

Health and Social Care Committee

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

Tuesday 20 March 2018

Ordered by the House of Commons to be published on 20 March 2018.

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

Questions 265 - 417

Witnesses

I: Professor Steve Powis, National Medical Director, NHS England; Professor Jane Cummings, Chief Nursing Officer and Executive Director, NHS England; and Simon Stevens, Chief Executive, NHS in England.

II: Ian Dalton, Chief Executive, NHS Improvement; and Ben Dyson, Executive Director, Strategy, NHS Improvement.

III: Jonathan Marron, Interim Director General, Community and Social Care, Department of Health and Social Care; and Stephen Barclay, Minister of State for Health, Department of Health and Social Care.

Written evidence from witnesses:

- [NHS England and NHS Improvement](#)
- [Department of Health and Social Care](#)



Examination of witnesses

Witnesses: Professor Powis, Professor Cummings and Simon Stevens.

Q265 **Chair:** Good afternoon. Welcome to our final session on integrated care, systems and partnerships. For those following from outside this room, would you mind introducing yourselves?

Professor Cummings: Good afternoon. My name is Jane Cummings. I am the chief nursing officer for England.

Simon Stevens: I am Simon Stevens, the chief executive of NHS England.

Professor Powis: Good afternoon. I am Steve Powis, the new national medical director of NHS England.

Chair: Thank you very much. I should say at the outset that we are not here to second-guess what is going to be, rightly, the subject for the courts in the judicial review. We are going to try, if we can, to keep a focus on patients during this inquiry. Andrew will open the questioning.

Q266 **Andrew Selous:** Thank you, Chair. If we can have in our minds a lady in her mid-80s, with a number of long-term conditions, perhaps living on her own with her family around the country, could you explain as clearly as you can how the changes you are making will improve care for this elderly lady in her mid-80s living on her own?

Professor Powis: As somebody who has practised in clinical medicine for 30 years, that is not an uncommon scenario for me. My background is as a kidney doctor, a renal physician, but I managed many complex patients, including patients in their 70s and 80s on dialysis who had had renal transplants, with many complex needs.

A good integrated care system will provide a much more joined-up and much less fragmented system of care for that lady in her 80s; as our colleagues in Frimley have said: "A single team that understands all of my needs and delivers care smoothly and easily for me." Too often in the past, patients looked to multiple teams, multiple specialities and perhaps multiple levels of care, primary care and secondary care, for a package of care that was not as joined up as it should be. Sometimes it seems that they have to navigate themselves through a system going from pillar to post.

The concept of multidisciplinary teamworking, where professionals work together, is now very common within organisations. One way of thinking about integrated care is extending that concept into the wider health system, so that a team of individuals come together to manage your care, rather than relying on individual interactions. In practice, that means fewer outpatient visits, fewer hand-offs between professionals, and better communication, so there is a more holistic approach to the care of the patient.



Q267 **Andrew Selous:** You told me there will be fewer outpatient visits. What will there be more of? I still do not quite have the picture of how it will be different. We all have a picture of how she currently navigates her care, which, as you quite rightly said, is difficult, and you said there would be fewer outpatient visits. Can you put it in language that that lady and others like her round the country can understand?

Professor Powis: Let me give you an example based on my own specialty of kidney disease. A patient in their 70s or 80s with chronic kidney disease might need to attend outpatient appointments in a specialist kidney clinic, which is usually in a large hospital. I recently visited a practice in Tower Hamlets that is working very closely in an integrated way with Barts Health, so that dedicated specialist time from the consultants in kidney medicine at Barts is spent discussing individual patients with GPs in that practice.

In practice, that means that you avoid the requirement for the patient to travel to the specialist to seek an opinion, and you bring the opinion, in that multidisciplinary way, to the patient. It is very obvious. It is what we would all want for ourselves and our families, but, like many obvious things, putting in place a system that facilitates and encourages it can be challenging.

Q268 **Andrew Selous:** Could I ask about the actual definition of integrated care that underpins the changes you are making, and can you set out a little bit about the journey as to how we are going to bring that about?

Simon Stevens: Certainly. Integrated care occurs along a spectrum. Services can be more or less integrated, and it is not the case that full integration of services will be needed for every patient in every place; it is not the case that if you look across the NHS in England today we have equal degrees of integration. The extent to which services work together has arisen differently over time. At the core of the idea of integrated care are three big changes that are affecting all healthcare systems in western countries.

One is the idea that Steve just talked about. Because a quarter of people in this country now have a long-term condition, and a significant minority of those have many conditions at the same time, we need services that are more joined up.

When the NHS was founded in 1948, we were principally dealing with working-age populations requiring one-off treatments; it was, if you like, the "Brief Encounter" era of medicine. Now we are in the enduring relationships phase. We are living 10 years longer. At the same time, medicine has become much more complex and specialised. When the NHS was set up in 1948, there were 5,000 consultants; now there are 48,000—10 times as many. At the same time as all the specialisation of medicine, we are dealing with the fact that patients have multiple problems occurring at the same time and therefore they need joined-up care. That is the first construct for integration.



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The second is that, traditionally, health services, not just in this country but around the world, have been quite reactive. They have waited for a health problem to occur, for the patient to present to the GP or the A&E department, and then they try to do something about it. It is not exclusively the case. Obviously, we have national screening programmes and we have funding for GPs that incentivises preventive services, but by and large we are quite a reactive health service. The second idea, alongside joined-up care, is that we do more prevention and anticipatory support to keep people healthier or to manage their condition over time.

Traditionally, health services have taken a rather paternalistic attitude towards looking after the people we are here to serve. In an era where, if you have type 1 diabetes, you will probably have type 1 diabetes for the rest of your life, you are the expert needing support rather than the passive recipient of things very occasionally done to you by the formal healthcare system, so the third big idea is about supporting patients themselves to take control, where that is appropriate.

Joined-up care, based on a move towards more anticipatory and preventive services with more influence being shared with patients themselves are the three animating ideas for care integration.

Andrew Selous: Thank you very much. That is very helpful.

Q269 **Chair:** Before we move on to some of the concerns that have been raised with us, could you set out, having expressed how you want it to work at patient level, why you need integrated care systems, partnerships, organisations and STPs to achieve that? Many people have put it to us that this has been happening for a long time in other forms throughout the NHS.

Simon Stevens: Yes. These are all means to the fundamental end of improving care in the way I just described. When we produced the NHS Five Year Forward View in 2014, I coined the phrase that we need triple integration of services, and very specifically that was not what had been traditionally happening across the NHS.

Triple integration is more of a join-up between what is happening in primary care and GP services and what is happening in hospital specialist services, in the way Steve described. The second join-up is between physical and mental health services, where we know that for a lot of people with severe and enduring mental health problems it is their unaddressed physical health conditions that account for the 15 to 20-year lower life expectancy; and, vice versa, we know that at a time when people are having their physical health needs looked after, often their mental health concerns are being neglected, so physical and mental health is the second big integration.

The third is the interface between health and social care. Not just for frail older people but for people with learning disabilities, for people with physical disabilities and for children, the way those two systems work



together needs to become increasingly integrated. The triple integration is that they are all advancing.

Q270 **Luciana Berger:** No doubt you will have seen the evidence that we have had so far in this Committee where a number of different individuals and organisations have raised their concerns about what the process means. There are four key concerns, and I will you ask you for your answers to the concerns that have been raised about each. The first concern is that this will lead to increasing privatisation of our NHS.

Simon Stevens: I absolutely dispute that. We will probably see a significant decrease in the number of services that are subject to procurements. Having had a chance to look at some of the evidence that you received from one of the panels of activists, I have to say that, frankly, some of the claims that were being made are made year in, year out, almost regardless of what is happening in the national health service. Indeed, I came across an article talking about how the NHS was being turned into an American health system, which it is not.

The article talks about the fact that the Government's reforms are going to "move the NHS towards an insurance model," where "primary care groups could sound the death knell of equity, universal coverage and care free at the point of need in the NHS." That privatisation and Americanisation article was written 20 years ago by Allyson Pollock. Then I see in the *British Medical Journal* in 2001 an article by Allyson entitled, "Will primary care trusts lead to US-style health care?" The answer is no, and they did not. We look forward to 2010 and see another article from the same author saying that the NHS in England is to be dismantled, and instead healthcare will be run on US healthcare lines. That is not true.

We see a subsequent article saying that Brexit is in fact going to lead to the destruction of health as a human right in this country. We see the really curious claim that "the Health and Social Care Act 2012 abolished and dismantled the NHS in England." The million patients who are being looked after by their GPs, in A&Es or as hospital outpatients, let alone the 1.3 million staff who are working in the NHS today, will find it a curious claim that the NHS was in fact abolished four years ago.

Q271 **Luciana Berger:** Another concern is about people paying for what is currently classified as healthcare, when the boundaries between healthcare and social care are blurred. Do you have anything to say to address that concern?

Simon Stevens: It is absolutely crucial that NHS care remains free and based on the needs of patients rather than ability to pay. That is a founding and enduring principle in the NHS, and nothing that is proposed will change it. There is nothing that has been proposed about the ability to join up the way health and social care services work that was not established by Parliament as far back as 2006, and in other places that has been working perfectly satisfactorily. If it were happening, it would be a concern, but it is not and it is not going to.



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Q272 **Luciana Berger:** We also heard the concerns that people had about NHS staff losing their current terms and conditions. Is there anything you want to say to address that issue that has been put to us?

Simon Stevens: Can you say more as to what was supposedly going to bring that about?

Q273 **Luciana Berger:** With the creation of these new organisations, would current terms and conditions transfer into the new organisations or would they have different terms and conditions?

Simon Stevens: Integrated care systems are not new organisations. They are different parts of the health service and, where appropriate, the voluntary sector and local government services working closely together. Even if we end up in a small number of parts of the country with a new funding mechanism that brings together for the first time the funding for GP services, community health services and hospital services, there will still be a single provider responsible for that funding and organising those services, and that is almost certain to be an NHS provider. I think you have evidence from two parts of the country that were contemplating this, and that is indeed the position they have reached.

Professor Cummings: We are working currently on what we are calling a staff passport, which will enable staff to rotate between perhaps different organisations and get different skills, but not feel at risk as a result of moving from one organisation to another. That is something we are actively working on at the moment with the strategic partnership group and the unions across England.

Q274 **Luciana Berger:** When will that come forward?

Professor Cummings: I cannot give you a date, but I will come back to you on that. It is being actively pursued, and it should not be that much longer before it is done. We have parts of the country where they are already looking at it.

Q275 **Luciana Berger:** The final concern—the key concern—that has been raised with us is about public accountability of services, particularly concerns raised in the case of ACOs, where public accountability may or may not exist.

Simon Stevens: It will, so that concern is not well founded. We will be publicly consulting on the standard NHS terms that will apply. All the legal duties that currently exist will continue to exist, including the public accountability arrangements that exist for CCGs and for providers of NHS care.

Q276 **Mr Bradshaw:** This is a bit of a tangent, but on concerns about staff pay and conditions, does the fact that some NHS organisations are pursuing wholly owned subsidiaries, about which there are real concerns when it comes to staff pay and conditions, feed some of that narrative of concern around the models? Can we have your very quick take on wholly owned



subsidiaries, which we are very worried about on this Committee?

Simon Stevens: They are separate questions in that the wholly owned subsidiaries relate principally, I think, to things like payroll services and estates maintenance services and so on. They are not what we are talking about this afternoon. I know that you have evidence from my colleague Ian Dalton later this afternoon. This was raised at the Public Accounts Committee, and Ian responded to the Chair of the Public Accounts Committee and I am sure he will be happy to talk further about that.

Q277 **Mr Bradshaw:** In response to Luciana's question about privatisation, you made the assertion that you thought that integrated care systems would lead to less private contracting. What is your justification for that claim?

Simon Stevens: At the moment, community health services in particular are subject to periodic re-procurement. To the extent that they are part of an integrated care delivery service, with hospital specialist services and GP services, they will not be subject to that three-yearly, five-yearly re-procurement cycle.

Q278 **Dr Williams:** Coming back, Simon, to the notion that clinical staff are unlikely to lose their terms and conditions, I reiterate Ben's concern, which I think we all have, that non-clinical staff may in the future have diluted terms and conditions. We have seen with the transfer of some IAPT services from NHS Providers to third-sector organisations that staff who are doing the same job have terms and conditions that are no longer NHS terms and conditions. Is there a future in which, for example, a special-purpose vehicle could be set up, with an NHS trust joining with a private organisation, and new staff would be employed by that special-purpose vehicle to perform clinical services on diminished terms and conditions?

Simon Stevens: We will be making it absolutely clear in our public consultation on the draft contract that subcontracting of that nature would not be permitted without the authorisation of the CCG as exists at the moment, so that there were no new risks arising.

