinchingbrooke, it would be unlikely that anyone would bid for it. How likely do you think it is?

Dr Nagpaul: No, I do not think so. The point I was trying to make there is the ability for a provider to walk away, whereas my local NHS acute trust cannot walk away from its responsibilities to provide care. That is the bit I was talking about. Otherwise, there are many services. Capita is a very good example. It has not walked away, although many GPs would like it to walk away. There is the ability to outsource large parts of the NHS. That is a very valid concern.

Therefore, I come back to what I believe is the fundamental issue here—that we need a different legislative arrangement. If you believe in an integrated arrangement, if you do not believe in having the commercial sector run the NHS, then change the arrangements to enable it to happen properly rather than put it out—

Q122 **Chair:** This is an issue for the accountable care organisations, but for the integrated care systems and partnerships you see that as obviously separate; you see them as completely separate.

Dr Nagpaul: Yes. An accountable care organisation is contracted under current procurement rules. As to other forms of collaboration, my experience is that collaboration can and does occur bottom-up, and that is where it works best, but I also think that, even within those collaborative arrangements, they are battling hard on competition and procurement rules.

Q123 **Chair:** Finally, do you think we should drop accountable care organisations?

Dr Nagpaul: Yes, I do.

Q124 **Chair:** And just continue on with systems and partnerships. That was my simple question.

Dr Nagpaul: I really do. I think that putting out contracts for large areas of healthcare that are open for commercial organisations within a 10-year contract will be bad for the NHS.

Q125 **Chair:** Thank you. Can I ask Helga or Lara if you would like to add to that? If you agree, do not feel you have to repeat.

Helga Pile: One immediate change that could be made is to repeal the section 75 secondary legislation that enforces market competition rules, because if you could do that in the short term it would provide some breathing space and remove some of the concern and the fear that we are picking up in talking to people on the ground, which is that we feel we are bumping up against the point where we are going to be caught by that—the fear of legal challenge from private providers. That is an immediate thing to be done.

Q126 **Chair:** Section 75 is the point you would like us to raise with Ministers. Lara, was there anything that you—

Lara Carmona: I cannot say I agree because we have not consulted with our members specifically on that question, so I would not deign to say so on their behalf.

Chair: That is fine. Ben is next, and then we will see if anyone has any further questions.

Q127 **Mr Bradshaw:** If we are getting rid of ACOs, for argument's sake, and we have just got these voluntary bottom-up systems, such as the one we visited yesterday, why would you then want primary legislation apart from to do what Helga has just suggested, very sensibly?

Dr Nagpaul: I totally agree with Helga, and it is not a small issue. When you look at the microcosm of an example such as the primary care home model, it is just a microcosm. In real terms, it is not possible in my area to provide phlebotomy services without going out to tender, when GP services should be providing it. That is the scale of fear about the current procurement rules that permeate England. It is a really big issue.

I also would come back and say that that is not going to solve what I still believe is a rigid and unnecessary divide between general practice and hospital services. To overcome that, you need to get round the tariff arrangement for contracting and have an end to the idea of hospital trusts simply looking after their budget, which results in all sorts of perverse behaviour. If we want to look at integration in its fullest sense, we need to break down those barriers and transactions, and also the section 75 arrangements—if that competition bit could not be there.

Q128 **Mr Bradshaw:** How do you respond to those nurses and doctors who we met last week in Doncaster, Sheffield and elsewhere, at least some of whom said that they worried about an imposed legislative model. What they value in the current voluntary integrated model they are pursuing is that it is voluntary and they work together because they want to work

together, and that has helped to build trust? Somebody else said during this session that trust is so important for these models of integration to work well and, if you impose them from the top, that is not necessarily as fruitful as allowing them to develop organically from the bottom.

Dr Nagpaul: We are in absolute agreement because the ability for bottom-up working together is currently impaired by the procurement and competition rules. In fact, what you have now is a healthcare policy that is set by NHS England around collaboration, but the legislative arrangement works against it. If you add the payment-by-results arrangements, that adds a further division. I think you are absolutely right that no one wants to see top-down legislation. We want the ability to collaborate without having to think about workarounds and without having to spend thousands of hours looking at procurement.

