HOUSE OF COMMONS

Public Accounts Committee

Oral evidence: Introducing Integrated Care Systems, HC 47

Thursday 3 November 2022

Ordered by the House of Commons to be published on 3 November 2022.

Watch the meeting

Members present: Dame Meg Hillier (Chair); Olivia Blake; Dan Carden; Mark Francois; Kate Green; Anne Marie Morris; Nick Smith; James Wild.

Questions 1 - 150

Witnesses

I: Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; Matthew Style, Director-General for NHS Policy and Performance, Department of Health and Social Care; Amanda Pritchard, Chief Executive, NHS England; Edward Waller, Deputy Chief Finance Officer, NHS England.

Gareth Davies, Comptroller & Auditor General, National Audit Office, and Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, were in attendance.

HOUSE OF COMMONS

Report by the Comptroller and Auditor General

Introducing Integrated Care Systems: joining up local services to improve health outcomes (HC 655)

Examination of witnesses

Witnesses: Sir Chris Wormald, Matthew Style, Amanda Pritchard and Edward Waller.

Q1 **Chair:** Welcome to the Public Accounts Committee on Thursday 3 November 2022. Today we are talking to officials from the Department of Health and Social Care and NHS England about the introduction of integrated care systems, sometimes called ICSs. These are new bodies that are bringing together NHS services, local government, and other health and care providers in local areas in an attempt, as the name suggests, to integrate services and improve outcomes.

It does feel a bit like groundhog day, where we have had every set of initials: primary care groups, primary care trusts and clinical commissioning groups. One of the things we want to find out today is what is different, but also, as these are still in their infancy, it is an opportunity for us to explore them and ask questions about them as they are being forged. Obviously, we will be particularly keen to think about the money—we are the Public Accounts Committee—about the accountability and transparency of these new bodies, and, crucially, about what they are expected to deliver.

I am delighted to welcome our witnesses today. From the Department of Health and Social Care we have Sir Chris Wormald, the permanent secretary—he needs no introduction—and Matthew Style, the director-general for NHS policy and performance. Welcome back to you, Mr Style. From NHS England we have Amanda Pritchard, the chief executive, and Edward Waller, the deputy chief finance officer. Welcome to you all.

Before we go into the main session, though, Sir Chris, we have had some serious delays in Treasury minute responses from your Department. Other documents have been laid late to the House. I just want to be clear to you that this is not acceptable. We need to keep an eye on what is going on, and Parliament needs to be informed. I just wondered if you had anything to say about those delays.

Sir Chris Wormald: Yes. Obviously, we regret all those delays, and our aim is to get everything the Committee asks for on time. We have had some quite specific issues with clearing some Treasury minutes with which we were late.

We have now supplied, outside of the cycle, what our response would have been to the Committee. They are not formally published until the next batch in December, but I think we are now up to date with information to the Committee. That is, of course, not good enough, in that these things

ought to be in the regular publications. We will endeavour to do so in future.

Q2 **Chair:** Would you like to share any reasons why there was such a backlog and delay?

Sir Chris Wormald: It was three Treasury minutes. Treasury minutes set out a Government position and therefore it is important to get them cleared as formal Government positions. For a variety of reasons, which I expect the Committee can guess, that has been quite tricky over the last few weeks.

I am always very clear that, when we send something to the Committee, it is a full and frank statement of the Government position, and I do not send them until I am confident that it is. They were not in this case. Now, that is not an excuse. We ought to get these things to you on time.

Q3 **Chair:** Can I just remind you of the official guidance from the Treasury? We have the Alternate Treasury Officer of Accounts here, who I am sure can remind us of this as well.

This the guidance for Departments on Treasury minutes. It states, "It is at the discretion of the accounting officer to seek ministerial agreement but not a requirement. This may be for a change of policy or if a report is particularly sensitive or topical. Departments must alert their private offices of the deadlines at the start of the process". There should be no excuse for missing those. That is not me quoting; that is my parentheses.

Then, quoting again, "If Departments have not sufficiently planned enough time to seek any further agreements, then final drafts cleared by their accounting officer should be submitted. This ensures the Treasury minutes are laid on time in Parliament". Is the hold-up with you, or is it with Ministers? If it is with Ministers, why have you not overridden that, in accordance with the guidance?

Sir Chris Wormald: I am not going to attribute blame. Clearly, the Department should get these things done in time, as I have said. I have always taken the view that I supply Treasury minutes only when I am absolutely confident that they do, in fact, set out the clear and honest position of the Government. I have always taken the view that I do not share unless that is the case. As you say, I can override those things but personally I do not think it is a good idea.

Q4 **Chair:** Let me just be clear. We are the Public Accounts Committee. We do not deal with policy. We are not actually making recommendations about Government policy or any changes or suggestions on that. It is about the economy, efficiency and effectiveness of policy. It is about strands of work that you are responsible for as accounting officer, which we are then holding you to account to deliver and making recommendations on. Probably the nearest we stray to challenging is on timetables, but nothing that would be without your remit, I would suggest.

Sir Chris Wormald: The wording of Treasury minutes sets out that either the Government do or do not agree with that recommendation. That is clearly a decision of Government.

Q5 **Chair:** Sir Chris, let us be clear. For those purposes you are the Government, as the accounting officer of the Department.

Sir Chris Wormald: Yes. When I speak for Government, I seek to ensure that I am actually doing so and representing the views and agreed position of the Government. That said, as this is clearly a matter of concern to the Committee, I am quite happy to review how we do this and, in cases, submit Treasury minutes where I say, "The Government have not yet concluded their position." I am quite happy to do that. I am not going to say that there is a Government position where I am not confident that there is.

Q6 **Chair:** Sir Chris, either you are telling us in not so many words that there is massive tension between you and your political masters, or there is just a chaotic system in the Department. There is no other Department that has such a problem with the words "this is the Government's position" or "the Government agrees with". It is simply an accounting officer interpreting the clear policy line of the Government, but then most of what we are talking about is practical application of that policy and how that is delivered. It is not about the policy. We are not a policy Committee.

Sir Chris Wormald: Of course, all that is correct. A lot of health and care issues, for a whole series of reasons, are particularly controversial. I have always done it this way in my entire 10 years as a permanent secretary. I cannot comment for other Departments.

Q7 **Chair:** You have been in front of me in this Committee now for over a decade. I do not remember such delays. What has changed? If you have always done it this way, what has changed, so that you have had such a lot of delays?

Sir Chris Wormald: We have had a specific period where there has of course been an enormous amount of change within Government and that has undoubtedly complicated things.

Q8 **Chair:** Some of these delays go back well before the right hon. Member for Uxbridge and South Ruislip (Boris Johnson) was Prime Minister. They were before his time. That was a point that was relatively stable.

Sir Chris Wormald: I do not think we had any delays on those three Treasury minutes before that point.

Q9 **Chair:** We have had two months' delay on some Treasury minutes. I could go through them all, but I think we would divert from our main agenda today. For 11 years, you have sat here in front of this Committee, when I have been on it, and we have not had this level of delay. What has changed that you are suddenly unable, as accounting officer, to say, "This is the Government's position on something," when other accounting officers are managing to do that across Whitehall?

Sir Chris Wormald: I have always gone through the same process for those 11 years. For the last few months it has been particularly difficult. I am expecting it to go back to normal from now on.

Q10 **Nick Smith:** Sir Chris, there has been Government turmoil in the last few months, for sure. Will you, in the future, ensure you stick to the advice from the Treasury and produce your reports on time for the Committee to see, please?

Sir Chris Wormald: Yes. That will mean, in some cases, I need to change the wording and, as I say, given the Committee's concerns in this area, I think that is what we will do in future.

Q11 **Mr Francois:** Sir Chris, we have received Treasury minutes from across Whitehall and across Government. What we are asking is why you are now so much poorer than, literally, everybody else.

Sir Chris Wormald: We missed on three. As I say, that is not good. I have set out the reasons why, and we will have procedures in the future in the way that we have described.

Chair: Thank you very much. It needs to improve because it is not acceptable. I think we have made our point.

Q12 **Anne Marie Morris:** Ms Pritchard, it will be no surprise to you that there is huge concern about lack of access to NHS dentistry, and there continues to be a challenge with access to GPs. The Government regularly tell us, with regard to dentists, that it is all about renegotiating the contract and they are on the case. With GPs, we are given all sorts of statistics about increasing numbers of GPs who have been recruited. On the ground, it is not making any difference.

Dentistry is absolutely crucial and, certainly in my part of the world, we now have a situation where there is not a single NHS dentist offering an opening to any individual who wants to register. That is not acceptable. We find ourselves in the position that the health of children's teeth is getting worse and worse and worse. We see that in how they present in hospital.

With regards to GPs, albeit the numbers are going up, we still find that people are waiting a very long time for a basic appointment. What are you doing about that? We cannot sit and wait while a contract is agreed on the dentists. We cannot sit and wait while we sort out more GPs and their seven to nine-year training. What are you going to do now? If we do not do something now, we are going to land up with a much more acute health problem than we had before the pandemic.

Amanda Pritchard: I will talk about the two groups separately, if I may, because they are different in terms of the challenges, as you say, but also some of the solutions. On dentistry, I am very aware that there has been a real concern about access to dentistry. This is a concern we share. In July, we announced the first step of dental reform. That was the first change in nearly 15 years. I was really pleased that that was widely welcomed by the profession and very much seen as a first step. It is not the whole answer, but it is a first step.

It did a number of important things. One of the things it did in the contract was ensure that NHS dentists would be paid more for more complex work. For example, for three fillings or more, you now get a much better recognition of the complexity of that in the way that the contract works. It also did things like allowing dental therapists to accept NHS patients for treatment, freeing up dentists to do that complex work and see patients more urgently. Another important component was allowing those high-performing practices to increase their activity by a further 10%, not capping them, but saying, "If you have the capacity, absolutely do more. We will ensure the money will follow."

The process of implementation of those changes is under way. I am certainly not going to claim that is going to solve all the challenges in dentistry. As I say, it is very much a first step, but it is an important first step and the first big change that has happened in nearly 15 years. Crucially for us, it is important that we continue to work with the profession as we look at what further reforms can follow. Your point about ensuring that whatever changes we come up with next are getting the right framework in place, particularly for those new patients who need urgent access, is definitely front of mind.

Q13 **Anne Marie Morris:** That is very helpful but that does not solve the problem. I am delighted some first steps have been taken. I am horrified it has taken 15 years. It is not acceptable to sit here today and say to me that we have had the first step, without coming up with anything more creative to deal with the genuine day-to-day problem that people are now facing. It has a very detrimental impact on their health.

We managed to create a vaccine, come the pandemic, in weeks and months as opposed to the 10 years it has taken before. I cannot believe that it is impossible—because that is effectively where we seem to be—to look at how we can get more dentists, either because they are properly remunerated or because they are attracted through other schemes, on to the frontline. You talk about the cap. Surely, today, remove the cap. That ought to be the first step. Do we really have to wait for this to be ticked off in black and white?

Amanda Pritchard: As I say, the implementation of those first step changes is under way, so we would expect that to make a difference sooner rather than later. Let us not pretend that is the whole solution.

Q14 **Anne Marie Morris:** What do you mean by sooner?

Amanda Pritchard: That is happening now. The implementation of those changes I have just set out, that were announced in July, is happening now.

Q15 **Anne Marie Morris:** When will they actually impact? When am I going to find that I have constituents coming into my surgery and they are able to get an appointment?

Amanda Pritchard: That is where we need to talk about some of the other things that are now planned as part of further changes. You have rightly talked about workforce. We know that attracting more people to want to

do NHS work is important, but so is training more dentists and making sure that those dentists we have are being supported to work in places where there is less access now. There are schemes in place now to look at whether we can scale them up to make it more attractive for people to work in those places that are currently underprovided with NHS dentistry.

We are exploring how we can better incentivise the taking on of new patients. With HEE and other colleagues, as part of the workforce plan work that we are doing now, we are looking at how we can reform not just dental training but the whole oral health team, so that we can change the way we think about that pipeline into dentistry and make it a really attractive place to come and do NHS work, and to stay and do NHS work. Your challenge is one that we recognise. That is why we have already taken steps, but that is also why we have a whole pipeline of other things that are now being worked on to make sure that we get a more sustainable future in the long term.

Q16 **Chair:** Ms Pritchard, I can sum up Ms Morris's question as, "When?" That is what she asked.

Amanda Pritchard: We have already begun.

Q17 **Chair:** When will dentists be in those places on all these schemes, for Ms Morris's patients and ours?

Amanda Pritchard: I am afraid I am going to have to come back to saying that the first steps are already being implemented. That is making a difference. That will make a difference.

Chair: When?

Amanda Pritchard: The answer to the bigger questions about workforce and broader dental reform are things that we really do have to work with the profession on, because we know that will not work unless we are doing it with colleagues who are really experts in this.

Chair: You do not know when, then.

Amanda Pritchard: This is why the first step is so widely welcomed. It is a really important plank in the Government's recent *Our Plan for Patients*, which talked very explicitly about not just short-term but long-term initiatives. Where we really want to get to is a sustainable answer for dentistry that has a series of short-term things, which we are already doing, but does not shy away from saying that some of this has to be about workforce reform and bigger contract reform. We have to do that with the profession.