Q279 **Rosie Cooper:** The worrying bit of your last statement, Simon, is "without authorisation of the CCG." If you were in the hands of the former Liverpool CCG, you would be very worried that that would have so many holes in it that—

Simon Stevens: I almost took a bet as to how long—

Q280 **Rosie Cooper:** Forgive me. You can guarantee it. The comment you just made was about community services not being subject to cyclical procurement. What happens where those contracts are currently held by the private sector?

Simon Stevens: When those contracts expire, they will be included, for those who are going down this route. As I said, I doubt that the whole of England, or anything like the majority of it, will be using this particular



contractual vehicle, but those who want to integrate funding may do so. As you know much better than me, Rosie, in your area it is Lancashire County Council that has been driving the outsourcing of children's services and has awarded a contract to Virgin, which is currently being challenged by some of the NHS providers, I believe.

Q281 Rosie Cooper: Absolutely; Lancashire Care. But West Lancs CCG awarded its community services contract, which I am talking about, to Virgin Care, so that has nothing to do with politicians. It is to do with the very unit you were talking about before—the CCG. They are not all good; in fact, some of them are really poor.

Simon Stevens: I thought you were going to welcome the fact that you are getting a new medical school, one of three in England. Ormskirk will be receiving new medical students from 2020, which will be a huge boost for the health service in your area.

Q282 Rosie Cooper: It will be fantastic for the health service in my area, but, do you know what, unless you can actually govern the services you are already responsible for, that leaves me very worried.

Can I ask you a question? If you cannot properly govern and control the governance of things like Liverpool CCG and Liverpool Community Health that are easily identifiable, when you are creating accountable care organisations, and whatever hybrids you end up with, including these subco organisations, how are you going to organise proper, decent governance arrangements that stick, in which people like your good self will have assurance and not reassurance?

Simon Stevens: You would not expect me to accept the premise of your question, but no new questions of statutory accountability—

Q283 Rosie Cooper: Kirkup? Capsticks? Deloitte's?

Simon Stevens: There is no change to the statutory accountabilities just because we are moving to integrated care delivery for the kind of patients we were discussing earlier. CCGs and trusts, for better or worse, will still be there, and no doubt we will continue to have the kind of dialogue we have about the oversight that exists for them.

Q284 Rosie Cooper: Absolutely. The question I am asking is: if you cannot regulate organisations that are as clearly defined as those you have now, when you create ever-more complex arrangements and connections, how are you going to ensure that patients—after all, that is what this is all about—get the best service and are not endangered? In some sense, I have to bring forth all those unexplained deaths in Liverpool that have not been investigated properly. Let us leave that aside. How are you going to assure yourself and the British public that they are being regulated properly?

Simon Stevens: This is all about patients. This is all about means to the end of better patient care, and in the hospital serving your constituents yesterday, a quarter of the patients who were in there were ready to go



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home or be looked after somewhere else, but because the system is not sufficiently joined up between the hospital, community services, the care homes and home care, those people, your constituents, are stuck in hospital. The test will be: do these things make a difference to improve discharge flows? For example—

Q285 **Rosie Cooper:** Is that the only test?

Simon Stevens: It is a very important test.

Q286 **Rosie Cooper:** What about actual care?

Simon Stevens: That is care. I do not see why you would think that being stuck in hospital when you should be back home—

Q287 **Rosie Cooper:** Yes, it is not good for you, but it is not the only test.

Simon Stevens: It is a pretty important litmus test of the non-functioning hand-offs between health and social care, which, by the way, are improving. We have seen reductions in the number of delayed transfers of care over the last year.

Q288 **Rosie Cooper:** South Sefton apparently are doing really well, so, yes, I am on top of that.

Simon Stevens: Good. I knew you would be. Therefore, I am surprised you did not mention it yourself because it shows that actually these kinds of integrated joined-up services will produce the improvements for the patients you ask about.

Q289 **Rosie Cooper:** Shall I tell you why? It is because I am encouraging health professionals to do the best job they can, and only by testing where the rules fall down can you ensure that those patients who do not have a voice are looked after, so don't be so darn smug.

Simon Stevens: I am not. I am explaining to you—

Q290 **Rosie Cooper:** You are.

Simon Stevens: I apologise if that is the case, but I am trying to point out that, at the moment, the fragmented nature of care is bad for patients, and, to the extent that we are able to do something about it, that represents real improvement. That is the only point I am making.

Q291 **Rosie Cooper:** I agree with you, so where is the voice for the patient at the bottom of the pile who has been treated appallingly when you are sitting there just saying, "Discharges—things are getting better in little bits of it"? Things are also bad in other parts of it and you should concentrate on those people.

Simon Stevens: That is what we are trying to do.

Q292 **Rosie Cooper:** I hope so. Let's go to where we started. Could you define the potential benefits of using an ACO contract informing a single organisation over what we have heard, quite often, are the already



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agreed partnerships happening on the ground—the partnership arrangements—without the need to absolutely integrate? What is the difference that an almost contractual organisational thing has over informal agreements and partnerships?

Simon Stevens: It will take out some of the complexity and some of the administration. I think you heard from the people from Dudley and from Manchester in the evidence session the answers to those questions.

On the visit that I understand the Committee took to South Yorkshire, I think you would also have heard evidence to that effect. Even coming pretty close to West Lancashire, if we go up to Blackpool and the Fylde coast, we can see very practical examples of what people are doing. They can also point out that, at the moment, the way the funding flows work sometimes reinforces rather than helps us overcome some of the care fragmentation, and in particular the fact that one of the defining legacies of the way the health service came into being was the split between the GP service and the hospital service.

Back then, community services were, of course, run by local authorities, and they transferred to the NHS in 1974, but that three-way split between GPs, community services and hospital specialists is not helpful given what modern medicine and nursing now require.

Q293 **Rosie Cooper:** Absolutely, but we have heard statements from people on panels in previous weeks that this is all based on GP co-operation and there is no guarantee that you are going to have that, or that the independent contracting model that GPs have will allow it. We have almost got a semi-detached situation; you can be fully integrated or you can be a semi-detached version of it. How are you going to encourage GPs to really be the basis of it?

Simon Stevens: I think you are right in that it requires GPs to feel that this is a sensible approach and they want to do it, in parts of the country where the health service wants to do it. That is why it should be an option, but it is not a requirement.

Q294 **Rosie Cooper:** Earlier this week, most people got an email from NHS Providers about wholly owned subsidiaries. It included the phrase that wholly owned subsidiaries would be a “key tool to deliver the current strategic requirements expected of them.” Do you believe that is true?

Simon Stevens: Yes. I saw the briefing that you are referring to, and I think NHS Providers makes the point that there are circumstances where that may be a sensible thing to do, but I would suggest that before forming a final view on the subject the Committee might want to hear evidence from some very thoughtful hospitals and leaders around the NHS describing what they are and what they are not, and then form a final judgment.

Q295 **Rosie Cooper:** The question I asked was: is it a key tool to deliver the current strategic requirements that you have out there right now?



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Simon Stevens: Certainly not in terms of what we are talking about today, in terms of integrated care; no, it is nothing to do with that at all.

Q296 **Rosie Cooper:** Is it a strategic requirement in any sense?

Simon Stevens: To the extent that it may contribute to greater efficiency in services, it is obviously something that the whole of the health service is working very hard at, but I am not exactly sure what is being referred to there.

Mr Bradshaw: It is essentially a VAT fiddle, isn't it? It does not save the Exchequer a penny.

Rosie Cooper: Pardon?

Mr Bradshaw: It does not save the public purse a penny. It is a VAT fiddle.

Rosie Cooper: I have actually written to the Treasury and asked if they have evaluated these schemes and whether they meet their models, and, if not, will they be clawing the money back as soon as they have created one of these companies, and they should.

Chair: I am quite keen that we should not get too far off the central theme, and we can maybe raise that with NHS Improvement next. Ben and Luciana have quick follow-up points and then we can move on.

Q297 **Mr Bradshaw:** This is about the answer you gave to the privatisation question, Simon. You said that when the community care contracts come up in areas that have these integrated systems, they will basically bring them back in-house. How will that be defensible in the legal framework established by the 2012 Act in the face of a challenge by either Virgin or another current private provider, on which there are already challenges out there?

Simon Stevens: In the scenario where people are using the alternative contract to the NHS standard contract, there will have been a fair process that will have met the requirements of the 2012 Act and its predecessors.

Q298 **Mr Bradshaw:** But a fair process that is preconditioned to exclude a private provider.

Simon Stevens: No, a fair process that is covering a broader scope of services. Therefore, the number of people who might be eligible to participate may be lower.

Q299 **Mr Bradshaw:** Can you be more explicit? Are you saying that for a single provider of the type we are talking about there is no private company that could fulfil all those requirements and therefore, in effect, the private sector will be excluded?

Simon Stevens: I have to tread a careful course, because these matters are before the courts. I am happy to talk further subsequently, but I



think our consultation paper will make very clear the answer to the question while also being clear that we are, we believe, fully compliant with the law as it currently stands.

Q300 Luciana Berger: You talked about the organisations having an option or a choice—forgive me if you have covered this already—but just to get it on the record, do you see a moment in the future where it would not be an option or a choice, where all parts of the country would be mandated to have this?

Simon Stevens: No, I do not see that scenario, precisely because it is so important, apart from anything else, that GPs choose whether or not they want to be part of these arrangements.

If Nye Bevan were sitting here now, I think he would be a strong advocate for the kind of integrated care systems and combined funding streams we are talking about. A series of historic compromises that were made at the start of the national health service, which were acceptable and reasonable at the time, are not what a modern future-proofed health service should look like now. I think integration of various kinds is clearly the future, but, no, it is not likely that it will be used everywhere and it certainly will not be a requirement under the new arrangement.

Q301 Dr Williams: If it is so much better for patients, why would we let some parts of the country deliver a service that is not as good for patients? Why not mandate it?

Simon Stevens: We have different GP contractual arrangements right now, don't we? We have the GMS contract, and previous Governments have tested alternative models—PMS and so forth.

Q302 Dr Williams: Those are being merged.

Simon Stevens: Yes, but horses for courses is a legitimate principle in a country as diverse as this one.

Q303 Chair: Can I move on to the financial challenge that underpins all of this? One concern about Americanisation of the system may have been linked to the original choice of “accountable care organisation” as the terminology. In the States, they have very hard financial control. Could you say a little more about what the impact of control totals will be on the systems, the partnerships and the organisations?

Simon Stevens: Let's be clear. The move towards more integrated services for those patients who will benefit is part of the answer to a well-functioning and sustainable NHS, but it is not a silver bullet. We also need a properly resourced national health service, and the fact is that, looking out over the next five or 10 years, clearly—this is not new news; I have said it very publicly on a number of occasions—we will have to return closer to the trend of funding growth that the NHS has had for the majority of its history.



The question of a well-funded health service is independent of the question about whether, for any given level of funding, it makes sense to have more fragmented or more integrated services.

Q304 **Chair:** One of the challenges we face is that, because of the financial challenge, money is drawn out of all the other parts of the system just to go into the sustainability part of it rather than the transformation part. Are you able to give us an idea of what you feel would be necessary in order for the system to work as it should? How short of money is it?

Simon Stevens: One way of answering the question, indirectly, is to point out that the National Audit Office has recorded the fact that over the history of the national health service average funding increases have been 3.7% a year and over the last seven they have been under 2%.

The difference over the last five years between trend rate and what we have received is equivalent to, if we had had trend rate, receiving £8.8 billion more next year than we actually will. Cumulatively, over that five-year period, constrained NHS funding growth has contributed £27 billion to debt reduction as part of the economic turnaround that the country is going through post the 2008 recession.

Q305 **Chair:** Moving on to the impact of control totals, if we carry on with the funding rate we have now, what will we not be able to do? How much impact will that have?

Simon Stevens: We have set out very explicitly what the health service is aiming to do for the year ahead—2018-19. I made a set of comments last October about the very difficult circumstances we would be in were the 2018-19 budget not reviewed, which it was in the Budget. As a result, we have £2.14 billion extra for next year than we previously had pencilled in.

We have been clear about the deployment of that money for unfunded services that are currently being delivered for emergency patient care, for the commitments we have made on mental health and cancer and primary care, and for seeking a faster increase in non-urgent waiting-list operations next year than we are able to have this year. We have constructed a set of planning aims for the health service for next year that broadly is consistent with the funding envelope. Looking out to the years beyond, I have said what I have said on that.

Q306 **Chair:** Yes, but is it still your view that the NHS will not be able to meet its commitments under the constitution to meet routine care?

Simon Stevens: For next year, the agreement we have with the Department of Health and Social Care and our partners is that we have set out what the A&E performance is expected to be, and we have set out the increased number of waiting-list operations that we are seeking to fund. We were very clear, a year ago actually, when we published the document called "Next steps on the NHS Five Year Forward View," that, although we would be increasing the amount of elective surgery, it would



not, over the next couple of years, get us back to the 92% standard. We said that a year ago, but for the year ahead we should see more waiting-list operations and a reduction in the over-52-week waiters compared with what we have now. If we are successful, the current trends on waiting lists will stabilise, or in some places improve.