Q129 **Mr Bradshaw:** I have a final question, which is more of a political question, for your three organisations as trade unions or staff organisations. Do you have a concern that, given the absolute importance of funding and workforce out of the NHS and social care, this campaign that focuses on privatisation and Americanisation of our NHS is or could be an unhelpful distraction from the really important central crisis of our NHS, which is about funding and workforce?

Dr Nagpaul: I do not think it is an either/or. The issue about funding is not shroud waving. There is a very serious issue about having about a third of the number of doctors per head compared with other nations—

Mr Bradshaw: That was not my question.

Dr Nagpaul: I do not think—

Mr Bradshaw: Does not focusing on this Americanisation thing weaken and detract from that really important case?

Dr Nagpaul: No, because I think we should look at both issues. One is the funding, and it is a fundamental issue, but if you get the funding right you still also need to make sure that the arrangements in the NHS are true to its values. Do not fragment it and do not squander in transaction costs that funding that you have put in. One problem we have at the moment—in fact we have not discussed it—is how much money is spent in the processes of tendering. Even a single GP surgery is forced to go out to the market if it closes. That itself could cost hundreds of thousands of pounds of local tendering processes. That has to stop. It is illogical that we are throwing taxpayers' money away through these processes.

Q130 **Mr Bradshaw:** Helga, you have a very important campaign—in my view, an absolutely justifiable campaign—against these wholly owned subsidiaries that has not received nearly as much political or public attention. Do you not sometimes feel that we would be better off campaigning against those than against what you earlier said could be quite useful forms of integration at local level?

Helga Pile: Absolutely. I think we need to be highlighting that particular issue because that is happening right now—

Mr Bradshaw: Absolutely.

Helga Pile: —in at least a dozen places, including the one you mentioned. That is impacting on staff right now and will impact on the services that they are able to deliver. The fears about funding feed the fear about Americanisation because people are fearful that the funding situation is going to lead to political solutions that say we cannot afford this any more and therefore we need the American model. They are very interrelated. One real concern about all of this is the complexity of it. Staff and members of the public who know what they want and value, which is all the staff employed by the NHS and working for their benefit, will worry about how to find a way into that locally, how they will be consulted and so on. Inevitably, things will get conflated, but anything that we can do to highlight the real risks right now from wholly owned subsidiaries is really important.

Chair: Thank you.

Q131 **Johnny Mercer:** Briefly on GPs—Ben touched on it—clearly, the arguments around money for the NHS and money for GPs in particular have been won, in a way. Everybody accepts that we need to have—and even the Secretary of State will sit there and say we need to have—a fundamentally different structure of healthcare settlement funding going forward. The problem comes about when GPs—I have GPs, for example, in Plymouth who do so—rail against the idea that you can have one of these hubs that the Committee visited, which work really well and improve patient outcomes and so on. They then come and say to me that they are going to oppose this because they do not believe that their surgeries should be amalgamated and so on. What does someone who is trying to legislate and make decisions for the benefit of everybody do? How do we mitigate all these conflating factors? They organise meetings and so on. I went into a school the other day following such a meeting, and one child put her hand up and said, "My dad was at that meeting last night and he said the Tories kill more people than cancer." I am thinking to myself: how are we ever going to address the fundamental issues that my party knows so well around funding if it becomes so unionised and so militarised?

Dr Nagpaul: I do not know the exact example in your area in Plymouth, but they may be referring to pressure to conform to a particular system that has been developed, because GP practices inherently want to work together. They want to have a primary healthcare team to support them. They want to work with community nurses, they want good social care and they want to work within a wider team. They want to do that. I do not know the specific example.

When GP practices are asked these questions, that is what they say. What you are describing is probably a proposal to herd practices together

against their will, and that is what they are probably rejecting. I do not know the specifics, but when GPs are asked, they want to have teams to support their workload, yes; they do want to do that. Most of them feel they do not have the resources provided to them. They have seen cuts, as I said earlier, in the number of community nurses they want to support them. That is what they are seeing. The hubs you describe may be a very good example in that particular area, but it is certainly not widespread, because we do not even have the nurses around our practices to support us.