Q18 **Anne Marie Morris:** Ms Pritchard, will you write to the Committee and set out all those things that you have mentioned and when they are going to be taking place?

Amanda Pritchard: I am very happy to do that.

Q19 **Anne Marie Morris:** Thank you, that will be helpful. Can we then just briefly move to the GPs?

Amanda Pritchard: Perhaps the first thing to say on primary care is that we are seeing more GP appointments now than before the pandemic. In fact, we are seeing significantly more. My colleagues in primary care do over a million appointments a day. That has been a rising number; they are doing more face-to-face appointments now than we have seen since before the pandemic. That is part of the reason why we are seeing primary care under so much pressure at the moment. We hear that consistently from GPs because they are working incredibly hard—harder than they ever have before.

Yes, it is great to see more GP trainees and more people coming off the pipeline into primary care, but that should not detract from the level of very real pressure that there is on primary care at the moment. What are we doing right now to support access to primary care? It is a range of things. It is supporting people with things like moving to cloud-based telephony, because if you have a single phone, that is part of what we know patients find really difficult. They just cannot get the phones answered. For GPs, it is equally frustrating because phoning out of the practice to make contact using the phone is equally challenging. Cloud-based telephony is part of the answer. We have changed the rules around the appointment of additional roles to be much more flexible about the additional roles that can be recruited into primary care. Over 19,000 new roles are already in primary care, so there is more flexibility there.

We are working with ICBs; we are going to be talking about that, are we not? They are working with individual practices to look at things like what further digitisation and further support might help them. We have a load of work going on in different ways, including across Government, about reducing the administrative burden on GPs to free up beds. I am including some of the work that sits between primary and secondary care. There are a load of things already happening now to support primary care, in light of how much work they are already doing. Again, that is not the end. We have to think medium to long term and that is what we are working on—the fuller stocktake implementation.

Q20 **Anne Marie Morris:** That was not acceptable as an answer. Is it not the truth of this that the demand is higher than we have expected, and nothing has been done to deal with that? The fact that there are more appointments does not matter if the reality is that the demand has already gone up exponentially, because you are still going to find that the gap is huge and people are waiting a long time. What are you doing about that gap?

Amanda Pritchard: On our data, and I know the Government have talked about this quite a lot recently, 40% to 45% of patients were seen the same day they contacted the GP surgery, and 85% within two weeks. That clearly has to be based on need, because one thing that the additional roles have done with primary care is offer people much more flexibility to say, "I want my cervical smear in three weeks' time. I do not need it today."

Where we are in primary care, if you look at the data, it tells us an awful lot of people are getting seen very quickly, within a timeframe of that two weeks that we have talked about. Equally, we know, particularly from the

patient feedback, that getting through on the phones is a problem and that there are a group of patients—

Anne Marie Morris: I am going to stop you there, because you are just repeating what you said before and we are short of time.

Amanda Pritchard: This is why we are doing all of the things I have just described. It is not true to say nothing is happening. I am afraid I would strongly dispute that. It is equally not true to say that all the things I have just described are, in themselves, going to be a silver bullet for this. That is why we need to do the longer-term work around the fuller stocktake implementation as well.

Chair: We will leave it there because I am sure we will be coming back to both GPs and dentists in future. Certainly, our sister Committee is likely to as well.

Q21 **Kate Green:** Mine is a question for Mr Waller, and I hope it will be much simpler to answer. My understanding is that, during and since Covid, NHS trusts have been calling off PPE from central supply and not being charged for it. Is there an intention to change that from April next year, or indeed at any time? What is NHS England's plan for that?

Edward Waller: The arrangements for PPE are actually made in the Department of Health, so my colleagues may want to comment on that. From our perspective, we are in the middle of a discussion with Government about the NHS funding position for next year and the year after, and issues around how the remaining costs of dealing with Covid are dealt with. That is all bound up in that discussion at the moment.

Q22 **Kate Green:** When do you think trusts will have some certainty about what the position for the next financial year will be?

Edward Waller: The discussion we are having is largely about how the funding arrangements work behind the scenes. Obviously, we will make sure that trusts know exactly what the position is for them well in advance of the financial year.

Sir Chris Wormald: The system is no different from in any other financial year, so this is all in the discussions about what the planning guidance is for the NHS for the following financial year. That is normally issued in mid-December, and these discussions are no different from any other of the financial discussions that we have with the NHS.

Q23 **Kate Green:** Given that they have not been paying for this equipment for some years now, is there an assessment being made of what the financial implications would be for trusts, if that changed, and how they would cope?

Sir Chris Wormald: What we do with both our Treasury colleagues and the NHS, and this is completely normal, is to look across all the financial pressures on the NHS and resources, and set our planning guidance accordingly. I do not think there is, as it were, a separate set of systems about PPE specifically. They are part of the general discussion about what

the pressures are on the NHS and, therefore, what is appropriate planning guidance for the NHS.

Q24 **Kate Green:** We are expecting that in December.

Sir Chris Wormald: We normally aim to issue it in mid-December. It sometimes runs up until Christmas. That is the absolutely standard process that we do with the Treasury and the NHS every year. Of course, this year there are particular pressures to discuss, but it is all being done by the standard process.

Kate Green: Fine, I know when my trust will know.

Q25 **Olivia Blake:** Sir Chris, when will the baby loss review be published and what will the timeframe be for Government, or Department, response to it?

Matthew Style: As you would expect, this is something that our new ministerial team will take a close interest in, in the context of a whole set of broader commitments that were made, for example, in the women's health strategy. New Ministers will be reviewing the approach they want to take, and then we will update the Committee as to when that will be published once decisions have been taken.

Chair: It is on Ministers' desks. I thought it was already committed to.

Q26 **Olivia Blake:** We have been waiting almost five years now for this to be published.

Matthew Style: As I say, we will update the Committee when we know when that will be coming forward.

Q27 **Chair:** Perhaps we will follow that up in writing as well. Thank you very much indeed.

We need to move into the main session, and we are talking about integrated care systems. The obvious question, first of all, Sir Chris and Ms Pritchard, is what is different about integrated care systems, compared with primary care trusts, CCGs and all the other systems that have been in place before, which get ripped up every 10 years and we start again? What is going to be different about integrated care systems?

Sir Chris Wormald: I will start and then Amanda can carry on. You are completely right, Chair, that there have been a lot of reorganisations of the NHS with varying results over time. I thought the National Audit Office Report set out very clearly what is different about how we have done ICSs. Although it was contained in legislation, this is a much more evolutionary change based on what local systems were already doing, which we have then enshrined in legislation, as opposed to starting with a very prescriptive model, legislating for it and then implementing it.

Some of the National Audit Office's findings were about how the system has welcomed the way the change has been done, noting the very, very different reaction to this set of changes than to any previous set of

changes. I would say the biggest thing is that approach to the reform that has been taken.

One of the other two key differences I would point to is the question that we are asking of integrated care systems. This is much more the population health question than the treatment of illness question. The third thing I would point to is the breadth of them. While we have not changed any of the statutory responsibilities about who is responsible for health, who is responsible for care, what is free and what is means tested, there has been a much greater effort in this set of arrangements to create a platform where there is a different type of conversation between the NHS and its local government partners. Those are the three things I would point to.

Q28 **Chair:** The breadth of this is obviously geographical as well as across organisations. How are you going to make sure that the best areas bring up the poorer areas? In certain parts of the country, areas have been put together that are not natural bedfellows. They have felt separate before. They are coming together in bigger—you could almost say small health authority-esque—areas.

There are some where you have very weak performance and strong performance in the same area. There is a real worry on the ground that the weak areas will just sap the energy, money and resources from the stronger areas of performance.

Sir Chris Wormald: I will ask Amanda to comment on how we spread good practice. There is no answer to what the right geography is to do health and care, because health geographies vary by condition, et cetera. We have tried to come up with a reasonable number of ICSs, so that they are local enough to understand their areas but strategic enough to be able to look across different types of service. It will never be perfect.

This is the approach we have taken: let us do some pragmatic things, and then let us try to work with places to make it work in practice, as opposed to continuing to argue about what the right geography is, what should be more local, what should be more national, et cetera. You are completely right that ICSs, because of their histories, are in very different places. Some are building on some very longstanding arrangements; others are brand new. There is a mixed economy out there. NHS England is doing a lot around how we bring in the places where this is a newer way of working.

Amanda Pritchard: I agree with the way Chris has described the ICSs and the importance of it being an evolutionary process, even though it still is a major reform. It is a big change in the way the NHS works in the same way the NHS has been changing constantly over the last 74 years. In this case, a range of things are in place to support that spread of best practice locally. That includes provider collaboratives, which are a part of the structure, but we are also seeking to support more strongly through a set of national support offers. We also have a retention of the important place-based partnership, so that that is not lost in the move to a bigger geography.

We also still have powers of intervention. That means that, if a provider or system is off track, we have the ability to continue to provide bespoke support. For example, if an organisation or a system is struggling financially, we can do that. That has not changed as part of this process. In a sense, all that has happened is that we now have the additional layer of the ICB available to provide that support in the first instance, before needing to escalate. We also have very clear arrangements in place for monitoring performance, so that, should there be a change in the performance that you have described, we would hope and expect to be able to pick that up very quickly and get involved.

Q29 **Chair:** When you say "pick up", one of the challenges in the past has been that stronger performing institutions financially sometimes had to bail out weaker institutions. You probably remember that. You have been in the NHS long enough to remember those days. Areas like mine in Hackney, which always had a good budget, had to pay money into west London, in that case, which at the time had poorer performance.

When you say you are going to intervene, are you going to intervene to financially support the weaker areas or are you going to raid the better-performing areas?

Amanda Pritchard: It is an obligation of ICBs to plan for their patch. That may well mean, in some cases, that there is an element of mutual aid, but you would expect it to work the other way as well. Clearly, if there was a situation where one organisation needed short-term support to reconfigure services in order to drive longer-term financial sustainability, the new structure allows for that to be planned and delivered together, and for colleagues to be held to account for doing it.

It is also why place matters and why it is written into all our guidance. We do not want, as I am very clear that my colleagues in the NHS do not, to see local ownership, local needs and local arrangements for services lost in this. We want the best of both.

Q30 **Chair:** In a moment, we are going to come on to some of the Government's local accountability issues. Can you sum up, perhaps, in simple terms to our constituents, your patients, what will be a difference for them on the ground in the quality and accessibility of the services they get when ICSs are fully up and running?

Amanda Pritchard: ICSs have four purposes, which are clearly set out and described, very helpfully, in the NAO Report. I would boil it down to two things that are worth talking about. For the first time now, we have an obligation for partnership and collaboration within the NHS at a place for that population. It is no longer acceptable for there to be wildly different outcomes for patients living, potentially, streets apart. It is no longer okay for one organisation to be doing all right over here, while another organisation is not, because they are being managed completely separately.

Q31 **Chair:** Take it right down to a patient. You are a patient. You go into your GP, you are diagnosed with something and you are perhaps sent for a local

specialist treatment. What will be the difference? Will you have to travel further to get a better treatment? Just explain what that would mean for that individual.

Amanda Pritchard: Just to boil it down exactly as you said, it will mean that there is an obligation on the ICS to ensure that the needs of the population are met in a consistent way. Rather than saying that there is acceptable variation, ICSs are designed to make sure that they are taking a partnership approach. That means providers working together, mental and physical health working together, primary and secondary care working together, so that that individual patient gets the care they need in a consistent way, no matter where they live in that geography.

Q32 **Chair:** To get consistent podiatry, for example, could someone in my constituency in Hackney be asked to travel to Redbridge? It sounds like not very far away, but actually it is a bit of a difficult journey for lots of people. Is that the sort of thing that might happen in order to maintain consistency? That local care matters to a lot of people because of the challenge of travelling.

Amanda Pritchard: It does. One of the themes of our elective recovery plan is the offer of choice. We have seen that happen a lot over the last couple of years. I can use my old patch, south-east London, as a good example. They have used a site in Beckenham, which belongs to King's, in order to protect their elective flow, but it is an offer to patients; it is not a requirement that people travel. It does mean that there is a lot of flexibility locally to use capacity for those patients so that, overall, everybody benefits. Clearly, the aim is never going to be to force people to do something that is not in their own best interests, but it is to use the assets, skills and clinical strength of the whole patch to make sure that every individual patient is getting the best possible deal.

That partnership responsibility that we have now and we did not have before is a critical difference. We see that in practice all the time. Coventry and Warwickshire has a new stroke pathway that is consistently offered to every patient in that patch, not different from one place to another. That is a big change, because of the way that people are now working together. People have collaborated, for example, to improve learning disability services. We have seen that in Leicestershire really recently, where they turned what had been regarded as a very poor service into something very successful. They reduced the number of in-patients with learning disabilities by 25%. They have been able to do that because they are working together for the benefit of patients.

Q33 **Chair:** We are going to come on to some of the outcomes issues. Finally from me, governance issues are quite significant, and Mr Francois is going to pick up on some of this. I know that we have seen some ICB chairs who have just been appointed and some who have gone through a competitive process. How have you gone about setting up the governance? Why have you had this very different approach to appointing the people who have oversight of these quite significant health bodies?

