

Health and Social Care Committee

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

Tuesday 6 March 2018

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[Watch the meeting](#)

Members present: Dr Sarah Wollaston (Chair); Luciana Berger; Mr Ben Bradshaw; Rosie Cooper; Diana Johnson; Andrew Selous; Derek Thomas; Martin Vickers; Dr Paul Williams.

Questions 157 - 264

Witnesses

I: Ian Williamson, Chief Accountable Officer, NHS Manchester Clinical Commissioning Group; Paul Maubach, Chief Executive Officer, Dudley Clinical Commissioning Group; and Simon Whitehouse, STP Director, Staffordshire and Stoke-on-Trent STP.

II: Councillor Jonathan McShane, Local Government Association; Niall Dickson, Chief Executive, NHS Confederation; Saffron Cordery, Deputy Chief Executive and Director of Policy and Strategy, NHS Providers; and Julie Wood, Chief Executive, NHS Clinical Commissioners.

III: Professor Chris Ham, Chief Executive, The King's Fund; Professor Katherine Checkland, Professor of Health Policy and Primary Care, University of Manchester; and Nigel Edwards, Chief Executive, The Nuffield Trust.

Written evidence from witnesses:

- [Local Government Association](#)
- [NHS Confederation](#)
- [NHS Providers](#)
- [NHS Clinical Commissioners](#)
- [Professor Katherine Checkland](#)
- [The Nuffield Trust](#)



Examination of witnesses

Witnesses: Ian Williamson, Paul Maubach and Simon Whitehouse.

Q157 **Chair:** Good afternoon, and thank you for coming to our session on integrated care: organisations, partnerships and systems. As a note before we get going, we are not here to examine the issues that will be the subject of the judicial review. If possible, we would like to keep a patient-centred approach to this inquiry. Before I kick off with questions, for the benefit of people following from outside the room, can I ask each of you to introduce yourselves and who you represent?

Simon Whitehouse: I am Simon Whitehouse. I am the STP director for Staffordshire and Stoke-on-Trent.

Ian Williamson: I am Ian Williamson, chief accountable officer for Manchester Health and Care Commissioning, which is a partnership of Manchester Clinical Commissioning Group and Manchester City Council. I am also the accountable lead for Our Healthier Manchester, which is the health and care plan for the city of Manchester under the auspices of the health and wellbeing board within Greater Manchester devolution.

Paul Maubach: I am Paul Maubach. I am the chief accountable officer for Dudley CCG and Walsall CCG, but I am really here today because I am the lead for developing the multi-specialty community provider in Dudley for which we hope to use the ACO contract, should it become available.

Chair: Thank you all for coming. Ben will lead off today.

Q158 **Mr Bradshaw:** All of you will be aware of the controversy surrounding these integrated care models, so it might be helpful to the Committee and those watching from outside if you could outline what is going on in your area, why you are doing it and how you think the public in your area will benefit from what you are trying to achieve.

Simon Whitehouse: The principles of what we are trying to deliver in Staffordshire and Stoke-on-Trent are really simple. Fundamentally, we need to improve the health and wellbeing outcomes for the population we serve. We need services we can deliver that are clinically sustainable and financially viable. That means we look after people well; we look after them closer to their own home; we keep them in their community for as long as possible; and we use hospital services at the appropriate time and with the right resilience in those hospital services. I do not think there is anything radical or challenging in that, but we have to do better in Staffordshire and Stoke-on-Trent around the outcomes for the population we serve and the patients we look after.

Ian Williamson: In Manchester, we are setting up integrated proactive neighbourhood-level care that can improve health and wellbeing and also help us to become more sustainable in finance and workforce. We think that in order to set up that neighbourhood-level care we need



organisational integration as well, to enable delivery on the ground, in particular to enable health and care staff—doctors, nurses, social workers and others—to work together to common aims in each of our 12 neighbourhoods, and to move from a small-project mentality to doing things in a consistent way across the whole of the city.

Our local care organisation, which is the organisational design, goes live in 25 days' time. It will have a budget of about £150 million initially. As commissioner, we are commissioning that through existing contracts, wrapped around by a partnership agreement signed up to by all the participants in the local care organisation.

Our integrated commissioning is between the clinical commissioning group and the city council, and that is entered into voluntarily. We retain our legal accountabilities statutorily. The local care organisation is a partnership of four: the GP federation, the city council and its adult social services, the community services provided by our acute hospitals and the mental health trust. That partnership has been entered into voluntarily. They are working together to deliver integrated services at neighbourhood level. In common with Simon, our intention is to provide and enable improved care for residents at neighbourhood level.

Paul Maubach: In Dudley, we are developing what we call a multi-specialty community provider, or MCP. It is designed to meet the needs of our population. The predominant needs we are trying to address start with improving same-day access to urgent appointments in primary care. About a third of our population are living with at least one long-term condition, so we are looking to bring together the services around that which should be supporting people better to manage their condition.

In addition, we have more and more people with multiple complex needs and multiple comorbidities who need proper multidisciplinary co-ordinated care in the community. That is another part of the model of care for the MCP. It brings together primary care services, social care services, community services, community mental health, prescribing medicines management and long-term conditions management services from the hospital to enable our frontline staff, who should be working together in collaboration, to meet those needs in the community. It brings them together into one team to support and address those needs. We are currently running a procurement to bring together those services, and a partnership of our local foundation trust and GPs is putting together plans to establish the MCP as a stand-alone organisation.

Q159 **Mr Bradshaw:** I do not know whether you had a chance to see last week's evidence session, but you will be well aware of the criticisms of the levels of the models of integration: they are a Trojan horse for privatisation; they are about cost-cutting; and they may even be illegal. How do you respond to each of those criticisms—cost-cutting, Trojan horse and illegality?



Simon Whitehouse: In Staffordshire and Stoke-on-Trent, we are not as advanced in that level of integration, as you will hear from my colleagues, as Manchester and Dudley. We are starting from the principle: how do we build collaboration across the public sector, working across health and social care, with the voluntary and third sectors, to start to build relationships in a more collaborative and co-operative way, set against a previous approach driven by the policy around competition? We are trying to move away from the competition approach that would then drive privatisation and the other elements.

In terms of the challenge of whether what we are trying to do is legal or illegal, Ian and Paul will comment on that in more detail. For us, the starting point in Staffordshire and Stoke-on-Trent is very much about strong community services, with current providers working well together to meet the needs of the population, and starting to challenge some of the barriers between health and social care so that we do not have the artificial hand-offs or inefficiencies that those create for local people.

Chair: Before we continue, I remind you that we are not examining the legal aspects of that because that will be the subject of the judicial review.

Q160 **Mr Bradshaw:** I will rephrase the question. The suggestion is that what you are trying to do is work around the Lansley Act. I would not expect you to prejudge the outcome of the legal proceedings, but I am sure you can find a way of answering the question that does not do that.

Ian Williamson: I will try. For us, the contract is an enabler, but it is not the main thing. The main thing is to enable staff locally to work with local communities to deliver better care, making sure that we can put an organisational arrangement in place where people know who they are working for and are working together in teams at local level, and that we have a contractual system, which obviously stays within the law—we have done that at all times—but does so in a way that tries to make it as smooth as possible for a GP, a district nurse and a social worker on the ground to deliver co-ordinated care for their patients without always having to revert to different organisational approaches.

You asked about cost-cutting. Frankly, we all live in a world where we have budgets that we must stay within, and it is our role to do so. I do not think there is a part of the NHS in the country that is not struggling to manage a set of very competing pressures. We think we have no choice but to try to transform the current system in the city of Manchester. We have no choice but to try to find a better way of professionals being recruited and retained and a better way of meeting needs on the ground. Inevitably, that means we have to manage the money within that, but this is not a cost-cutting exercise at all.

On the question about privatisation, as I said in my introductory comments, in the same way as Dudley we have been through a procurement process because we are legally obliged to do so. We have



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reached a certain point with that. We have now paused it pending a number of national and local measures, but the preferred provider that has been chosen is an entirely public sector set of providers: local GPs, the council, the mental health trust and the community services operated by the acute service.

Q161 Mr Bradshaw: You said you have paused it because of certain national measures. What national measures?

Ian Williamson: We are waiting to see whether there is a contract from NHS England that becomes available and is useful. From what we have understood so far, there are a number of barriers or challenges around things like VAT to try to overcome. Most importantly, we also need to move at a pace within the city where we keep those partners together because, for example, there is no point in pursuing a contract if it means that one or more of our partners will be stepping aside from the operation. We are proceeding this year with existing contracts with a partnering agreement around them, and, depending on what is available, we will assess in the autumn whether we proceed to a different type of contractual arrangement.

Q162 Mr Bradshaw: Why might one of the partners step away from it?

Ian Williamson: NHS and social care is a fiendishly complex world, as I am sure you know. The different partners I have described—foundation trusts, councils and GP federations—are all subject to very different types of regulation and statute, so it is important that on the ground all of those partners feel as if they are moving forward together at each step along the way. If one of them becomes unsettled or uncertain because of regulations, we will obviously want to make sure that together we can find a way of proceeding.

Q163 Mr Bradshaw: This is quite important. Can you elaborate? What regulations, and which partner might become unsettled by them?

Ian Williamson: Let me give a tangible example. Ideally, we would like to have a contractual arrangement that brings together health and social care. The current draft NHS England contract does not include social care, so it would be suboptimal for us to proceed with that if social care has to be dealt with differently. In order to bring social care fully into the arrangement, there are also, we think, pretty significant VAT implications because of the way staff or contractual arrangements are impacted in VAT terms, possibly a hit for us in Manchester of about £9 million, for which there will be no patient benefit. We need to understand each of those issues before we can proceed properly, and if one partner or other is unwilling or unable to proceed we need to assess that situation.

Q164 Mr Bradshaw: Perhaps you could write to us about that in a bit more detail because the Committee might want to say something about it in our recommendations. Mr Maubach, on the three points I raised, how about your patch in Dudley?



Paul Maubach: I agree with everything Ian said. In terms of cost-cutting, our job is to try to get best value within the resources available. This is not about cutting costs; it is about designing the care to try to best meet the needs of our population. That is one of the critical things about the contract. It is an important enabler—perhaps we can go further into the detailed reasons why—to help us mobilise, support and incentivise the way in which we want frontline care to be delivered and the kind of outcomes that both our population and clinicians want to achieve. The contract is designed specifically to support that.

As to privatisation, that is a complete red herring and misunderstands what we are doing. You put in place something like the ACO contract only once you already have really strong and effective partnerships in the system. In Dudley, we have a long history of collaborative and partnership working. We have had a partnership board that brings together GPs, the voluntary sector, the council and NHS providers to collaborate and look at how we redesign and develop services, and the contract enables us to take the next step forward. You will not implement this contract if you do not already have really strong and effective partnerships in place. If you already have strong and effective partnerships in place when you run a procurement process, it will be incredibly difficult for any private sector organisation, or any other partner outside the system, to demonstrate that it can add value over and above the partnership you already have.

In our system, in the procurement phase we are at, it is a partnership between the NHS foundation trusts and the GPs. In most of the conversations I have had with private sector organisations, their predominant interest is not about running the ACO, but about how they can add value to it by providing the right technical IT infrastructure or the right supportive business intelligence capability that the NHS system locally might not have. To consider that as a move to privatisation is, I think, a fundamental misunderstanding.

Q165 **Mr Bradshaw:** Is there a chance that from the other end you could be hit, as Surrey was, by a legal challenge from the private sector for doing what you are doing, basically keeping them out and keeping this public, which is not, they would argue, in line with the 2012 Act?

Paul Maubach: We have not kept them out. We have run a procurement process that is in line with procurement legislation. All I am saying is that I think it is incredibly difficult not just for the private sector but for another NHS organisation outside that local partnership to demonstrate how it could add value over and above what is already there. In theory, it is technically possible for that to happen, but I would say the likelihood is very rare. As you can see from the two systems you have here, they are NHS partnerships that are coming together.

Q166 **Dr Williams:** Ian and Paul, my understanding from what you have described is that neither of the organisations emerging in your areas includes acute services. Is that right?



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Paul Maubach: Dudley's MCP does; it includes long-term conditions management services such as diabetic and respiratory care.

Q167 **Dr Williams:** But it does not include acute admissions to hospital.

Paul Maubach: It does not include the delivery of those. It includes issues around how you best manage the interface between primary community services and the hospital, but not the mainstream hospital services.

Q168 **Dr Williams:** Is that right for you, Ian?

Ian Williamson: It is very similar for us. The local care organisation—the out-of-hospital provider—is trying to avoid unnecessary hospital admissions and to enable people to be discharged from hospital as appropriately and effectively as possible, but it is not providing acute hospital services.