Chair: Thank you very much to all of you for coming this afternoon.

Examination of witnesses

Witnesses: Imelda Redmon, Dr Charlotte Augst, Don Redding and Kate Duxbury.

Q132 **Chair:** Thank you very much to our final panel. I am sorry we have kept you waiting this afternoon. For those following from outside the room, could you start by introducing yourselves and who you are representing today, perhaps starting with Charlotte Augst?

Dr Augst: My name is Charlotte Augst. I lead the work of the Richmond Group of charities, which is a collaboration of 14 large patient and care charities, and together we provide services, but we also engage with health and care to better support people with long-term conditions.

Kate Duxbury: I am Kate Duxbury from Ipsos MORI. We do a lot of polling with the public on the NHS and so we are here to represent the public side of things.

Don Redding: Hello. I am Don Redding, the director of policy for National Voices. That is an umbrella coalition for around 140 health and social care charities working together on policy issues in England and health and care. We have been particularly associated with integrated or what we would call co-ordinated care since 2011.

Imelda Redmond: I am Imelda Redmond. I am the national director of Healthwatch England. Healthwatch England is a non-departmental public body. Its sole purpose is to bring the voice of the public into the heart of health and social care. There are 152 local healthwatch, one in every local authority area of the country.

Chair: Thank you. Lisa is going to start the questions.

Q133 **Dr Cameron:** Thank you. To be successful, what must integrated care partnerships deliver for patients and the public? That is at the core of holistic health. I do not know who wants to start.

Don Redding: We agree on an awful lot of things and we are going to try hard not to repeat each other. One review of the evidence on integrated care looked at definitions and found there were more than 170 in the literature. When you are asking about integrated care, or when somebody is describing integrated care in relation to new care systems, we have to ask what it means.

We worked to produce a national definition that was in a 2013 document called "Our Shared Commitment," which not only the Department of Health but all the leading arm's length health bodies, including the regulators, the LGA and ADASS, agreed was their shared definition for integrated care. That definition was based on work we had done on what it means for people, which is that care is co-ordinated. They are not interested in integration. I think MORI has probably tested this.

Integration means nothing to the average person. They want to feel that their care is co-ordinated, that the professionals and services they meet join up around them, that they are known where they go, that they do not have to explain themselves every single time, and, therefore, that their records are available and visible.

Q134 **Dr Cameron:** If I am picking up what you are saying correctly, it is about an integrated care pathway where professionals are co-ordinated.

Don Redding: It is about a holistic approach, but I would not necessarily call it a pathway because, particularly for people with more than one long-term condition, if you look at the new NICE guideline on multi-morbidities, that says we should not be on pathway or protocol-driven care packages for such people. We need a tailored approach, where the person is at the centre.

Q135 **Dr Cameron:** The patient journey.

Don Redding: We find out what their priorities and goals are, we work to support those, and we judge outcomes by the extent to which people can achieve good outcomes.

Q136 **Dr Cameron:** You are saying it is co-ordinated care—that it is not necessarily that the systems are integrated.

Don Redding: Absolutely not, and one of the big problems with the area into which we are inquiring is that it is yet another example of believing that structures are the answer to quality of care.

Dr Cameron: That is very interesting.

Dr Augst: I would very much agree with Don and, therefore, keep it very brief. I have yet to meet a patient who says they want integrated care for themselves, but people want to not have to repeat themselves all the time, they want to know who is in charge, and they want that to be in a simple question and answer. People want to know what to do in a crisis. Often, I think it is only the patient and their carer who understand who is on the team. Therefore, if you do not start by asking that question, you do not understand which pharmacy, which GP, which hospital consultant and which charity are on the team and therefore what we are co-ordinating. From the patient perspective—the care perspective—it is really important to understand what it is we are trying to co-ordinate so that you are rolling it out from that end rather than from the integration end, which always starts with structures.

Kate Duxbury: I would absolutely echo that it is not about structures for the patient. It is about how they experience their care. Just to give you an illustration of that, if you talk to the public about social care in the NHS, they are not able to identify what services are provided by the NHS and what services are provided by social care. To them, it does not matter who is providing it. What matters is that pathway, continuity of care and all the things that my colleagues have explained.