Amanda Pritchard: There might be a specific circumstance that you are talking about in terms of chair appointments. We had a very small number where we had to make interim appointments, because there were gaps to fill. Everybody who has been appointed substantively has been through a competitive process, and that is true both for chairs and for the chief executives of the ICBs. That has been run nationally to ensure that there was appropriate consistency.

Q34 **Chair:** Basically, you are saying that anyone who has just been appointed should have only been interim.

Amanda Pritchard: Anybody who has not been through a formal process has been appointed on a short-term contract to fill a gap. There is an absolutely clear expectation and intention that there will be a process.

Q35 **Mr Francois:** Sir Chris, looking at the NAO Report on which this hearing is based, if you turn to page 10 and the bottom end of paragraph 13, it says, "In our survey of senior ICS staff, 57% (172 of 298 responses) expect it will take between three and 10 years for their ICS to significantly improve outcomes in population health and healthcare". Given the vast additional resources that have gone into the NHS—tens of billions in recent years—why do the people who are running these organisations now believe it will take between three and 10 further years to significantly improve outcomes?

Sir Chris Wormald: We might need to ask the NAO to comment on the exact question that was asked.

Mr Francois: Sorry, the question was asked by the NAO, not by us.

Sir Chris Wormald: No, that is what I mean. The question as reported here is talking about population health.

Q36 **Mr Francois:** It says "population health and healthcare", to be fair.

Sir Chris Wormald: But the drivers of population health, as I am sure you know, are very long term. In terms of what the health of the nation is, that is driven by obesity, smoking, diet and all those long-term issues. It does not surprise me at all that, given we have the words "population health" there, people are taking a long-term perspective.

On the healthcare side of the equation, and this goes back to what Amanda was describing in answer to Anne Marie Morris, there are things that happen much more quickly about whether you can get a GP appointment, et cetera. As I say, if you are talking about population health, pretty much any clinician would say to you that it is that sort of timeframe.

Mr Francois: With respect, we have known these things for decades. Why is it now going to take a further decade to do something material about it? You have been in the Department for 10 years, so you have seen all these changes from PCTs, to CCGs, to super-CCGs, to ICSs. As a constituency MP, I can tell you that not only has it been highly confusing, but it was very difficult to get a decision out of anyone about anything. You never dealt with the same person twice, and all you were ever told was that everything

was under review or being looked at again. Even allowing for the challenge of Covid, which we all appreciate, the system always seemed to be in transition and it was very difficult to get firm decisions from people. Now it is in transition yet again. How are we going to prevent that problem on the fourth crank of the handle?

Sir Chris Wormald: Just as a matter of fact, I have been in the Department for six years. I have been a perm sec for 10, but six in the Department.

Mr Francois: I am so sorry.

Sir Chris Wormald: This goes back to the question I was discussing with the Chair about what is different about this set of reforms. No one is going to dispute that the health system has been reorganised on a number of occasions and that was confusing for everybody, in the way you describe. As I say, what we have here is a set of reforms that are much more evolutionary and based on place.

As Amanda was just describing, the idea with this new organisation, and we will have to see this work in practice, is that we have a focus from the leadership of these organisations much more on what is happening in that place, as opposed to all the national wiring questions you have just been describing. That is the intention of the reform. As the National Audit Office notes, this is brand new. We cannot sit here and say that is happening right now, but that is the intention of the reform.

Q37 **Mr Francois:** I am sorry to interrupt you. We are always very limited for time in these things unfortunately, so if you could make your answers just slightly more focused that would assist the Committee. You talked about place. Are you familiar with the military concept of ground truth?

Sir Chris Wormald: I am not as familiar as you will be.

Q38 **Mr Francois:** It means, in simple English, what really happens on the ground, in the real world, and not on some general's glossy PowerPoint presentation 4,000 miles away, or indeed on a glossy PowerPoint presentation in the Department of Health. In other words, it is what really goes on.

Let me give you some ground truth about how this system does and does not work. I have been trying for five years to get a first-floor extension on a GP surgery in Hullbridge in my constituency. I kept dealing with different people. I went to see a man called Mr Anthony McKeever, who is now the chief exec of the Mid and South Essex ICB. I wrote to him about it and I went to see him some weeks later. We had a meeting and, after about 10 minutes, it became completely apparent that he literally did not know what I was talking about, even though he had written to me about it. When we explored what had happened, it turned out that he had not even seen the letter he had written to me. Someone had put his e-signature on the letter and sent it to me on his behalf.

Do you think it is acceptable that people in these positions of authority write letters to Members of Parliament that they have never even seen?

Sir Chris Wormald: I cannot comment on the specifics of your case.

Mr Francois: You most certainly can. Do you think it is acceptable?

Sir Chris Wormald: I will answer at the general and I can only speak for myself. I read all the letters that I send out and I do not have my signature put on anything that I have not read. That is not the same as saying I know the detail and of course I am advised, but I read every letter.

Q39 **Mr Francois:** I have made the point. He then sent me a grovelling email about three months later: "I am terribly sorry. There was a great deal going on. I got one of my staff to PP it." They did not. There was no PP. Someone typed a letter in his name, put his signature on it and sent it to a Member of Parliament. That is the ground truth of what goes on in Mr Anthony McKeever's empire.

We hear the term "interim" a lot in the NHS. Some people would think that that means holding the fort or temporary; that would be natural. It also means outside of the traditional NHS pay scales, does it not?

Sir Chris Wormald: I do not think so, in the cases we are talking about.

Mr Francois: I think you will find it does.

Amanda Pritchard: Not for chair and chief executive appointments, no.

Q40 **Mr Francois:** Yes, but elsewhere in the NHS. Is it not also correct that some of the people who hold these interim appointments are not full-time employees of the NHS? They are effectively one-person companies that contract to the NHS to, say, run a hospital or a similar NHS organisation. That is correct, is it not, Ms Pritchard?

Amanda Pritchard: For leadership roles of the ICBs and ICSs, no, we do not have that arrangement in place at all for any of them. Certainly for technology staff and whatever, yes, we have agency staff who work across all the professional groups within the NHS.

Q41 **Mr Francois:** For instance, some of my local hospitals are run by an interim managing director. Ms Pritchard, turning to you, who are ICSs accountable to?

Amanda Pritchard: The ICBs are directly accountable to NHS England. The ICP, which is the partnership between the NHS, local government, the voluntary sector, et cetera, has an arrangement whereby there is a level of mutual accountability. The formal accountability line is split between our bit, which is holding to account the NHS contribution to delivery of that plan that they have committed to for their place, and indeed local government then holding its colleagues to account through its processes.

Q42 **Mr Francois:** On page 13 of the Report towards the end of paragraph 19, it says, "ICSs need the time and capacity to build relationships and work together to design services that better meet local needs." Who are those key relationships with?

Amanda Pritchard: Is that for the ICBs?

Mr Francois: Yes.

Amanda Pritchard: Our expectation has always been that the ICBs would work partly through the formal partnerships of those who sit on the board. That includes representatives from across the NHS family, so primary care and secondary care. In addition, it requires non-executive appointments, of which we have asked for two, and local government must have at least one seat. That is a minimum expectation. That is part of the formal governance. Obviously, they have to work with the ICP, which has a much wider membership.

In practice, nothing has changed in the expectations that you would have of an ICB from, say, a trust or a CCG. When we talk about "working with", that is everybody from your local MP through to local government colleagues, elected members, community groups and the voluntary sector.

Q43 **Mr Francois:** I am interested that you mention local MPs. On a scale of 1 to 10, how important is it that ICBs and the people who lead them have good working relationships with local MPs?

Amanda Pritchard: It is incredibly important.

Mr Francois: Give me the number.

Amanda Pritchard: I would say probably not far off 10, to be honest.

Q44 **Mr Francois:** Brilliant—well, here is some ground truth. I organised a meeting between six south Essex MPs and local NHS chiefs for 19 October, because we have some very serious challenges including a crisis at Southend Hospital with ambulance warehousing, of which you may be aware. We did it weeks in advance. The whole point was that these six local MPs would sit in a room, not on Zoom, with senior NHS leaders and thrash all this out. Everyone had it in their diary. Everyone agreed.

Then the dropouts began. The first one to drop out was Hannah Coffey, who is the chief exec of the Mid and South Essex Trust. Unfortunately, she had a family funeral. We sent our condolences. It was unfortunate timing, but of course we understood. The night before the meeting, Mr Anthony McKeever, the chief exec of the ICB, dropped out. He wrote me a letter saying that other people would be going. "So, given my other diary commitments, I think it best if I join you on another occasion". Then, on the morning of the meeting, Morag Olsen, the interim managing director of Southend Hospital, I was told had effectively rung in sick.

Having spent weeks trying to arrange this, the chair of the Mid and South Essex Hospital Trust did not turn up, although she had a funeral; the chief exec of the ICB basically pulled out the night before; and the MD of the hospital in crisis pulled out that morning. You said relationships with local MPs were extremely important, almost a 10. How do you want to score that against that scale?

Amanda Pritchard: There is some detail in there that I would want to understand a little more. If somebody actually was sick, I would not expect them to come.

Chair: I do not think Mr Francois is asking you to comment on every individual case.

Amanda Pritchard: However, can I say that I am really sorry to hear that?

Mr Francois: So am I.

Amanda Pritchard: It is an incredibly important relationship. The NHS has always had that relationship locally not just with MPs, although particularly with MPs. As a former chief executive of a trust, I recognise it from my own personal experience. It is hugely important.

Q45 **Mr Francois:** I have all the letters; I will leave you copies so that you can read them at your convenience. I have to tell you, despite the public line of the Department, at local level often constituency MPs are treated with thinly veiled contempt by these organisations.

The only people they are worried about are their regional directors, in this case a lady called Clare Panniker, who in my experience is actually very good, and you at NHS England headquarters. They are not worried about us. We have no influence over them and, even when we try to talk to them and set up meetings, they bail out the night before. This is your much vaunted system. I just want you to understand the ground truth of what really goes on in the organisation that you lead. Have you any comment on that?

Amanda Pritchard: One of the things that is really important for systems is the holding to account that comes through the ICP. What I want people to worry about is their accountability to the public and patients. That is why we all do these jobs.

Mr Francois: With respect, that was the point of the meeting—to hold them to account—and then they bailed out.

Amanda Pritchard: Your primary accountability in these roles should be to the people you serve. That is something that we can continue to reinforce. It has not been my experience, working with colleagues for 25 years across the NHS, that they do anything other than wake up in the morning worrying about the quality of services and what they can do to improve it. The engagement has clearly not worked in this case, for which I apologise.

Q46 **Chair:** Ms Pritchard, Mr Francois has raised a specific point to illustrate the wider point that we have had feedback on from colleagues around the House, frustrated about who is who in their system, and who they go to when they have a problem with a particular issue. It is very opaque and challenging.

It is not that we are saying MPs are exceptional and we need special treatment, but we are standing up for the people who themselves are trying to get through the glue of the system, very often. They come to us, and others in the system, thinking that we can get through. If we cannot, that suggests that it really is opaque.

Amanda Pritchard: I wonder if perhaps one of the things I could undertake to take away from this discussion is to do some work with colleagues and see whether we could provide a bit more clarity to colleagues in Parliament. We have just issued the NHS operating framework. I am not suggesting any of you would necessarily wish to read that, but perhaps we can be a bit clearer about who to go to for what. We can provide that information very straightforwardly. Equally, what I think I would need to do within the NHS is to make sure that we have been very clear about our expectations of how those relationships should work.

Q47 **Mr Francois:** To be equally clear to your equally clear, I am not talking about the clinical staff in the NHS. I am not talking about the doctors, the nurses or the paramedics. They do a brilliant job. That is why the public like them so much. I am talking about very highly paid senior NHS bureaucrats, who in my experience do not do anything like as good a job as the clinicians they are paid by the taxpayer to lead. I just wanted to make a very clear distinction. Would you give me your personal word that you will go back to your office and find out what went wrong?

Amanda Pritchard: I absolutely will.

Mr Francois: I am very grateful. I look forward to your letter on it.

Chair: The wider point about making it clearer on who to go to is really critical. MPs can be great allies to the system as well as critics of the system and holding it to account, so it is important.

Before we move on, I want to warmly welcome the chair of the Public Accounts Committee of the Maldives, the honourable Mohamed Nashiz, who has joined us. He is also chair of the Commonwealth Association of Public Accounts Committees. Thank you and a very warm welcome to you.

Q48 **Anne Marie Morris:** On the challenging issue of funding, Ms Pritchard, I am sure this is going to be very close to your heart. I am not going to ask you whether you are worried about cost pressures, because the answer to that is going to be yes. Rather, what are the cost pressures that you are most concerned about, and about which you are beginning to feel frustration and concern as to how you are going to fix them? Looking at the ICBs within your overall organisation, how are they coping? They are the ones on the frontline, if you like, in terms of trying to manage the funds.