Q169 **Dr Williams:** Why have you not brought acute services into the mix in these organisations as well?

Paul Maubach: We have where we think it is appropriate. To give you the specific example of diabetic care, it stems from what we are trying to achieve. We are trying to address the needs of our population. As I said, a third of our population is living with a long-term condition, and more and more patients have multiple complex needs.

If we take a long-term condition such as diabetic care, at the moment the way we commission that is that there are two providers: the GP service and the hospital-based service. We pay for the GP service at the moment on the basis of practice population, and there are incentives aligned with that around stable management of the patient's diabetic condition. At the moment, we pay the hospital service on the basis of how many times the patient goes, regardless of the outcome. That is complete nonsense. The reality is that the clinicians, both GPs and diabetologists, are in effect delivering the same service. GPs are delivering it to our 20,000 diabetics; diabetologists are delivering it to a subset of that, but what we, clinicians and patients really want is for those professionals to collaborate for the same outcome objective, which is stable management of patients' conditions and to help individuals to manage better their health and wellbeing.

Through this process, we are bringing those services together. Instead of commissioning them on the basis of how many times you see someone, we are commissioning them on the basis of a shared objective around shared outcomes that both patients and clinicians want. We are designing the system of care and the service based on how we encourage and enable the achievement of those outcome measures.

The MCP that we are developing is really about supporting people out of hospital. Which services need to come together better to help people manage their own health and wellbeing, or which services need to come



together better to care for people in their own home? It requires some hospital-based services to be part of that, but it does not need intensive treatment or cancer services and so on; they still need to be in the hospital provided separately in the way they are at the moment.

Q170 **Dr Williams:** Ian, is it the same philosophy for you?

Ian Williamson: For us, it goes back to the Our Healthier Manchester plan, which I touched on. In its first iteration, the description was that we wanted to simplify our fragmented and complex system, based on the unfortunate reality that we have the second-worst life expectancy figures in the country, despite our growing economy. What we want to do is to try to connect better our population to our growing economy. That means we need to find better ways of improving health and wellbeing. As we all know, only about 20% of the health of any of us in this room is directly attributable to health and care; most of it is attributable to education, housing, employment and so on.

We developed a plan with three main pillars. One is to create a single commissioner, which I lead. That is commissioning the £1 billion-worth of health and care in the city, but it is also about trying to reach out and improve our connections with education, housing and jobs because we know that has a real impact on health.

On the provider side, we are creating a single hospital service and a single out-of-hospital service and making sure that there is very close collaboration between the two, but effectively keeping them separate for several reasons, including the risk that something is too big. Inevitably, there are some concerns historically that hospitals, given their power and size, take over and swamp, and have an impact on other things.

Q171 **Dr Williams:** I agree with you entirely. You are doing exactly the right thing, but I wanted to check your rationale. The next part of my question is about how that will affect the resource allocation. Will there be an opportunity for a shift of resources away from the acute sector and into more community-based healthcare?

Paul Maubach: That is absolutely our intention. I think the Dudley model is very similar to Manchester's, in that our objective is to have two main providers so that we have a multi-specialty community provider, which includes primary social care and community services, and a hospital provider. At the moment, half our resources go to the acute sector and half to the rest of the system, but the rest of the system is in multiple different organisations, so bringing them together enables a better balance in the system in the way our care is organised.

There are significant challenges to that. For example, in the planning guidance this year, there is a growth model around acute care; there is not a growth model in the planning guidance around primary and community services. There are very clear requirements in expectations about growing emergency admissions by 2.3% and elective care by



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3.6%. There are expectations around investment in primary care, but there is not the same growth model set out by the regulator. While we are trying to achieve that shift, the purpose of which is to bring together services in the primary and community sector to enable them to be more resilient, we are still working in a regulatory environment that is not necessarily fully aligned to that. Part of the challenge we face is not only how we deliver it locally but how we demonstrate that we are making that shift happen.

Q172 Dr Williams: The final part of my question is about the need to form a single organisation. I guess the best way of asking that question is this: if NHS England was to turn around tomorrow and say the ACO contract would not exist, would you still be able to deliver what you want to achieve through an alliance contract with a number of different organisations? How does forming one single organisation really help you?

Paul Maubach: There are several elements to that. It would be a significant challenge. I do not think we would be able to move with the pace of integration we want. The first point to be clear about on the ACO contract is that it starts with primary care. It offers the opportunity fully to integrate primary care with the rest of the system. There is no other contractual mechanism available to do that. Without the ACO contract, you cannot formally integrate primary care with community mental health and other services.

Why do we want formally to integrate primary care? Primary care is not resilient at the moment. You will have seen examples of primary care homes. We have the equivalent in Dudley, where we have multidisciplinary teams around practices. I have been in Dudley for five years. When I started, we had 52 practices. With closures of branch surgeries as well as practices themselves, we are losing practices at the rate of one every six months. That trend is continuing. The reason that is happening is that primary care is not resilient. There are not enough GPs coming through, but the demand pressures on primary care are huge. They are huge because we have a changing demographic; we have a changing population, who are presenting with multiple comorbidities and complexities that require a multidisciplinary response. It requires primary care not to stand in isolation but to be supported by the other community services around it.

Q173 Dr Williams: Does this result in the nationalisation of primary care as well?

Paul Maubach: It results in a kind of integration of primary care with the rest of the NHS.

Q174 Dr Williams: At the moment, GPs do not work for NHS organisations.

Paul Maubach: No, they are outside that.

Q175 Dr Williams: If an ACO was formed, would that be an NHS organisation and, therefore, would GPs be working for the NHS rather than as private



companies?

Paul Maubach: The way the MCP arrangement works is that there is flexibility. Practices can choose to be either fully integrated, which means they are employed and then they would be part of the NHS along with all other staff, or partially integrated where there is a formal integration agreement between the practice and the MCP. They retain their own identity as a practice and their own GMS contract, but there is a formal agreement about how they collaborate and work together on the outcomes we are trying to achieve.

Q176 **Dr Williams:** That is an MCP, but, if it became an ACO, would it be an NHS organisation?

Paul Maubach: MCP is a form of ACO. We are using the ACO contract to create the MCP.

Q177 **Dr Williams:** It would not be an NHS trust that held the contract.

Paul Maubach: The proposal coming forward through our process is that the MCP would be an NHS foundation trust.

Ian Williamson: Your original question was in a sense about funding available for community service and whether we expect to see that.

Q178 **Dr Williams:** A funding shift.

Ian Williamson: One of the benefits of the devolution agreement for Greater Manchester was the later agreement of a transformation fund for Greater Manchester from NHS England. That is a £450 million non-recurrent fund over four years, which has enabled us to start pump-priming, double-running and investing in community services to build them up, so that they are capable of providing more effective wrap-around care, in the expectation that it can have a real impact on the way we use our hospitals.

Q179 **Dr Williams:** That came as part of the devolution deal, did it?

Ian Williamson: Yes. For example, in the city of Manchester our local care organisation, which I have referred to, will receive, if it performs, about £30 million over the four-year period to invest in programmes such as the one we call high-impact primary care, which is a set of multidisciplinary professionals working together to care for people right at the top of the triangle of need, and ensure that their needs, whether physical health, mental health or social, are managed in such a way that they do not go in and out of hospital, as we know patients too often do.

Paul Maubach: The other part of your question was about what we would do as the alternative. We would have to have some form of alliance arrangement similar to what we have now. We would have to contract for the outcomes we want to achieve separately from each organisation rather than commissioning it collectively.

Q180 **Dr Williams:** That just makes it more complex. It makes accountability



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more difficult if people are working for separate organisations, including some that may be non-NHS organisations.

Paul Maubach: Exactly. We are trying to achieve alignment, so that we have a single organisation enabling the way our frontline staff want to work. We think we can deliver much more progress more quickly if we have a single leadership arrangement around that rather than multiple different organisations.

Q181 **Dr Williams:** Simon, do you have any comments you would like to make?

Simon Whitehouse: Ian made a really important point about the transformation fund. With Staffordshire and Stoke-on-Trent being one of the more challenged areas in terms of both performance and financial viability, we have a real challenge. We need some of the flexibilities that are being offered and talked about in the more successful parts of the patch to enable us to make the scale of changes we need to make, but the resource, effort and focus is going to areas that are doing really well; they are advanced and probably had strong and robust relationships in place previously to enable some of that to happen. I would make the case, and articulate really strongly, that while we understand that and we need to learn from those areas, if all of that resource and effort goes into the ones that are at the leading or cutting edge, we are creating an even greater gap in terms of what that looks like.

In Staffordshire and Stoke-on-Trent, we are having some really positive conversations with both NHSE and NHSI about what flexibility might look like at local level, to enable us to make some of the changes we are all committed to. The model is no different: integrated community teams; strong general practice; strong community services with integrated mental health services, linked with social care provision; and looking after our nursing and residential home patients in a fundamentally different way. However, at present the money and resource does not exist in our system to enable us to do some of that double-running, and we do not have the same level of flexibility.

Q182 **Chair:** Can I clarify a point you made earlier, Paul? You said that GPs who are currently independent contractors to the NHS could remain independent contractors to an ACO; they would not have to be directly employed.

Paul Maubach: That is right. They would retain their GMS contract with us as the CCG and they would have a separate agreement through the ACO about integration and shared objectives around delivery of the outcomes we are trying to achieve.

Q183 **Chair:** From the patients' perspective, if you are not able to proceed with an ACO contract in your area, will that result in any detriment to them compared with what you would want to do if you could achieve it through the contract?



Paul Maubach: Yes.

Q184 **Chair:** Could you set out for us what the difference would be from the patients' perspective?

Paul Maubach: From the patients' perspective, the developments we are trying to implement would happen at a much slower pace. The detriment is that I do not think we would be able to achieve as much progress as quickly as we would like, because we would not have the singular drive of one organisation with everyone working to one set of objectives; we would still have staff in multiple organisations. It takes time to negotiate changes you want to make. We already have in Dudley very clear collaboration. We have multidisciplinary teams working with each practice. At the moment, patients see that working and experience that. We have incredibly positive reports from our patients about the quality and experience they get from that holistic service, but the efficiency with which it works could be better if everyone was in one team rather than in separate organisations.

Q185 **Chair:** One other thing that often arises from the perspective of patients is that, if there are lots of different organisations and they complain to one, they are passed from pillar to post. Would this mean that, if something was going wrong, they would have a single organisation to which they could make a complaint?

Paul Maubach: Yes, one organisation. A corollary is that we have one organisation called "the hospital." If I told you today that I was proposing to split the hospital into lots of divisions, each with its own management team, and they would have to work out an alliance about how they collaborated to deliver the acute contract, you would say I was completely mad. Why do we have that arrangement in the community? We have multiple organisations, but actually the public want one joined-up service. Why are we not delivering one organisation that does that for them?

Ian Williamson: To give a brief answer to your last question about the key point of contact, in Manchester at neighbourhood level, in each of our 12 neighbourhoods and the local care organisation, there will be a single leader responsible for that area. That may be a GP; it may be a nurse; it may be a social worker, but a single person has a line of accountability for delivery of services in that area.

Q186 **Chair:** Very many integrated systems have a single point of contact. It is when something goes wrong that issues can arise. You would have a single person who is accountable across the whole system if something went wrong.

Ian Williamson: Yes.

Q187 **Andrew Selous:** As part of the Committee's visit a week or so ago, we went to see a GP surgery that was part of the primary care home model, where basically they were seeing patients the same day. There were



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paramedics, pharmacists and community and voluntary activities there. I understand that about 1,000 of the 8,000 GP practices in the country offer that type of model, trying to abolish the distinction between routine and emergency. Does the STP process put real rocket boosters under that improvement of primary care practice? How quickly can we move GP practices through the STP model up to that sort of higher level of provision?

Simon Whitehouse: For us, general practice is absolutely central to all of the plans. Paul has already talked about the challenges of sustainable general practice. A significant focus and piece of work in our area and patch is absolutely on that. We know we will not bring in enough GPs to cover the vacancies and make general practice resilient on its own. How do we get GPs to work together, with general practice at scale, where that makes sense? How do we bring in physiotherapists and other allied health professionals? How do we bring in the paramedics?

We need to be careful not to throw the baby out with the bath water, however, because what is really important to local communities is strong, embedded general practice that they recognise and have a relationship with. Often, it has looked after generations of their families and that builds a strong relationship. How do we keep the real strengths of general practice, while adding resilience to it and putting support structures around it, to enable it to look after more people and the changing demands of the patients who walk through the door?