Imelda Redmond: To add a little to that, the public do not see themselves as patients. Unless they are in front of a clinician, they are just people, and certainly they do expect that joined-up health and social care around their needs.

Q137 **Dr Cameron:** Yes, but it is a joined-up social care around their needs; it is not necessarily an integrated service at that level.

Imelda Redmond: From the public point of view, if you are talking about rail services, it is the same: we want to have trains that run on time and get us to where we need to be. We are not thinking about who has which part of the franchise.

Q138 **Dr Cameron:** When patients are thinking about quality, it is not about the service structure; it is about—

Imelda Redmond: No. It is the quality and it is their outcomes.

Don Redding: They are thinking about quality. The most important thing about the quality is that it is the outcomes that matter most to them, and they are not always necessarily expressed as clinical, medical or treatment-type outcomes. It is how people manage their lives in the context of health conditions, many of which are not going to go away.

Kate Duxbury: Can I add something? There is also an assumption that these things are already integrated. If you say to a person that a hospital might not have access to their GP records and vice versa, they are very surprised about that and will assume it is already happening.

Imelda Redmond: Likewise for social care. They just think that it is there—that they will be able to move seamlessly from one part of the service to the others with the information flowing.

Q139 **Dr Cameron:** It is about that seamless care co-ordination. What, if any, changes would you make to ensure that ICSs, ICPs and ICOs deliver those benefits to patients?

Imelda Redmond: I do not mind starting on that. People tell us that they—and Kate will tell you more about this—feel very passionately about the health and social care system. They care passionately about it. They want to be able to have their say within it. They want to be taken seriously. They hate things like waste, they hate duplication and they want to help the whole system run more smoothly. That comes up time and again when you talk to the public. They want in some ways for it to be understood that it is their service. They do not want to be "done to." It is theirs and they want to be an active part in that.

Q140 **Dr Cameron:** They have an ownership of it and feel a real value for the service.

Imelda Redmond: Yes, absolutely.

Dr Augst: If I might add to that, if you think about the people who are trying to lead these efforts on integration—and I am talking now based on the work we are doing in Somerset where we as the Richmond Group have partnered up with one STP in particular as well as with 2,800 local charities and many more community groups—they have very limited bandwidth to make headway. We have heard today that the system is under pressure and we all know this. The system is running red hot. If we want to really make progress for the people who are using services, it is not helpful if that very limited bandwidth is taken up by constant churn of initiatives and demands from the centre to restate, redefine and re-govern the case for change.

One thing I would like to land with you all on how we can strengthen local leadership on change is for those people to have the bandwidth to focus on the change where it needs to happen, which is at the interface where people are using it, looking at need, looking at unmet need and looking at how best to meet that need. We need to stop demanding so much other stuff of these people—so much upwards reporting. We do vanguards, then we do STPs and then we do ACSs, and then we call it integrated. If you only have a few hours a week to engage with local change—and that is already probably quite an optimistic estimate—we must not squander that. The opportunity cost of constant initiative churn, in our experience, based on the work we are trying to do there but obviously also on the work member organisations are trying to do all over England, is immense.

Q141 **Dr Cameron:** The constant reorganisation in some ways detracts from quality of patient experience and care.

Dr Augst: It takes away the focus on service user need: what is going to be different once we are done with this initiative for this woman who has survived a stroke and is looking after her husband, who has Alzheimer's? How is it going to be different for her? If you want to stay focused on that, you have to stop focusing on so much other stuff.

Don Redding: Going back to the 2013 shared commitment, it came out of recommendations that the Government commissioned from the King's Fund and the Nuffield Trust on what were the most important things they could do strategically to support integrated care. Their view was to create a single compelling narrative for what it is about and what it is going to achieve.

Imelda Redmond: I think that is partly what you saw when you went on your study to Bassetlaw. They get why they are doing it, do they not?

Mr Bradshaw: Absolutely.

Q142 **Dr Williams:** Is that more about organisational culture than organisational structure?