Q307 Johnny Mercer: Simon, on the more strategic view of healthcare, we talk about more money and we talk about reaching targets that have been set and things like that, but it seems to me that we will always have this argument about money. How do you fundamentally change the debate around demand? What do you need to change in what people think of when they think of our health service that will fundamentally alter what it looks like in future?

Anybody can see that there is almost no way out of the “demand versus what we can actually pay for” question, and there is a very painful gap that is sometimes met by patients having suboptimal care, but largely by staff working in the NHS who are constantly asked to do more for less. What is the strategic answer? We could be sitting here in five years’ time saying, “More money for next year and the year after.” What fundamentally has to change?

Simon Stevens: We should not talk ourselves into a counsel of despair. Actually, many things have improved over the course of the 70 years of the NHS. July will be our 70th birthday. If you think back to 1948, 23,000 people that year died of tuberculosis; we had more than 30,000 hospital beds just for looking after people with TB. We have obviously, for the most part, zapped TB, and new possibilities for treatment have expanded in its place.

There are some broader changes that would make a big difference to the future demand profile of the NHS, one of which relates to the obesity epidemic, which clearly, as we pile on pounds around our waistlines, is piling pounds on to pressure on the NHS budget. We see that particularly with conditions such as type 2 diabetes. Even over the last year, we have 100,000 more people with type 2 diabetes principally linked to obesity.

Action is being taken on child obesity, on reformulation and on our food environments—all of those things—so that not this week, next week or the week after, but, to your question, Johnny, looking out over five, 10 or 15 years, in just the same way as we have had a huge dividend from smoking reduction, we could do the same on obesity reduction. That would mean that, whatever we choose as a country to spend on healthcare in a decade, we will be spending on the good stuff, not going round afterwards dealing with some of the avoidable morbidity and cost.

Q308 Chair: The trouble, of course, is that the scale of the financial challenge is such that the money is coming out of prevention and all that kind of thing. It would be helpful to us if we could be more explicit about what needs to happen to make sure that the transformation piece happens and the prevention piece happens. If you could please update us with that, it



would be great.

Before we move on to the next thing, how are you going to make sure that local leaders do not find that all their time is consumed by system change, and that they are not distracted from the core purpose of making sure that we deliver good clinical care? I think that is Rosie's point as well.

Professor Cummings: It is about keeping the end point in mind, which is that it is not about systems, processes and acronyms; it is about what you are trying to do to deliver changes for patients. We have some really good examples across some of the systems that we have put in place, some of the organisations that have come together to make changes. A lot of them have done it by coming together.

In Frimley, they have a leadership group where our clinicians and managers come together with patients to look at what system changes they need to make. They are beginning to see some really important outcomes. What drives that change and drives all of us who are clinical professionals working in the service is making it better for patients. The message for me, like the lessons we have from the people who have already done this, is not to focus just on the process but to look at what we are trying to achieve. Then put the changes in place, measure the outcomes and look at how we can improve.

You just asked about prevention and asked Simon to come back. In Buckinghamshire, at very low cost, they have focused on increasing physical activity. They have lots of different options; they have Active Bucks and they have healthy walks. We know about the park runs that many places are doing. There is some clear evidence from that showing a decrease in inactivity levels and an increase in the number of people who are hitting the required activity levels. We are also seeing a 57% reduction in falls that result in harm. We have some good examples of people coming together, whether clinicians or managers, that really show a difference. That is the focus we need to work on.

Q309 **Chair:** There are also many examples around the country where fantastic voluntary groups are providing those kinds of activities, particularly working with children—I can think of some in my area, for example—but they are really struggling to get even very basic, small amounts of funding to keep going. They often do not know which part of the system they should go to for that kind of support.

Professor Cummings: Exactly. That is the benefit of what we are trying to do. Steve talked about Tower Hamlets and renal patients. In Tower Hamlets, they have care co-ordinators, or care navigators, who can identify what services people need, how they can put them in place and use the voluntary sector and, therefore, what small amounts of money are needed to keep those services going.

In Tower Hamlets, they have up to 1,500 local voluntary organisations providing support. The outcomes of that are that people are much more



able to self-care; it improves their health and wellbeing and reduces social isolation—all the things that have a really positive impact on physical and mental health.

Q310 **Chair:** It is fantastic where that is happening, but there are many places where it is not happening, and it would be useful for us as a Committee to know how we are going to drive that forward, so perhaps you could write to us specifically about that, Jane.

Professor Cummings: Absolutely!

Q311 **Andrew Selous:** I want to follow on from that point. Your written evidence to us is full of fantastic examples, whether Buckinghamshire, Wakefield, Erewash, Rushcliffe—it goes on and on—where great things are happening, but I share the Chair's frustration. It is the age-old problem in the NHS, isn't it? We have brilliant examples that we have difficulty in spreading across the system. Is there anything different you can do to get that best practice embedded everywhere?

Professor Powis: I agree that that is the challenge, to focus on how those systems that are further back in their development can be brought up to the levels of the systems that we have been describing. Leadership, particularly clinical leadership, is a key component. We brought the clinical leaders and the STP and integrated care system leaders together for the second time in early February, very early after I had started, and I co-hosted, with Jane and colleagues from NHS Improvement.

What struck me was the absolute enthusiasm of the clinical leaders from all those systems, whether they were at the fast-track end or further back, in terms of their commitment to making this work. In fact, the way we ran that day was exactly as you described, on a shared-learning basis, where we had a set of speed-dating sessions where those systems could learn from the ones such as South Yorkshire that were further ahead. We absolutely need to do more of that.

We need to ensure that best practice in the high-performing systems is rapidly transferred. We will be thinking very hard and working out how on the clinical leadership front we can do that. In my experience, clinicians absolutely see that integrated care is the correct and best thing for patients. Frankly, it is usually the best thing for staff as well, because it makes staff's lives easier.

People get out of bed in the morning to do the right thing for patients, so, when you bring clinicians and managers together to design the best thing in an environment that is permissive, you get the additional enthusiasm, the discretionary effort and the buy-in, which means that we get the really difficult balance that you describe, between keeping your jaw to the millstone and doing the operational stuff and your eyes to the horizon doing the transformational stuff. That is when that happens. The good systems such as Frimley, as Jane described, and others are ahead on that, and we need to bring the others up as well.



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Q312 **Diana Johnson:** Professor Powis, you mentioned sustainability and transformation plans and I would like to return to them. The joint evidence from NHS England and NHSI said that partnerships are more important than plans. Could you enlighten the Committee as to whether you are still expecting the 44 plans that were published in December 2016 to be put in place and actioned? Perhaps this is a question for Simon Stevens.

Simon Stevens: They were a conversation starter. I think the answer to your question is that in some parts of the country, no, because people have evolved their thinking since. In a sense, it was the first time that many different agencies had come together to try to answer difficult questions under financially challenging circumstances. As I explained to the Chair a moment ago, the financial position for the coming year, 2018-19, is more benign than it was when those plans were drawn up a couple of years ago.

I do not think we should criticise the fact that people were being asked to plan under very financially constrained circumstances and, therefore, some of the answers that were put out for discussion were probably undesirable, but seen as inevitable given the financial envelope they were having to plan against at the time. That has improved somewhat. We would expect that a number of those plans would be refreshed.

Q313 **Diana Johnson:** Do you think there was a problem with the way the STPs were established in the first place? Would you do the same thing again?

Simon Stevens: Clearly, they are not perfect, and nobody is saying that. They were a good-faith effort to try to overcome some of the fragmentation that existed, recognising that, increasingly, we have to think about how to plan for the health of the population, and to think not just about the NHS but about other local services as well.

The thought was right. We are doing that, obviously, in the context of a legal framework, which we must be consistent with, not least because we find that its fiercest critics are those who then sue us to ensure that we are rigidly compliant with it; irony is not yet dead. Lessons have been learned along the way.

Q314 **Diana Johnson:** What will STPs look like when they go through that refreshing process? How will they look different from what they were in December 2016?

Simon Stevens: It will depend on different parts of the country. I cannot give you a generic answer. In some places, such as Dorset, they had a clear plan, and I think they are able to push on with that. We have backed it with capital and they are progressing well. Others were given birth to under difficult circumstances but are making real progress—for example, Devon.

For those of you interested in Devon, there is an excellent paper from the chief executive of Devon County Council explaining what it is all about,



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reviewed by their cabinet last week. It makes the case very clearly that staff are working across organisations and that, if people need to be admitted to hospital, they will be supported to get care at home more quickly, and the NHS and local authorities are now working more closely together than ever. That is what Devon County Council is saying. That is an example of where I think people are now motoring.

Q315 **Diana Johnson:** If, Chair, you can indulge me for one more question, that is very interesting, and there is a lot of interest in Devon around the Committee table, but—

Simon Stevens: It was not plucked entirely at random.

Q316 **Diana Johnson:** No, but I have a particular interest in East Yorkshire, and I know that the STP footprint in East Yorkshire is not working quite as well as you have been pointing out in Devon. What do you think should happen where there are areas that geographically have been cobbled together with parts of an STP that is powering ahead and doing well? I am thinking of Hull in particular. What should happen there? Is that STP geographical area going to stay the same, or could it be modified in the refreshing process?

Simon Stevens: It could be modified. These are entirely pragmatic answers to the need to get a job of work done. Nothing is set in stone in that regard, and we are very open to those sorts of conversations.

Q317 **Mr Bradshaw:** You have bemoaned several times the legal framework left by the disastrous Lansley Act of 2012.

Simon Stevens: I do not think I said quite that, did I?

Q318 **Mr Bradshaw:** Several times you said “within the legal framework.”

Simon Stevens: I just said that we are acting in a way that is consistent with it.

Q319 **Mr Bradshaw:** You accused your opponents of ironically trying to make you stick to the legal framework of the 2012 Act. Would you like to see that framework changed?

Simon Stevens: At some point in time, there will be benefit, I suspect, in taking a look at whether or not, in the light of where care integration has evolved, there might be a different statutory construction, but the fact is that we are compliant with the framework as it exists and are collectively using our best endeavours to do the right thing for patients. What we are not doing, as the NHS, is sitting back and projecting on to you guys as Parliament, and saying, “Until you do something, we are just going to sit here and let things fizzle on.” We are getting on with doing what we can to improve care for patients.

Q320 **Dr Williams:** We want to help you, Simon. What changes would you like to make that cannot be done within the current strategy framework?



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Simon Stevens: You tell me if you think legislation is likely any time soon, and I will tell you what it might contain.

Q321 **Mr Bradshaw:** Are you looking for it?

Simon Stevens: The national health service is democratically accountable to you as Parliament, and to the public and to patients, so I am not sure it would be appropriate for me to take up that kind invitation.

Q322 **Dr Williams:** We are looking for your advice, though. What changes would you like to make that cannot be made within the current statutory framework, and what is the current statutory framework guiding you to have to do that you do not want to do?

Simon Stevens: It is a kind invitation, so thank you. One of the things that you will see increasingly is much closer joint working between NHS England and NHS Improvement. Ian Dalton and I and our boards are committed to that. We can get a long way in that direction, but, nevertheless, we cannot go all the way, given the way the statute is currently constructed, so that is something that at some future point Parliament may want to consider.

Once we have made further progress on the journey towards integrated care, there will be an interesting discussion about the way provider trust governance structures are established, but we are not saying that that has to hold us back right now. I think Jim Mackey and I previously sat here before you and said that we think we can get two thirds, three quarters, four fifths of the way, and that is what we are seeking to do.

Q323 **Dr Williams:** We are interested, though, in what the final third, quarter or fifth looks like. Is competition an impediment to progress?

Simon Stevens: Again, this is a discussion we have had in the past. As I said earlier this afternoon, I think we will see less competition as a result of the integrated care changes that we are supporting and advocating. We do that, however, within a framework of not just UK law but European law, so, after 29 March 2019 and whatever else follows, those questions will obviously be before Parliament.

Q324 **Dr Williams:** It is okay; even the Conservative manifesto in the last election said that, if necessary, they would introduce legislative changes. As a Committee, I guess we are just looking for continued guidance, just as the Five Year Forward View was the NHS speaking about what the NHS wants to deliver, on what we need to do as enablers of change.

Simon Stevens: Yes, and I take the question in the spirit that it was asked. As our work with the integrated care systems develops, it will be clear where there are friction points, and we would be very happy to give you chapter and verse more comprehensively on some of that at the right time.

Chair: Yes. We would like you to do that, please. Thank you.



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Q325 **Dr Williams:** When there is a need for future legislation to be designed, will you involve local areas and local representatives in that design?