To answer your question about whether the STP brings a rocket booster to that, for us it absolutely brings a renewed focus, discipline and interrogation in saying, "How do we bring attention to detail in strengthening and making general practice resilient?" because the rest of our model is built on that.

Ian Williamson: A three-letter acronym such as STP is only as good as the relationships of the people and organisations within it. I am not sure that in itself it delivers anything particularly. Greater Manchester will say that we are a precursor to the STP arrangements, and there is a long history between the councils and with the NHS of building relationships, trust and experience in delivering different services.

In relation to general practice in this context, we have some very good examples. One is seven-day access. Manchester was an earlier adopter of improving access both at evenings and weekends to all our residents. We have found that we need to work with general practice rather than impose any model on it. Every practice is unique. The more we can encourage them to work collaboratively within federations—or whatever the different language is where groups practise together, so that they can learn from each other, work with each other and increasingly provide some services at a scale that would otherwise not be possible—the better. Primary care home can be a solution for some practices in some areas. The key thing is developing the relationship such that we trust each other and do things for the benefit of patients.



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Q188 **Andrew Selous:** Are you having success in encouraging GP practices to go down the road you have just described?

Ian Williamson: Yes. All of our practices are members of the GP federations within the city. In their different ways, they all provide enhanced services either for their own patients or across a bigger geography, and they are full partners of the local care organisation.

Chair: We are running short of time. Rosie has a quick supplementary and then we must press on to the next question.

Q189 **Rosie Cooper:** It really is a follow-on from your line of questioning, Sarah. HMRC and the Treasury have commissioned a not yet published report into the ways GPs are paid. I am told that there is an embarrassingly high number of variants throughout the country as to how GPs are paid. Do you think the way GPs get paid and the mechanisms they are using with regard to tax will make a difference to their involvement and level of engagement in ACOs?

Paul Maubach: At the moment, I see GPs really struggling. Sometimes, a lot of practices are struggling even to pay GPs a decent salary. That might not be consistent across the country, but the pressures primary care is under are such that we need to find a different way of enabling general practice. The model of care for general practice has been the same since the inception of the NHS. I do not think it is a resilient model going forward.

Q190 **Rosie Cooper:** The core of the question is about the mechanisms used by GPs to receive their pay at whatever tax level they decide it ought to be. Do you think those kinds of decisions and mechanisms will impact on the way GPs look at and get involved in ACOs? When that report is published, I believe it will be quite an event.

Paul Maubach: I can probably comment on the report once I have seen it.

Q191 **Rosie Cooper:** Me too, but you will know about the various mechanisms used. Do you think that will influence the way GPs approach this?

Paul Maubach: All I can talk about is my experience of the situation in Dudley. I know that a lot of our GPs are struggling to ensure that they can deliver sustainable care and take home a decent salary at the same time.

Chair: I do not think we can continue with a report that has not been published.

Q192 **Rosie Cooper:** Do you think it is okay that, for example, GPs get paid into their practice and not directly so they pay their tax independently?

Paul Maubach: Their practices are their businesses, aren't they? That is the way you pay businesses—into the business; that is the way it works.



Ian Williamson: In my experience, the vast majority of GPs work incredibly hard and far beyond the number of hours anybody would expect them to do. We need to have proper regulations in place to manage those who are doing something different or untoward, but let us not forget that we need to work with the vast majority of them to improve the NHS.

Rosie Cooper: I could not agree more, but they should play by the rules.

Chair: Andrew, do you want to go on to your group of questions about integrated care systems, or do you feel that has been covered?

Andrew Selous: I think it has been covered.

Q193 **Diana Johnson:** Before I start my questions, which are more broadly about STPs, I want to be clear about the Manchester model. You talked about the councils and the CCG in your introduction. We have also talked about devolution. We have a mayor in the Greater Manchester area. Where does the mayor fit into the ACO? What role does he have or not have? Is there any accountability to the mayor?

Ian Williamson: I am not here specifically to represent Greater Manchester devolution. What I can describe is my understanding of the arrangements, which is that existing accountabilities remain. CCGs are accountable through NHS England; councils remain accountable through democratic means and through DCLG. The Greater Manchester mayor—it is not just a mayor for Manchester—can have a real and positive impact, frankly, on particular issues that are important for the whole area. One key area our mayor has focused on is homelessness. He has encouraged successfully all public sector and private sector bodies to work together to try to reduce the blight of homelessness in Greater Manchester. I think that is a very worthwhile activity. He does not have direct accountability for the health and social care system.

Q194 **Diana Johnson:** Okay. I thought he had a role in that.

I want to ask all three of you about STP processes and the way they have been managed nationally. I think they have had quite a bumpy ride. Could you say something about your view about how STPs were established and what has happened since?

Simon Whitehouse: The challenge of the pace at which they were brought in and talked about is well referenced and evidenced. Ian and Paul have both touched on that. I am less worried about whether we talk about an STP or a different three-letter acronym. The absolute focus for us is on how we build a strong and robust collaborative relationship between our health and social care partners that is focused on meeting the needs of the population we serve. Irrespective of what abbreviation you put across the top, or what iteration of guidance sits with it, that needs to be the central core and tenet of everything we are trying to do.

The initial challenge, which Mr Bradshaw talked about in terms of whether it was cost-cutting, privatisation or a secret set of plans drawn up, was



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undoubtedly unhelpful in building strong relationships and a commitment to delivering their objectives right at the very start. Having come through that, we clearly recognise that we need to engage much better with our local communities. Having patients, lay members and non-execs holding people to account, driving it and talking about how to meet the needs of the population so that we get the right decision making and do that collaboratively across organisations is fundamental.

There is also recognition that as we sit here now STPs in their widest sense are not statutory bodies; they do not exist in an organisational form. It is literally the strength of the relationship and the collaboration that sits underneath it that drives it. We have to keep coming back to why we are here and what we are trying to deliver for the population we serve. For me, you can change the three letters as many times as you want, but we need to serve the local population, improve health outcomes, bring a real focus to rigorous continuous quality improvement at local level and get partners to work collaboratively to drive that change.

Ian Williamson: I agree with Simon. The most important thing is getting people from different parts of the health and care system talking and working together. The process of creating, for us, GM devolution and, for others, STPs has been very powerful in getting people together to have conversations we would not previously have had.

I have two extra points. One is that it cannot stop at just the statutory sector or public sector bodies; it has to reach out to neighbourhoods, community groups, be they communities of interest or geographical communities, and the voluntary and community sector. It is crucial that this is a journey we go on together, so to speak.

The second point is that, from my background largely as an NHS person, this has given us the opportunity to have conversations about, for example, how we try to reduce childhood obesity, or how we work on emissions in our atmosphere in a way that we have not previously been able to do. Those are real things that impact on people's health and wellbeing, and it has given us a way to address them.

Paul Maubach: I agree with those comments. We need to do things at the right level for the right population. Primary care home is about collaboration with a population of about 20,000 to 30,000. How do we get teams working at that level? In the work we are doing at MCP level, there are populations of 300,000 where we are bringing in extra resources, capacity, resilience and long-term conditions management.

STPs are operating at population levels of 1 million-plus, so it really needs to be predominantly about how we get the acute collaboration we need. In our STP, we have been focusing on things like cancer targets and ensuring that we get those delivered across the network. It is about doing the right thing at the right level. We do not want any one of those to be predominant over another; we need the flexibility and



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sophistication to be able to deal with different things at different population levels.

Ian Williamson: In a sense, the key is working at a place level rather than just individual organisations. If there is one lesson I have taken from the last three or so years, it is place-based focus rather than organisational focus.

Paul Maubach: It is population.

Q195 **Diana Johnson:** If you have a model that is place based—you say that is the preferred model and the one that works for patients—how does that fit with national regulation and oversight, which tends, as I understand it, to be in silos? Do you think there needs to be a new way of oversight and regulation designed for place-based, or do you think the models we currently have will carry on? It seems that there is a lot of failure to communicate across those systems of regulation.

Simon Whitehouse: Regulation at the minute is on an organisational basis, and we are talking about the place-based bit. There is a clear contrast, which is what your question is about. At local level, I would articulate examples where NHS England and NHS Improvement are already starting to work with us to say how they might align their resource and work with us in a different way. There is some really good work around that in Staffordshire and Stoke-on-Trent with our regulators.

Q196 **Diana Johnson:** Can you give an example?

Simon Whitehouse: If you are trying to get assurance on something, it is always the case that when you send out spreadsheets, questionnaires and requests for information and receive them back, they do not quite answer the question you want to deal with in the first place, whether it be for winter planning, the 18-weeks or the four-hour targets. What we are trying to do is bring the teams from NHS England and NHS Improvement closer together to work with us in the STP, to develop assurance together and understand the questions we are trying to answer jointly, so that it is not the backwards and forwards bit of the responses and paperwork.

We are starting to add value to the process much closer to the patient in terms of how we develop the assurance mechanism around continuous service improvement, or the modernisation agenda, where we are trying to change services or the way we look after the population. We are bringing some of that regulation closer together and doing it once and well, and doing it with them, rather than at a distance where you get a backwards and forwards information flow. That also creates additional capacity. It creates management capacity that we can focus on saying, “Can we go further with the improvement? Can we go further with the transformation?”

Ian Williamson: We think that regulation works best where it works with us and tries to reflect our needs locally. For example, where NHS England and NHS Improvement work together with us to help us to



achieve our aims, that is great. A specific example is in the city of Manchester. I mentioned at the start that we had a large number of services and quite a lot of fragmentation. With the help of national regulators, we have changed our mental health provider from one that was not working to a better, more established and effective one. We have moved from three clinical commissioning groups to one clinical commissioning group. We have merged two of our big hospitals into one. We have done all those things in full collaboration with our national regulators. They are supporting us to achieve what we want to do in architectural terms to give us a stronger basis for providing the integrated neighbourhood-level care I described. It works best where we can have a dialogue that enables them to support us.

Paul Maubach: I want to raise one risk with the way things are at the moment. Where is the centre of gravity in the NHS? The centre of gravity is towards the acute sector, not towards integrated primary community provision. That is on multiple levels. It is on the level of the growth model I described earlier for acute care, not primary community care. It is on the level of control totals; there is talk about sharing control totals. The only organisations that have control totals are NHS providers and CCGs. Primary care does not and councils do not, so it pushes the gravity of attention towards the acute sector.

In terms of the leadership model in the NHS, there are large-scale hospital-based organisations; we do not have any large-scale integrated care providers at the moment. We might have two soon in Dudley and Manchester. There is gravity in the system towards the acute sector. If you look at the historical growth in investment, it has been towards the acute sector. A major challenge at the moment is how to shift that gravity towards integrated care to support people, managing and supporting them to live with the complexity of the conditions they have, in their own homes. At the moment, there is still a structural deficit in the NHS, which gravitates towards the acute sector rather than integrated care delivery in the community.

Simon Whitehouse: We have all talked positively about where that alignment is happening and how it can go. Your question was very specific: does it need to change going forward? Yes, it does. It also needs change as we move forward, even though we have all articulated the positive way we can work with it now in local systems.

Q197 **Dr Williams:** The process by which all the integration is happening has been described to us as a bit of a fudge, because the legislation still requires competition, in particular section 75 of the Health and Social Care Act 2012. Would it help your job in delivering integrated care to patients if there were legislative changes?

Paul Maubach: Yes.

Ian Williamson: Yes.



Paul Maubach: I will give you some specific examples. It would be quite helpful if we were not legally required to go through a procurement process, because it is very time-consuming. If we have a system that is working well, to be able to switch from the current NHS standard contract to an ACO contract without the need for procurement would be extremely helpful because it would speed up the process significantly.

We have quite rigid structures and rules around NHS providers. There are only two organisational forms for NHS providers: NHS trusts and foundation trusts. We need a different kind of NHS provider that can deliver the integrated care model, taking some of the strengths of primary care, which is more around a partnership model, and some of the strengths around CCGs, which is a clinical leadership model. I would like to see legislation that facilitates much more flexibility and enables you to create new NHS providers, because it is incredibly difficult to do that—almost impossible, in fact—and it stagnates our ability to innovate. We need much more flexibility in the design of organisations.

Lastly, we need legislation in the longer term that guarantees integrated care. I do not think there is anyone who disagrees that we need integration focused on sustainable primary community services, but how do you guarantee that when you have a system at the moment that gravitates towards hospital care, understandably? We need policy decisions on prioritising investment in primary community services, and a focus on what the public really want, which are the health outcomes and benefits for them around their long-term care needs, long-term conditions management and long-term health and life expectancy. You can do that with integrated care.