Don Redding: That is one way of looking at it. You would do well to get Nick Goodwin from the International Foundation for Integrated Care in to

talk about this, but most of the successful programmes of integration that have survived the churn of reform, whether here or elsewhere, have had a very strong idea of what is the litmus test for where we are going. That has very often been a narrative, such as Mrs Smith in Torbay—that was one of the originals of that, but it has been used in many other places. The litmus test is: how will this make it better for Mrs Smith? If we cannot answer that, we do not do that piece or we do not get involved in that process.

Imelda Redmond: Culture is very important.

Don Redding: It is having a vision, and a strong single narrative: this is where we are going. Progress has been made, I think, in some areas and the better STPs will reflect the fact that they have come out of, or come through, the previous vehicles of change and reform, whether it was the integration pioneers and then the vanguards, and now the STPs and ACOs. The same areas that will look good now are the ones that, even before the integration pioneers were started in 2013, had already been trying to put those trusted relationships and collaborations in place and have managed to make those survive.

Chair: Kate, did you want to comment on this at all?

Kate Duxbury: It is fine, thank you.

Chair: Paul, did you have something else?

Q143 **Dr Williams:** We are on question 17. The NHS five year forward view described an aspiration to strengthen partnerships with the community and the voluntary sector. To what extent has that aspiration been realised so far?

Imelda Redmond: I think you get a different answer depending on where you are in the country. In some areas, they have done absolutely fantastic work. In south London, they are doing a huge amount of work with the STP. There are six healthwatch in their patch. They are doing huge amounts of work to get right into the communities and, through community groups, getting to the voices of people who are rarely heard. You might go somewhere else in the country and have no talk of partnership. It is very variable. There is no way at the moment on the dashboard of measuring whether or not people are engaging well with all the different key stakeholders.

Dr Augst: I would also question that. If that was the strategic intent of the five year forward view, which is obviously one we would wholeheartedly agree with, it has not been very clear that the STP process was set up to deliver on that strategic intent. It is not entirely clear what the strategic purpose for the STP process is, full stop; that is part of the problem. The ill-defined nature of the STP endeavour means that people can project on to it whatever anxieties or hopes they have

about it. It is certainly not clear that the USP of them was to strengthen partnerships with communities and the third sector.

Clearly, we welcome the intent to create a place-based dialogue around health and care, and to bring local authorities and the NHS into a much closer conversation around these issues. Where it has worked well to engage with the VCS, I think there was probably a history and culture of collaboration. At best, I would have thought that the STP process has been neutral in how it has been involved with the VCS, and initially, because of the sort of rushed nature of how this process was set up and the need to—I can only think of loaded terms—concoct plans very quickly, the VCS felt frozen out. I do not know whether people want to—

Don Redding: In the first year, it was very poor in most places, including Greater Manchester, which now have pretty good partnership arrangements with the voluntary and community sector. Actually, in advance of this session we asked our friends at NAVCA, which is the membership body for councils for voluntary service and other such local infrastructure bodies, to put out a question to their members. Often, that is what they said: it was a disastrous start, but it has got much better since. There is a sense that there has been more reaching out now, and there are more organisations getting on to key partnership bodies, pathway panels or consultative committees, but I think it was a slow start.

Q144 **Dr Williams:** We have also heard, as part of this inquiry, from voluntary sector organisations that say that, even when the level of engagement is good, they are not necessarily commissioned on a long-term basis to deliver.

Don Redding: That is certainly true, but then you need to keep a little bit of separation between delivery and engagement in changing the design of care, I think.

One thing that NAVCA, ourselves and others here would say is that, if you want to engage the voluntary sector in general in this endeavour, you need organisations that can broker that engagement, because the sector is very wide and diverse and it is very common for health services to reach for those organisations that they have already heard of that already have the size and capacity to be able to engage in delivery. The majority of the sector, in terms of numbers of organisations, are small to medium bodies that need an honest broker to help them engage. Those bodies have had their funding severely cut because they mainly took their grant funding from local authorities. When we talk about the austerity years, our sector does not come with free resource ready to make it up for the public sector.