Simon Stevens: Yes, absolutely. Our whole process of change through the Five Year Forward View has not been just about issuing a single administrative blueprint and then a reshuffling of the administrative deckchairs. It has been entirely grounded in the question of what care should look like and how patients should be looked after, and then everything else, be it funding flows, organisational structures or governance, is the means to the end of trying to get that right. That is what distinguishes this set of changes from just about every other reorganisation the health service has been the victim of since 1948.

Q326 **Martin Vickers:** I am new to the Committee. This is only my third meeting and I am trying to fathom out this demand for legislative change. Over the last few years, the one message I have heard loud and clear from local health officials is, "Please don't change anything at the moment. We have had enough change. We just want to settle things down." I am trying to find out where the middle way is between the local views that I get and what you have been saying this afternoon.

Simon Stevens: You are accurately representing a view that was certainly particularly intensely held in the immediate aftermath of 2012. The reality is that we are trying to navigate a course under very difficult circumstances for three particular reasons. The first is the big shift that is happening in the practice of medicine that we talked about: how do you combine increasing specialisation with a holistic view of what individual patients need? We are doing that, which every healthcare system is doing, at the same time as we are enduring the deepest slowdown in NHS funding growth we have had since 1948, and we are doing it in the context of a statutory framework that is not entirely future-facing for what we are seeking to achieve.

Q327 **Chair:** Would I be paraphrasing you correctly by saying that you do not want a major system churn, but that if there were legislative changes it would be helpful for us to know what you think needs to be done to make the system we have work more effectively? Would that be fair enough?

Simon Stevens: Yes.

Mr Bradshaw: Isn't the truth, Chair, that the Lansley Act was so disastrous that any reorganisation is toxic within the NHS? But actually reorganisation is now required.

Simon Stevens: Was there a question mark at the end of that?

Mr Bradshaw: No. It was a statement.

Q328 **Derek Thomas:** I want to talk about how we look after and support those who want to integrate on the ground. Actually in Cornwall, we have seen services come from non-NHS back into the NHS as part of this process, to confirm the question earlier.



The GP and the community care services that you referred to, the local authority, the commissioning group, the acute trust, and so on, all work enthusiastically to become integrated care systems. Then the Department of Health and Social Services, NHS England, NHS Improvement and the CQC join the party, but appear to have different priorities and lay different expectations on different parts of what is supposed to be an integrated care system. That is certainly the experience of what it feels like in the south-west. Do you share that concern and do you have plans to address some of that, and begin to have some integration at that level, not just on the ground?

Simon Stevens: Yes, that is the experience in some parts of the country, if we are honest about it, so I think you are accurately representing how that may have felt. It is part of the reason why NHS England and NHS Improvement are committed to a much closer join-up ourselves at regional level, and we will be setting out further action on that front very shortly.

Q329 **Derek Thomas:** Can I ask you specifically about the joint arrangements between you and NHS Improvement in the south-west and the south-east? How have they been working, and do you have plans to replicate those arrangements in other areas? We have touched on this, but what can't you do within the current legislation to improve the way you work with NHS Improvement?

Simon Stevens: The boards of the two organisations are going to be discussing a set of concrete proposals, learning from the south-west and the south-east, over the course of the next fortnight. I do not want to prejudge those, but as part of our public board papers we will publish what those proposals look like next week. I think you will see further progress.

Q330 **Derek Thomas:** Finally, would it be fair for those areas—the south-west and the south-east—to look forward to that, and maybe see some pressure reduced as a result of those conversations? I guess they would welcome that, but do you think that would be the experience?

Simon Stevens: If it is not the experience, in a sense we will have failed in the effort. The real-world caveat is that in itself that will not detract from the very difficult sets of clinical and other issues that have to be sorted out, including across Cornwall. Doing so in a shared way is obviously better than doing so in parts, but there are still some really difficult judgments that have to be made.

Derek Thomas: Sure, and I would argue as a south-west—Cornish—MP that the systems on the ground are doing their level best to do that and some of their efforts have been frustrated, which you have addressed, so that is good. Thank you.

Q331 **Dr Cameron:** As someone who has worked in the NHS for the majority of my life, when I read the paperwork around this, ACOs, STPs and all the acronyms, it seems to me completely alien in terms of the NHS that I



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know and value. How are you going to ensure that you do not completely transform the NHS from anything that is recognisable as our one NHS that we value so much?

Simon Stevens: In a sense, we have been talking about that all afternoon, haven't we? Clearly we are putting a lot of work into how best to improve the experience of care that our most vulnerable patients are receiving, and that plays out in all kinds of very practical ways. It plays out in the work that we are doing in care homes across England, where we are embedding clinical pharmacists with GPs to help reduce the likelihood that people end up being admitted as medical emergencies to hospital. That is being rolled out across England over the course of the next year. It is a practical thing.

You do not need to worry about acronym soup. Just focus on the fact that those services are going to be improving for vulnerable people in care homes. Focus on the practical fact that many patients who have diabetes, asthma or congestive heart failure also have other conditions, including sometimes depression or anxiety, so that is why we are investing in rolling out talking therapies specifically for people with physical long-term conditions.

Last week at a Diabetes UK conference, we talked specifically about the benefits that patients with diabetes in places such as Cambridgeshire are seeing. Those are the things to focus on, and that is where we are putting our energies. Everything else is just a means to an end.

Q332 **Dr Cameron:** But surely you do not have to reshape the whole NHS concept in order to make clinicians work better together in an integrated way.

Simon Stevens: We are not reshaping the whole NHS concept; I do not know what you mean by that.

Q333 **Dr Cameron:** As I said, I hardly recognise what I am reading in terms of the NHS that I worked in most of my life.

Simon Stevens: I do not understand why not because it is an NHS that is—

Q334 **Dr Cameron:** In the way it is described, it seems fragmented to me.

Simon Stevens: It is fragmented, and that is what we have to change.

Q335 **Dr Cameron:** It is becoming fragmented in terms of who provides this and who provides that and the funding arrangements. It does not appear to be the one NHS that we value and love, that we want to see continue.

Simon Stevens: No. We are creating that. You are completely backwards in that, because actually the NHS, as you know, has been fragmented from the get-go between separate funding streams for GP services, which have been independent contractors, separate funding streams for community health services and separate clinical teams



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working in hospitals. For the first time, we are having a huge national effort, the biggest single move towards integrated care of any western country, happening here now in England.

Q336 **Dr Cameron:** So why isn't the NHS a preferred provider?

Simon Stevens: When you say the NHS is—

Q337 **Dr Cameron:** Moving forward and commissioning services, why isn't the NHS itself the preferred provider? Why is it about contracting out to other services?

Simon Stevens: There is very limited contracting going on, as you know; 7.5p in the pound of NHS funding is spent on private provision. We act within the framework that you as Parliament have established, and you as Parliament have told us how we have to go about that task.

Q338 **Dr Cameron:** Surely patients and people across the United Kingdom want to see the NHS as the preferred provider, because it is all becoming extremely complicated and very difficult to navigate.

Simon Stevens: The NHS clearly is the preferred provider for far and away the vast majority of care. If Parliament wants to change the statutory framework under which the NHS in England operates, that is the conversation you should be having. It is a matter for yourselves.

Q339 **Chair:** Thank you. Before we move on to our next panel, can I take you back to the comment you just made about improving the service for vulnerable people in care homes? You referred to the paper in front of you about Devon. One of the challenges we face in an area such as Devon is the closure of care homes and the loss of community beds. How are you going to make sure that this system of integrated care systems, partnerships, STPs and ICOs is going to stop that process happening?

Simon Stevens: Integrated care will help for the things for which it is designed to help. It is not in itself the answer to a resilient social care sector or a proper future funding settlement for social care. That is something on which the Government are clearly committed to setting out proposals.

I believe that the Health Secretary has given a speech today talking about the upcoming social care Green Paper, and, as you know, I have been vocal on the topic, arguing that you cannot have a well-functioning health service without a well-functioning social care sector. They are two sides of the same coin. I agree with you.

Q340 **Chair:** We are coming back to the financial piece again. Can you answer a final question from me on how we are going to make sure that the transformation money is there within the system?

Simon Stevens: One of the things that the parts of the country with integrated care systems covering just under 10 million people have is



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their dedicated share of transformation funding, which they are using for many of the kinds of changes we have been describing.

As I said at the Public Accounts Committee last week or the week before, the reality is that, given the great pressures that the service is under, we have had to use a lot of the resources available to us to keep current services going. The fact is that, as everybody knows, the health service has been under huge pressure, including this winter, so we have to support frontline services in the here and now, and that has meant that some of that funding is not then available for other programmes.

Chair: Rosie has a final question and then we must move on to our second panel.

Q341 **Rosie Cooper:** It is very short, Simon. People watching this at home, the British public, will see a very large gap between the words and the reality. A few seconds ago, you talked about patients with physical conditions, co-morbidity and maybe that being related to depression and, therefore, you are rolling out talking therapies. There are so many people who are not getting anywhere close to being able to get those services. The gap between the intention and the reality is huge. How are you reaching out, through the TV, to those patients and saying, "It is real; it will happen for you," so that it is not just an intent?

Simon Stevens: I agree with you in part, particularly on mental health services; Luciana has been a vigorous campaigner on that point as well. There is huge unmet need. It is the case, if you look at children and young people's mental health services, for example, that we started a couple of years ago in a situation where one in four young people who might have a need for mental health services were getting those services.

We think that over the next couple of years, given the workforce constraint and the rest of it, it will become one in three by 2020, but is that going to be mission accomplished? Definitely not. There is a heck of a lot more to do. I do not in any sense believe that it will constitute, within the next 12, 24 or 36 months, mission accomplished. No. This is the right journey to be on, and progress is being made, but there is a hell of a lot more to do.

Q342 **Rosie Cooper:** Who looks after the two out of the three who are not getting it?

Simon Stevens: Right now it is parents, carers and friends and family, and that is an unacceptable situation to be in. We all believe that. This is why it is so important that we are protecting increases in mental health spending, including at every CCG next year, and being subject to external independent audit to make sure that it is happening, including in Liverpool CCG.

Q343 **Rosie Cooper:** Those two out of three people need a voice, and it is not going to be a pat on the back.



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Simon Stevens: Yes, I agree.

Chair: We need to move on to our next panel, but I know Luciana has been tempted to a question on mental health, so I am going to let her ask it.

Q344 **Luciana Berger:** I was not going to, but, just for clarity of the record, it is worth saying that the figures you relate to are based on the prevalence study in 2004 and we are awaiting—

Simon Stevens: Which we are updating.

Q345 **Luciana Berger:** We are awaiting the outcomes of the prevalence study later this autumn, which might indeed expose the fact that far fewer than one in three children will be reached by your plans. Do you acknowledge that?

Simon Stevens: It will be an increase because, obviously, in absolute terms, whatever the number was a few years ago, it will be more than that, but what percentage that represents will depend, as you rightly say, Luciana, on what the prevalence survey shows in the autumn, if that is when it is published. It is very unlikely to do anything other than underline the huge gaps that exist in services.

Luciana Berger: Thank you.

Chair: Thank you all for coming this afternoon.

Examination of witnesses

Witnesses: Ian Dalton and Ben Dyson.

Q346 **Chair:** Could we start with you introducing yourselves to those who are following from outside the room?

Ian Dalton: I am very happy to. I am Ian Dalton, chief executive of NHS Improvement.

Ben Dyson: I am Ben Dyson, executive director of strategy at NHS Improvement.

Chair: Thank you. Rosie will start the questioning.

Q347 **Rosie Cooper:** I noticed you were here during the previous session. Could you answer the question whether you support the narrative as described by Simon Stevens, and can you describe the theory of change you and other national bodies are taking to integrated care? I hope you will talk not just about the airy-fairy generalities but about patients; they are who this is about. Do you agree that this is the place to be?

Ian Dalton: In a short word, yes. The reasoning for that is that I have come to this job relatively recently; I took up post in December. Prior to that, it was my immense privilege to run one of our largest teaching hospital trusts at Imperial College Healthcare.



The reason I think the points that have been made about integrating care being the best way to look after people in an ageing society, with more long-term conditions, is that when I walk round and talk to the clinicians in hospitals providing the services, seeing patients when they come in, often in acutely unwell states, it is very clear that there is a strong hunger for joining up care in the way that has been described. In a nutshell, yes, I buy the analysis, and we are committed to playing our part in supporting that move.

Q348 Rosie Cooper: Are you talking about integrated care or co-ordinated care—ACOs as opposed to partnerships? How do you see that model throughout the country?

Ian Dalton: Fine. I suppose at its heart this is about every part of the country: hospitals, GPs, community services, local authorities and the professionals within them coming together to plan out how they work together to provide integrated care.

Of course, organisational structure is always another conversation, but, ultimately, we know that, from the patient's point of view, care is no longer purely episodic, if it ever was: I have something wrong with me, I go into a hospital, I get it fixed and I go out. If we walk around the emergency departments in our hospitals, we see more and more older people. In hospital, we see increasing frailty, and we know that co-ordinating care from end to end in what is ultimately often a very long-term and continuous engagement with health services, rather than the episodic care that we talked about in the past, is the right thing to do.