Q198 **Mr Bradshaw:** Would it be helpful to you politically if that legislation explicitly ruled out a sole contract with the private sector?

Paul Maubach: I do not think that is necessary.

Q199 **Mr Bradshaw:** The danger that the critics point to is that that is theoretically possible.

Paul Maubach: I think that is a political consideration.

Q200 **Mr Bradshaw:** Would it help you politically in terms of the controversy surrounding these models if that was specifically ruled out by the Secretary of State in the legislation?

Paul Maubach: It would not necessarily help me as the commissioner. It would certainly give confidence to NHS staff and also to the public. When we did the original public consultation around developing the MCP, the one concern that came from our staff and from patients was about privatisation. We have been able to demonstrate that that is not real, but if you talk to the public and ask what they want, they are not averse to the private sector facilitating or helping with development in the way I described earlier, but most of the public and most staff would prefer NHS providers.



Q201 **Dr Williams:** Most of the staff want to work for the NHS.

Paul Maubach: They want to work for the NHS.

Ian Williamson: The 2012 Act is not fit for purpose in pursuit of integrated care. That is the case. It will need an overhaul in time, when, for example, primary legislation is available. In the meantime, we have to, and we will, make progress locally in the ways we have described, sometimes with work-arounds. What would help in the shorter term is a serious look at some of the underpinning regulations, such as the VAT issue we touched on right at the start, to make sure that there are not perverse incentives or real barriers to pursuing what we can pursue within existing primary legislation.

Simon Whitehouse: Everything we have been talking about is how you break down the commissioner/provider split. We can go so far with that on the basis of working through relationships and collaboration, but ultimately primary legislation articulates the commissioner/provider split, and going forward the sustainable integrated way of delivering care is not to have that distinct split in the same way as now.

Chair: That is a very helpful note on which to end. Thank you all for your evidence this afternoon.

Examination of witnesses

Witnesses: Councillor McShane, Niall Dickson, Saffron Cordery and Julie Wood.

Q202 **Chair:** Thank you, all. I am sorry to have kept you waiting. For those following from outside the room, could you introduce yourselves and say who you represent?

Councillor McShane: I am Jonathan McShane. I am a cabinet member for health and social care in Hackney in east London. I am here representing the Local Government Association.

Julie Wood: My name is Julie Wood, chief executive of NHS Clinical Commissioners, which is the independent membership organisation for clinical commissioning groups across England.

Saffron Cordery: I am Saffron Cordery. I am deputy chief executive of NHS Providers. We are the membership organisation for 99% of NHS trusts across England.

Niall Dickson: I am Niall Dickson. I am chief executive of the NHS Confederation, which spans the health service, incorporating both commissioners and providers of all types, including specialists, ambulance trusts, mental health trusts in the acute sector and the independent sector that provides services to the NHS.

Chair: Thank you very much. Martin will open the questioning.

Q203 **Martin Vickers:** I would like to explore a little the progress that some



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areas are making in comparison with others. Why are some STP areas more advanced, or further behind, than others?

Councillor McShane: If you ask anyone involved in the system who is doing well, they would point to Greater Manchester, which is effectively an STP, and they would probably talk about Nottingham and Nottinghamshire. Those are probably the two that come up most often. What they have in common is good engagement with the relevant local authorities. They have a very clear sense of place that the people who live in those areas would recognise. That is not the same with all STPs. They also both happen to have leadership that comes from a local government background, which may be part of it.

The areas struggling to make as much progress are those where place may be based on acute patient flows, rather than the other assets that exist within a community, such as community services, or a local authority footprint. The places that have not engaged sufficiently with local authorities have struggled to make progress, and I think they will continue to struggle.

Niall Dickson: I think that is true. As has been said to you before, the history of relationships, both within the health service itself and between the health service and local authority, seems to me the crucial factor in how quickly organisations were able to take forward the STP signal when it was given. Where there has been no history of very close relationships, they have struggled to make it work and go forward at pace.

Saffron Cordery: From the provider perspective, what we have heard from trusts in our membership is that there is huge diversity in the progress being made. Some at the front are really flying, and they need to be enabled to do whatever they can. One of the factors that underpins the diversity is that those right at the front, the top five—I do not want to rank them necessarily—that have been making real progress have been fully supported by the national system, so there is a full support programme in place.

What we are worried about is that we have STPs at different rates of development. As colleagues have said, that is for a number of reasons, including the fact that some of them are new relationships, with new organisations coming together and working together for the first time. However, what we have not seen is widespread support spanning the whole sector. What we have to do is make sure that we offer differential support to different STPs depending on where they are on their journey. It is often no fault of theirs that they are not as developed in their relationships, integration and collaboration; it can be the fault of circumstance and what is already happening on their patch, which means that they cannot make progress without additional support and financial investment.

Julie Wood: I agree with what my colleagues have said. The starting point in history and relationships is very important, also the geography.



Some of the geographies the STPs were built on were the same as the places people were working in—for example, Nottinghamshire or Dorset. We heard from Greater Manchester that they have been working in that way for some time. Some of the other geographies did not feel as natural, so it has taken time to get to first base. Those are some of the reasons. Relationships are really important.

I echo Saffron's point. We heard from Ian that Greater Manchester had a transformation fund. Some of my colleagues in other areas would look at that with envy because they have not had that extra start. We know that having some headroom in terms of resource to help you make the changes you need to make helps you to get on your way. Those are some of the reasons why some are flying further ahead than others.

Niall Dickson: The other obvious point is money. Inevitably, areas that are under financial or operational pressures have found it more difficult to lift their heads and try to look over a longer period of time than just trying to cope with the here and now.

Q204 **Martin Vickers:** To sum up, in areas that are behind, engagement, leadership, relationships and finance are perhaps the four key factors they have to focus on.

Saffron Cordery: And the level of investment and support they have. I differentiate that from finance.

Julie Wood: Yes.

Q205 **Martin Vickers:** STPs have had a lot of comment in the media and in Parliament. Do you think that has affected progress on the ground at all?

Saffron Cordery: Obviously, the national and local media impact on how things are received locally. One of the critical things is about how well, or not, the narrative around STPs has been articulated. What we have seen is a direction of travel that was very clear in the architects' heads but not necessarily very well translated into plans on the ground, if I can use that analogy. We have to see a clear articulation and some alignment in what we expect from STPs.

If we think about where the system is at the moment—the different parts of it and what they expect of NHS trusts and everyone else in the localities—the CQC is focusing heavily on quality and the level of staff involved in each different activity. Then we have an HSI looking at things like whether we can bring the sector into financial balance—is the performance okay and are they going to improve their CQC ratings? Then we have NHS England, which is looking at the vision it wants to implement—will local systems work together, and can they implement their cancer, mental health and maternity taskforces? Then we have DH, which predominantly looks at things like patient safety, and previously things like seven-day services and a paperless NHS. We have something that is quite atomised and is not giving us a complete picture.



What came to mind when I was thinking about this was the parlour game where you fold over pieces of paper and everyone draws a part of a person. You have someone wearing a bowler hat and then someone wearing a leotard, someone wearing a skirt and someone wearing a pair of hobnail boots. You get a person, but not a coherent person dressed in a way we would accept as usual. What we are seeing is a bit like that. It is atomisation and not a really clear picture, which means that people do not have something to hold on to; they do not have a piece to latch on to that says, "I understand the direction of travel and what this is about. That is what the national level wants; this is what we do locally, and we know there is an enabling framework in place."

Niall Dickson: The history of the health service has, frankly, long struggled with public engagement. The traditional means by which you consulted the public was to have a very firm plan. You took that plan out, you went through a period of time and you either got it through or you did not. The way STPs started was probably not terribly helpful; they were seen as secretive. As was reflected in the earlier session, people were saying, "We probably did not go out enough."

The lesson is probably about going out and being more courageous in engaging with communities and the public, even when you do not have a firm plan. That is quite nerve-racking in some ways, but the history in this area tells you that if you engage with people, even if you do not yet have a firm plan, and say, "This is the direction we want to go in; these are the trade-offs," having that honest argument with local communities is the right way forward. I am quite optimistic. I think it will get better going forward than it has been in the past. People have struggled.

As was mentioned right at the start when Jonathan referred to local authorities not being involved, local authorities have more experience in this area. Going forward, there is a real prospect that we can go out and have very grown-up conversations, hopefully supported by local and national politicians, because there are some difficult conversations, as well as ones that explain how the new models of care will work.

Q206 **Martin Vickers:** Are you saying that quite a bit of the comment has been misinformed?

Niall Dickson: A lot of the comment is misinformed. The idea that this is a secret plot in Jeremy Hunt's desk to privatise the NHS is palpable nonsense. Everybody involved in the process knows that that privatisation argument is nonsense, but it has certainly tainted the brand. I suspect that Mr and Mrs Smith walking down the road probably do not know what STP stands for and do not understand a lot of this process. That is part of the problem, but the way it was launched and people's genuine fears about what might happen have become attached to both the letters and the process, and we have to move on from that. The way to move on is to engage with local communities.



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Building on Saffron's point, at national level there is something about setting out the narrative more clearly and simply. Where are we trying to get to? What is different? It is also being honest about the difficult choices being faced. When we are under financial pressure, there is a terrible meeting whereby organisations face very difficult financial decisions, yet for a good reason we want to move on to a new space. They are not the same, but they are absolutely held as being, "Oh, the only reason you want to do this is to make cuts and save money."

Q207 Chair: We have a lot of questions to get through, so could you just add to or disagree with any points?

Councillor McShane: It would have been of assistance if local government was helping to sell what the STP was trying to do, but why would they go into that when they had not been involved in the development, and they think it is primarily focused on the NHS side of things and not focusing enough on social care, public health promotion and other things local government can do? This evening, I am going to a public meeting in my borough about our plans for integration. I will go into that because we have been involved in it from the start. Even if it involves some difficult proposals and decisions, we will defend it and, if needs be, we will take a hit on it. That was not the case with STPs. As Niall said, local government, perhaps not through choice, has a lot of experience of discussing very difficult decisions in service redesigns with its residents, and the NHS needs to tap into that.

Q208 Andrew Selous: Saffron, you represent the acute trusts. Is there nervousness in the acute sector that STPs might be a bit of a play for their budget, or do the acutes get the fact that if we get this right it can significantly reduce unplanned and unnecessary admissions to hospitals? Where is the acute sector overall on this?

Saffron Cordery: It is important to note that the acute sector sits among our membership because it has close working relationships across all types of trusts. I think acute trusts are fully behind the integration and collaboration agenda. They are already working in STPs and ICSs to focus on things that really matter, not just to their bottom line but to the quality of care they offer patients and the public. Areas such as Frimley, which is probably often quoted, are doing brilliant things on reducing length of stay and getting demand down, and making sure that there are fewer emergency admissions. Those are the nuts and bolts of acute care on a day-to-day basis. I would say absolutely that acute trusts do not see it as an attack on where they come from; they see it as a way of easing the issues and challenges they face.

Q209 Dr Williams: We asked the previous panel whether or not any legislative changes were needed in order to help care organisations and the new environment in which people are being asked to work. Do you have any opinion on that?

Saffron Cordery: Yes.



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Julie Wood: Yes, indeed. What we do not want is a top-down reorganisation of the structures, because that will distract. However, we see the need for an easing of parts of the commissioning process that are causing some of the problems my colleagues talked about a little earlier. Some relaxation around the rules on procurement would be helpful. It is where our current systems are running close to where the legislation ends. Our new system of working together in an integrated way depends much more on collaboration between organisations, and at one point that pushes up against the procurement and competition elements you talked about earlier in terms of section 75.

There are also some interesting dilemmas and challenges around choice, and where choice plays through in our new system. If we are working in a much more integrated and collaborative way with all of the providers and commissioners around a place, working together with the very scarce NHS pound, we want to make sure that we utilise the workforce and everything we are currently paying for. If you then have a free choice system playing in and you have to pay for the staff but pay again for an intervention, that creates a difficulty. In those sorts of areas, some relaxation around secondary regulatory freedoms would be welcomed, so that my colleagues from whom you heard can get on and deliver the health improvements and transformation they need for their population.

Niall Dickson: Legislation is inevitable, but it will not come any time soon and I think we all recognise that. That means people have to do the work-arounds people have talked a lot about. I do not think there are a large number of supporters for the 2012 Act and what it has done. There will come a time when Parliament will have to intervene and set out a new form of legislation. I hope it is approached in a very different and much more consultative way, which allows for greater flexibility at local level, but nevertheless gives ordinary users of the service guarantees about what they can find in their local area, because it is still a national service and still needs to be. It needs visible governance and accountability.