Dr Augst: That very much resonates with our learning from Somerset, where we have just published a learning report, which I think we have shared with the Committee. You need bridging organisations and we have tried to act in that way in our engagement in Somerset, but we could not

have done it if there had not already been a bridging organisation, which is the local VCS forum there. One reason we decided to work with Somerset was because there was already a strong relationship there between the local authority and that forum and part of the NHS and that forum. There is no way a hospital or a GP federation can engage with 2,800 charities.

We need to find ways of bringing collaborations of collaborations together around places. That can only happen if, as Don has said, you are clear on what it is you are trying to achieve. Because it is hard to achieve, it has to be something that people feel passionate about, and people are more likely to feel passionate about making things better for people rather than creating efficiencies. If the only thing that brings you together is a desire to create efficiencies, you are going to stop at the first obstacle because it is not something anyone is really very passionate about, whereas making things better for people is why health professionals get out of bed in the morning and why charities exist.

Imelda Redmond: Could I pick up on that? I have seen it work well where the local STP has properly engaged with the local healthwatch, which does have a role in co-ordinating and bringing things together, and really recognising their role. The example I gave a moment ago was about south-west London, which brought six healthwatch together, and then they went on and co-ordinated out through all those communities. Manchester is doing the same now. We have seen some great examples in Devon and also in Suffolk and north Essex, so when it works well—and I would say it is maturing—it works really well, because you can get right into those communities and you can get real engagement with people who feel, as we have said, passionate about this and they come on that change journey with you. It is really important that we do that so that, across the board, people really do understand that they need to bring their communities with them.

Q145 **Chair:** Thank you. Can I move on to how we engage the wider public in service change? I have certainly been to public meetings where almost nobody is there at the early stage of planning, but, at the later stage, when there are proposals to deliver the change, you can have a packed meeting. At that early stage where you are trying to communicate or co-design, it can be quite difficult to engage people. Do you have any thoughts, Kate, on how we can better engage the public to understand and look at how services are designed at the earliest stage?

Kate Duxbury: We see in consultations around reconfigurations that you quite often do hear from your very engaged population who have very strong views and know an awful lot about the NHS and how it runs. That of course is not your typical person, so you have to do something different to get your typical people—something beyond just having an open process where people who are interested can get involved.

To highlight that, we asked back in December 2016 about STPs and whether people wanted to be involved in developing their local STP. We

had 44% who said they would like to have a say in the STP for their area and another 39% who think people should have a say, but say, "Not me. I am too busy. I do not have time to engage with that." It is very difficult to get people engaged.

There is something about having a range of different techniques to call on, and targeting your engagement depending on what you are trying to achieve. The open side works brilliantly for everyone who is interested to come in, but then you have pockets of hard-to-reach groups—people living in more deprived areas, for example—which you would have to get into. That is not going to happen by just opening the doors and letting anyone have their say. Through the voluntary and community sector in particular, you can go out to the very specific experts who work with those groups and make sure you are covering those off.

I would also say you sometimes just need to recruit a general group of people. I always say this, as a polling company, but a representative survey means that you are including lots of different people who do not have strong views, and so you have a much more representative idea from them of what they would and would not accept. Equally, you can have a more detailed conversation where you can recruit 30 people who are not experts and do not have any preconceptions about this, put them together in a room and talk them through the challenges, and what we are trying to do differently within the NHS, and then you can get their responses to that. It is a small number of people, but it really allows you to develop your communications approaches because you can see what messages land for people and what messages turn people off.

Q146 **Chair:** That is a citizens' jury-type approach.

Kate Duxbury: Yes, like that, and through the course of a day or an evening you help people develop their views. The advantage of that is really to develop your comms because it is such an emotive subject. Suggesting changes that might impact on a district general hospital brings in a whole other level of emotion for people, so you have to find out what are the benefits to talk about and what real impacts that would have on people so that, when you communicate with the wider population, you have those hooks to hang it on.

Q147 **Chair:** Imelda, I know healthwatch do a huge amount of this work. Is that something you would like to say more about, engaging with the public right through from the very earliest stages through to service change?

