

Health and Social Care Committee

Oral evidence: Integrated Care Systems: autonomy and accountability, HC 587

Tuesday 8 November 2022

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[Watch the meeting](#)

Members present: Steve Brine (Chair); Lucy Allan; Mrs Paulette Hamilton; Rachael Maskell; James Morris; Taiwo Owatemi.

Questions 1 - 38

Witnesses

[I](#): Rob Webster CBE, Chief Executive, NHS West Yorkshire Integrated Care Board, and Chief Executive Lead, West Yorkshire Health and Care Partnership; right hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney, and Deputy Chair, Norfolk and Waveney Integrated Care Partnership; and Patricia Miller OBE, Chief Executive, NHS Dorset.

[II](#): Chris Hopson, Chief Strategy Officer, NHS England; Sir David Nicholson KCB OBE, Chair, Sandwell and West Birmingham NHS Trust and Dudley Group NHS Foundation Trust; Professor Sir Chris Ham, Co-Chair, NHS Assembly; and Councillor David Fothergill, Chair, Community Wellbeing Board, Local Government Association.

Examination of witnesses

Witnesses: Rob Webster CBE, right hon. Patricia Hewitt and Patricia Miller OBE.

Q1 Chair: This is the Health and Social Care Select Committee, with a new Chair and a new inquiry. We have a plethora of guests ready to give evidence to us today.

The inquiry is titled “Integrated Care Systems: autonomy and accountability”. It is an opportunity for us, as the new Health and Social Care Select Committee, to get a sense of how ICSs are working so far, what early autonomy and accountability challenges are developing, how the new structures are different from their predecessors and how existing NHS bodies and structures may need to adapt to work with them. Over the coming weeks, we will explore how the systems are balancing local and national and short and long-term priorities, and whether the structures that Parliament has put in place give ICSs enough space to pursue the aims that we have set for them in law.

We have two panels today. Our first panel consists of Rob Webster CBE, who is West Yorkshire Health and Care Partnership chief executive, the right hon. Patricia Hewitt from Norfolk and Waveney integrated care system, and Patricia Miller OBE from NHS Dorset. You are very welcome. Thank you for joining us.

On 1 July, through the Health and Care Act, Parliament put 42 ICSs on a statutory basis. Four months on, how goes the revolution? I suppose that is the opening gambit. Mr Webster, let’s start with you. Is your ICS, to quote NHS England, a partnership “of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in” West Yorkshire? Don’t just say yes.

Rob Webster: I will say yes and expand on the wider point.

Q2 Chair: Say yes and then expand. Thank you for joining us, Mr Webster. Go ahead.

Rob Webster: I genuinely believe that it is. In answering yes, I remind everybody that the ICS is a system that is overseen by a partnership board and has an integrated care board as an organisation within it. Our ICS has been working in partnership for the last six years. Since the creation of sustainability and transformation partnerships in 2016 and, subsequently, non-statutory ICSs, we have worked very closely to develop the sense of a West Yorkshire partnership, which meets in public, is governed by local politicians, local chief execs of councils, the NHS and third sector organisations and representatives of the community, and has very strong place arrangements—five good places that correspond to upper-tier local authorities that are thinking about how they spend their collective resources to improve outcomes for local people. That has continued following the change in the law.

Q3 Chair: How are your priorities coming together off the back of the STP? Have you ported your priorities from the STP? It was interesting to hear



HOUSE OF COMMONS

you mention STPs, because that lexicon has almost been forgotten. Remember them? Remember when they were the future once? Have your priorities come across from STPs, or have you spent the first four months redefining your priorities as a system?

Rob Webster: We continuously look at priorities and our strategy. In 2016, 2018 and 2020, we published updates on performance improvement and our strategic direction. There are hundreds of things that we are required to do as a system prior to the statutory changes. We boiled those down into 10 big ambitions for our integrated care system. They link to health inequalities, clinical priorities and societal and other priorities, such as our contribution to the economy.

The latest version of that strategy was published in March 2020, just before the pandemic struck. In the last few months, we have been making sure that our short term is focused on today and delivering services for folk, that our focus for the next period, over the winter, is clear and that our strategy for the future builds on that 2020 set of priorities. The 2020 priorities include things like reducing health inequalities faced by people with a learning disability and serious mental illness, making sure that we detect cancers early, making sure that antimicrobial resistance is tackled and ensuring that we have a leadership that reflects the population that we serve.

All of those issues have got harder because of the pandemic. For example, people have not come forward for their cancer treatment, and people with mental illness have faced greater deprivation because of the pandemic and so on. Our early thinking on the strategic medium-term priorities is that the 10 things we said we had to deal with will still have to be dealt with, but, in addition, we will have to do more on children, because of the impact of the pandemic on children, and on the workforce, because of the workforce challenges that we all face, exacerbated by the pandemic. We will have to address waiting. Prior to the pandemic, waiting was a challenge, but it has now become a problem.

Q4 **Chair:** Thanks for that. Patricia Hewitt, welcome back. I am sorry not to see any of you here in person, but I understand that there were challenges today with transport. You are the chair of the integrated care board in Norfolk and Waveney and the deputy chair of the integrated care partnership. By my reading, you are well placed to be the master of all you see. Is it working, or can it work?