To support what Julie was saying, although I am saying something different, there is a need to recognise a variety of provision within any new structure. There is a danger of creating airless rooms in which you simply have one provider who is there for a huge amount of time. There is huge diversity supporting the NHS, not just the independent sector but the third sector that is so important in the delivery of services. I think there is a feeling among that sector, and indeed the independent sector, that there is a danger that we are moving towards closing it off, so any new legislation would have to be very clear about entry to that and its being part of the service as well.

Saffron Cordery: It is very important that we separate the notion of collaboration and integration. At the moment, what we have in place does not prevent collaboration. I will not say it fully enables it, but it does not prevent collaboration. Organisations are coming together; they are



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working together. We have to recognise that we are operating at significant risk under the current framework. There is governance risk and decision-making risk at the moment, and if we want full integration with local government across the piece—primary, secondary, mental health, social care and acute care—of course we need legislation.

At the moment, things are operating on the basis of, say, committees in common, which have representatives from all the different organisations coming together. They can agree decisions, but because STPs are not statutory bodies they do not have decision-making powers. Those powers have to go back to the individual institutions. Therefore, they are operating at a distance from the decisions they are making. That has an impact on the level of risk, and on governance, accountability and lines of sight over what we are doing.

I would not urge legislation, because we do not want to see wholesale change, having had one system bedding in; but the current system is not working, so perhaps we need evolution, testing out and then some legislation. The devolution deal in Manchester was tested and then there was legislation. That finalised the deal and it could go ahead, so that might be a model to follow.

Q210 Dr Williams: How can legislation make sure that local progress is not impaired? What I have heard is that it needs to be done by consultation and at the right time. Are they the two main factors?

Julie Wood: It needs to go with the grain of what is working locally. We now have the examples of the two devolution deals; we have the eight ICSs, so let us look at how they are working and what they are putting in place to make their systems work. Then let's build any legislative change around what is working locally. That will give us the benefit of building it from the bottom, but it will give us the national frameworks we need.

Q211 Dr Williams: It also needs to be built around knowledge of the areas of the country where patients are not getting the services they need.

Julie Wood: Absolutely, because at the end of the day even with the ICSs only 20% of the population will be covered, so for 80% they are still using work-arounds to try to do the best thing for their populations.

Saffron Cordery: It is worth remembering that to put STPs on the statute book, quite far-reaching legislation would be needed. We should not underestimate that. This is not a simple process of perhaps repealing elements of the Health and Social Care Act 2012 and putting in place something different. It would be quite far-reaching, because the governance, accountability and reassurance you would need in place to make sure that we do not create huge and unwieldy organisations that no one can access is really important.

Q212 Dr Williams: You have already said that accountability is unclear.

Saffron Cordery: It is unclear at the moment, absolutely.



Q213 **Dr Williams:** My question to Jonathan on this is about whether or not regulation or new legislation needs to support a different kind of place-based approach as well, and how we bring local authorities into the mix.

Councillor McShane: It is difficult to legislate for partnership working or collaboration. That is very much about behaviours and cultures. What the Local Government Association would like is that, if at some point there is legislation, we do not miss the opportunity to introduce real local democratic accountability for the NHS. You can vote Governments in or out, depending on their priorities for the NHS, but it is quite hard to raise issues at that level.

Q214 **Dr Williams:** What about a locally elected NHS commissioner?

Councillor McShane: That is the last thing I would suggest. Why not build on what is there and already working well? A really good example is health and wellbeing boards. They are democratically accountable, and they include representation from providers, the DCS, often the police and fire service and other people with a contribution to make. I would not propose the creation of a new structure.

Julie Wood: There is something about having a single regulatory framework at national level that responds to the point that was made in the previous session. At the moment, in accordance with the Act, we have CCGs assessed by NHS England on an annual basis against a set of metrics; we have NHS Improvement rating trusts; and we have CQC. There is something about bringing some of that together so that, as we move towards place, and regulation and oversight of a place, we are not just adding another place-based assessment on top of the existing organisational ones. We really need to look at that. Indeed, NHS England has said that it will do that this year, and from a CCG perspective that is something our members are certainly looking for and would support.

Saffron Cordery: On regulation, it is important to remember that the current regulatory framework will only go so far. If we genuinely want place-based regulation, we need legislation for that. Currently, the CQC does local area reviews, but it is doing them under special powers. They are not done on a rolling statutory basis, so we would need to think about something wholly system-based and place-based, and where it sat.

Q215 **Chair:** Julie, can I seek a tiny point of clarification on the place-based issue? How much does it complicate things that patients can now register outside their area with a GP elsewhere? Would you like to see changes to that?

Julie Wood: There are some very positive parts in patients being able to register elsewhere, particularly those who commute, but we have to make sure that we do not inadvertently have a breakdown in continuity of care. The sanctity of the registered list, and that remaining with the practice, with that practice being part of a CCG that is responsible for commissioning all the care that is within the CCG powers, is really important. Once you start to have a lot of movement outside practices, it



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begins to complicate some of that. I would not want to restrict the ability of people to see a GP for specific problems, but you have to get the balance right and that is a bit difficult.

Q216 **Chair:** In some areas, people are being encouraged to register out of area, particularly large healthy populations of young people. Is that going to start to have an impact on the budgets available to commissioners?

Julie Wood: It could, if we are not careful.

Q217 **Chair:** Would you like to see it remain as geographical budgeting?

Julie Wood: It is much easier if it remains a geographically budgeted proposal. It gets more difficult, however, when you start to look at how you respond to the needs of very mobile populations. That is a challenge.

Q218 **Chair:** Perhaps you could send the Committee a note on how you think it should operate. That would be helpful in responding to some of the points raised by the first panel last week.

Julie Wood: We can do that.

Chair: Thank you.

Q219 **Rosie Cooper:** Everybody wants us to move to closer co-ordination in the patient's interest. When I listen to the words, it is motherhood and apple pie—"It's really great and it's all going to be wonderful." Then I listened to some of the quotes today: "Regulation works best where it helps us achieve our aims," which is great when it is a benign system, and, "It's better to go with what works locally." Everybody wants to relax the rules on procurement, but we are in a slight difficulty when we hear, "We are running close to where regulation ends."

The big question for me in all of this is: who holds the ring? How does governance work in this nice lovely system? Despite the rules we have now, which I would have thought were straight-line rules, and before we get into the fudge-mudge and work-arounds, in the Mersey area, Liverpool CCG lost the chief exec of an FT and paid its non-execs £106,000. Fact. LCH is subject to national reports and huge system failure, and that is becoming apparent in Wirral as well. When the system and the local decision making is far from benign, who is going to make sure that the system works in the patient's interest?

Julie Wood: NHS England has the assurance and oversight role of the commissioning system.

Q220 **Rosie Cooper:** How is that working for you so far? I do not think they have woken up yet, have they?

Julie Wood: They have been in existence since the 2012 Act. They have changed their assessment process and the metrics so that it is more aligned to the STPs, and looking at health outcomes rather than processes.



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Q221 Rosie Cooper: Julie, the point I am trying to make, which you are going around, so I will ask it directly, is that, if they are responsible for overseeing CCGs, how did Liverpool get into that mess? How did it pay a non-exec £106,000? How did it lose its chief exec? How did it become subject to a report by, I think, Deloitte? How does all that happen now? If it is happening now when there are rules, who is going to look after the patient's interest so that money is not wasted as it is now? Who is going to protect the patient in this new, lovely, motherhood-and-apple-pie world?

Julie Wood: NHS England has responded to the specific issues with regard to Liverpool, and has assessed Liverpool as being inadequate in terms of the four categories of assessment that it makes.

Q222 Rosie Cooper: But not before I made them do that.

Julie Wood: They have done that in relation to the specific issues and are dealing with that. Clearly, in any system, it is critically important that we get the governance and accountability right. As far as the CCG accountable officer is concerned, it is clear accountability, and the CCG has to make sure that it delivers against that. Where it has not, it has to respond accordingly, and NHS England does.

As we move towards a more integrated system, it is important that we do not fudge that accountability and governance and that we get it right, because CCGs and all the other organisations that work within what are collaborative and voluntary partnerships still have their statutory accountability to ensure that they deliver. That has not gone away in all of this. It is important that they take time to be clear.

To go back to Saffron's answer, it takes time for some decisions to be taken, because they have to go back to their governing body in some instances, and their trust boards in other instances, to make decisions that are legal and, therefore, will withstand scrutiny and governance as a statutory organisation. We are expecting people to live in two worlds at the same time at the moment—the world that sits with statute and the world that is much more collaborative and place-based—and there are challenges in that, in places.

Q223 Rosie Cooper: You have not given me any assurance that the new fudge and mudge world is going to be any more successful at managing situations and holding people to account than the old world.

Julie Wood: What the systems are trying to do locally is make sure that their governance and accountability, where they are working across a bigger geography, is clear, so that there is clear accountability for the decisions they are taking. It will, however, take time, because they are quite complex in some instances, for the reasons we have talked about—geography and all of those points—and they have to work through that in order to be able to make decisions that will stick for their population.

Rosie Cooper: I am sorry, but, as someone who has spent the past four



and a half years doing this, that is as clear as mud.

Q224 **Chair:** In the previous panel, the chief executive of Dudley, Paul Maubach, made the point that if it was an integrated care organisation, or an accountable care organisation, it might make it easier, because they would not have to keep going back to other organisations. Would you agree with what he said, or not?

Julie Wood: Paul was talking about an integrated provider organisation, so yes, as to the provision of care. Rosie was talking about it from a commissioning perspective. Once you start to get all the organisations that are delivering care—general practice, community services and mental health—becoming part of a single entity, and the governance is set up right, it is clear who will be accountable for the delivery of care across that place. In terms of delivery, yes, that would help.

Q225 **Rosie Cooper:** LCH in Wirral is not a commissioner.

Julie Wood: No. I was responding to the CCG comment.

Niall Dickson: The existence of a regulatory system, as Rosie knows very well, does not guarantee that things will not go wrong or that people will not do the wrong thing. There is a question about whether under the existing system NHS England responded in time or spotted things in time. Those are perfectly legitimate questions.

Going forward, you raise a really serious point, which is that holding individual organisations to account may seem easier than when you are starting to work with systems. We have to be absolutely sure about the regulatory system that exists in a more system-based world, which may also start to measure more important things than some of the things we measure at the moment. Not all the things we measure are the most important things; some obviously are, but we should be moving much more to outcomes. What effect does the organisation's place-based activity have on the population, and has it started to move the dials around that?

It is right in some ways. If you were sitting in a healthcare organisation 30 years ago, you would not have felt some of the regulatory weight, which I think was described in terms of time-consuming stuff that people have to do, that is currently felt by a lot of providers, and indeed by commissioners. We have to think through the regulatory system. It is also, as has already been described, very fragmented as between NHSI and NHSE. They are starting to come together and think about the new world they are moving into, but we have quite a lot of progress to make. I agree with you. Making sure that the regulatory system is fully accountable and very visible, and that ordinary patients and users of services can see how that accountability works, is going to be very important.

Q226 **Luciana Berger:** May I ask all the panellists, on behalf of the people you represent, what you would like national bodies to do to support local



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areas to transform care? You might think it is already being done, but there might be other things you would like to add.

Councillor McShane: The first thing would be to reflect on when the "Five Year Forward View", which kicked all of this off, was published. I think the reason it garnered universal support was that it was a simple document. It set out the challenges clearly, it made the case for change and there was a road map to achieve it. When the forward view next steps document was published last year, it seemed that there had been a collective loss of nerve.

The financial and performance pressures on the NHS meant that all the really good stuff in the original five year forward view about the role of prevention, social care and the wider determinants of health had been squeezed out. It became a very NHS-focused document. That sends a signal to the system about what is important, so to try to reset it would be really important. The emergence of integrated care systems, perhaps particularly if they are on a more logical and real-place base, and on a smaller footprint than some of the larger STPs, feels like an opportunity to reset the relationship with local government, and to reset the ambition around trying to create a genuinely sustainable system, which, for understandable reasons, seems to have been lost because of financial and performance pressures.

Julie Wood: We have worked with our members over the past nine months asking them what they want from the system to support them to move towards more strategic commissioning. They say six things, some of which I think are beginning to happen.

The first is about getting national clarity on the direction of travel. Helpfully, the refresh of the planning guidance has started to describe integrated care systems in a better way than perhaps the previous three-letter acronyms have done. That is helpful. However, we need to go further and understand which bits of the commissioning functions will be transacted by commissioners working across a bigger place, and what we might call tactical commissioning will be transacted more through the integrated delivery systems of MCPs, or whatever delivery systems we have. We need more clarity about some of that.