Imelda Redmond: Yes, please. One thing that we find, particularly with health services more than local authority-provided services, is that people feel that they cannot go out to the public until they have an answer to consult on. We see that that is a real mistake and that you need to take people with you from the beginning—all the methods that Kate is talking about: deliberative events that get into the deep and see what changes people's minds, and higher-level survey work with a group of experts who

come and talk about a particular pathway. You need a range of methods to engage the public, but also you need to make it tangible.

I saw some very nice work done by Suffolk and North East Essex STP. They did all their deliberative events with the public and they could interpret what people were saying. They could understand the difference in life expectancy between Southwold and Jaywick, which are both in their patch—I cannot remember how many years it is—so they could quickly get to, "The public think that is not fair." Then they can relay back to people in very tangible ways, "We will improve the life expectancy," "We will reduce that gap," or, "We will have a zero tolerance on suicides in our patch." These are tangible things that people get, which is quite a different language to, "We will improve the pathway for people who need tertiary care on blah."

STPs need to really invest in their comms and engagement people to make it real for people, and then people will come forward because they do care. Some 44% said that they would like to be involved in an STP. I was not asked that question. I do not know whether I would have said yes on a rainy Wednesday night when I was walking down the high street.

Kate Duxbury: There was also another 17% who just want it done and do not want a say in it.

Imelda Redmond: They want someone else to do it, yes.

Q148 **Andrew Selous:** I have a very small point, picking up on something you said, Don, which struck me quite powerfully. I think you said that there was not a simple, clear narrative that people could latch on to. I wanted to check. I have four bullet points in front of me here from NHS England and NHS Improvement. They are: "Creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS. Supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation. Delivering more care through re-designed community-based and home-based services, including in partnership with social care, and the voluntary and community sector. Allowing systems to take collective responsibility for financial and operational performance and health outcomes." That is all a bit of a mouthful and it is a bit technical.

Am I right, first, in saying that there is nothing in there with which you would disagree much? To me, it all sounds eminently sensible and quite urgent that we get on with it, but what is your take on those four bullet points?

Don Redding: That is from the planning guidance, if I remember rightly.

Andrew Selous: Correct.

Don Redding: That is the closest set of statements to having some definitional clarity about what STPs and ICSs are for, but they are not the only statements.

Q149 **Andrew Selous:** Are you broadly supportive?

Don Redding: There are others. The one we would be particularly supportive of is moving care closer to home where it can become person centred and co-ordinated and where you have sufficient resource to support that. The problem is that there is not any money for that one. There is absolutely no resource for that, so you are asking people to achieve something that they are not being resourced to achieve.

Q150 **Andrew Selous:** I take your point about money, though perhaps with a system-wide pot some reallocation might be possible; but let us park the money for the moment. I am focusing on the narrative, which was your very good point, and people do not get it. Did you want to add to that?

Dr Augst: If it is supposed to be a narrative that inspires, engages and leads to more cohesion, then, again, it needs to start with user need. It needs to start with people using services. For me, at least three of those bullets are very system focused. A point around cross-sectoral working needs to be re-phrased as, "The system not getting in the way of you getting what you need when you need it; not walking constantly into conversations where people are not the right person to talk to right now because it is someone else's job to do this bit for you." The narrative needs to start from that end of the lens rather than, "We are going to achieve these great goals for the system."

Q151 **Andrew Selous:** You would say it perhaps needs to be re-written in slightly more layman's terms from the patient's and person's perspective as to how it is going to impact on them.

Don Redding: Can I try a statement out on you, Andrew?

Andrew Selous: Please do.

Don Redding: I can plan my care with people who understand me and my carers, allow me control and bring together services to help me achieve the outcomes that are important to me.

Andrew Selous: That sounds admirably crisp and simple.

Don Redding: That is from the 2013 shared commitment. That is the summary goal of integrated care.

Q152 **Chair:** Do you sometimes feel concerned that these statements are made in public consultations that are perhaps about the closure of a community hospital? I have been to consultations where people can feel very concerned that they are being asked to agree to a statement that is then taken implicitly to mean that they are giving consent to something that they do not agree with. Do you think sometimes the way we consult with people does not allow them to answer or respond to the question that

they have all come to the room to answer? Do you know what I am getting at?