Amanda Pritchard: I am conscious that the Committee is after brevity, but it probably is worth just taking a step back to the spending review that was agreed this time last year. That set out what the NHS would deliver, but it also set out quite clearly what the assumptions were that underpinned that settlement. As part of that settlement, we signed up—quite rightly, and I absolutely stand by this—to a very ambitious level of efficiency. That was £12 billion over three years and reflected both the expectation of the removal of additional Covid costs and genuine efficiency savings. We are on track to deliver £5.6 billion-worth of efficiencies this year. I know my colleagues agree with me that it is right that we continue to drive for efficiency, and we have a clear responsibility to the taxpayer to make sure we are spending their money wisely.

We have experienced, as colleagues will know, much higher volumes of Covid patients than were expected when the settlement was agreed last year. We have never had fewer than 5,000 patients in hospital at any one time this year with Covid. We have also had higher inflation and pay settlements than were originally envisaged. This has had a bit of an impact, of course, but we are broadly on track financially this year.

In relation to ICSs, two things are probably worth saying. They get a passthrough of about 90% of the funding; that goes straight to ICSs. That is how the allocations work. That gives them quite a high level of flexibility in how they use those resources locally to meet the needs of the population and to deliver the efficiencies in the way that works best for them, building on the national efficiency programmes we have set up to support that, whether that is in procurement, medicines management or devices, but ensuring that they are getting the benefit of that locally.

In order to make sure that we were not passing on completely unreasonable efficiency expectations to ICSs, we did provide nationally for two things. There was £1.5 billion of funding to cover the additional inflation pressures this year, and another £1.5 billion to cover the pay award. I am not saying for a single second that it is not very challenging, because of course it is, but ICSs were given that additional support, which meant they could manage those unexpected pressures that have come through this year. As I say, we are now broadly on track financially for this year, but support is going in for those organisations and systems that are experiencing the greatest challenge on their finances.

Q49 **Anne Marie Morris:** I think your answer is looking at the ICBs in the round. It is certainly very good to know that you are on track. Within the family of ICBs and the ICS system, I suspect that some are going to be more challenged than others. How, given that they are supposed to stick within their budgets, are you dealing with the outliers at both ends of the system?

Amanda Pritchard: That is exactly how we do it. As I say, at the moment we have two levels of things we can do. We have informal engagement and support, which is what you do as a first step into systems that are struggling. Then there are the more formal special measures, as they used to be called, which have now been rechristened as the recovery support programme. That puts a whole package of support in place for a system or, indeed, for a trust, if it is off track financially. Ed might be better placed to get into the detail of how that is working.

For those organisations that have been in recovery support, it takes time, of course, to deal with some of the underlying causes of financial challenge, but we have some really great work going on. Some of those places that have been challenged for some considerable time are now on the cusp of coming out the other side of it. I would cite Cambridge and Peterborough as a particularly good example. By working as a system, using that flexibility that they have with the scale of the budget and the support from the recovery support programme, we are seeing that come to fruition.

Q50 **Anne Marie Morris:** Mr Waller, that answer, which I think was a pass across to you, gave me some answers but not much detail or the flesh on the bone, if you like. I am delighted to hear what Ms Pritchard has to say, but it does not resonate with what I am hearing from my local ICBs and ICPs. I am just a little confused because there seems to be a bit of a disconnect.

Edward Waller: I will add a bit of detail. We start the year with a process that asks every system to give us a financial plan for the year. That plan starts by setting out the pressures they are facing, what they propose to do to reach the efficiency targets, et cetera. Then there is an in-year monitoring process by which we hold them to account for their plan. Every month, we go back to the plan, look at what they committed to do and see if they are on track. That gives us multiple points of intervention if we think things are going awry, where we can step in to find out why that is true, both from systems to providers, so trusts, and from NHS England to systems.

Q51 **Anne Marie Morris:** Would I be right, Mr Waller, to say that you are really talking about the NHS piece of this rather than the social care piece?

Edward Waller: That is right.

Q52 **Anne Marie Morris:** Given that the whole ICS system is to look at the pair of them together, given the real challenge and, inevitably, the impact on the NHS piece if we have a problem within the social care piece, and given what we talked about right at the start—how the benefit of this new integrated system was that these should effectively work together, that it would be seamless and that, effectively, Peter would bail out Paul—I have a question. Given that they are still two separate budgets, how can that actually happen in terms of good governance and good will? Does it actually happen, even if it is legally possible?

The picture on the ground is very much still of huge, huge pressure on the NHS. When I talk to many of my local doctors, they are having to—dare I say?—be very creative with the way they interpret the rules. They are saying, "In the real world here, I have to look at what I need to do to ensure the best patient outcome for the majority of my patients. I cannot do that using the current rules." They are having to do things for which I am sure, Ms Pritchard, if they fessed up to it, you would be slapping their wrists. You would have to. We are therefore in a situation that, frankly, does not bear any resemblance to the happy picture that you present.

Amanda Pritchard: I apologise if I have given the impression that it is not very challenging this year. It is extremely challenging this year. I would be equally clear that, if you look at the numbers that Ed has just described in terms of our month-on-month reporting and forecasting, we are, as an NHS in total, broadly on track to deliver what is a percent reduction—

Q53 **Anne Marie Morris:** My point is that you are talking about the NHS numbers. My question is that ICSs are supposed to be responsible across local government, social care and health. They are separate budgets. That, I get. My challenge is that, because they are separate budgets, the fact

that the NHS, as you present, is fine does not solve the problem. It does not mean that the patients, the constituents, in any of our areas are getting the health and care provision that they should have. Would you agree that that is fair?

Amanda Pritchard: Apologies, I had not quite understood that your question was about the difference in funding flows. You are clearly completely right. There are still separate funding flows for social care versus the NHS. Two things are worth saying, and I am sure Chris will want to come in on this. The better care fund has existed in recent years as a way of pooling budgets so that it can be spent and agreed jointly, in a way that benefits populations without needing to get into the question, "Hang on—has it come down this route or down that route?" The BCF is still a really important component of that broader financial picture at local level.

Secondly, this has existed in legislation for some time, but now the ICSs have reinforced it. You can choose to pool budgets around particular services. We have, again, lots of examples where that has happened, particularly around discharge. That is an area where Chris may want to come in, but, thirdly, the additional funding that the Government have made available to support discharge this winter is then going to be a third significant opportunity for ICSs to work collaboratively in order to identify how to spend that funding for the best outcomes for their patients.

Sir Chris Wormald: Amanda said 90% of what I was about to say. Just to be very clear, we covered a little bit of this at the beginning about what ICSs do and do not do. An ICS creates a platform for better joint working between the NHS and social care. It does not change either the quantum of the money or the statutory responsibility for the two budgets. We have debated with the Committee a lot whether that position should change or whatever, so I will not go into that again. It does not change those two facts at all. It does that thing.

Q54 **Anne Marie Morris:** I am very conscious of the challenges of time, Sir Chris. Would you be willing to share with the Committee some of these examples about pooling, to clarify exactly what the position is that enables pooling, how many of the different ICSs have pooled and in what capacity? That would be very helpful in understanding the blockages.

Sir Chris Wormald: I am happy to write on that.

Q55 **Anne Marie Morris:** On the better care fund, which Ms Pritchard mentioned, yes, it is a help, but it does not solve the whole problem. I would quite like to also have some indication across these systems where that has been used and to what benefit. Would you be able to produce that?

Sir Chris Wormald: I am delighted to write on both those things. As I say, it is very important to be clear what problems the ICSs solve and what they do not. That there is a national NHS budget free at the point of delivery, and a local authority-managed means-tested budget, is not changed by any of this. ICSs are not designed to solve that fundamental

tension and issue that we have discussed before. That is a question of legislation.

Anne Marie Morris: Thank you. That is very helpful.

Q56 **Chair:** Just to pick up on the challenges and the differences, page 39 of the National Audit Office Report highlights some of the very tough challenges individual NHS providers face. Some look extremely challenging, the NAO agrees. I will not list it all, but it is there in paragraph 2.22. We have to recognise that these are being set up against a very challenging financial backdrop.

Mr Waller, do you think that we are setting them up to fail because they are trying to do all these new whizzy things—although we have gone round the block on some of these integration things before—in this very challenging financial situation?

Edward Waller: As Sir Chris and Amanda have said, the existence of ICBs does not change the amount of money available to the system at an aggregate level. There are two ways in which ICSs could help us address the financial challenge the NHS has, as Amanda laid out. One is that they are able to adapt services locally to make services as efficient as possible and to deliver them in the best way. The second is that they are operating at a footprint that allows them to do things more efficiently than their predecessors in CCGs did.

Chair: Because they are a bit bigger.

Edward Waller: They are a little bit bigger. Just to give you an example, we have ICSs that have established things like collaborative banks across trusts in an area. That is happening in South Yorkshire and Bassetlaw. That allows them to agree a set of common terms with agencies and makes sure that they are getting a collective good deal on their agency spend. We have ICBs looking at back-office consolidation across an area. We have procurement collaborations, for example the one that is going on in London. There are ways in which ICBs can make themselves more efficient and reshape services.

Q57 **Mr Francois:** Sir Chris, we all know as local MPs that the NHS is under great pressure. Remember, our constituents are your patients. Over the last couple of years, in order to alleviate some of the financial pressure, you loaned money from the centre both to CCGs and to hospital trusts. You then converted that subsequently into public dividend capital. In layman's English, you wrote the loans off. Why did you do that?

Sir Chris Wormald: We did this towards the beginning of the Covid position. They are not written off; they continue to sit on the national Government balance sheet, so they are still there and accounted for.

Mr Francois: As far as the trusts and the CCGs are concerned—that is my point.

Sir Chris Wormald: You are completely right. We did that towards the beginning of Covid and it was very specifically to ensure that trusts had

greater financial freedom in the tackling of Covid, to take that liability away from them and to bear it as a national pressure.

Q58 **Mr Francois:** In simple English, it was done as a Covid emergency measure. That is what you are really saying.

Sir Chris Wormald: Yes.

Q59 **Mr Francois:** We have got that. We understand that. Again, if I come back to what I know and my ground truth, when they formed the Mid and South Essex Hospital Trust, they merged Broomfield Hospital in Chelmsford, Basildon Hospital and Southend Hospital. Fundamental to that merger was £118 million of capital to improve facilities at all three hospitals, especially at Southend. That was in 2017.

We as the local MPs, who were a bit sceptical about the merger, were faithfully promised in the boardroom of the old NHS at Richmond House that the money was there. Five years on, we have not seen a penny of it. In fact, we are now having to argue over £7 million of facilitating money to facilitate the rest of the works. We have not even got that either. Where has that money gone?

Sir Chris Wormald: I cannot comment on the specific, because I do not have it with me. I am quite happy to go away and then write to you about the specifics of that case.

Q60 **Mr Francois:** I and my fellow south Essex MPs would be deeply grateful if you did. I just use it as one example, again as some ground truth about how, particularly with capital in the NHS, it is extremely difficult to get people to take decisions, whether it is three hospitals or putting a first floor on a GP surgery in 2022, when we put a man on the moon in 1969. Why, as a Department, are you so poor at this?

Sir Chris Wormald: I do not accept that we are poor at it.

Q61 **Mr Francois:** Where is the £118 million then?

Sir Chris Wormald: As I say, I will look at the particulars of that individual case. As we have discussed with this Committee on a number of occasions, we took a series of very explicit decisions to cap revenue switches before Covid. Those were taken as very explicit public decisions about budget management. I will not deny that that has put pressure on capital programmes. As I say, that was a set of explicit decisions that we debated with this Committee. I do not know whether that is the cause of your specific problem.

Q62 **Mr Francois:** Is this not one of the problems in the system, which you see both at national level and at ground level? In simple terms, about 75% of the NHS budget goes on pay, very roughly. On top of that, you then have the operating costs of hospitals, clinics and suchlike. Then you have the costs of the drugs and pharmaceutical bills. Once you have allocated all the money for that, there is very little left for capital investment. That capital is then fought over, tooth and nail, between different elements of the NHS. Because of all the reorganisations from PCTs to CCGs to super-CCGs to

ICBs, for years, you have had projects that have been endlessly analysed and re-analysed rather than going ahead, because no one wants to take a decision on how to allocate a relatively small pot of capital. It is what the military call paralysis by analysis. Everything is reviewed. Everything is endlessly analysed. No one takes any decisions. Why is your system so terribly prone to this?

Sir Chris Wormald: Where I would agree with you is that capital budgets within the NHS have been under considerable pressure, and we have taken some very explicit decisions to reduce capital investment. I would not deny that.

Q63 **Mr Francois:** But my breakdown of the costs was broadly right, yes?

Sir Chris Wormald: As you know, we get from the Treasury a separate capital budget from the current budget. Your description of the current budget sounded pretty much spot on to me. I recognise all your numbers. Of course, pay is the biggest one.

Within that capital budget, the pressures are the level of capital need in the NHS, which we know is great, and the decisions we took around capital-revenue splits. I am not going to say I do not agree with you, but the bit I have not seen any evidence to support is that it is reorganisations of the NHS that have caused difficulties in decision-making. I am not saying it is not; I am saying I have not seen evidence.

Mr Francois: I will send you all the stuff about Riverside surgery.

Sir Chris Wormald: As I say, I will not comment on your locality. That is a challenging position undoubtedly. I am not sure it is to do with reorganisations.