We desperately need to continue to share best practice. I think we are doing that. We have to learn from the vanguards. Certainly, all of us in this panel and the organisations we represent have been doing work to share good practice. We need to do more than that, so that we do not reinvent wheels unnecessarily.

We have to support leaders to manage. That means giving them time and headroom, and skills development. If you are to be a strategic commissioner, what do you need in terms of population health management and actuarial skills so that you can do risk stratification at a big population level?



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We have talked about time and space. The final one, which I have mentioned, is an improved regulatory framework, which is about getting alignment across the arm's length bodies around regulation and assurance.

Saffron Cordery: Definitely on my list is national vision. We need to agree on the narrative and what it is there for. The support across all STPs that I mentioned earlier is really important. There needs to be national recognition that perhaps they are not going to work everywhere. We need to think about what the policy is if they do not work, where we are going to go with that and how we will take forward approaches in areas where they are not working as well. For me, sometimes that is the elephant in the room. We talk about the ones that are flying, and we want to support them as much as possible, but what about the others?

We have to be realistic about what we expect from STPs, and integrated care more generally. This is not going to solve all of the ills. There are many issues that need to be tackled, some at individual institutional level as well as across the piece. We have to be realistic about what we are expecting from STPs and integrated care. The regulatory alignment is absolutely critical, and the financial incentives are very important across the piece, not just for the ones at the front end.

I do not think I have heard anyone talk about information sharing at the moment, but that is another key issue. If one thing was to come out of STPs over the next year or so, pulling down the barriers to information sharing would be amazing.

There are two further points. We have to come down on one side or the other. Are we talking about sustainability or are we talking about transformation at the moment? Right now, given where we are at, I do not think you can have both at the same time. We need to say that at the moment we are in sustainability mode, and that will pave the way for transformation, because without huge investment for double-running we are a long way off that.

My final plea is that we need a bit more national consultation. Consultation has disappeared from the policy environment as I have known it over the past 10 years of working in healthcare. There is not as much consultation, either on the big-picture issues or on the individual elements that fit underneath them. We are making a lot of mistakes up front because we have not thought about them through consultation.

Niall Dickson: I have scored through most of my points. It is important that the narrative does not try to say we are in panacea country. We oversell and under-deliver as a system, and it is important that we have a very honest conversation about what is achievable. This is the right direction to go in, but we have to be honest about what is achievable. As Saffron says, the S is constantly trumping the T. We have to keep very focused on transformation, because if we do not do that it will not be sustainable. That is our huge challenge going forward.



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They are starting to do this, but what I would say to NHS England and NHS Improvement is, "We need to hear single things from the two of you; we do not need to hear alternative stories going down to local level, where you can cause more friction as a result." We need better dialogue with local government as a whole. There is a lot of resentment in local government at the moment about what they perceive as inappropriate instruction and control from NHS England. I am not saying that is all NHS England's fault, but it reflects at local level, and relationships that were going well start to go less well.

The final point is that we should remember others, not just the NHS. Remember the independent sector, community organisations and the third sector. In terms of performance management and support going forward, as has been reflected, there is a lot of attention on the goodies in the class, as it were. We have to think about the middle, which is probably the most important area. Sometimes, the middle feels neglected in some ways, in that it is not able to do double-running because it has not been given the money to do that, and there is a real sense of frustration.

There are also those at the bottom. Recently, I heard about a member who complained that they had moved from quality measures into financial measures. When they got their quality right, they did it by trying to spend a bit more money; then they got into financial measures and they were putting it back into quality. There is a sense in which some organisations find themselves in a really difficult position. Just taking their STF money away from them is like somebody digging a hole. Instead of the regulator helping them to get out of the hole, they jump in with a larger spade and dig even faster. I think the regulators have started to do some of those things, but the whole system of how we performance-manage the process needs to be looked at.

Chair: Before we finish, do any of you have any points that you have not been asked about today that you were really hoping to make? No. Thank you all for coming.

Examination of witnesses

Witnesses: Professor Chris Ham, Professor Katherine Checkland and Nigel Edwards.

Q227 **Chair:** Welcome to our final panel of the day. I know that Nigel has to leave at 5 o'clock. Thank you for letting us know that in advance. For those following from outside the room, could you start by introducing yourselves?

Professor Checkland: I am Kath Checkland, professor of health policy and primary care at the University of Manchester. I have been researching in that role. I have been researching changes to NHS service delivery and commissioning for about 15 years. Since 1991, I have been a GP. I am currently a GP in a rural practice in northern Derbyshire, so I



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guess I am here for my academic expertise and possibly as a frontline GP as well.

Professor Ham: I am Chris Ham, chief executive of the King's Fund. I am serving as one of the advisers to the Committee on this inquiry.

Nigel Edwards: I am Nigel Edwards, chief executive of the Nuffield Trust, which has been looking at STPs, the development of commissioning and a number of issues around the evidence underlying some of the current policy.

Q228 **Chair:** Thank you. Nigel, you have stated that the "pressing question" is whether integrated care systems "will be able to achieve the sort of positive change hoped for." Could you talk the Committee through your concerns about the evidence behind this?

Nigel Edwards: If we start with what is in the STP plans, which were put together very quickly and based on a financial envelope they were given by NHS England, a number of them are positing extremely ambitious assumptions about the ability to reduce both admission to hospital and length of hospital stays. The length of stay one is probably more backed up by evidence, but the current evidence that integrated care will allow you to make very major reductions both in hospital activity and costs is not very strong.

In quite a few evaluations of interventions of that sort, we found that you can have increases in activity and hospital use, at least initially, as you uncover significant amounts of unmet need that sit in the community. We found a major disjunction between the assumptions that had been made about bed numbers in particular, which are driven by admission to hospital, and what the population statistics seemed to say about what is likely to be seen over the next few years.

The second issue is optimism bias, where Chris can probably talk to the evidence much more eloquently than I can. These models take a long time to develop. They are based largely on changing the way people practise medicine and how complex organisations interrelate, and indeed how individual relationships between different clinicians and organisations change and morph over time. There is very little way of accelerating that process; it has to be learned and developed. The second issue is about the optimism bias that has been built in.

Q229 **Chair:** There is no evidence in the short term that they are reducing admissions or saving money, but you said that sometimes they identify unmet need. Do you feel there is evidence that they are benefiting from the patient's perspective?

Nigel Edwards: Yes, that is where the evidence helps us out more.

Q230 **Chair:** That is what we are interested in. Is it helpful for patients?



Nigel Edwards: This is the right thing to do. It will definitely improve care for patients. It may well have an impact on flattening the level of growth, which is some of the US experience, although it is not universal. It should reduce the problems patients experience through conflicting management plans, the failure of transmission of information between different bits of the system and the problems created by poor co-ordination and a number of other issues. There is a very good case for better integration. I have yet to find anyone disagreeing with that. Where we have more worries is perhaps in the over-extrapolation of some of the benefits you can expect in terms of when and how much.

Q231 **Chair:** In terms of patient experience in using the systems—having to tell their story, terrible times and that kind of thing—you have expressed that there will be benefits. Is there any evidence as to their clinical outcomes?

Nigel Edwards: It depends on how we define outcome. If your narrow outcome is admission to hospital, there is a bit of evidence.

Q232 **Chair:** From the patient's perspective.

Nigel Edwards: From the patient's perspective, from the studies I have seen—Chris and Kath are probably more familiar with the literature—there certainly seems to be good evidence that patient experience is improved in this area, not universally but generally.

Q233 **Chair:** Chris and Katherine, would you like to comment on the NAO report and what you feel about the evidence base?

Professor Checkland: I would agree. I think we are looking at different levels. One of the important things to remember, as we heard in some of the earlier evidence today, is that we are looking at organisations that are integrating care at a micro-level and at a much greater level. At the micro-level, as Nigel said, there is good evidence that integration is good for patients, but it is not at all clear that it will reduce overall activity or costs. There is a lot of fairly clear evidence that that is not the case.

Q234 **Chair:** What about helping to stop the rate of change increasing so much? Does it flatten demand slightly?

Professor Checkland: There are some figures from the vanguard programme that suggest some flattening of the demand curve. I lead the national evaluation of the vanguard programme, and I know that the NHS England new care models evaluation team led by Charles Tallack is looking at that to see whether it is robust statistically. We do not know yet.

Q235 **Chair:** There is the time issue; you cannot evaluate these things in the short term. When do you think we will be able to evaluate robustly the financial situation or the demand curve?

Professor Checkland: Charles and his team are working on that at the moment and, hopefully, there will be a report from them some time this year, looking at whether or not it is robust statistically. Our work is much



longer term. We have been funded for four years; we are only a year in, so we will be looking at it over the next two to three years. We do not expect to be able to tell yet whether it is going to be robust.

Q236 **Chair:** It is too early.

Professor Checkland: Yes. It is difficult to tell because, as you know, there are lots of random fluctuations. To some extent at the micro-level of the integration agenda, and at the broader level of organisational integration, which the people from Dudley and elsewhere talked about, there is not a lot of good evidence from the organisational studies literature and the economic literature that integrating organisations achieves anything that cannot be achieved by collaborative working. There is not much evidence. Although it sounds like a good idea that if we are all in the same organisation it is easier to work together, there is no good evidence that that is the case.

Q237 **Chair:** Chris, could I turn to the NAO report? The other thing that report highlighted was that it did not think there was evidence that integration improved outcomes. Do you have any comments on the NAO report?

Professor Ham: It depends on what counts as evidence. There is academic evidence from research studies, which Nigel quite rightly referred to. The results of those studies are very mixed in terms of the impact integrating care has on whatever metric you care to look at: admissions, patient outcomes or patient experience.

The other kind of evidence is real-world experience. What is happening in the best examples we can identify that have been working for some time, because time is a critical variable? Does that give us confidence that this is the right direction of travel? I have no doubt at all, from the evidence of my own eyes over very many years, that it is absolutely the right way to go. In this country, you can see recent examples. In Frimley, parts of Nottinghamshire and parts of Surrey—the vanguard programme that Kath referred to—although the evidence needs to be confirmed and checked, we are seeing an impact on hospital activity; we are seeing a different way of people accessing the care they need.

Further afield, the Canterbury health system in New Zealand, which we have studied over 10 or more years, has achieved similar results, and better patient experience and patient satisfaction. Going back further, in the late 1990s, the Veterans Health Administration in the United States went through a major transformation from being a very fragmented hospital-centred system to a much more integrated regionally based system. Properly evaluated papers in academic journals demonstrate the improvements in clinical quality and the shift from hospital to the community. Real-world examples give us great confidence that this is absolutely the right thing to do.

The difference between the examples that have succeeded and those that have failed is largely around the leadership of the organisations. You can



implement the same change in different contexts to get very different results, depending on how well engaged the doctors and nurses are and how well led the systems are by their managers.

Q238 Chair: As you will all be aware from the panels last week, a number of organisations have expressed concerns around ACOs, ICSs and STPs. Those concerns are particularly about whether this is a Trojan horse for privatisation and the idea that it is all a secret plan of some sort. It would be nice to hear your views on how valid those concerns are.

Nigel Edwards: There is nothing to privatise at the moment. These things do not exist in any form. As you heard, these entities are very complex and large. They would be foundation trusts. To privatise in the sense of handing over all the assets and staff to a private contractor is a theoretical possibility. I suspect it would require primary legislation change. There is also the issue that GP contracts, which are a key part of this, are not the type of contract you can simply revoke and reissue to the private sector, so there is a real issue.

Q239 Chair: What is the real issue?

Nigel Edwards: The NHS's ability to write and manage these contracts. We have heard that it is already struggling with the existing ones. I doubt that there is any appetite among any commissioners at the moment to have contracts operated by private sector contractors. There is a whole series of reasons why that is a very unlikely outcome, and it is also quite clearly not the intention, as we heard in the earlier sessions, of those who are putting the models together.

Q240 Chair: There is neither the intention and nor is it likely to happen in practice, as far as you are concerned.

Nigel Edwards: Yes. I thought Paul Maubach summed up the situation very well.

Professor Ham: There has been a really unhelpful conflation of the different acronyms used in this debate. There are the ACOs, which I will come back to; we have the now 10 integrated care systems across England working across bigger footprints and planning services; and then there are the more local examples of integrated care partnerships where trusts are working with GPs and local authorities.

If you look at what is happening in the partnerships—places such as Salford, Northumbria, Wolverhampton, Yeovil and south Somerset—there is absolutely no evidence of privatisation. These are public sector partnerships based on collaboration between NHS and local government organisations working around their populations and places.