Patricia Hewitt: I certainly do not see myself as the master of all I see. Thank you very much for inviting me to give evidence, and congratulations on your appointment as Chair.

Yes, it is working. Like Rob Webster's system, we embarked on this six years ago, as an STP and then a non-statutory integrated care system. We have been building really strong relationships between the NHS and local government and, crucially, with our voluntary and community sector.



HOUSE OF COMMONS

Every system is different. That is a point that we would probably all want to stress. It was enormously important in the early years of integrated care systems that we all had the opportunity to respond to the particular needs of our local residents and the differences in our history, relationships and structures. In Norfolk and Waveney, where we serve just over 1.1 million residents, it is crucial for us to wrestle with all the challenges of a very large rural and coastal geography. We have a two-tier local government system. Because of our boundaries, which are the whole of Norfolk but also part of Suffolk, we work with two county councils and eight different district councils. Except in Norwich, we have an elderly population. In North Norfolk, we have, in age terms, the oldest district council in England. Each ICS is unique and needs to have the space within the national policy framework to respond to those differences.

I will give you an example of how it is working and how we have built on what was happening before we became statutory bodies on 1 July. Pre-covid, one of our biggest challenges was the apparently inexorable increase in the number of people ringing 999 and then coming by ambulance, or sometimes on foot or by car themselves, to the emergency department. As a system, we agreed what we felt were really challenging, and possibly unachievable, targets to work with our 111 provider and re-engineer all of that, and to do a whole bunch of things to reduce that—in the jargon—front-door problem. If you compare the last three months before covid with the equivalent period most recently, we have significantly beaten the targets that we set ourselves as a system. We did that by working together.

What we are now doing is working together, in a way that I think would not have been possible before 1 July, to tackle—in the jargon again—the back-door problem: the huge difficulty of patients trapped in our acute or sometimes even our community hospitals, who, medically, do not need to be there and are actually becoming worse and frailer from being stuck in hospital, but who, for all kinds of reasons, are really difficult to discharge from hospital. Because of the new statutory framework, we have been able to get agreement from all NHS providers and the county councils that our new director of nursing will lead for the entire system on discharges, with the full backing and authority of all the chief executives and senior local government officers. That is a big breakthrough, and we badly need it, given all the challenges that we are facing today and with the winter to come.

Q5 Chair: That is great. Patricia Miller, you head NHS Dorset. Can we have the early report from you, just in a few minutes, on how you think it is shaking down?

Patricia Miller: We are in a slightly different position from Rob because we have been operating for six years, since the STPs were developed. It was slightly easier for us to develop an STP because we had just concluded quite a big exercise—a health and care review across Dorset—



HOUSE OF COMMONS

and had had the public consultation document and the business case approved by the national investment committee. Putting together the priorities for that was relatively simple because we had just done the work.

We have not ported the entirety of that into the new strategy because that work was done five years ago and things have changed. Communities and their needs have changed. We have established the integrated care partnership. We have the NHS, local authorities, the third sector, the police and fire on that partnership, and there is a real sense of mutual accountability. We have two places, which predominantly serve an urban and a rural community. We have significant levels of deprivation and challenges around a third of our population being over 65 but, more worryingly, the working-age population exiting Dorset. If we do not do something radically different in the next 20 years, we will have literally one to one for over-85s and those of working age, which means that we cannot look after the population.

We have a slightly different set of priorities going forward. We have ported some of the reorganisation of health from the clinical services review, but we have just entered into a real community dialogue to develop a citizenship model to understand the needs of our community. You will not be surprised that a lot of the insights that have come forward are more about non-NHS services that support people to stay well. There will be a really strong focus in our strategy on health and wellbeing and non-statutory services that support people, and are their first port of call when they are unwell from either a physical or a mental perspective. In the medium to long term, a huge part of the strategy that gets submitted in December will end up being about delivering on NHS operational standards and moving the clinical services review forward, but there will be a strong focus on health inequalities and what the wider partnership can do for social and economic development.

There are things that we have done really well since July that would not necessarily have been possible before. Recognising just how tricky winter is going to be, and that the age of our population and the complexity of long-term conditions mean that care needs and, therefore, the costs of care are increasing significantly, we have just developed, together with local government and the third sector, a completely different model for delivering social care and intermediate care. That should mean that we intervene much earlier and keep people healthier for longer, which will in turn take the pressure off our care systems, which are struggling not only in terms of financial resource but in terms of workforce. We hope to move forward with that new model from April.

Chair: That's great. A perfect scene setter from all three of you. I will bring in Lucy.

Q6 Lucy Allan: Good morning to the panel. As we have already heard from you this morning, an ICS may cover an area with varying degrees of



HOUSE OF COMMONS

inequality and varying degrees of need. How do you focus on local priorities? To whom are you accountable for delivering on those local priorities? Can I start with you, Patricia Miller?