Matthew Style: If I may add a very brief point to link back to the Report we have before us, it is important to say that integrated care boards have much greater discretion locally about how they target capital resources than they have ever had before. The people who are making those decisions about how to balance their budgets and prioritise their investments can do that in the context of the priorities of their local populations, identifying those investments that will make the biggest difference to the sustainability of the local health economy going forward.

Q64 **Chair:** If they sell off something, a site, to reconfigure, can they keep all that money? Does some of it, or all of it, go back to the Department?

Matthew Style: There were some announcements made very recently, by the previous Chancellor of the Exchequer, if I get the chronology right.

Chair: One of the recent Chancellors of the Exchequer.

Matthew Style: That gave the NHS much greater flexibility to retain the proceeds of asset disposals and then deploy those.

Q65 **Chair:** Is that all? There was a period where trusts were allowed to retain some, but not all. That was an incentive to manage their property, basically, to get the money.

Matthew Style: The Government have set out their intention to ensure that the NHS will locally be able to retain the full value of those receipts. Further guidance will be coming forward on exactly how that flexibility will be managed. It is a big step forward.

Chair: What is the timing on that guidance? All of us will be interested in that.

Matthew Style: In due course.

Chair: Mr Style, you are such a mandarin. You have learned the language already. We will push you on when "due course" will be.

Q66 **James Wild:** Ms Pritchard, I return to the familiar theme of the Queen Elizabeth Hospital in King's Lynn, which at the last count had 3,000 timber and steel supports holding up the cracking concrete-cancer RAAC roof. What is your message to staff and patients who are desperate for confirmation that it will be part of the new hospitals programme?

Amanda Pritchard: That might be for Chris actually, because the new hospitals programme is a departmental programme.

Sir Chris Wormald: Mr Style was going to cover these predicted questions.

Chair: It is being passed along, Mr Wild. You might have worked out by now that you might be asked this.

Matthew Style: The pressures on hospitals affected by RAAC are, as we all recognise, incredibly significant. Additional investment has been put in to help trusts understand those risks and to plan for the remediation of those risks in the future, and additional investment has been put in to support trusts to overcome, as effectively as possible, the immediate operational issues that those pose. We absolutely recognise the scale of those risks, and ensuring that we can make a difference to all of the trusts affected by that is a priority for us. Through the further announcements to be made on the new hospitals programme but also across the broader capital budget, we will absolutely be prioritising dealing with that challenge.

Q67 **James Wild:** The decisions on the eight new schemes were originally due in the spring. We are now in November. When will a decision be made? When will there be certainty for the staff, patients and constituents across Norfolk, Cambridgeshire and Lincolnshire who rely on that hospital and who, when they go there, see 3,000 steel and timber supports holding up the roof?

Matthew Style: We expect the decisions about the final eight, as it were, to be announced later this year.

James Wild: Later this year, so not much longer.

Mr Francois: We are in November now.

Chair: Mr Wild has been waiting since he joined the Committee in 2020.

Q68 **James Wild:** Indeed, and the Department is committed to getting rid of

RAAC by 2030. The lifetime of the Queen Elizabeth Hospital is 2030, so we need to have the decisions in the short term to be able to do that. As leader of the NHS, Ms Pritchard, what is your message to your staff in that hospital? Are you making the case to Ministers and to Mr Wormald that this is a scheme that needs to be backed?

Amanda Pritchard: You have just heard the clear commitment from both of my colleagues to say that there is absolute ownership of the importance of finding a solution to those organisations that have the RAAC plank challenges, not just yours—there are, as you say, a number. It is extremely high on the Department's radar, and we are extremely keen to do anything that we can jointly, as we are doing now, to support colleagues in the short term and in the immediate term to make sure that we have the right surveillance and expertise in place and the right additional short-term funding to ensure that we are doing everything that we can to support those buildings while the longer-term plans are being made. I appreciate that it puts colleagues under real pressure.

Q69 **James Wild:** We had the chief property officer before the Committee a couple of weeks ago. He said that he was making the case to the Department to do this. Are you making the case that this is a priority scheme? The regional NHS has put this as priority number one. Are you endorsing what it has put forward?

Amanda Pritchard: We are absolutely clear, as colleagues have just said, that a solution to the RAAC plank hospitals is an absolute priority.

Chair: Mr Wild and his constituents are very patient on this, I have to say.

James Wild: Impatient, I think.

Q70 **Chair:** Indeed, impatient, but it has been a long time. We all know a lot more about Mr Wild's hospital than you would expect, because of the problems there. I just wanted to go back to you, Mr Style. We were talking about what happens to the capital if an ICB sells a property at present. I was just checking back what I thought. The legislation removed some of the foundation trusts' freedom to spend their capital. Some of it had to go back to the Department. ICBs and their provider trusts have a capital limit, so can you be clear about what has been decided by the Chancellor, whichever Chancellor it was?

Matthew Style: There is a distinction between the ability to retain the cash or the direct proceeds of the receipts, and the capital spending limits that are set, not for individual NHS providers but now, indeed, to go back to the hearing, at integrated care system level. The commitment that has been made is that we will give both individual providers and the local integrated care board the flexibility to draw on the full value of any capital receipts that they acquire.

Chair: But only up to their capital limit.

Matthew Style: Precisely how that is managed over time will have to be agreed and worked through with those individual providers and with the local integrated care board to ensure that it is affordable nationally.

Chair: So whether they can roll that over from year to year.

Matthew Style: Yes, exactly. Clearly, we will need a degree of predictability and certainty about that, so that we can manage the capital budget in aggregate. Although there will be some cases where this is true, in most cases an individual provider will not want to use the full value of a receipt in the same year or immediately. They will wish to have the flexibility to deploy that. Further guidance will set that out and we will need to work with them to do that.

Q71 **Chair:** There will be huge pressures, such as at hospitals like Mr Wild's, where there will be a real call for the system to draw capital into there. What you are saying is that it has not been bottomed out yet, and that guidance could be issued that there is a top-slicing effect of any capital receipt in an area for some of the really strategically challenging capital issues across the NHS.

Matthew Style: As I said, it is important that integrated care boards that have the view across the local health economy of what the economies are have the flexibility to make the decisions about how they want to deploy capital resources across their system over time, in order to ensure that local priorities can be reflected.

Q72 **Chair:** There is still the prospect that some of it could be clawed back.

Sir Chris Wormald: The question of limits is a slightly different one and we will need to have some conversations with the Comptroller and Auditor General about exactly how this is scored, because, correctly, according to the NAO, if you sell an asset and spend the money, that is public expenditure, just like any other public expenditure. We want ICBs to have the freedom to decide what their estate should look like and to get the proceeds and spend them. Of course, we have to do that within the general expenditure control system. The policy intention is exactly as Matt has described it. We have some accounting conversations to have about how we make that work in practice.

Chair: So there is still a lot at play there. We have that message.

Sir Chris Wormald: Just to be absolutely crystal clear on your top-slicing question, as Matt was describing, if a trust sells an asset, the money does not necessarily flow into that trust. It is considered, at ICB level, what is best. That is different from us taking money back nationally and moving it to another bit of the country.

Q73 **Chair:** But the latter could still apply. It is not yet firmed up. We are facing a major public spending crisis. You have the Chancellor making big decisions. It is not impossible, at this point, as we sit here, that, if an ICB sells assets, some of the money could be clawed back.

Sir Chris Wormald: I have given you the policy intention and I am not going to speculate on what might happen after 17 November.

Chair: We have the message loud and clear on that. We will be watching like hawks in our area as a result.

Q74 **Anne Marie Morris:** Sir Chris, on the workforce plan, can you commit that we will finally see this long-term strategic framework that was promised in the spring this year, and the 15-year forward plan, by April next year?

Sir Chris Wormald: I will pass over to Mr Style.

Matthew Style: As you know, Ms Morris, Ministers have said that they will publish the key conclusions of the long-term workforce plan in due course.

Q75 **Anne Marie Morris:** With respect, Mr Style, they have been saying that for rather a long time. With respect, you will appreciate that that is not very helpful, because the workforce is in crisis. I am assuming that you are beavering away, doing the work to support the Government in getting this thing in place. Why is there not a date? What is causing the delay?

Matthew Style: I will not add to what I know Ministers have said both at the Dispatch Box and in Select Committees about the importance that they attach to having a long-term workforce strategy in place and to addressing what are very significant pressures on frontline staff across the NHS. Our commitment to grow the workforce, to deliver on our commitment to increase the nurses by 50,000 and our commitment to increase the number of primary care professionals—

Q76 **Anne Marie Morris:** I am going to interrupt you there, because we are short of time. That is lovely to hear, but you will appreciate that an aspiration is really no good to God nor man. What we need is action. I need a time and I need a good reason—and you have not given me any good reason—why promises that were made to deliver a workforce plan by the spring of this year have not materialised.

Matthew Style: There is action, to go to your point. As I say, we are delivering on our commitment to recruit 50,000 more nurses and 26,000 more frontline professionals in primary care. We are very focused on delivering and increasing the workforce.

Q77 **Anne Marie Morris:** Mr Style, let me take you to task on that. Have you worked out whether that is still the correct number of people to recruit? I think I am right in saying that that figure was set before the pandemic and, unless I am very mistaken, the demand has grown exponentially since then, never mind the size of the population.

Matthew Style: Exactly as you suggest, Ms Morris, precisely what the long-term workforce strategy is there to do is to look at the future needs of the NHS and to take into account changes in the nature of clinical practice and the productivity opportunities, and to establish the right size of the workforce and, therefore, the investment that needs to go in to deliver that.

Q78 **Anne Marie Morris:** Telling me how you are recruiting against a target that is well out of date is not really very helpful. You are telling me—and, indeed, we hear it at the Dispatch Box on many occasions—that many GPs and nurses are being recruited, but that is all in the context of a demand set before the pandemic, which is well out of date now. Is it acceptable, given that this is aspirationally the most important thing that the NHS, the

Government and the Department of Health must come out with, that we have seen nothing of it and, worse, there is no timeline for it and, perhaps worse still, no reason why not?

Matthew Style: It is very important that we not only deliver a long-term workforce plan for the NHS but that we do that in a way that is integrated with the service planning, the operational planning and the financial planning across the NHS. That is why we are bringing together Health Education England and NHS England into one organisation, and why Health Education England and NHS England will be working together on that workforce plan to ensure that it does take that comprehensive, systematic view of the future requirements of the system. We recognise the urgency of that and, as I have said, Ministers have said that they will publish the key conclusions.

Q79 **Anne Marie Morris:** Ms Pritchard, in the light of that, are you a bit concerned at the level of vacancies and the impact that that has had?

Amanda Pritchard: The number of vacancies across the NHS is hugely concerning. I would say it is no secret that workforce pressures are the thing that, as you said, we are most conscious of at the moment, because we are heading into what will no doubt be an extremely challenging winter, and so making sure that we have the right staff in the right place, well supported and able to do their best for patients, as they do every day, is going to be critical. We are carrying a lot of vacancies at the moment. The NHS has always carried a large number of vacancies and we have been incredibly successful in recruiting more people, particularly into education, but we have more vacancies, as you rightly say.

Q80 **Anne Marie Morris:** What is an acceptable level of vacancies, and how does that compare to where we are now? It is going up, not down.

Amanda Pritchard: We have seen an increase in the number of people leaving the NHS since the end of the pandemic. We retained lots of people, because they were so committed to doing their best for patients during the pandemic. Unsurprisingly, that has gone up.

Q81 **Anne Marie Morris:** But the question, Ms Pritchard, was, "What is an acceptable level of vacancies?"

Amanda Pritchard: I would say two things. The first is, just to the point that you were making earlier about the 50,000 target and, indeed, the 26,000 target, additional staff of any number are hugely valuable to the NHS. "Is it enough?", is a really important question, but is something better than nothing? Yes, absolutely. We are really grateful for the work that Ruth May and colleagues across the Department continue to do to make sure that we are really focusing on that.

Secondly, in terms of what an acceptable level of vacancies is, you would always aim to have an absolute minimum, but that is why the workforce plan is so important, so that we are thinking ahead about what we need to do to train, as well as to retain, staff. Otherwise, we will never get to that position. We are working, as Matt just said, very closely with HEE. Navina

Evans, who is the chief executive of HEE, is also the chief workforce officer, and she is leading the work on the workforce plan.

Q82 **Anne Marie Morris:** Ms Pritchard, these vacancies really are now at crisis level, are they not? With the best will in the world, even with the figures that are regularly trotted out about the number of doctors and nurses, et cetera, it is not going to fill the gap, is it?

Amanda Pritchard: We have, at the moment, as you rightly say, more staff working in the NHS than we have probably ever had before. We have seen record numbers of people coming into training, which is great. Equally, we are now seeing more people leaving, and that is people retiring as well as choosing to leave earlier in their careers. The overall picture for the NHS is not straightforward, so it is definitely not as simple as saying, "Gosh, we have more people, and therefore we must be all right," because, as you rightly say, the number of vacancies is well north of 100,000. We need to look at the two together. The level of pressure, as you have also said, that colleagues are under because of the level of demand in the system means that it is hugely challenging.