The integrated care systems are led by local government and NHS leaders, and they are all about planning the use of public resources across local government and the NHS. In some of these areas, we are actually seeing previously privatised services coming back in-house. Look



at Surrey, one of the 10 areas; Virgin won some of the contracts there for community services that the NHS commissioners have now put out to tender again. They are being brought back into the NHS to be run by NHS trusts. That is not privatisation.

The area where there is legitimate concern is the proposed ACO contract. You talked about that earlier. In theory, it could be won by private companies when CCGs go out to the market—when they are allowed to go out to the market, because it is on hold at the moment. I agree it is unlikely that the private sector will want to bid for those contracts, because NHS organisations are almost universally in deficit. There is no profit to be extracted from the NHS these days, so why would private sector organisations want to bid? Secondly, the contracts will be for a comprehensive set of services, not narrow niche community services, but usually, if not the full range, many of the services needed by a population. Private providers do not have the capabilities to do that.

Professor Checkland: I agree with what Nigel and Chris said. My concern is more about the accountability and governance arrangements that we talked about earlier. In these very big and complex local health economies, it is not clear where responsibilities lie. Earlier, you were talking with Paul from Dudley about complaints. Is there someone to complain to? That is one question. Another one is: who is actually responsible if things go wrong? I am more concerned about governance and accountability.

In terms of the private sector, my concern would be about the danger of the private sector challenging to try to get in, and the time-consuming thing around that of judicial review and those types of things.

Q241 **Chair:** What would need to be in place to allay your concerns about the accountability part of it?

Professor Checkland: It is about clear governance arrangements. For STPs, at the moment it is not clear where decision-making responsibility lies. We have heard about committees in common and everything having to go back to the statutory organisations. It would be about having a much clearer set of accountability relationships. Who is responsible for what in the system?

Professor Ham: In the current system, accountability can mean only the accountability of integrated care providers or partnerships to the commissioners of care, put very simply. The commissioners will be a combination of CCGs on the one hand and often local authorities in partnership with them on the other.

Q242 **Derek Thomas:** We have heard quite a lot of stuff this afternoon on issues about pressure while trying to achieve quite significant change. We understand there is pressure to make significant savings in the context of rising costs and demand. We are aware of staffing shortages, particularly in community district nursing, general practice and so on, at a time when



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we are looking to do more in the community, and we are expecting some of the financial savings to be delivered by the reduction of hospital beds. We have already heard from the Nuffield Trust that more beds are needed due to demographic change. I am a west Cornwall MP and that is certainly the case in our neck of the woods.

Kath, you mentioned that further reorganisation shortly after the introduction of the Health and Social Care Act would not necessarily be welcome. We heard that earlier this afternoon as well. Based on the evidence, and what I have said about pressures on the system and the political context in which we are operating at the moment, what advice would you give Simon Stevens?

Professor Ham: Can I go back to the point raised by Saffron Cordery in the previous session? I think I am correct in saying that she argued that you have to choose between whether focus is on sustainability of the current system or on transformation. With respect to Saffron, whom I respect enormously, I fundamentally disagree with that.

Transformation holds the key to sustainability. What I mean by that is that we are not going to sustain the NHS simply by asking staff and leaders to work harder within the current envelope of available resources. We have to embrace doing things differently, reforming the service models—for example, in Cornwall, which I know reasonably well, by investing in neighbourhood teams, aligning them with GP practices, getting social care involved and doing far more to prevent people going into crisis, and, if they do, being available to provide support in their own home. That is a model we are seeing not just in Cornwall but everywhere now. That is an example of transformation. It is small scale, but, if we could replicate that in every part of the country and do things differently, there is a chance that we could take more pressure off our acute hospitals and sustain through transformation; it is not either/or.

Professor Checkland: There is not necessarily evidence that that is cheaper and that it will save money. We do not know that it is going to save money, and it may well not. They need time to build the relationships we have talked about and money for double-running. You cannot do these things without money for double-running. Personally, I find the word “transformation” slightly difficult. As a frontline GP, I get a bit tired of people telling me I need to transform. It makes me tired.

Nigel Edwards: Most transformations fail.

Professor Checkland: Exactly. What tends to work is incremental change. A lot of the stuff we are doing now, we have been doing for 20 years. As a GP, I have been round this block many times. We have done much of this stuff previously, and we know how to do it. We have managers out there who know how to do it, but some of our research has shown that, if you have to badge everything as transformation, you cannot learn from what you have done before. We need to be careful



about the words we use. “You need to transform,” can feel like a stick to beat people with.

Nigel Edwards: I agree with all of that and would add a point about the time and space for people to do what are often very big and complex change projects. Even within a practice, there is no time for people to be able to do some of that. Some investment was put in as part of the initial “Five Year Forward View”. That is now tailing off. We are underspending on creating time and space for people to make some of the changes that very often need to be driven bottom-up.

Professor Ham: To give Kath some encouragement, the Committee saw a real-world example of transformation on the visit to Steve Kell’s practice in Bassetlaw, one of the primary care home initiatives around the country. Those who were there were incredibly impressed at the level: providing same-day appointments for GPs who those who need same-day appointments, and improving staff experience as well as improving patient experience, with a little bit of extra money. That is an actual example of what it means.

Q243 **Derek Thomas:** If you could bear with me, I would like to stick with the Cornwall and Scilly model, because it helps to understand the next point about confrontation or conflict in oversight of NHS England and NHS Improvement. In Cornwall and Scilly, it is fair to say that NHS Improvement has prioritised financial sustainability over transformation. NHS England and partners in Cornwall, from community pharmacies through to GPs and right across, are working incredibly well together, with the local authority, to progress an integrated care system; but when MPs meet the system leaders, they are constantly talking in the framework of the pressure from NHS Improvement to deal with the money challenges, which are not unique to Cornwall. Are NHS England’s and NHS Improvement’s approaches to oversight sufficiently aligned? If not, what issues does that pose to the work of integrated care systems?

Professor Ham: They are becoming more aligned, and they are making efforts to do that by having a single regional director across the two regulators to relate to places like Cornwall, but the lived experience of leaders in the NHS is that it often does not feel like that. There may be alignments at the top between Simon Stevens and Ian Dalton, or indeed at a regional level, but when it comes to the day-to-day interactions of places like Cornwall you get very mixed messages. I do not think that anybody this afternoon has argued that we want to retain that very unhelpful divide between NHSE and NHSI. The Committee could provide a very useful service by making a very clear recommendation on that.

Derek Thomas: Thank you.

Q244 **Dr Williams:** Kath, you mentioned, and we have heard mentioned a couple of times today, double-running costs. That sounds very good in theory, but presumably the money has to be spent on people, so even if the money were provided, where are the people going to come from?



Professor Checkland: That is a really big problem. Certainly, in community nursing and general practice, it is one of the really big problems, and we have not got on top of it. We can help by reducing the pressure that people are under; we can make jobs more attractive by investing differently. A skill mix could help with that. We could help with practices; for example, including pharmacists in practices can help to reduce pressures. It is a real problem, and we do not have an answer.

On investing in primary care, we have heard about some of the pressures that GPs are under. There has been no increase in investment in primary care for years. That is something we really need to look at.

Q245 **Dr Williams:** The double-running costs would presumably be for a finite period of time, because you cannot double pay for everything forever. It would mean either getting the existing people to do more work for a finite period of time or bringing in a different cohort of people temporarily. I can see that people have presented the lack of double-running costs as a barrier to transformation, but I cannot quite understand how you can double run something when you do not have the people to double run for a finite period of time.

Professor Ham: As well as double-running, there is something Nigel referred to earlier: some extra resources—it does not need to be a huge pot of money—to pump-prime some of the new care models. Some of it is about staffing, but it is not all about staffing. Greater Manchester has the most advanced integrated care system and has a slug of money—£400 million-plus at the beginning of its devolution programme. Kath is closer to this. If you talked to people up there, they would say that they would not have made the progress that they have made without having had access to that. Each of the 10 areas that make up that conurbation has had a share of that £400 million to support some of the integrated neighbourhood teams and the other investment they needed.

Professor Checkland: Sometimes it is about buying out time, so that people can spend time together working out how to work differently and what they can do differently while covering the work for GPs back at base. That is often the thing. Somebody needs to do the work back at base. You need to buy out their time so that they can sit down with their colleagues and local government colleagues to talk about doing things differently. The day job still has to be done, but money can help with that.

Q246 **Luciana Berger:** I think we have largely touched on this; it is about the funding envelope, which has been referred to. Where there is no double-running, what is achievable under the current financial envelope? What challenges does the current financial envelope present in achieving success in all this?

Nigel Edwards: That is hard. It touches on the difference between Chris's view and Saffron Cordery's view. A significant number of systems are under such financial distress that even the task that they have been



set to try to agree shared control totals is causing problems. One of the reasons why many change programmes fail at the system level is that people stop working in a system way and go back to managing the financial objectives of their organisations. There is a significant number of systems where the level of financial distress is such that the time and space to be able to deal with some of the bigger transformational changes that we all know need to be made is being diverted by the search for financial balance.

While Chris is right that the longer-term answer, hopefully, to financial balance is some of the transformation that we are talking about, it is a real challenge to get across the valley of death from where we are now to the sunlit uplands where it all works. The model of spending—often at the insistence of the regulators, as it happens—is large amounts of money on consulting companies to repeat efficiency improvement-type work, which then leads to lots of micro-focus on lots of small things, and is probably taking away the very limited managerial time and space to deal with some of the bigger transformations. Not many compromises can be made on day-to-day performance that give you a bit of space to take a step back and redesign what you do.

Professor Ham: It would be foolish to believe that STPs and, now, integrated care systems, will bridge the growing funding gap for the NHS and, I would add, social care. They absolutely will not do that, and all the 10 integrated care systems face exactly the same financial and operational pressures as the rest of the NHS. Some, like Frimley, seem to be coping better than others, but we should not start from the position that we are doing this because it will enable the system to live within the current funding envelope. That will not happen.

Q247 **Chair:** It is very unfortunate that they have come to be seen as a vehicle for cuts in many areas. Is there somewhere you could point the Committee to where you feel there is the sort of funding that would make a real difference in achieving the transformation? Has each STP area set out clearly what they would like to be able to achieve their objectives?

Professor Ham: No, because they were not asked to do that. They were asked to produce a plan by whenever it was—October 2016—that showed how they would balance their collective budgets within the envelope that they knew they had available. That was behind the realistic concern that this was about a cost-cutting exercise rather than about transformation of care. Sadly, STPs got off to a very bad start, a very difficult start, because of that.

Nigel Edwards: We also know that, where they have made capital requirement estimates, they are significantly in excess of what is likely to be available, even if there are substantial land sales. The London STPs alone would account for an entire year's capital allocation, and more.



Professor Checkland: On where that work has been done, John Appleby has done as much as anyone else, in terms of looking at the funding needs.

Nigel Edwards: We do not have a number for the level of investment. The King's Fund did a piece of work looking at creating the transformation fund. It is very difficult to estimate. Sometimes, it is not necessarily large amounts of money; it may be more about carving out space and time for people to do the work. Money is not the only ingredient, but I have not seen a quantification of that, so I think it would be quite difficult to do.

Q248 **Chair:** Especially when so much of the transformation money has, as you say, got sucked into sustainability in any case.

Nigel Edwards: Yes, that is absolutely correct for almost all of the sustainability and transformation fund. We can send you a report on that, which demonstrates that that money has effectively been moved from transformation into propping up the current very substantial—

Professor Checkland: It has actually been renamed the sustainability fund.

Nigel Edwards: It has indeed.

Professor Ham: There is some extra capital available. That is only part of the picture. The 10 integrated care systems are getting preferential access to a pot of capital money. Dorset has received some funding to help with its improvements in hospital care. Frimley has got some money to invest in neighbourhood hubs. One of the prizes, if you are identified worthy of the title of an integrated care system, is precisely capital funding, which is not then provided to the rest of the NHS.

Nigel Edwards: Although the criteria for making that assessment appear to be somewhat—

Professor Ham: Judgmental.

Nigel Edwards: Yes, and perhaps not very scientific. It perhaps creates the problem of success to the successful, whereas some of the systems with the deepest problems might actually benefit from substantial capital expenditure to get out of them. Cheshire, Mersey and Wirral is not a star performer, as we heard earlier, and there are issues in Staffordshire. We could go on; there is quite a long list of places that have not been favoured by the assessment process, which is a concern.

Q249 **Chair:** You think that it is widening inequality and variation across the system.

Nigel Edwards: Yes. I agree with Chris's comment on finances, but we certainly will not manage it if we concentrate all these efforts in a small number of areas. It is useful to have demonstration projects, but we need wide-scale change.