Dr Augst: We did some consultative work with members of the public who were not very expert in health and care, not priority users of healthcare; obviously, some of the people we work with are very expert. I would argue, to start with, that if you want to redesign why people with mental health crises turn up in A&E on Friday, you need to ask them, but let us park that; they are obviously very expert.

The people who are not very expert care very passionately about the principles behind the NHS, and anything that looks like messing with that sets all sorts of alarm bells going, so it is not that they do not care. What they really care about is, "The NHS is a safety net for my life. I do not think about it, but I want to know it is there and I have two access points into that safety net. I can call my GP or I can go to A&E." Anything that messes with that is, in their perception, radical.

Everything else that we think is radical because we know it is hard—risk-stratifying populations, wrapping care around them and working across sectors—is not radical because people think that is what happens anyway, but messing with access to a GP and to A&E is important even if people do not think very much about health and care. I think that any engagement that does not have a really crisp answer to that question is on a hiding to nothing.

Q153 **Chair:** Right. We have to really address the questions that matter to people. Thank you.

Kate Duxbury: You also have limited time for them to be interested in what we are trying to say to them. Therefore, you have to pick the messages that we really need to talk to them about and leave the others. The other thing I would add is that what you just said is an example of the mistrust that we see within the system at the moment. With the more recent qualitative work that we are doing with people we find that there are even higher levels of mistrust now than before. Part of that, I think, is about how you put the messages across and who does that. Frontline staff are trusted a lot more than managers within the NHS, so if you are going to try to put those messages across, it is about the "who" and trying to get the people whom the public will trust. Then they are less likely to think that we are going to take this principle and try to apply it in a way they are not happy with.

Q154 **Chair:** Thank you. Do any of you have any key messages or points that you would like to make that you would like to appear in our report about how STPs and integrated care partnerships and systems should be upping their game in effective communication?

Kate Duxbury: This is a slightly negative point, potentially, but it is worth bearing in mind quite how much has to be engaged about. One STP is looking at so many different issues that matter to so many different people in different ways that actually it is very difficult for them to

engage with the public and represent everything they are saying. It is worth recognising that it is a difficult job with the public, a percentage of whom are not actually interested.

Q155 **Chair:** Thank you—the sheer scale of it, yes.

Kate Duxbury: Yes. It is nice to ask how we are going to get them to engage earlier, but there are some people whom we are never going to get to engage.

Dr Augst: I have already said something about that. Another point I would make is that the people we had in our deliberative workshops were very allergic to jargon. Not only does jargon go over people's heads but it raises suspicions. It makes people suspicious that there is a story there that they are not being told about, which is, when you look at some of the communication that comes out of STPs, things like, "We are going to do outcome-based, place-based population health, and integrated commissioning systems." I do not even know what that means, so the jargon is not just ineffective; it risks—

Q156 **Chair:** It is alienating.

Dr Augst: —the good will, because people say, "I am sure there is something here. I do not get it, but I am sure there is something here."

Chair: Yes, thank you very much.

Don Redding: I would return to my point about ruthlessly defining what integration means, preferably doing so from the point of view of the outcomes that matter most to people and, in terms of metrics, using those outcomes plus outcomes in relation to staff satisfaction with the role and the service they are working within.

Imelda Redmond: We think that there has been too much focus on sustainability and not enough on transformation in the plans. That came through from a lot of our local healthwatch. Also, they believe there would be less cynicism in the system if the STPs had independent chairs, because they often see parts of the system as their own hobby horses.

The final point is that in the dashboard that is used to define how well STPs are doing there is a new measurement—a new metric on engagement—and on engagement we would put the public and staff.

Chair: Thank you. Those have all been incredibly helpful points. Does anyone have any further points to raise?

Mr Bradshaw: I want to thank this panel particularly and say how much, for me, this emphasises the importance of having the patient and user voice at the centre of all of these discussions, and of health policy in general, because this has been a much more fruitful session. One reason I did not ask a question is that you were excellent.

Chair: It has been incredibly helpful to have such clear messaging, so

thank you very much.