Q83 **Anne Marie Morris:** Given that we have a gap that, by your own admission, we are not filling, what innovative steps are you putting in place to change that? Are you going to shorten, for example, the training time that it takes for a doctor? In America, it is two years less. Are you looking at shorter training careers? Are you looking at slicing and dicing? We have to have some innovation because, at the moment, as things move forward, there is no obvious way of closing the gap.

Amanda Pritchard: There are three things worth saying. Step one is we are hugely grateful at the moment for the number of people we are able to bring in as international recruits. That is making a difference right now to support on the ground. Equally, there are things that we are able to do with bank staff, and Ed mentioned a little earlier things like collaborative banks. Those are the sorts of things that give us access to temporary staff, which is hugely important on an everyday basis to keep services going.

Secondly, supporting our staff remains really important. You asked about innovations, but we have done lots of things over the pandemic that are about providing digital access to support as well as local access. That matters and it remains hugely important that we are doing everything that we can to support our current staff with flexibility and sharing best practice across the NHS.

Your big question, which is the right one, goes back to the workforce plan. Yes, absolutely, and the value of doing the workforce plan is that it is not just about numbers and demand, but is really thinking about the more innovative supply-side reforms, including training, that we are absolutely keen to go for.

Q84 **Mr Francois:** Ms Pritchard, we all know the pressure that clinical staff in the NHS are under, so we must have this workforce plan to explain how that pressure can be relieved. There are clinical staff leaving in far larger numbers than anyone would want. Many of them go and do agency work,

turn themselves into one-man or one-woman companies, and then come back in part time. That is why some hospitals, for instance, are under such immense pressure. We must have this plan. I will just ask you again, very simply, when we will get it.

Amanda Pritchard: We have been commissioned jointly with Health Education England to do the work on the plan. It is going well. We are engaging widely, as you would expect, because it has to be a plan that people recognise and own. The expectation is that we will have something that we can deliver back to the Department certainly within the timescale that we were discussing.

Q85 **Chair:** Which is when? Can you just be clear when the timescale is?

Amanda Pritchard: We are hoping to have it finished this side of Christmas. I would not want to give that as a guarantee, but certainly this financial year is what we have been talking about.

Q86 **Mr Francois:** So it might be by Christmas or it might be by the end of the financial year in March.

Amanda Pritchard: The commitment that we have made is to make sure that we have engaged widely. Doing something, for example, that the Royal Colleges have not looked at and do not recognise, or some of our other important partners and stakeholders are not involved in, means it will not work. That is why I am giving you some flexibility.

Q87 **Mr Francois:** You are still not firmly committing. There are people leaving the NHS in very large numbers. This plan is designed to help arrest that. None of you, consistently, will give us a date when we are going to see it. You have just given us two different dates. Paralysis by analysis—that should be your unofficial motto, because, time and again, that is what NHS England does. Are you aware of the Messenger review into NHS leadership?

Amanda Pritchard: I have been very clear. We will have completed our part of the workforce plan, at the absolute latest, by the end of this financial year. We are aiming to do it earlier and have it done by Christmas, and it is not analysis; it is engagement that we are doing to make sure that, when it lands, it is the best possible, because this really matters and we want to get it right. That is a different question to what you have asked my colleagues about publication.

Q88 **Mr Francois:** With great respect, Ms Pritchard, as local MPs who see the effect of this in our constituencies every day, we do not need to be told that it really matters. With respect, we have already worked that one out. If you are going to deliver it to the Department by the end of the financial year, so by the end of March, effectively, how long will it then take the Department to publish it? You delivering it to DHSC is not the same as the plan being published. Mr Style, if you get it by the end of March, how quickly can you then publish it?

Matthew Style: Mr Francois, you will understand that when the Government wish to publish the long-term workforce plan will be a matter for Ministers, not for me here today.

Q89 **Mr Francois:** Okay, so it is more paralysis by analysis then. The Messenger review—

Sir Chris Wormald: No, you will find that is normal procedure for Government, where Ministers take decisions about what is published when.

Chair: We have been talking about a workforce plan for a long time. Baroness Harding did some work on a workforce plan.

Q90 **Mr Francois:** Sir Chris, with respect, I have been a Minister. I was a Minister in the MOD. The MOD understands the concept of a sense of urgency. If something was really urgent, as the Minister, you turned it round sometimes in hours. You turned things that were urgent round very quickly. You did not sit on them for months and months, which is what your Department is world champion at.

Sir Chris Wormald: I am simply making the point that, as I am sure was your expectation when you were a Minister, you got to take the decisions on what was published when, when you had properly considered it. That is all we are saying about the workforce plan.

Q91 **Mr Francois:** Gordon Messenger, who was at the MOD and was a very successful general—I had the privilege of working for him—did a review into NHS leadership along with Dame Linda Pollard. Have you read the Messenger review?

Sir Chris Wormald: Yes, we commissioned it.

Q92 **Mr Francois:** Can I just refer you quickly to page 5 of their executive summary? "Beyond cultures and behaviours, we chose to focus on the current absence of accepted standards and structures for the managerial cohort within the NHS. With known exceptions, it has long been a profession that compares unfavourably to the clinical careers in the way it is trained, structured and perceived, and we received strong feedback from managers at all levels that greater professional status and more consistent, accredited training and development are required."

We all have the most utter admiration for clinical staff in the National Health Service, but there are desperate weaknesses in the management cohort of the NHS, and Messenger makes that very plain. What are you doing about the Messenger review?

Sir Chris Wormald: I will ask Amanda to comment in a moment. We worked with the general throughout Covid. He was, as you say, a tremendous asset to us. That is why Ministers commissioned him and a very respected NHS chair, who you have also quoted, to do that review. We were very pleased with his work and we agreed with his assessment. I believe the NHS is taking forward all his recommendations.

Amanda Pritchard: I would absolutely echo everything that Chris has said about working with both Gordon and Linda as part of the review. Colleagues will know that 19 out of 20 managers in the NHS are clinical, because, of course, most people come up through a clinical route. What I particularly welcomed about the work that Gordon and Linda did—

Q93 **Mr Francois:** Are they senior managers?

Amanda Pritchard: Many of them are. Particularly if you look at the leadership teams within trusts and ICBs, they will always have a nurse and a doctor. Quite often, the chief executive themselves will have a clinical background. That gets truer as you go through to less senior roles.

Q94 **Mr Francois:** What about at NHS England?

Amanda Pritchard: Yes, absolutely at NHS England. One of the things that was particularly good about Gordon and Linda's review was that it recognised the importance of training teams. The idea of putting just one individual through training—you would never do it in the military, I am sure—and expect them to turn something round on their own and to provide leadership to as complex an organisation as a big hospital or, indeed, an ICB is one that they absolutely recognised was never going to be right.

Therefore, this is about leadership and teams. For us, that means really thinking very carefully about how we support clinical leaders through the system. There is and always has been a really important role to bring some people in externally.

Q95 **Mr Francois:** Gordon Messenger got the DSO not once, but twice. He is an extremely capable man. This was published on 8 June. What have you done to implement it since then?

Amanda Pritchard: Within the NHS, we have accepted, as the previous Secretary of State did, all of the recommendations and are currently working them through. There is a question, as you look down the list, about some of the things that are easier and quicker to do and some of the things that will take longer. I am happy to write to the Committee with an update, if that would be helpful.

Q96 **Olivia Blake:** Sir Chris, why is the NHS so poor at predicting staffing shortfalls in specialisms?

Sir Chris Wormald: What is behind your question?

Q97 **Olivia Blake:** For example, the inability to stem the flow of staff leaving a specific specialism. For example, of those 100,000 vacancies, 8,000 are midwives, which is having a national impact on midwifery across the board. Why is the NHS not able to predict that?

Sir Chris Wormald: I will ask Amanda to comment. I am not sure that the challenge is so much prediction as mitigation. Most of the workforce challenges in particular specialisms are well known, and it is not about identifying the problem. The challenge—and I am sure that Amanda will add to this—is that the mitigations on those things tend to be quite long-term. Therefore, dealing with issues in real time is the challenge, as opposed to predicting which specialism.

Q98 **Olivia Blake:** Certainly from my point of view, it seems that, when the snowball effect happens, patient safety becomes difficult and staff feel under pressure. How responsive is the system to recognising that? It

seems that multiple services, including midwifery, are really struggling at the moment. Why are there no interventions that are working to stop the number getting higher and higher, which it has been, with a brief blip in Covid?

Sir Chris Wormald: I will divide that question in two. As the Committee well knows and we have discussed before, we had, prior to Covid, a level of workforce pressure, and a number of measures in place to deal with it, including in particular specialisms, and that was all predicted. It does not make the answer easy, because we are talking about highly skilled professionals who take a long time to train, and you know about all of those issues.

The Covid effect was not predicted, and that has taken all of those existing problems and magnified them. Undoubtedly, we are in a much more challenging position than we expected to be.

Q99 **Chair:** On the midwifery theme, I was at my local hospital the other week, which lost eight Spanish midwives who left, partly because of Brexit, and is finding it a struggle to refill those vacancies. There are other factors as well, and it is not all down to Covid. Let us just be clear.

Sir Chris Wormald: There are all possible factors. I have not checked the numbers recently, but every time I have checked before, we have seen more colleagues from the European Union working in the NHS than there were on the day of the referendum. I think that is still true, but I will check. The reason I make that point is not for a wider political point, but simply that this is all multifactorial.

Chair: We do not need to know the motivation. It was just a local anecdote.

Q100 **Olivia Blake:** I am curious, because it seems that, at this Committee, we always hear about the global nursing figures. What I am concerned about is that, within particular specialisms, patient safety is really at risk because staffing has got quite critical.

Sir Chris Wormald: Again, I will break that down. There were some very specific issues in maternity services that have been very well tested. Amanda might want to say something about what we are doing there. No one is satisfied with the position of maternity services, for all the reasons that you know. How we get to our global numbers is by looking at individual specialisms, and we debate it a lot. There are particular NHS trusts that, for example, have issues with anaesthetists, which is another specialism, and we do take specific actions on specialisms. I can assure you that we do look specialism by specialism, as well as at the global numbers. There are very specific issues in maternity.

Q101 **Olivia Blake:** My point is about how you, as a system, both Ms Pritchard and Sir Chris, respond when there is an emerging issue that is affecting patient safety across the system in a certain specialism. How do you speed up your efforts and how responsive are you to that?

Sir Chris Wormald: We will talk specifically about maternity services, because they are unique in a whole range of ways. In general, there is no

silver bullet to this. The other interesting thing about the report that Mr Francois was quoting is that none of this is magic or new. What he was applying were all the standard things that you do when you want to improve an organisation, so it will not surprise you that we look at three main things, which are recruitment, retention and return. Return is an increasingly important part and, as we know, we saw a lot of return in Covid, which was one of the ways in which we managed to get through.

The final bit of the jigsaw for us, which comes back to some of the points that Anne Marie Morris was correctly making, is that we need some innovation in the system. In particular, and probably the biggest one, which comes back to some of the things we were saying about what we are doing in GP surgeries, we need every profession working at the top of its profession. We need to take away from our very expensive and highly skilled specialists anything that can be done by somebody else. In your example, midwives should be focusing on those things that only a midwife can do, and we are putting in other support staff to do everything else. We ought to say something particularly about maternity, because it is a very unique case, and not in a good way.

Chair: Very briefly, because our session is not mainly about maternity.

Amanda Pritchard: Just to build on what Chris said, I should say that, in terms of this great opportunity that we have with ICSs, some of those things that you can do more flexibly and immediately, such as moving staff between organisations to support, as we did in Covid, and digital-passporting some of those innovations, are also some of the things that you would look at to try to support where there are particular gaps in staffing.

On maternity, there have clearly been some incredibly distressing reports that have been produced recently. We have talked about Ockenden before. We have also, just very recently, had Bill Kirkup's report from East Kent. These are hugely distressing, and all our thoughts would be with the families as we read them, but we have taken action immediately in response to Ockenden. Following her interim and final reports, action was taken immediately around those incredibly important recommendations. The work is now going on to pull all of it together into a single plan. Importantly, I should also say that investment went in to boost the midwifery and obs and gynae workforce.

Q102 **Chair:** We are not at all diminishing the very important work of Ockenden and Kirkup, and all the tragedies recently at East Kent. It is very important, but it has been obvious that there has been a gap in workforce in these areas before the crisis. What Ms Blake is partly driving at is that, when you see that there is beginning to be a problem, the workforce planning is not delivering the inflow of people, whether through immigration or training, to bring them into those roles. What is the answer to that? The workforce planning has been critically bad for a very long time, as Ms Morris was highlighting.

Amanda Pritchard: In some areas, it is easier than in others. For example, in terms of international recruitment, we were really successful at bringing in nursing colleagues, but particularly things like critical care nursing, which was a gap that was particularly exposed through the pandemic. It is harder for some professional groups where there is not an international source to bring people in, or it is highly specialised staff. That is where, getting upstream, the workforce plan will help us with that, but also making sure that we are using those flexibilities that now exist, particularly within ICSs, to help manage some of those particular pinch points.

Matthew Style: Can I give just one very specific example to your point about rapid response?

Chair: Very briefly, please.