Things like sustainability and transformation partnerships are a forum in which different bits of the NHS that have an interest in looking after patients can come together and plan the future models of care that we will need. While it is not all about structures—absolutely it is not—it is providing a forum for that.

Things like integrated care systems, which I also support, offer a further opportunity for devolution to local areas to take responsibility for planning the care of their patients. Those moves have huge promise, and certainly from my side, as the person who is supporting the 232 NHS trusts and foundation trusts to deliver compassionate and high-quality care to their patients, it is an important part of our work to support them.

Q349 Rosie Cooper: In conversation earlier, we described that a major part of this is the involvement of GPs. How do you see that? How are you going to ensure almost universal coverage to the same level, and what if GPs or organisations do not want to be part of it? How much is the contract going to be enforced? How do you see that sort of model?

Ian Dalton: I will come back to the GP bit particularly in a second. First and foremost, I am very heartened by the fact that, when I talk to both clinicians and leaders across the provider sector, people recognise absolutely the benefits of joining up care and delivering integrated care.



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To give one example, a few days ago I hosted a meeting with chief executives, which most of the hospital and mental health chief executives attended. We asked them, as part of the dialogue, what things were really important in looking after patients using their services going forward. Very high on that list was integrated care, so I think there is real interest from both the leaders of the services and the clinicians providing the services in doing that, which makes it very likely that people will work together.

As regards general practitioners particularly, obviously NHS Improvement as an organisation is not responsible for general practice, which is an NHS England responsibility, but certainly in relation to the 232 hospitals, community and mental health services that employ the vast bulk of NHS staff, there will be a great interest in being part of that system.

Q350 **Rosie Cooper:** I asked a question about governance.

Ian Dalton: You did.

Q351 **Rosie Cooper:** I know you are new to your role, but NHSI abysmally failed to govern the health economy in Liverpool. As I put to Simon Stevens, the organisations may remain; NHSI is almost a mix of Monitor and TDA, both existing legal entities, and you are in charge of both of them. As this continues and the complexity gets more difficult, if you did not spot it when it was so damning and dangerous and lives were lost, how will you not be reassured but assure yourself that you will be able to govern properly this complicated mess?

Ian Dalton: We could talk for a long time about Liverpool. I was there a couple of weeks ago talking to people providing healthcare in Liverpool. Clearly, the Kirkup report raised really unacceptable events, which caused me, as somebody who has worked in health services for a long time, real concern. We will be bringing proposals to our board later this week as to how we specifically respond to the recommendations of Dr Kirkup.

Looking ahead more generally, I am not really accepting of the premise, and I think this may be worth putting on the table, that the governance arrangements that bring organisations together on integrated joined-up care in any way stand in the very clear and strong accountability that sits on the shoulders of the people round the board tables.

Certainly when I was a hospital chief executive, before I came to NHSI, I was very interested in joining up care, but I also felt that both in law and in my own personal aspirations for patients that the quality of care was on my shoulders, as the person running the health services provided by those five hospitals. None of the arrangements that we have been talking about today in any way alters that.

Q352 **Rosie Cooper:** Forgive me—I accept your words, but that still did not stop what happened in Liverpool. You say you are learning from Kirkup. You did not do anything after Capsticks. You learned nothing.



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Ian Dalton: I look forward to a conversation with you, after we go to board later this week, on the specifics of Liverpool. It is absolutely clear, and I have been clear about it since I first got involved, that we have to respond. We have to make sure that the oversight from national bodies is improved as part of the work that we have to do. I think you will see, and I hope you will be able then to discuss with us, the recommendations that we take forward.

I reiterate the point that there is no dichotomy whatsoever between the personal and corporate responsibility that all 232 NHS trust boards take for the quality of care that they provide their millions of patients and the moves we are talking about this afternoon to join care up and to make it better for those patients. Those two things are both simultaneously—

Rosie Cooper: And learning from Capsticks and Kirkup.

Q353 **Chair:** Thank you, Rosie. Mr Dalton, to what extent do you see evidence that collaborative working at local level through STPs and ICSs is helping the systems to manage their finances more effectively?

Ian Dalton: We are certainly seeing examples across the country, and I think we quote some of them in our joint evidence with NHS England, where new ways of caring, particularly for frail older people with multiple conditions can make a real impact. I think we quote examples such as in Erewash.

Q354 **Chair:** Yes, absolutely. It makes a difference for them in their care, but I am talking about the financial aspect. Are you seeing any evidence that it is helping them to manage their finances more effectively as well as delivering different care for patients?

Ian Dalton: Where it has an impact on the otherwise rising trend of emergency admissions, it will be a really good thing for patients and should have an impact on the excess costs in the provider sector this year. In my Q3 report, which I published a few weeks ago, I talked about the financial pressure in our hospitals. Much of that is occasioned by the impact of older people coming in as medical emergencies.

For me, it is not a direct, “Do this and it will unlock all the financial pressures that exist in the health service.” On the other hand, it is about doing the right thing by those patients, and we need absolutely to do more of that than we have done so far. As a result, if we can have an impact on, say, the 6% year-on-year increase in non-elective admissions that we saw in the month of December compared with the year before, there will, as a by-product of that, be a beneficial impact on hospital finances. Obviously, the predominant reason for doing this is that it is what patients need. I cannot give you—

Q355 **Chair:** It is not being financially driven.

Ian Dalton: No.



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Q356 **Chair:** What we have heard over a number of years in this Committee and in our predecessor Committees has been that it takes time to deliver savings from good integrated working. Will you be giving the systems time to demonstrate any savings, or mitigation of future demand?

Ian Dalton: Whether I talk to clinicians or managers running hospitals, everybody wants to join up care and everybody wants to take the pressure off hospitals. It is fair to say that that is taking time. There are some fantastic examples up and down the country, and we talked about some of them. At the same time, we are seeing a significant year-on-year increase, which is driving the real pressure in the acute sector that we are seeing as well. Inevitably, it will take time, as people come together and plan services. My interest is in what we can do to move as rapidly as possible in that direction.

To answer your question directly, this has to be about the model of care. By doing the right thing by patients in a situation where they have ongoing relationships with lots of different bits of the health service, including the acute sector, we will make things better for other patients, and for the finances of the sector as a by-product of that.

Q357 **Chair:** Do you recognise that it takes time sometimes to demonstrate that change?

Ian Dalton: I do. The evidence is visible on the ground that everybody is moving in this direction, and there is a commitment to do that. Remodelling care takes time.

Q358 **Chair:** Returning to the issue about start-up and transformation funding, this is the same question I asked Simon Stevens: are you actually going to set aside and protect money for transformation, and can you identify how much transformation you will need, to be able to deliver what you want to deliver?

Ian Dalton: Simon referred very eloquently to the choices that have had to be made. It is obviously really important that we also look at the financial sustainability of the 232 NHS organisations that provide care. It is absolutely reasonable to say that we have had to spend much of the new money we have had in the system on supporting care for the increased numbers of patients who have been coming through the door, and, all things being equal, that is not suddenly going to end.

I am very heartened, though, by the idea of moving to integrated care systems, where we move away from individual organisational focused control totals and look at control totals devolving the resource to groups of organisations to spend as they think best for their patients. As the regulator, I am very interested in doing what I can jointly with Simon and NHS England to facilitate that. Ultimately, that is where the financial decision making will sit.

Q359 **Chair:** But when the pressure gets too great on combined organisations, we have heard evidence that it can then drive them apart, as they retreat



to their own legal obligations.

Ian Dalton: I can understand the point. At the same time, we are engaged in something that has huge support across the system. The evidence is that organisations see the benefits that you heard from the clinicians during the NHS England evidence, and I think people want to go in that direction.

Of course, hospitals also want to balance their books, and that is something to be done at the same time, but in some ways, if we do not make the changes to care, we will be committing to dealing with potentially an ageing population, and the consequent rising demand, with care models that were designed for a different era, and we know that that is not the way forward either.

Q360 **Chair:** Sometimes the NHS part of a risk-share arrangement is told that it has to pull out because of the financial risk as a merged organisation. Is that somewhere you would be prepared to step in, to give people more support when that has happened?

Ian Dalton: We would be very interested in the sense to which the 232 NHS organisations that I have responsibility for are engaging in this work. For instance, our single oversight framework specifically talks about the expectation that organisations need to work together to join up care for their populations, and to be part of that strategic move locally. We have moved a long way from the caricature of a hospital being able clinically to stand on its own. That is not the model that necessarily exists going forward. We will play our part.

We will also, as Simon said, be bringing forward proposals to our board to make sure that, as regulators, system overseers and leaders at the national level, NHS England and NHS Improvement give consistent and clear messages to the NHS out there, rather than potentially giving different messages to different bits of the NHS, which I think will also be important.

Q361 **Martin Vickers:** I have a couple of points. How are you supporting local areas to integrate care? Perhaps you could give some specific examples. What would be your response to those who have told us that there are competing priorities between the various national bodies?

Ian Dalton: Perhaps I could deal with those in reverse order. My last answer to Dr Wollaston may go some way towards that. It is really important, if we expect the NHS to integrate and to work together across different bits of the NHS, that we, as the local superstructure that supports the frontline, even if we do not deliver care directly to patients, give consistent and clear messages about that.

I should not pre-empt the fairly lengthy discussion that we will be taking to our boards over the next couple of weeks, but I think and expect, assuming the boards agree, that both NHS England and NHS



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Improvement will be working far more closely together to that end than we have been able to do before.

Q362 **Mr Bradshaw:** Simon Stevens said you might have something interesting and useful to say to us about the wholly owned subsidiaries, in the light of the National Audit Office report.

Ian Dalton: I leave you to judge whether anything I say is of interest, but I will do my best. What can I tell you?

Q363 **Mr Bradshaw:** What do you think of them? We have some quite serious concerns about them.

Ian Dalton: I had this conversation with the PAC a few weeks ago when I was on the stand with Simon. Parliament decided, back in 2006 I think, that NHS foundation trusts could establish wholly owned subsidiary companies to further their objectives. That is a long-standing power. It is fair to say that there has been relatively little, if any, controversy about that in the past until recently.

There is clearly more interest now, and we are seeing developments, particularly in relation to things such as estates and facilities, where hospitals on their own, or potentially working with neighbours, are looking at creating a real focus for those services through those legally agreed models. Clearly, the first point is that Parliament has decided that that is legal.

Secondly, if they are vehicles for releasing efficiencies to go to the frontline of care, that can be beneficial. I have also heard that there can be benefits in terms of providing a real professional focus, potentially across several organisations, on areas that do not always get the attention they need within trusts, such as estates and facilities. I think there can be upsides to them as well, but, fundamentally, the sense that I understand is that they are legal entities and, as long as the law is complied with, trusts are entitled to take them forward.

Q364 **Mr Bradshaw:** They may be legal entities, but the power has not really been used until recently. A number of people are critical that they are simply a VAT wheeze—a means of those organisations avoiding VAT—so the public purse does not benefit in the round, and that they could also result in significantly inferior pay and conditions for the staff involved.

Ian Dalton: I would make two points, if I can. First, the Department of Health and Social Care wrote—I think in December, but certainly towards the end of 2017—making it clear that to be legitimate they had to be for genuine commercial purposes, so it cannot simply be an issue over VAT. That is very clear, and I obviously support it.

On the point about terms and conditions, if you are looking at areas of scarce skill, where the NHS may be competing with the private sector, there is an opportunity to provide terms and conditions that could be potentially more attractive for staff in areas of specialist leadership, say,



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in the estates function. The variability of terms and conditions can be potentially a benefit for the success of those arrangements.

The other thing that may be worth mentioning is that they can provide an alternative to the delivery of functions that are often outsourced from the NHS, and ensure that people delivering those very important functions are part of the NHS family. I am not necessarily saying that these arrangements are always the way forward. I am saying that I think there is a clear legislative framework for them; that, on the expectation that they are just about VAT, it has been made clear that they have to have a legitimate commercial purpose; and that the issues will need looking at on a case-by-case basis.

Q365 **Mr Bradshaw:** Will you speak to Unison about its concerns on that?

Ian Dalton: I would be happy to speak to Unison about its concerns on that.

Chair: Thank you. Does anyone have any other points?

Q366 **Dr Cameron:** Do you have any particular concerns about the variability of staff terms and conditions? You have spoken about potential positives, but what would be the concerns, and are any safeguards going to be put in place so that staff do not end up with adverse terms and conditions compared with counterparts doing the same job?

Ian Dalton: The most important points would be twofold. The first is that, as somebody who has run hospitals in the past, I know that it is incredibly important that staff are motivated to do a great job. All your employees are really important in delivering care for your patients, so your predominant motivation is to make sure that, whatever the employment arrangements, staff are serving patients.