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Chair: Thank you. I am starting to impinge on Andrew's questions. I am sorry.

Q250 **Andrew Selous:** That's all right. This follows on nicely. I wanted to ask what needs to happen nationally, or be done by national bodies across the country, to help to reduce variability and try to get those that are further behind to emulate the examples we have seen in the more advanced areas. What needs to happen nationally to pull everyone up? You mentioned that some people are a bit further behind. How can we best try to move everyone up to a peak level of readiness and collaboration, moving towards the outcomes that we all want to see in this area?

Professor Ham: I do not think that we can get everybody up to the peak level. That is a desirable and ambitious objective, but realistically—

Q251 **Andrew Selous:** How would we try to help them move in the right direction, if we cannot get everyone up to peak level?

Professor Ham: Part of it is drawing on the experience of those already in the advance guard, if you like, of STPs and, now, integrated care systems, and using their experience and expertise to help those coming along behind. If we have 10, hopefully, in a year's time we will have 20, and the people leading this work in Manchester, Nottingham, Bedfordshire, Luton, Milton Keynes and elsewhere will be able to free up some of their time to work with the second wave and perhaps the third wave coming along behind.

The learning about what it means to work in this way is out there, within the NHS and local government, much more so than in the national bodies. Part of what the national bodies can do is no harm, and to get out of the way, facilitate and support people at a local level to do more of the good things already happening, and extend that to more areas. I want to be realistic, being a natural optimist: given the huge financial pressures on the system, and that there is absolutely a focus on sustainability as well as transformation, this will take time, as Nigel said right at the beginning.

Q252 **Andrew Selous:** I am interested in your very good idea, Chris, that we might take senior leadership teams from the areas that have done well. Is there any formal programme to try to get them to run a masterclass, or travel around and offer help around the country, to come alongside other areas?

Professor Ham: It is beginning to happen. NHS England and NHS Improvement at a national level are providing a little bit of development and support of the kind that Saffron Cordery argued for earlier, but it is quite small scale at this stage. We are talking to them about the next wave and doing what I was just describing—the challenge being that, if you take skilled leaders away from areas that are already doing well, the risk is that you might impair their ability to sustain and go further and



faster with their work programmes, because the expertise is in short supply.

Professor Checkland: There is such a programme, called the vanguard programme, a very extensive support programme provided by NHS England, which formally comes to an end at the end of March/beginning of April. That team will move over to a different part of NHS England. I guess that one thing you could say is that we should capture the learning of the team supporting the vanguard. The early stages of our evaluation have demonstrated, for example, that in the vanguard programme they had local account managers, who looked after a number of vanguards, and that has been experienced very positively locally. It is about not losing the stuff that has been done and learned with the vanguard programme as we move into the next phase of integrated care systems.

Q253 **Andrew Selous:** What is the mechanism for best capturing that learning and making sure that it does not disappear in a dusty file in the bottom drawer of someone's desk?

Professor Checkland: The people. Make sure that the people who have been involved in that programme and doing that work are then involved in spreading it through the integrated care system, so that the people who have done the learning are captured and used.

Professor Ham: Something for me to recognise, which we have not touched on so I want to put it on the record, is that the 10 integrated care systems are beginning to show what is possible through place-based working that goes beyond STPs. Let's not underestimate how nascent and fragile those systems are. They depend on the willingness of organisations to come together in the same room and collaborate, in a system that was not designed to make that the easy thing to do. There is clearly a risk that some of them will not be able to build on the progress they have made so far because, with the growing pressures, the focus will be on organisations dealing with their deficits, which may get in the way of systems playing a bigger part in supporting organisations to do that collaboration. I do not want to exaggerate, but I do not want to adopt an overly optimistic view either.

Q254 **Andrew Selous:** I have a final question about the actual geographic areas and the footprints. Do any of you think that there are fundamental problems with how some of the footprints have been formed that need to be rectified?

Nigel Edwards: Rectifying them may be difficult. As was said earlier, there are areas that have been based on the same approach the British empire took to drawing lines in the middle east, which seems to bear no relationship to real places or geography. There are a number of examples of those. I live in Hertfordshire, founded in 931, with whatever logic applied before the Norman conquest, which has been paired with west Essex. That is not a recognisable place. Wirral, Mersey and Cheshire is a



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collection of three different places, and Lancashire has issues. There are some issues, and unwinding them may be really very difficult.

Q255 **Andrew Selous:** Is it too late?

Nigel Edwards: It may be too late in some cases. The solution that has been adopted is to try to find the places within those areas. We have already had quite a few STPs having to do what they call a reset, because they have not quite managed to get their processes and systems to work. I would really discourage any intervention now that got in the way of that. The NHS is getting increasingly good at work-arounds for this, and I am not immediately sure that a national intervention to sort it out, as opposed to giving people licence to help to define sub-areas that work for them, would be a better solution.

Q256 **Andrew Selous:** Were local areas asked who they wanted to partner with, or were they just told?

Nigel Edwards: They were asked first and then told.

Professor Checkland: Yes.

Nigel Edwards: What they were told was not necessarily what they had said.

Professor Checkland: The NHS has done cross-border working before. In my area, when I refer in, half my patients go to South Yorkshire, to Sheffield, although that is a different STP, and half of them go to Derbyshire. That has always been the way; we have always done that cross-border working. It is difficult.

Professor Ham: If you go beyond the STP/ICS framing of it, most of the important work that we are talking about will not be done across those footprints; it will be done in Salford, Tameside, Bassetlaw, Doncaster and, dare I say, in Luton and, separately, in Milton Keynes, because they are the definable communities where it makes sense to focus on place, population and how you join up services.

Nigel Edwards: The difficulty, to take the Bedford, Luton and Milton Keynes example, is that because we are starting to mix up the development, planning and integration agenda with the performance, management and accountability agenda, bodies such as NHS England will probably want one accountable officer for the whole of Bedfordshire, Milton Keynes and Luton, whereas the logic of the places in those areas is that you develop them separately. We come back to the perennial problem that there is no real right organisational level for such complex things as healthcare.

Organising your footprint to be able to determine where a specialist surgery is located, for example, and where particular hospitals go, runs the risk of obscuring and getting in the way of all the local development, the work between local government and health and the engagement with



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general practice, because you suddenly have an entity that is too big and distant to have a sensible conversation with general practice. There are some real complexities. There is no particular answer, but the focus needs to be on the place that makes sense for local government, local GPs and patients, not the accountability requirements of NHS England.

Andrew Selous: That is very helpful, thank you.

Q257 **Luciana Berger:** Nigel, you touched on the Mersey and Cheshire area. I am an MP from that area. My question is whether your organisation or any other organisation has done an assessment of the impact on health inequalities of how the STP areas have been organised. I draw on the example of the Mersey and Cheshire area, where we have inherited a massive deficit from the Cheshire area, which has better health outcomes. Essentially, there is concern about the impact on health inequalities in the Liverpool city region as a result of that. Has any assessment been done?

Nigel Edwards: No.

Professor Ham: I am not aware of one. All the STPs have identified health inequalities as one of their priorities, and there are some very good public health directors leading the work on what needs to be done, but on the specific question you are raising I am not aware of any work.

Q258 **Luciana Berger:** If you connect that to what is available financially—

Nigel Edwards: Sorry, yes, it is an interesting question. Statutory allocations are made to CCGs and, in theory, should not therefore be used to subsidise healthcare in other parts of the system. There has been a long-standing debate about how far you can play ducks and drakes with different pots of money that have been allocated for very deprived areas, which historically tend not to be able to spend all their money, for a variety of reasons, and that money has been reallocated to more affluent areas. That is an issue that is likely to recur as the systems become more concrete, and we start to have a debate about what it means to have a control total across the whole system. It will be important to track whether there are implications for inequalities in terms of spend per head against what the resource allocation formula ought to be saying.

Q259 **Luciana Berger:** I would prefer us not to track what happens, but to prevent any issues in the first place. What assessment is being done at this moment and what should we as a Select Committee consider to ensure that the plans the Government pursue do not further broaden and widen the health inequalities that we see across our country?

Professor Ham: Perhaps the answer should be that national bodies, when they are assuring the STP/ICS process, should bring in a strong test around the impact on health inequalities and the resource allocation that goes along with that.

Q260 **Rosie Cooper:** To follow on from Luciana's comment, it is an old problem



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in a renewed context. Southport and Ormskirk acute trust, which is part of west Lancashire, in my constituency, in essence, would look to and has always been included in Cheshire and Mersey. Most of the services surrounding the STP would be in Lancashire, yet Southport and Ormskirk's hospital or acute services will be decided by Cheshire and Mersey. How would you join up the governance arrangements for that little mess?

Professor Ham: I am sure that is very important for Southport and Ormskirk, Rosie, but there are examples everywhere. Epsom and St Helier is part of the Surrey Heartlands integrated care system, but it is really part of south-west London and the STP there. Boundary issues are pervasive.

Q261 **Rosie Cooper:** But acute services were always provided by Cheshire and Mersey, and primary care is Lancashire. That is how it has always been. There are two systems, hardly any governance and a load of work-arounds. How do I look at my constituents and say, "The decisions that will be taken that may or may not destabilise your hospital have been taken in your interests and not the Cheshire and Mersey interests"? How is that one going to work? How is that system justifiable?

Professor Ham: I suspect, with respect, that you overestimate the importance of the STP in Cheshire and Merseyside at this point.

Rosie Cooper: Oh, I wish.

Professor Ham: Most STPs got to the finishing line of October 2016, submitted their plans and breathed a huge sigh of relief. No further work has been done on those STPs. The governance and leadership they brought together remains very weak by comparison with what is happening at the organisational level in most parts of the country.

Rosie Cooper: Fine. I shall come back and revisit that, but I think that you might find that it is slightly changing. Thank you.

Q262 **Andrew Selous:** I have a final question, because I know that Nigel needs to be on his way, about what lessons can be learned from the STP process about how best to communicate and engage with the public, staff and stakeholders.

Nigel Edwards: I agree with comments made in the last session, that perhaps the biggest weakness, not just with the STP process but arguably with the "Five Year Forward View", is the lack of a very strong story about what we are trying to achieve, where we think we are going, what the advantages of that are and what the risks might be. That has been largely absent. That would be one thing.

The timescale in which they were produced, which Chris alluded to, is a significant issue. It left very little time; people started meeting in the middle of summer. In some cases, geography is an issue. To cite another one, in Humber, Coast and Vale, which is a collection of bits of Hull and



bits of Yorkshire, people had not met each other and had never actually worked together; some of them had not even crossed the Humber in recent memory. Giving people more time and really understanding the importance of forming those relationships would be one of the other lessons. Another is framing the problem as entirely about solving an NHS problem, as the LGA representative said, and then expecting local government to be able to engage in that positively. That is another significant challenge.

Professor Checkland: Engaging with staff is important. Engaging with the public and local government is really important, but it is also about engaging with staff. I told my GP colleagues that I was coming here today to talk about STPs and they said, "What are those?" It may not be wrong that they do not have a lot of meaning at the frontline, but they do not.

Professor Ham: I think that we said in some of our observations that STPs were the right thing to do but they were done badly.

Rosie Cooper: I have never agreed with anything more in my life.

Q263 **Chair:** Do you think as well that we just need to keep talking about the people who use services, rather than the systems? Do you think that is the other issue we have?

Professor Ham: Yes, and we need that as part of having a story, to demonstrate that, where there are positive things happening in Bassetlaw and elsewhere, it is because they are making a difference and an improvement to the lived experience of patients and people who need access to our services.

Professor Checkland: I would turn it slightly the other way. Frontline staff and social care staff have been doing the work of integrating for years and years, and the structures and other things matter in so far as they make that work of integrating easier or more difficult. They do not matter in themselves; they matter in terms of making that work.

Q264 **Chair:** The key question is whether that is what they do. Do you think they achieve that?

Professor Checkland: They can in some places, but they can also make it worse. There are things you can do. For example, creating an integrated organisation does not necessarily make it easier to do integration work. It is about relationships and communication, and knowing where people are and who to speak to. It is the day-to-day work of integration.

I would take issue with Chris on his difference between real-world and academic evidence. They are the same thing. Academic evidence is real-world evidence; it is just more systematic. It is important that we do not read too much into the experiences of individual areas where good things are happening. We need to look over the longer term as to whether those



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changes have happened as a result of the work that has been done. We do not know that yet; we do not know whether these new care models are the things that are causing any changes that are seen, and we do not know yet whether those changes are meaningful in a statistical or more robust sense. It is dangerous to start talking about the difference between real-world and academic evidence, because academic evidence is a systematic look at real-world evidence.

Chair: Thank you all very much for coming.