Matthew Style: As Amanda said, ICSs do have flexibility to deploy their resource between different organisations, and we have made support available nationally for investment in the digital infrastructure that will allow diagnostic images to be read much more flexibly by people in different bits of the country. This is targeted investment made available rapidly to tackle an identified workforce shortage post pandemic.

Q103 **Olivia Blake:** With investment in digital, I am always a little bit worried about it being fast and effective, given the history in the NHS. As one final point on this, what seems to be happening—and this has been reported in trusts up and down the country, and has happened in Sheffield—is that mothers are presenting at hospital, the staff are not safe, and they are being sent to Rotherham. Is that the ICS's response to this—rather than moving staff around, getting patients in labour to move around the system? Is that acceptable?

Amanda Pritchard: I am not familiar, I am afraid, with the detail of what is going on locally. I am very happy to take that away and have a look at it. In an absolute, most extreme situation, I know that moving patients does happen occasionally. It is an absolute last resort, so the expectation would always be the other way around—that it would be staff, with the right support, who would move, rather than patients, and certainly in the circumstance that you have described, but perhaps I could take that away and have a proper look.

Q104 **Olivia Blake:** I appreciate that. Moving on to local government, I just wanted to ask you, Sir Chris, in the face of local authority resources being very squeezed and the big shortfall in social care funding, how you are going to ensure that social care secures the funding that it needs.

Sir Chris Wormald: I am not going to speculate about future Government decisions on funding. I will say what we are doing on social care. As everyone is aware, we are very concerned about the social care workforce in the same way as the NHS workforce, and they also have a vacancy rate that is much too high. At right this second, the numbers are moving in the right direction, which is not to say that there is not a problem, but we are seeing expansions at the moment of both the domiciliary care workforce

and the care home workforce. There is a long way to go, but it is at least moving in the right direction.

The Government are doing four things, basically. First, yesterday we launched the latest stage of our national advertising campaign to get people to work in social care. The second is the additional £500 million that we announced as part of the plan for patients. The third, which has been very successful so far, is that we put social care on the shortage occupation list and we have seen 10,000 to 15,000 new recruits to social care from abroad, which has been part of the difference. Fourthly, we are working with our colleagues in DWP on how we match jobseekers to social care. It is an improving situation. It has a long way to go, but those are the actions that we are taking.

Q105 **Olivia Blake:** In terms of the local authority funding that underpins all of that, how are you making the case to Government for extra funding for local authorities to enable ICSs to work?

Sir Chris Wormald: What I have described is the immediate action. As I say, I am not going to speculate about future Government funding settlements, particularly before the Chancellor sets out the overall position later this month. We work very closely with our colleagues in DCLG about our inputs to the local government finance settlement announced each December and the needs assessments that underpin that.

The decisions are first national decisions about the local government finance settlement, and then, of course, 141, or whatever it is, top-tier authority decisions about how much money they raise themselves and how much of that is allocated to adult social care. As I said, we work very closely on that. Of course, the big change in the system and the legislation that Parliament just passed is that we have put a lot more focus on the oversight of the social care system through the provision of data nationally about the situation in local government and the CQC's oversight role of commissioning of local authorities.

Q106 **Olivia Blake:** Do you share concerns that the capacity of local government will have an impact on the ICSs' objectives and how they are delivered?

Sir Chris Wormald: It quite clearly does, yes. You are completely correct. All those separate decisions that I have just described impact on what local authorities can and cannot do, both in their social care responsibilities and in their public health responsibilities, and, of course, in their wider responsibilities that impact greatly on health—housing and transport, et cetera—so we are very conscious of all those. Just as a statement of fact, that has to be set against, in the normal way, the financial pressures on local government, national Government and, of course, on the nation as a whole at the moment.

Q107 **Olivia Blake:** We have a number of councils that have commissioners in. How does that impact the working of local authorities with ICSs and how do you manage that as a Department?

Sir Chris Wormald: The commissioner system is, of course, for my colleagues at DCLG.

Chair: We know that.

Olivia Blake: We understand that, but how does that impact?

Sir Chris Wormald: It should not impact at all, except that, of course, it is the commissioners who are working with the ICS, as opposed to the traditional way.

Q108 **Olivia Blake:** Just thinking back, the financial arrangements around some of these pooled projects, with shared risk, for example—

Sir Chris Wormald: Sorry, I am with you now.

Olivia Blake: Commissioners would then take the decision. It would not be in local politicians' hands. How would you manage that if there was a conflict, for example, between what a commissioner wanted to do to reduce risk on a pooled budget? How would you manage that?

Sir Chris Wormald: There is no difference between that debate with a commissioner running it than were a local authority to be taking the same decisions. As I said earlier, the ICS creates a forum for those decisions to be discussed and taken better. It does not change either the quantum or the statutory responsibilities. We would have to deal with that situation in exactly the same way as if a "traditional" local authority was taking the same decision.

Q109 **Olivia Blake:** Would the Department consider a mechanism for managing such a conflict? The impact in the long term to the ICS could be huge, if a pooled resource was determined to be unaffordable for a local authority.

Sir Chris Wormald: We certainly have not done that and, off the top of my head, I am not sure we would want to. We would want, as I say, the relationship to be exactly the same as with any other local authority. As you will have just gathered, it is not something that I have thought about. We are not doing that, and I do not believe it is in—

Q110 **Chair:** You are saying that the tension would be managed locally. Commissioners go in for a reason. You could have a weak partner in the ICS, but you would leave that to local boards—yes or no?

Sir Chris Wormald: We want ICSs to deal with all these problems in a place, for all the reasons that the Committee has said earlier.

Q111 **Chair:** The answer to that question is "yes".

Sir Chris Wormald: Yes.

Q112 **Olivia Blake:** I guess the question is about what happens when things go wrong. How does the Department intervene? Is there any planned intervention at all? We all want it to go well, but, if it does not, what happens?

Sir Chris Wormald: The intervention systems are unchanged. NHS England has a series of intervention powers, as does DCLG, with the

exception—and it is not in this reform, but it was in the same Bill—that, as I say, we have considerably enhanced both the information we get about how the social care system works and our oversight, via CQC, of how commissioning is done. That is the only change to the oversight and intervention system.

Matthew Style: Just very briefly, we have also made provision for the CQC to look at the effectiveness of partnerships locally, and that is a very important change as well.

Chair: Yes, that is a very important safeguard.

Q113 **Kate Green:** Could I understand how the ICSs will balance some of the short-term expectations, for example, to get waiting lists for elective treatment down, along with the four core purposes for ICSs, including prevention, improving outcomes in population health and reducing inequalities? How will they trade off those two pressures and how will you be ensuring that they are dealing with them appropriately?

Amanda Pritchard: They are hugely complementary, and it is really important that we hold both. As you say, the four purposes of ICSs are really clear about that. There are some things that need real, short-term, urgent focus, and those are well understood by all of us, but, if we are going to get upstream on really managing some of the outcomes that we know we need for the population, which we talked about earlier on in terms of population health and prevention, that is action today as well, but it will take longer to flow through, as we know.

There are two things that are worth saying. It is a responsibility of ICSs to produce their five-year strategies, which need to reflect those four purposes and describe how they are going to be working collectively to deliver that for their local populations.

Secondly, I have already talked a bit about oversight, and the way that we will do the oversight of ICBs will have a number of different aspects. We have the formal oversight framework, which uses metrics that cover both short and long term. We will also do the annual review, which will look at progress against that overall plan, not just the metrics in the oversight framework. Then, of course, we have the CQC also looking at the whole piece, including how the whole thing is joining together.

The important bit for me in all of this is that the ICSs give us the chance to get the best of both, so the national opportunities to do things like share best practice, look at where there are those hugely important efficiency programmes that I have talked about already, the digital underpinning, and the data that you need locally, with that local ownership of what is going to work for your population, which, of course, is where that particular focus on inequalities and prevention will be so important.

Q114 **Kate Green:** Who is responsible for monitoring outcomes that show that incidence of disease falls, because prevention has been effective, and inequality gaps are narrowed?

Amanda Pritchard: That is part of the oversight framework that we will use within the NHS to look at the ICBs. It is part of what we would expect to see described in the strategic plans that ICSs will be producing. That is a partnership responsibility, so that will be something that all partners have signed up to and it will be part of the annual review process and, as I say, something that the CQC will look at as well. As Chris has said, through the local government line, the primary responsibility for public health sits there, and those metrics are well established within local places, often looked at through the health and wellbeing board structures, but there will be many others as well.

Q115 **Kate Green:** We have, certainly at national Government level, a whole range of Departments that are responsible for the wider determinants of health outcomes. The NAO identifies 12 Government Departments in the Report that have a bearing on health outcomes. How does NHS England and, through NHS England, the ICB work to ensure that you can play your part in—and, indeed, ensure that others play their part in—improving health outcomes in line with the four core purposes and the ones that I have particularly highlighted?

Amanda Pritchard: You are absolutely right to say that this is a real partnership responsibility. Although the primary responsibility for public health sits with local government, there are processes that are well established, like the joint strategic needs assessment, which underpin that joint understanding of what the needs are of the local populations, and then we have these various processes in place as part of the formal governance that give life to oversight of the delivery locally.

It is worth saying, though, that, of course, prevention—not the social determinants part, but other aspects of primary prevention—

Kate Green: Screening and vaccinations and so on.

Amanda Pritchard: Particularly secondary prevention and early diagnosis are absolutely crucial parts of what primary care do every single day, day in, day out. It is writ large in the Fuller review. It is part of the big reform agenda for us around primary care: to make sure that, along with continuity, population health outcomes and access are all taken forward as described in Claire's work.

It is also true that, particularly for people with long-term conditions, you have multiple points of opportunity from the NHS's perspective to intervene at different points of the life course, in terms of making sure that things like medicines are optimised around particular conditions to get early intervention and prevent worsening of conditions, from cradle to grave.

Sir Chris Wormald: The only thing that I will add is that, although the National Audit Office is completely correct that it is that number of Departments, that Department is, in a very large number of cases, then discharging its responsibilities, either through local government or in partnership with it, so air quality, transport, housing—

Q116 **Kate Green:** It is a bit of a mess, isn't it?

Sir Chris Wormald: No. National Government is organised by theme, and local government is organised by place, and the themes come together in place. Why was public health made a responsibility of local government in 2012? The argument is that many of the levers over the wider determinants sit in other local government responsibilities.

Q117 **Kate Green:** From NHS England's point of view, I absolutely accept that, Sir Chris. How will you draw on that broad expertise that Sir Chris is talking about that they will have of the wider determinants of poor health in their communities? How will it be collated and used, as it were, within these new structures?

Amanda Pritchard: That is a particular responsibility of the ICP—the partnership—and that is very much part of what is behind making sure that it was established in the way it was: as a very clear, equal partnership between health and local government, but also patient groups, the voluntary sector, et cetera, because that is about understanding the local population, but also, crucially, about adapting and developing interventions that are going to be effective there. One of the things we learnt really clearly through the Covid vaccination programme is the power of partnership, so getting into local communities in a way that was going to work. We were enormously successful and there is a huge legacy to build on there as we think about the next steps on this.

Q118 **Kate Green:** What progress has been made by the Office for Health Improvement and Disparities to prevent ill health?

Sir Chris Wormald: That is a part of the Department. As part of the successor bodies to Public Health England, we brought all the health improvement functions back into the Department, reporting eventually to the chief medical officer. It focuses on how the overall public health system is working with local government and on the big national determinants of health, which we have already quoted. That is its role. It is very new. We brought it in only in the last year or so. There have been a whole series of measures that came in last month on obesity. Smoking rates continue to go down, but not as fast as the we would want.

Kate Green: That is the national picture.

Sir Chris Wormald: Yes, that is what OHID deals with.

Q119 **Kate Green:** If we look at the NAO's Report and figure 22, there is a growing gap in life expectancy. It is something that we have known for a long time, but it is now growing, alarmingly, between the most and least deprived. Within the new landscape of ICSs and ICPs, is it that the spending can or should be reallocated? Has it been wrongly allocated in the past?

Sir Chris Wormald: On those disparities, you would need the chief medical officer here to have a much more informed discussion than the one that we are about to have, so I will quote other people's opinions.

Chair: Yes, with that caveat.

Sir Chris Wormald: What we tend to see is that those local disparities are largely driven by those big national determinants of health, so differential smoking rates and differential obesity rates—all the classic things. Part of the point of ICSs and their population health focus was to have a greater focus, both from local government but also from the NHS, on those underlying drivers of health. As I say, it is a very new system, so I could not say that, as of today, it is better than the day we set up ICSs, but that is the intention.

Q120 **Kate Green:** So we should be able to see one of the consequences of the creation of ICSs as being improvements in those disparities. When would it be optimistic to expect to be able to see those improvements? Is it the three-to-10-year timescale that Mr Francois mentioned at the opening of the session? It feels quite slow for things that we have known about for a long time.

Mr Francois: And that is according to the people who are going to run them.

Sir Chris Wormald: Yes, but take an issue like obesity. You cut childhood obesity, which everyone agrees is a good thing to do. You see the health impact of that. You see some immediately, but you see a lot of it 20 years later in people who do not develop diabetes very early. The timescales are very long. That is just a clinical fact.