As to specific safeguards, the other point that is perhaps worth mentioning is that where a new entity is set up by a foundation trust, and staff are then transferred into it, hopefully with the expectation of proper engagement and consultation with those staff first, they would be transferred on their existing terms and conditions under the TUPE regulations. They would keep their protections and would take those with them. The legislation that exists provides significant protection to current members of staff.

Q367 **Dr Cameron:** That is for existing staff.

Ian Dalton: It is.

Q368 **Dr Cameron:** It would not apply to new staff coming on board.

Ian Dalton: It might, but ultimately it would be at the discretion of the organisation concerned. I reflect again on the fact that it is really in the interests of an organisation to make sure that jobs in vital services are done by motivated staff. Organisations will want to ensure that, whatever



terms and conditions they offer, they support the delivery of high-quality care.

Q369 **Dr Cameron:** Are you going to be able to evaluate or monitor that to make sure that staff are not adversely impacted? We have heard in other evidence that the morale of staff is key in the NHS, and you said yourself that staff feeling valued is important. If staff find themselves doing the same job as someone else on worse terms and conditions in one of those subsidiary companies, what is the recourse in that arrangement?

Ian Dalton: Predominantly, it is an exercise of a legal power by an organisation that should have at its heart the delivery of good-quality care for patients, and it should be a contributor to that. It is a legal power that has existed since 2006.

As regards NHS Improvement, we are looking at what our regulatory role is, if any. At the moment, we do not have a regulatory role particularly; it has always been assumed to be for local determination. I come back to the point that this is predominantly about local services deciding the models of employment and the structures around them that best support them in the delivery of high-quality care.

Q370 **Chair:** Mr Dalton, could you assure the Committee that you will be keeping a close eye on this as it goes forward and tracking any issues that arise?

Ian Dalton: When I wrote to the Public Accounts Committee Chair after the hearing a few weeks ago, I set this out, and said that we would be happy to continue with further engagement as the agenda goes forward, if there was interest.

Chair: Thank you, and thank you for coming this afternoon.

Ian Dalton: Thank you.

Examination of witnesses

Witnesses: Jonathan Marron and Stephen Barclay.

Q371 **Chair:** Good afternoon. I am sorry to have kept you waiting. Could we start by you introducing yourselves to those following from outside?

Stephen Barclay: I am Steve Barclay, Minister for Health.

Jonathan Marron: I am Jonathan Marron, the interim director general for community and social care in the Department of Health and Social Care.

Chair: Thank you. Andrew will start the questioning.

Q372 **Andrew Selous:** Could you first set out for us, please, the Department of Health and Social Care's definition of what integrated care means to you, and, secondly, give us your vision for 2021 of co-ordinated,



person-centred care? How will families and carers see a difference by 2021? What is the vision, the road map and the working definition that you are using in the Department?

Stephen Barclay: Thank you, Mr Selous. There are a variety of ways in which integration can work within the NHS; it is not that there is one specific model. What it seeks to do is respond constructively to the feedback we have had from within the NHS, which is that the NHS does not want big reorganisations but at the same time recognises that there are opportunities for different parts of the NHS family to work more effectively together. That is a question of NHS trusts, community hospitals, primary care and indeed other areas, such as the charity sector, coming together.

It is also reflecting patient change. Patients are presenting with more complex needs, so, as Mr Dalton mentioned in his evidence, perhaps the previous linear model where people would access a specific type of treatment is less the norm. There is now a need, particularly with the demographic changes, for people to access a range of services, so we need a more generalised service that brings in multiple aspects. There are a range of ways of doing that, through the vanguard programme and through the ACOs that the Committee has been looking at, as to how we bring different parts of the NHS family together.

Q373 **Mr Bradshaw:** I do not know if you were here for Simon Stevens's evidence, but he basically repeated a theme that we have heard throughout this inquiry, which is that what is going on with these integrated care models is, essentially, a well-intentioned attempt at local level for the NHS and social care to be more joined up, but there are legal and legislative obstacles to them doing that effectively. He dodged the question about whether he would like you—the Government—to address that. Are you going to address it in a way that would make the models watertight, so that we could be satisfied that they were wholly legal, and sweep away the obstacles to integration that we have heard repeatedly from people working on the ground?

Stephen Barclay: You are right, Mr Bradshaw, in that, first, a number of these models are happening organically; people are starting to work together on the ground anyway. That refers to my earlier point. There is a desire within the NHS for people to work in a more collaborative way and to recognise that that is what patients need, and how patients are presenting.

As came from the evidence that was given to the Committee in terms of Dudley, the issue with the ACOs is the pace at which that can be done and how we enable it in the most effective way. There is reluctance to have primary legislation, in part because the NHS itself has said there is a degree of wariness post the Lansley reforms for what might be seen as top-down reorganisation. The question is how you create a legal entity in the form of an ACO that can accelerate and enable that integration, rather than require lots of contracts between different silos of budget.



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This is responding from a push within the NHS to work in a more integrated way. It is not saying that it cannot happen without ACOs, but it is responding to say that perhaps it can happen more quickly if we have a legal form that enables that integration to take place, and we test that in a very limited way, which is why the proposal is purely to test it in Manchester and Dudley at this stage.

Q374 **Mr Bradshaw:** But it is still your intention, notwithstanding the judicial review, to bring forward the order that we were expecting before now, before the judicial review was announced.

Stephen Barclay: It is partly, I think, in response to the Committee, and a credit to the Committee, that, as a Department, we are very keen to hear the evidence from the Committee, but in particular to hear the feedback from the NHS England consultation. From a Department point of view, we want to see the response to that consultation prior to bringing forward the proposal, so that it is informed by that consultation.

Q375 **Mr Bradshaw:** Both your boss, the Secretary of State, and Simon earlier made it quite clear that in their view these systems of integration would make private contracting less likely. Is that a view you share?

Stephen Barclay: Very much so, but it is also, Mr Bradshaw, not just my view. It is the view of many others in the NHS family. The King's Fund is being very clear that it does not see the ACOs as a vehicle to privatisation. Likewise, David Hare from NHS Providers has made it clear that he does not envisage private firms being in a position to succeed in securing these contracts. Likewise, in terms of what is happening on the ground, Manchester and Dudley, the front-runner sites, are being taken forward by NHS foundation trusts, so that is not what is happening.

In addition, there are a number of checks and balances in the system in the requirement for CCGs to consult their local populations, their health and wellbeing boards and their oversight and scrutiny committees. On top of that, there are safeguards at a national level of CCGs going through the integrated support and assurance process. Actually, there are a lot of checks and balances as to the fact that this is not privatisation. I simply refer back, for example, to the argument on foundation trusts. When they were first brought in, some of us will recall that foundation trusts were characterised as a privatisation, and that is not the case.

Q376 **Mr Bradshaw:** We have also heard from the King's Fund and from your boss, the Secretary of State, that it is still possible within the current legal framework that a single provider under the ACO contract could be a private provider. If that is not your intention and it is not your hope, as you suggest, why do you not bring forward a simple one-clause Bill to Parliament ruling it out? I am sure that would attract wide cross-party support and you would get it through in a flash.

Stephen Barclay: You stray into a previous area where I worked—business and management in the House. First, if you bring forward primary legislation, as you well know from your own ministerial



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experience, amendments can be within scope, so it can end up looking very different at the end of the parliamentary process from where it started.

Secondly, if you had something like that, it would prevent GPs, for example, from playing a role within ACOs. Thirdly, we just do not think it is necessary. If you look at the very limited approach we are taking, in Manchester and Dudley, that is not what is happening on the ground. Operationally, it would be very difficult to envisage private firms satisfying the range of checks and controls I set out in my last response, and being in a position to win those contracts in the first place.

Q377 **Mr Bradshaw:** Why would it preclude GPs from taking part in the integrated care structures?

Stephen Barclay: Because they would be classed as—

Q378 **Mr Bradshaw:** Private contractors.

Stephen Barclay: Indeed, yes, as independent contractors.

Mr Bradshaw: It is an open invitation to you, and I am sure it would be warmly welcomed by our side of the House. We might try to amend stuff, but you could then reject those amendments and we could all agree on one thing—that we are excluding private providers in law and fulfilling what you say you want to achieve.

Q379 **Dr Williams:** This is on the same theme. When we asked the providers whether or not they would welcome legislative changes in order to bring clarity, they said that they would, unequivocally. We know that there is still a lot of uncertainty for commissioners, who feel that they need to put services out to tender. What would need to happen in order for you to bring forward the legislative changes that Ben is suggesting?

Stephen Barclay: The point I was making, Dr Williams, is that I do not think it is necessary to have legislation because, in practice, there are checks and balances in the system. Likewise, as I said, a number of the leading authorities in the area, such as the King's Fund, have said that they do not see it as a material risk, so we do not feel it is necessary to have primary legislation to rule it out because we do not see private firms actually securing ACOs in the first place.

Q380 **Dr Williams:** There would be nothing to stop a private firm going into partnership with an NHS organisation. The contracts are going to be written in such a way that NHS organisations are likely to be the only people who are going to win them, and, if I were running a private firm, surely the opportunity for privatisation would be by entering public-private partnerships in order for the private sector to get a stake in delivering them.

Stephen Barclay: Jonathan may want to come in on this. The contract will still sit with the CCG, so the CCG will retain the statutory responsibility of the commissioning body, but in any event, if you look



back to the Lansley legislation, it made it clear at the very start of the Act that services are free at the point of delivery. That is enshrined in the law, so the idea that this is an Americanisation, that this is looking to some sort of American model, which I understand Professor Pollock and others tried to suggest, is simply not borne out in the legal position. It is the case, going back to earlier legislation passed in 2006 under your previous Labour Administration, that private firms can bid to supply services. That complexity around EU and UK law, and existing legislation on the statute book, would need to be borne in mind.

Jonathan Marron: The Minister's comments around what is practically likely to happen are the most important. If you think about what these contracts are, they are to bring together primary care, hospital services and community services in a local area.

The idea that that will be won by a body outside the local health system seems very unlikely to us. Indeed, if you look at what has happened in the city of Manchester and in Dudley, it is, of course, local trusts, or collaborations of trusts, that won those contracts. In the same way, our acute contracts are not tendered because, frankly, the local acute hospital is always going to win.

Q381 **Dr Williams:** We agree. The point is, why not specifically rule it out?

Jonathan Marron: We think it is unnecessary, and that the risk that people are worried about will not come to pass. Indeed, experience so far has shown that it has not. Obviously, NHS England is about to consult on the contract. The Minister talked about our regulations for that process, which we are awaiting. That will allow us to have a debate, but it really does not feel like a genuine risk that we are currently facing. Can I return to some of Simon's comments on the legislation?

Q382 **Mr Bradshaw:** Before you do so, it would end in one fell swoop all the noise around this if you would just do it. You are a politician, Minister, and this political noise cannot be welcome to you. It is a very simple solution. Apart from the fear that you would create some Christmas-tree Bill on which everyone in the House of Commons would want to hang amendments, I am not quite clear why you are so reluctant to do it. If you want us to believe your assurances, just do it.

Stephen Barclay: I am trying to answer that. There are probably three things. First, we do not think it is necessary. Secondly, there are concerns on scope and legislation going through the House of Lords and the Government's position there. Thirdly, we think there are other checks and balances in the system.

Q383 **Mr Bradshaw:** Have you asked parliamentary counsel to draft you a simple one-clause Bill that could not be amendable in the way that you fear, and that could help you make—

Stephen Barclay: As I just said, I do not think it is necessary. If one goes back, STPs were characterised as privatisation, as were foundation



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trusts. The very first section of the Lansley legislation makes it clear that services are free at the point of delivery. The announcement today of additional teaching spaces—

Q384 **Mr Bradshaw:** That was not my question. Have you asked parliamentary counsel if it is possible to draft you something that will deliver what you say you want, to the satisfaction of everyone, without the risk that you are worried about, and, if not, will you do so?

Stephen Barclay: No, because I do not think it is necessary.

Q385 **Chair:** Jonathan, you wanted to develop a point.

Jonathan Marron: I wanted to go back to the earlier question around the legislation. Simon Stevens was very clear that integration comes back to how we make sure we are getting the best services for patients, and organising ourselves in that way.

The key challenge we face is that people have multiple conditions and it becomes a relationship, not an episodic change. How do we become much more proactive, so that we do not just wait for people to come to A&E or pitch up at a GP? How do we identify patients who need our help and wrap our care around them? His final point around support was, how do we empower people to take their own decisions about managing their care? We are our own experts on our own conditions.

None of that is really about the law; it is about how we organise ourselves. He gave a really good account of just how far he is able to drive the integration agenda without any changes in legislation. I think we are making great progress. The bits that we have agreed with NHS England, which are dealt with in the regulations that we will bring forward, following the consultation, are quite technical aspects. How do we make sure a new ACO contract provides the same protections that are currently provided in the NHS standard contract and the GMS contract? Changes to the regulations are needed to insert the ACO contract into those protections, and there is a specific issue around GPs.