Q121 **Kate Green:** That is not what I am interested in. What I am really interested in is how we will know that the ICSs have made that difference that would not have happened. As you say, we have a common understanding of the concerns. What we need to see is why these structures are working better.

Sir Chris Wormald: Yes, exactly. Measuring these things is not difficult. Knowing what the smoking rate is in an area, knowing what the smoking rate amongst pregnant women is in an area, knowing what the obesity rate is in an area or what the air quality is are not difficult things to measure, so we ought to be able to see whether those are things that drive future disparities.

As I say, they will play out over years and decades, not immediately, but we ought to be able to see whether those precursors, as it were, to the diseases that will show up in 10, 15 or 20 years' time are going down. You will not see a change in the health outcomes, but those underlying factors that drive health outcomes are quite easy to measure.

Q122 **Kate Green:** So we should be able to see and track the trends.

Sir Chris Wormald: Yes. The chief medical officer published an extensive report on this, if you would like to read it, at individual local authority level. Measuring the inputs is not a problem here. It plays out over a longer term.

Q123 **Kate Green:** In 2019, the Government published a consultation on prevention. It has not yet published the responses to that consultation. Will you do so and, if so, when?

Sir Chris Wormald: Ministers have not decided what they wish to publish in this area.

Q124 **Kate Green:** What is the hold-up? Responses were received in October 2019. We are now in November 2022. I appreciate that we have had a pandemic in the course of that timeframe, but the responses may be becoming quite out of date.

Sir Chris Wormald: There have been a whole series of actions on public health, a lot of them widely debated in terms of whether we have gone too far on obesity or not far enough, et cetera. The action has not stopped, but, as I say, Ministers have not decided.

Q125 **Kate Green:** As parliamentarians representing our constituents, how can we know that the responses to that consultation have informed the steps that you have taken? I absolutely appreciate what you say about actions having followed, but we are not able to see that audit trail, and you are saying that Ministers still have not decided whether they will even publish what was recommended in the consultation responses.

Sir Chris Wormald: It is a matter for you what you look at. I would say that what actions have been taken and whether they are working—

Kate Green: There might be better ones that are not being taken and we do not know what was suggested.

Q126 **Mr Francois:** With respect, we cannot look at it, because they have not published it.

Sir Chris Wormald: Yes, you can, because, as I say, we know what the obesity rate is and what the smoking rate is. We can see whether they are going up or down.

Chair: Mr Francois, just be clear in what you are asking, so that Sir Chris is clear.

Q127 **Mr Francois:** My colleague, Ms Green, was asking for you to publish something that you have had since 2019, if I heard her correctly, so where is it?

Sir Chris Wormald: As I say, Ministers have not decided what they wish to publish next on this issue.

Mr Francois: So it is more paralysis by analysis.

Chair: Also, this was a consultation, so it is not a policy document.

Q128 **Kate Green:** We are looking for responses to a consultation that had been received by October 2019, which you are saying Ministers have not yet decided to publish. I absolutely accept that we can go and look at improvements in obesity or smoking cessation or whatever it is, but what I do not know is whether, in the consultation responses, other perhaps even more effective measures were suggested, and so I do not know if you are carrying out the right actions or not.

Sir Chris Wormald: It is a fair challenge. I can only repeat where Ministers are on this subject. They have focused on what the actions are that you can do.

Q129 **Chair:** To be clear, the consultation is one thing. We understand that maybe Government Ministers have not made a policy decision on certain aspects of this, maybe for lots of reasons, but the consultation itself is not a document that is a policy document. It is just a consultation and responses.

Sir Chris Wormald: We are talking about the response to the consultation, which is a policy document.

Chair: Sorry, the Government response to the consultation.

Kate Green: I have not even seen the responses from the people who responded.

Sir Chris Wormald: I do not know off the top of my head what that is, but in terms of what they want to publish in terms of policy—

Q130 **Kate Green:** Normally, when you get a Government response, it would give you insight into the consultation responses. Because there is no Government response, we have no idea what the consultees said.

Sir Chris Wormald: But on the specific point, a response to a consultation is a policy decision, as you know.

Kate Green: It is a fine line.

Q131 **Mr Francois:** I am sorry, but this is sophistry. We are not asking you to publish the Trident codes. We are just asking you to publish the results of a consultation that ended three years ago.

Sir Chris Wormald: As was noted, quite a lot has happened that has—

Q132 **Kate Green:** It may be difficult to answer this, but I would be very interested in what you can say. What is the difficulty in publishing what consultees said? Is there something deeply concerning that is being covered up? If not, what is the reason?

Sir Chris Wormald: I have not looked at the specifics of what we have said about the consultation that has been received, and I will check.

Kate Green: Perhaps you could let me know what has and has not been—

Chair: We are going through a major discussion about the ICSs being created, the impacts of Covid, and all of the other health inequalities debates that were going on well before Covid, so it is not like the world has stood still while this has been going on. We could go down this rabbit hole at length. Let us get a letter back from you.

Q133 **Kate Green:** Yes, as much as you can tell us about what has been learned from that 2019 consultation process and what the Government have been able to demonstrate in terms of progress as a result.

Can I, just finally, go back to ask one question about the social care

workforce? I was very interested in what you were saying about the NHS workforce, but, of course, the crisis in the social care workforce is just as significant. The NAO points to vacancies being at 9.2% in the last financial year, and turnover rates are very high, in some areas approaching 40%. What are the ICSs able to do to address that, given that the social care budget and paying the social care workforce sits within the local authorities?

Sir Chris Wormald: I have already described what we are doing nationally and, as I say, just at this moment, the numbers are rising. What ICSs can do comes into the joint work between local government and the NHS, and the most specific thing is how the better care fund is used, that being the joint bit. What we would be expecting to see is the local authorities and the NHS in a particular area looking very specifically at what the biggest challenges are in the interface in that area—is it domiciliary care? Is it the availability of specialist dementia care? What is it?—and using their joint fund to meet those very specific challenges.

As I say, they cannot solve the wider questions about the NHS and local government, and how it works together, and they cannot change the quantum. What they can control is how that joint resource is used and where it is targeted.

Q134 **Kate Green:** There has been an investment of £500 million in the social care workforce. What difference should we expect our constituents to see in the social care workforce as a result of that expenditure?

Sir Chris Wormald: We ought to be publishing the next stage of what we are doing with this imminently. It is focused on discharge. That was what was announced, so we would be expecting local places to be investing that money in those measures that improve discharge from hospital into social care.

Q135 **Kate Green:** What would that mean for the workforce, Sir Chris? Would it mean employing more people?

Sir Chris Wormald: It will mean different things in different places. A lot of it will be workforce, and we would expect a lot of it to be in the domiciliary care part, but it would depend on what the blockage is in that place.

Q136 **Kate Green:** It could mean employing more people, changing terms and conditions, paying them more, or working with other Government Departments so that we can look at our access to international labour pools. What sort of tools could that money be used for?

Sir Chris Wormald: All of those things, based on what the best way is to remove blockages in that place. In the vast majority of cases, we will expect, because that is where the blockage is, that to be focused on workforce in domiciliary care.

Q137 **Kate Green:** Does that mean employing more people?

Sir Chris Wormald: Normally, yes, but not necessarily.

Kate Green: My constituents will be very reassured to hear that.

Matthew Style: Just to come back again to the Report, we are able to deploy those resources and set a clear expectation that local authority partners and NHS partners will work together to ensure that they are deployed with maximum effect in their health economy. That is the beauty of having integrated care boards and integrated care partnerships in place to do that.

Q138 **Chair:** They could be taking it from another area of great need, though, because that is also the challenge.

Sir Chris Wormald: Yes, which is, again, why place-based decision-making is the right thing to do.

Q139 **Chair:** Here comes the challenge. I am a great believer in devolution and local people making the right decisions and being involved with local politicians and so on. Mr Francois's point has, hopefully, landed with everyone in the room and, indeed, with all of us. You have that, and then you end up not giving them enough money, so you devolve to a city region like Manchester, or the West Midlands, or to an ICS, and there is not enough money coming from the centre, so the hard decisions are just forced upon the local area. We are paying for the social care, which is absolutely essential, but instead of perhaps providing some other essential local service. How do you make sure you get that balance and that you are not seeing another problem pop up?

Sir Chris Wormald: As I said right at the beginning, none of this affects the quantum. In terms of the NHS, those are national Government decisions taken in the way that you know, and I have described how they are taken in local government. None of this affects the quantum. This is all focused on, "Are we are spending well, whatever the quantum is?"

Q140 **Chair:** I could go through figure 8 and the risk to delivering integrated care boards' savings, because they are all making savings. There are still lots of financial elements that we have not even had time to cover today.

Sir Chris Wormald: As I say, I am very clear that this does not affect the quantum that is put into the system.

Q141 **Chair:** But going back to what Ms Blake said, we often talk here about the system at the top and about Whitehall, and we get that up to a point, but on the ground, whether it be in Rayleigh or in Sheffield, there are the real experiences of people, and a small cut at a local level can be a very big difference.

Sir Chris Wormald: That is completely understood.

Q142 **Chair:** Resolving social care is vital for the individuals concerned, vital for their families and vital for the NHS to free up beds. Those are critical things, but, if money is coming out of another very important local service, and perhaps that means not reducing obesity or smoking, that can have a long-term impact on inequalities.

Sir Chris Wormald: We appreciate all that. What we are saying—as I say, I am very clear on this point—is that, of whatever quantum is made available from the taxpayer, the decisions on what those trade-offs are that best serve patients are better taken at place level than at national level. Therefore, we have a structure to which the vast majority of NHS resources are devolved. It does not make the trade-offs any easier, but, if the system works—and, as the NAO says, it is very early days—they are better made at that level.

Q143 **Chair:** Those health inequalities on page 73 are going up. You could have decisions made locally that are rational on one level but that do not look at the 20-year projection on inequalities. How are you going to see that from your Whitehall seat?

Sir Chris Wormald: As I say, the drivers of health inequality are not difficult to measure in terms of inputs.

Q144 **Chair:** You can measure it, but what are you going to do to stop it?

Sir Chris Wormald: The formulas, both for local government and for the NHS, take account of the underlying health determinants and demography of the place. People will argue about whether those formulas are done right, so there is a distribution question. On the effect, we would make the same case. Who is more likely to know what is going to make a difference in your area? It is much more likely to be people in your area who understand how you get from Tower Hamlets to Redbridge than it is us sitting—

Chair: Or in Hackney, but nearby.

Sir Chris Wormald: Yes, that proves the point. They are more likely to understand that than somebody sitting in Whitehall or in the NHS. It does not make the trade-offs any easier, but it, hopefully, makes the decisions more relevant to local people.

Q145 **Chair:** You think that you have visibility across a dashboard, where you might see a sudden spike in inequality because a local area has made a decision that is perverse.

Sir Chris Wormald: Yes. I am not saying that it is simple.

Chair: I am just asking whether you will be able to see.

Sir Chris Wormald: Yes.

Q146 **Chair:** Lots of local authorities started investing in shopping centres, and Whitehall did not really have an overall picture of the risk to the sector of overinvestment in certain things. Will you have an overall picture of whether there is a pattern of behaviour that is dealing with one problem but just causing another problem to get worse?

Sir Chris Wormald: Yes, and there were two key national parts of that. One is the data, and we are not changing any of the national metrics here, so it will show up in what the national elements are, and our various intervention powers.

Q147 **Chair:** When you have the data, what are you going to do about it?

Sir Chris Wormald: The second, which Mr Style pointed to earlier, is a rather different role for the CQC, which allows it to look across place and at local authority commissioning, as well as the NHS. What we ought to get is a CQC view that can tell us what the impact is of all this, both in places and then nationally, and data that does the same. As I say, we have not changed any of our intervention powers, so the question will always be how we then intervene if it makes things better rather than not.

Chair: So you can see it. We will be questioning you over the coming months and years about that.

Q148 **Mr Francois:** Ms Pritchard, who is in charge of the NHS?

Amanda Pritchard: If you mean the NHS as an arm's length body, that is me. Do you mean who I am accountable to?

Q149 **Mr Francois:** No, I asked you who was in charge. That is you.

Amanda Pritchard: Yes.

Mr Francois: Not Ministers. Thank you.

Amanda Pritchard: The accountability arrangement is to Parliament and to Government, and that is why we work so closely.

Mr Francois: As they say in quiz shows, we will take your first answer. Thank you very much

Amanda Pritchard: Yes, but you also have to recognise where the accountability lies.

Mr Francois: If I may say so, you have just given the whole game away. Thank you very much.

Q150 **Chair:** Mr Francois, Ms Pritchard is here because she is the accounting officer responsible for the money and for the operation of the NHS on a day-to-day basis, but she obviously reports to Ministers through the Department of Health and Social Care.

Sir Chris Wormald: Just to state the obvious, the accountabilities are very clearly set out in legislation, and that is where they sit.

Chair: Yes, and managing public money and all of the rainbow of coloured books. We will leave it there on that question.

Can I thank you very much indeed for your time? The transcript of this session will be up on the website, uncorrected, in the next couple of days, and thanks to our colleagues at *Hansard* for their support. We will be producing a Report on the cusp of the year. Just like you, we cannot predict, so I have given the game away there. Thank you very much indeed for your time.