The Committee may know that the GMS contract is awarded in perpetuity, so we are trying to create a new situation to allow them to set aside their GMS contract temporarily to join an ACO, which will allow the fully integrated model to be tried without GPs having to say that never again would they be able to go back to GMS. I think you talked about the fully integrated and partially integrated models earlier in the Committee. There are changes, but they are quite technical and they are about enabling the set of safeguards we already have for other services, and allowing GPs to take full part.

The areas where we have had that kind of change to legislation were really willing to make the changes that allow NHS England to get on with piloting their models. I don't think we have had any conversation with NHSE or indeed NHSI about having a much wider set of changes to the legislation, or a much wider set being necessary to make the progress



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that we have set out in the Five Year Forward View, or indeed the next steps document that came out last year.

Q386 **Chair:** Can I come to a point that Andrew Lansley made repeatedly when he came to one of our previous Committees? He thought that integration would trump competition, but in fact what we have seen is often endless, wasteful contracting rounds. My understanding is that part of the purpose of these proposals is to get away from that and to allow greater integration. Could you explain to us how that is going to be more possible under the proposals that we have to move to ICOs? How is that, in effect, going to lessen the use of contracting rounds?

Jonathan Marron: There are two separate answers, if I can separate the two points. The movement towards STPs and integrated care systems is really about how we get the NHS to plan as an NHS. They are not individual organisations.

Q387 **Chair:** They are delivering for patients, but there is the separate point about the waste of time and energy that goes into these endless rounds of contracting.

Jonathan Marron: Having an STP, or indeed an ICS—with the challenge of an ICS being an evolved STP—taking much greater responsibility for performance and finance within the patch, and having a stronger common view of what we are trying to achieve, will help to align our healthcare systems, so that we are not competing unnecessarily but are all, across a much wider patch, trying to do a common job. That is important. After the Five Year Forward View, the ALBs would be able to create that structure to allow that planning. That is important as an overall piece.

The ACO argument is about whether we can create a much simpler structure, integrated across primary care, community services and hospital services, that allows the clinicians and the managers in that unit to get on and make the changes they want. It is about making it easier for a set of internal management decisions, if you like, to move resource and develop new services, rather than having to go back through the friction of a set of contracting arrangements, and indeed different payment arrangements, which sometimes just get in the way. It is about making it easier for people to get on. It is not, as I think Simon said, a magic bullet; it will not fix everybody. Indeed, it is important that people choose to adopt these services, where they are ready.

Stephen Barclay: In terms of the first one, it is already happening. You asked Simon Stevens for some examples. I have a couple of examples. In Wolverhampton, they have a vertical integration model; GPs have subcontracted their GMS contract to the trust and the trust then employs the GPs as salaried employees. In South Warwickshire, the foundation trust has a block contract for out-of-hours care services and therefore has much more of a stake in the out-of-hours care rather than just



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hoovering up the tariff-based treatments within the trust itself. These things are already happening.

The ACO approach is not to have people having local workarounds to get around the contracts. It comes back to the Dudley point in the evidence that you received: how do we make it easier? Instead of a body having to negotiate different budgets, different contracts and different employers, how do you bring that into a legal entity?

Q388 **Chair:** I am still not clear how you are going to reassure local systems, where they constantly feel under pressure to put contracts out to tender. What reassurance are you giving them that they will not need to do that?

Jonathan Marron: I come back to Simon's point about reducing the amount of tendering. The sector that we are putting out to competition on a periodic basis is community services. We have not done it for any other sector of the NHS. The point that Simon was developing earlier is that, as we move to more integrated systems, we will not have the same requirements to put those integrated contracts out to tender every five years in the way we have with community services.

Q389 **Chair:** It is not just community services. It is things such as, for example, sexual health services being put out to tender or, for example, pathology services. There are very many examples. It is most widespread in the community sector, but there seems to be a lack of confidence within the system that they have the power not to have to do that. Do you think it will continue at the same rate, or do you see it reducing?

Jonathan Marron: If we move to larger, more integrated contracts, as Simon set out earlier, it is much less likely that we will have a procurement process that rolls forward. It will become the case that there is only one credible bidder.

Q390 **Chair:** In other words, the fact that it is in-house and integrated genuinely means that we will be able to see it trumping competition.

Jonathan Marron: Yes. The procurement regulations are very clear that, where there is only one possible supplier that could meet the requirements, there is no need for competition. We do not run a competition for the Guy's and St Thomas's contract every year because there is no alternative provider. Actually, there is a perfectly legal route now to not running competitions, and it is based on making sure that there is only one credible provider. We can do that today. There does not need to be any change.

Q391 **Chair:** It would be helpful if you could write a more detailed note for the Committee about how it is going to work.

Jonathan Marron: Yes. I would be delighted to.

Q392 **Dr Williams:** How will you really make sure that accountable care organisations get transfer of resource into prevention in the community? Steve, you just gave an example of a block community contract being



held by an acute trust. I have seen that in the area I represent. Because of underfunding of the acute trust, it has sometimes had to divert resources from the community to the acute trust in order to deal with crises. How are we going to be convinced that we will see the shift of resources that we would all like to see with the new contracting model?

Stephen Barclay: That is partly what the pilots are for and part of what we will all look to bring out from them. Regulation 32 of the PCR 2015, which Jonathan was just alluding to, allows the commission not to run an open procurement for services where there is no reasonable alternative. The idea will be that, once the ACO is there as the legal entity, more services can be folded in, such as sexual health, community nursing, mental health and so forth, so that legal entity is not then going through the competing contractual rounds.

Q393 **Dr Williams:** This is not a question about competition. It is a question about cost improvement programmes. Because there is so much power in acute trusts, and because the demands on acute trusts are so much more visible than the demands on a prevention service, you end up with cost improvement programmes disproportionately affecting the community and the prevention services. It is more a question about how these new entities will prevent that happening and really get resource shift.

Stephen Barclay: It is partly in terms of the duration. That is part of the argument for having a 10-year contract. It is a bit like the debate, in a separate area, around rail franchising and how long you have a franchise and what are the incentives to front-load investment or not. It is in part about that. By having the one entity, hopefully, we will move away from the incentives being at the trust end and shift it so that they have more skin in the game.

Q394 **Dr Williams:** Hopefully.

Stephen Barclay: That is the policy intention, but it is also what the NHS and leaders in the NHS have themselves been pushing for.

Jonathan Marron: I have a couple of points. It is a really important question. As we roll forward, if we are to have these new models of care, with whole-population budgets delivering, how do we get a set of data, information outcomes, that allows us to know they are doing well? That is part of what we have to develop with Dudley and the city of Manchester going forward, but it is with the grain of what the clinicians are trying to do in those areas.

In the vanguard programme, much of what they have done is about how to get a better connection with hospital consultants, who are not sitting in their hospital all the time but are connecting with GPs and treating patients differently. The contract makes it easier to move those resources around, without having to have an argument about tariff, risk share or any other things.



It is a really strong question to ask about how we get a set of outcome measures that demonstrate that we really are, to go back to Simon's three points, tackling people with long-term conditions, being more proactive and helping to support people to look after themselves. Those are the deep questions, and actually whether it is an ACO doing that, or our current system where primary care, community services and the hospital are separately facing those challenges, it seems to me that actually putting people in the same entity gives us a much better chance of getting after that than we have currently.

Q395 Andrew Selous: Can I start by asking you about the position of NHS England and NHS Improvement? When Simon Stevens was speaking to us earlier he talked about ever-closer working, and we got the same take on the situation from NHS Improvement, which was welcome, but is it not, frankly, just another encumbrance to have these two organisations now? Would you be prepared to merge them, or is that not possible under the terms of the current legislation?

Stephen Barclay: First, you would need primary legislation, which goes to Mr Bradshaw's earlier point, to amend the 2012 Act, if you wanted to do that; but, secondly, through the mandate, through the remit letters and through the leadership of both organisations, there is a very clear desire to work much more closely together.

I have a fortnightly meeting with Dido Harding, who chairs NHS Improvement, and it is very clear that at the top of the organisations, there is a desire to work much more collaboratively, much more closely together, which is manifested not just in words but in deeds. In the regional structure of NHSI and NHSE, there is a programme to bring them together in a much more meaningful way. The leaderships of both organisations recognise that they need to work more closely together, and again I think there is reluctance to see yet more top-down reorganisation. The question is: operationally, how do we make that happen?

Q396 Andrew Selous: If I may, I would like to question you a bit further on the written evidence given to us by NHS England and NHS Improvement. There are some fantastic examples across the country of very good things happening, at the GP level, in nursing homes, community hubs, local authorities and public health initiatives. They are fantastic. I look at that, and to start with I am very encouraged and pleased about what I see. Then I think about my own area and what is not happening in it, and I am partly envious.

In terms of a systems point, in clinical care in the NHS, you have the Getting It Right First Time programme, which is all about driving out variation in clinical procedure. It seems to me that you almost need a similar sort of metric to take these isolated good examples going on around the country, because it is urgent out there. We have people waiting long times to get in to see a GP at the moment. GP involvement in nursing homes is very variable. We have parts of the country where



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some people are making a lot of unnecessary trips to a far-away hospital, and that is happening much less in other areas. We are beginning to get a degree of inequity, which is inefficient and not giving a good outcome. Politically, I am looking to try to understand how we really standardise and drive forward uniform best practice.

Stephen Barclay: I could not agree more, Mr Selous. The NHS is very good at pilots and innovation, partly because it has brilliant people who will innovate. Where I think its performance needs to improve is in how it industrialises that innovation across the system. I have been in post less than two months so I am very new to the field, but I find particularly striking the extent of variation between trusts. If you look, for example, at ambulance trust sickness rates, West Midlands has a much better performance than the other ambulance trusts. You could look at a whole range of metrics. If you look at the Model Hospital data and the Carter efficiency data, there is massive variance across the NHS system.

You are absolutely right about integration. There are lots of really good examples bubbling around the system where people are just getting on and doing it. The question for the ACOs is whether we can answer the Dudley challenge. Can we enable it to happen at pace in a more deliberate manner and make it easier for that integration to work?

The wider challenge politically for someone new to the field is how we address the extent of the variation within trusts. How do we understand where best practice is not being followed? How do we support areas that are particularly challenged? Where we need to reset, because there are factors beyond local control, to drive out a lot of that variance?

Q397 **Andrew Selous:** You talked a lot about trusts. To take you back to the GP level for a moment, the Committee went to see Larwood House in Worksop, which we were very impressed by. I read in the NHSE and NHSI evidence about Erewash, where GPs are doing “‘on day’ service that has contributed to a 3.8 per cent fall in non-elective admissions to hospital.” I do not really have a sense of how we take in primary care. You have talked quite a lot about the trust piece, and I get that, but in terms of primary care, as it is currently constituted, how are we going to see this real leap forward in improvement across the country, where we match what the best are doing, because there is quite big variance at the moment?

Stephen Barclay: There is. If I look at the two counties next to me, Norfolk has six CCGs, and last year spent, I think, £25.6 million in overhead; Suffolk, with a similar population, has two CCGs and had £15.6 million in overhead, so that is a straight £10 million. It is of interest to look at that and understand how that is being effective. This is not just an NHS issue. In our own field as Members of Parliament, an MP in one constituency might be really good at campaigning and next door there is one who is not. We all have variance within our behaviours and between populations.



What has come out of the Carter work, and a lot of the work that has been done by NHS England, is greater transparency on these issues. Then, through closer working, with which you started, between NHS England and NHS Improvement, it is a question of how we bring the two organisations together, because at the leadership level certainly what comes over to me is that there is a strong desire to address the variance in the system. One of the key ways of doing that is to have greater integration.

Jonathan Marron: It is great that we are getting some recognition for the great work that the vanguards have done. Across the 50 sites, they have done some really interesting things and have some interesting clinical models. Obviously, your challenge is absolutely right: how do we turn that from 50 sites to the NHS? Simon Stevens and Steve Powis talked a little about the work they are doing to try to spread good practice. They have work inside NHS England to pull together eight thematic reports about what we learned from the vanguard process. They are working on that now, and on a national learning report. That will be a really important piece of work to show what we have learned across the three-year programme, and how we make it have a much wider impact.

Q398 **Chair:** Will it also look at the issue of start-up funding? One of the reasons we get variance and things not being rolled out is that the pilot has start-up funding. Is that something you are going to factor into the review?

Jonathan Marron: It is a good challenge.

Q399 **Chair:** It is very difficult to get a clear idea of the figure for the transformation funding that we need.

Jonathan Marron: The other interesting thing is that there are definitely additional costs in going first, particularly if you are doing something innovative. The vanguards funding has not all been spent on the clinical service but in setting it up and understanding how it works. It is easier to be a fast follower than to be the first person to do something. One thing we should look at is what is breaking new ground and what we know works, so that others can much more easily pick it up and put it into practice.

Chair: Johnny has some more questions on that in a minute.

Q400 **Andrew Selous:** I have one final question. Can I press you on timescale? You said you have these eight thematic reports coming out of the vanguards. Roughly, by when do we expect a greater degree of standardisation lifting the broad mass up to the level of the best?

Jonathan Marron: You have also talked about some of the wider range of things we have, the GIRFT programmes and some of the others. Our push on transparency of performance across the NHS has been greater than we have seen ever before. We have a significant programme on trying to raise performance at CCG level, trust level and more broadly.



The vanguard work is about how we put information into the NHS that allows people to take on effective models that others have already tried, and get on with them. If you like, it is the question where GIRFT stops. GIRFT shows you where the variation is.

Q401 Andrew Selous: I am sorry, but my question was quite simple: how long and by when? I was after a time period. By what sort of date can we expect to see a level of proper transfer of best practice, and moving everyone up to these brilliant examples that you have given us in your written evidence?

Stephen Barclay: We mentioned Getting It Right First Time. From memory, there are 36 of them planned over a 24-month period. The first came out a few weeks ago. It was interesting that it showed that the hub and spokes model would save around 100 lives but it would also save £16 million. However, a key issue is that we focus too much on the money side and not on the patient outcome side, which is one of the constraints in getting agreement to change in the first place.

How quickly we deliver those, Mr Selous, is absolutely the right question. It is something that we need to challenge, and we need to ensure that we have the return on investment correct so that we are resourcing the right areas to deliver pace in the system. As to whether there is a lightbulb moment when these things are then aligned, of course there is not; it will be a moving feast. As you move on one area, such as agency, another area will pop up where there will be variance, and we need to be mindful of that.

Q402 Rosie Cooper: I have two quick questions, but more on the subjects I have been trying to deal with all afternoon. I asked questions earlier about governance and assurance in the ever-more complex organisation that the NHS will be in the future. If all the regulators failed, as they did in the Liverpool health economy, how assured can you be that this is not happening elsewhere right now or will not happen in the future?

Stephen Barclay: There is a wider question and then there is an ACO governance one. If I take the wider question, which is perhaps of help—

Q403 Rosie Cooper: The answers will be interrelated.

Stephen Barclay: I will try to deal with them, Ms Cooper. You are absolutely right, and, as I made clear on the Floor of the House, I am concerned that the system has not been robust enough on tackling bullying. The impact of bullying is underestimated and underplayed within the NHS family, and I have been very clear since starting my post that that is a particular issue of focus. That is point one.

Point two, as triggered through your work, is that the Dr Kirkup report has highlighted issues with the fit and proper test, and we are very close to having a QC appointed in order to take that work forward. I will be looking to work very closely with the Committee, as I signalled in the House, on how we strengthen the fit and proper test. I am in no doubt



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that it needs to be strengthened, and it is a source of concern to many of us in the House that we see people recycled around the system.

There needs to be a distinction within that for those who have perhaps been promoted over their heads and have made mistakes, where I do not think it should be a cardinal sin. If we are to have a duty of candour, we need a climate where people who are in the wrong job or have made genuine mistakes are able to learn from that and be candid about it. That is distinct from what we saw at Liverpool where, for example, all but one of the directors refused to co-operate with the Kirkup report, which I think is outrageous. Serious questions then attach to the suitability of people who are involved in either cover-up or denial and refuse to ensure that we learn the right lessons.

There is no confusion or uncertainty on my part that there are issues for us to address around accountability, as you will have seen from the letters sent to the various bodies referred to in the recommendations in section 6 of the Kirkup report, and indeed in the very strong response from NHS Improvement, to say how seriously they are looking at that. I know you have met Dido Harding to discuss that further.

As part of the wider issue of the accountability of ACOs, clearly the CCGs will continue to have a key statutory role, but it is important that consultations with MPs and responses from MPs are taken more seriously than perhaps they have been in the past. Again, it is not purely an NHS issue. It is an issue that has applied in other areas—for example, with local enterprise partnerships, as I think people know. We need to get the accountability into a better place.

Q404 Rosie Cooper: If I may, Chair, this is just a quick one. Minister, I really do thank you for your work on this so far, but I want to emphasise that the system did no learning after Capsticks, so why should any of us believe that it is really going to learn after Kirkup? If I could join together the two agendas today, we have heard Dudley being repeated as almost a vanguard for the ACOs, yet would it shock you to know that the finance director of the Liverpool CCG, who was required by NHSE to leave his post, has now turned up at the next stop on his magic roundabout, it would appear with an increased pay rise, as the finance director of Dudley? Do you have any real hope that proper learning will ever take place in this regard?

Stephen Barclay: First, Ms Cooper, you will appreciate that, as a Minister, there are constraints on commenting on individuals, particularly without having seen full details.

Q405 Rosie Cooper: It is about what it means.

Stephen Barclay: I will comment in the wider sense, if I may, rather than on the individual cited. The point, which is why we are appointing a QC to take forward the Kirkup review, is that, as anyone who has dealt with the employment law field knows, there are complexities in terms of



people's rights, due process and ensuring that there is suitable balance in how issues are dealt with, because this is people's livelihoods. On the other hand, there is legitimate concern in Parliament, as you have articulated and as I have recognised in the House, that those who have suffered, as people in Liverpool suffered, feel robbed of justice in many instances. We need to get that balance right. That has to be done in a very legal and thorough way.

Q406 Rosie Cooper: Minister, will you signal that the NHS has to start applying proper disciplinary procedures, not just moving their mistakes on?

Stephen Barclay: Due process has to be followed. The law has to be followed, and, as I have signalled previously, where we have compromise agreements being signed but they are not communicated to regulators, that is a failure we need to understand. If documents are destroyed, we need to understand what is going on. If people refuse to co-operate with an inquiry, we need to look at that.

There is a balance to be struck between people's legitimate right to employment protections and due process, to build in a culture that encourages those who have made mistakes to feel they can come forward and admit to mistakes without it being a hanging offence and destroying their livelihood. I think that is best done by getting very good legal advice that strengthens the procedures. There are two things: getting the right procedures, such as the fit and proper test in place, and then a question of ensuring that those procedures are followed. Sometimes you may have a procedure but it is not followed, and sometimes you do not have a sufficient procedure in place.

Chair: Thank you very much. I am keen that we return to the area that we are examining today. Johnny is going to finish the questioning.

Q407 Johnny Mercer: Steve, is there any planning going on within your Department at the moment, beyond the individual pieces of work that are listed in the House of Lords Committee response, which you have seen? What is the strategic thinking about the NHS and social care and the demands or the need to change beyond the period covered by the Five Year Forward View?

Stephen Barclay: That slightly takes us away from the ACOs into the wider funding debate. I would make a number of points, Mr Mercer. First, the Chancellor recognised, both in the autumn and spring Budgets, that the NHS faces a number of pressures, not least given demographic change, and that was recognised with some additional funding in the Budget.

Q408 Johnny Mercer: For those watching, what did he specifically allocate in the spring statement?

Stephen Barclay: It has been covered in previous Committee sessions. There is money for the winter pressures, for example. We have had



significant winter pressures, with around 2,500 flu cases at the moment creating pressures. Capital money of £2.6 billion has been allocated to the STPs. There is a range of things. That is well documented, and we probably do not need to run through it all now.

There is a wider debate in terms of the five year plan and to what extent we look at longer-term funding. That is an issue in which I know many parliamentary colleagues across the House have taken an interest. I know the Chair has spoken in the House on that issue. Those announcements will be made in the usual way.

Q409 **Johnny Mercer:** Great. In terms of any planning going on at the Department, is the answer no or yes?

Stephen Barclay: Planning for what?

Q410 **Johnny Mercer:** Is there planning for a strategic look, beyond the Five Year Forward View?

Stephen Barclay: The Department always has planning going on. The focus at the moment is on delivering the five year forward plan and addressing the challenges that the NHS faces, and we have the usual discussions with Treasury colleagues on that.

Jonathan Marron: One thing the Committee might be interested in is that the Secretary of State is this afternoon making a speech on social care, where he will set out the seven principles that will inform the Green Paper. The Green Paper is a fundamental step in setting out the long-term agenda for how we fund a major part of our health and care system, so I think that speech will be interesting to those who—

Q411 **Johnny Mercer:** Great. Is that part of that horizon-scanning effort within the Department?

Jonathan Marron: Yes.

Q412 **Johnny Mercer:** It is sort of, "What are the challenges beyond that period?"

Stephen Barclay: The Secretary of State, as Jonathan said, met Andrew Dilnot yesterday, and, as you know, my colleague Caroline Dineage's role, as Minister of State, has been created within the Department in order that the Department, as the Department of Health and Social Care, can take a more integrated approach. Again, that is part of the integration piece for the care and the acute side.

Q413 **Johnny Mercer:** Thank you. Do you have any plans to protect the existing funding for transformation itself? Are you prepared to pay double-running costs, for example, if they are necessary for that process?

Stephen Barclay: Additional funding has been allocated. As you know, Greater Manchester received £450 million of transformation funding over five years from NHS England. Dudley received vanguard funding of £3.02 million in 2015, £4.4 million in 2016 and £4.3 million in 2017, and



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obviously we have had the 50 vanguard projects, so funding has been allocated in terms of transformation.

As the Chair has previously said in the House, there is a balance between the sustainability and the transformation bit of STPs, and I very much hear the comments that the Committee has made on that. Mr Selous mentioned Getting It Right First Time earlier; it is not always an either/or, so what I found striking in the first report was that there was both an improvement in patient outcomes and a financial benefit.

If I look at a campaign I ran as a backbench MP, it always struck me as slightly odd that diabetics who were prone to infection—a leg ulcer—are admitted to hospital, where there is a risk of secondary infection and they are away from their home. It is not the best place patient-wise compared with being at home, but you need nurses to deliver the intravenous drips; there is a better patient experience but it actually was more cost-effective. It is not always the case that there is an either/or in transformation.

There are ways of delivering patient outcomes that are better and that sometimes have a financial benefit. Part of the difficulty is that if we communicate, as sometimes has been done in the past, that the reason for change is financial, it is often a lot harder to secure stakeholder support. Stroke in London is a very good example of that, but the fact that stroke in London is so often cited also makes the point.

Q414 **Chair:** Can I return to the point I made earlier, though, Minister? You said that Manchester and Dudley have both had considerable start-up funding? What is absent, as I see it, is a clear assessment of what transformation funding is needed for each of the integrated care areas in order to make a case to the Treasury for delivering that in the autumn Budget or sooner.

Stephen Barclay: Of course, there needs to be transformation and that requires a budget, and there is a question as to what that should be. The ACOs involve two areas at the moment. It is very difficult to make an assessment ahead of that. Part of the reason for having pilots is to understand what is involved, and to take that forward.

Q415 **Chair:** What I am saying is that there have been a number of different models, Minister—integrated care systems, partnerships, STPs. In all of these areas, we are trying to deliver change for patients, but we do not have a clear idea, on this Committee or outside, of what the total transformation cost should be in order to deliver what we want it to deliver. Is that something you are working on?

Stephen Barclay: Each of the pilots will better inform that. Each of the integration schemes, the vanguards, will inform that. Even between Dudley and Manchester, the actual cost per head varies. In Dudley, it is around £760, and in Manchester it is around £1,000 per person, so there is variance even between those two schemes. Clearly the outputs of the



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pilots and the vanguards work will be part of the discussions we look to have with Treasury colleagues as part of the next spending round.

Q416 **Chair:** You are not currently asking each of these integrated care systems, STPs and areas to give you a clear idea of what they would like to have as a budget to transform.

Jonathan Marron: Really the plan, which Simon talked about briefly earlier, is that we have set out a set of requirements for the NHS to show improvements against cancer, mental health and primary care services for patients, to improve the position on A&E and to do more elective activities to help us with waiting times. Those are the things that we have set out as the requirements, and additional money was found in the autumn to do that.

The way people are coming together in the NHS to make those things happen includes moving to ICSs, having a greater sense of common ownership across the system and, in two areas, trying to push for the ACO contracts that they believe will help them go further and faster in delivering the benefits.

Q417 **Chair:** I think you have not understood my question. Can you give us a clearer idea from each of these systems of what their ask is from you, in order to be able to deliver these kinds of changes, so that we can make the case clearly for transformation money and what it should be? Is that something you are looking at?

Jonathan Marron: We have worked with the areas. Each of the vanguards had money over the first three years. That has happened. The evaluation work we were talking about will show some of that and will give us further insight.

In terms of the integrated care systems, the systems are doing those with support from NHSE and NHSI, and some staff, but not with significant sums of money. It is really about how we bring the existing bodies together more effectively. It is not a major investment challenge in that sense.

Chair: Thank you. Does anyone else want to ask a question? No. Thank you for coming.