Patricia Miller: First, I think we have three layers of accountability. We are accountable to each other as partners, because there is a sense of mutual accountability around the table and we have a shared purpose and values that define that. Yes, we are accountable to NHS England, as the regulator, but we are also accountable to the communities that we are here to serve. That is a really important principle that sits underneath our integrated care strategy, in that the wider partnership is quite clear that many of our decisions around local priorities have to be community driven.

What was the first part of your question, please?

Q7 **Lucy Allan:** It was about focus on local priorities. You mentioned that you believe that you are accountable to local communities. I fully endorse that, but how do you make sure that you are focusing on their priorities and needs?

Patricia Miller: The work that we have done on engaging the community and determining a huge part of the strategy going forward is the first stage of that. We have done that by replicating much of the Wigan Deal—training huge numbers of our staff to go into our community, embed themselves in the community, interview members of our community, from all walks of life, in their own homes, and spend time with them to understand their needs. That is where we will start to build up the strategy organically, which is where we are now.

There is also a challenge for us, if I am honest, in dealing with the here and now, which is where the NHS needs us to focus, as well as creating headroom around local priorities. We have thought carefully about that and how we split our leadership and manpower resource to be able to do it. For example, in our transformation service we have a team that is dealing with the here and now and another part of a team that deals with the medium to long term. A lot of that is around transformation for local priorities.

In the health inequalities agenda that has been agreed through Bola Owolabi, our national director, a huge capacity is focused on local priorities. We have something called Core20PLUS5, which many of you will be familiar with. The point of the PLUS5 is that it enables us to go much deeper into five of our local priorities around health inequalities and wider social and economic development and focus some of our work locally within the five areas that are agreed with our health and wellbeing boards and our communities.

Q8 **Lucy Allan:** Rob, can I bring you in on that? How do you make sure that you are focused on local priorities and are not distracted by national priorities that sometimes get in the way of delivering to the communities



that you serve?

Rob Webster: Thank you for the question. The first thing I want to remind everybody of is that there is a statutory requirement for health and wellbeing boards in places to do a joint strategic needs assessment, which says, "Look, the evidence suggests that we've got some stuff that we have to sort out." Those health and wellbeing boards must have a strategy in place to focus on health and wellbeing and the wider determinants. For us in West Yorkshire, that is the bedrock of our West Yorkshire strategy. Local needs determine what the strategic work is, and things get done in places unless they have to be done at West Yorkshire level.

There are three tests for whether something gets done at West Yorkshire level. It is a matter of scale. You only want double hand transplants to be done at Leeds teaching hospitals—you do not want them anywhere else—so let us organise them at that scale. It is a matter of good practice that everybody should share. Bradford Healthy Hearts is reducing coronary heart disease and heart failure. Let's do it everywhere: West Yorkshire Healthy Hearts. If there is a wicked issue that we need to resolve and we cannot work it out, we will have to work it out together. That means that it is really driven by local places—

Q9 **Lucy Allan:** Sorry to interrupt you. Finally, is an ICS too big a structure—too regional—to be able to focus at a more granular local level?

Rob Webster: No, because we have a principle of subsidiarity that drives everything we do. It is enshrined in our constitution. Things get done mostly by people themselves. They get done in their homes. If they cannot be done there, primary care networks and neighbourhoods are the unit that you want to use. If they cannot be done there, it is place. If it cannot be done at place, it is West Yorkshire.

There are two final things that I will say briefly on this. We have a compendium of all the evidence and all the conversations that we have ever had with people, which we publish every year and which helps to drive our reflections on what we are doing. All the meetings that we have—of the partnership board, the ICB, the quality committee, the performance committee and the place committees—take place in public so that we can be scrutinised by those people.

Chair: Paulette Hamilton wants to come in.

Q10 **Mrs Hamilton:** Hello, Rob. I know you from a previous life. Like the other two chief execs, you talked about the three challenges that you see in Yorkshire, around waiting time, workforce and children. Does the system have the freedom, the capacity and the capability to pursue and deliver on those issues at local level?

Rob Webster: I am happy to answer that question. The three are in addition to the 10. There are lots of other things that we need to do as well. It is good to see you again, by the way.



HOUSE OF COMMONS

This capacity and capability question is a big one for everybody. We can and will have the capacity and capability if we change the way we work. Most things are delivered by providers of care: individuals themselves, informal carers, care homes, domiciliary care providers, trusts and so on. We need to make sure that they feel supported in that delivery and are working together. That means that the way former CCG staff—now ICB staff—and council staff work with them has to change so that we are all working in pursuit of outcomes and improvement for local people. That will take a bit of development and a bit of growth, but our experience of children's waiting times for ASD in Wakefield, for example, is that when you put the commissioning staff alongside the provider staff across councils, the third sector and the NHS, improvements are made. They have gone from being inadequate to being good with outstanding leadership because of that.

We will only be able to do that if we have the space to do it. One of the things that I am sure will be a consistent theme for the Committee through its deliberations will be that a lot of people at local level who are paid significant sums and have a lot of experience need to come together to drive the delivery locally. If we go for a top-down performance management approach on national targets only, that will get in the way of people working collaboratively. We need to make sure that people have the capacity and capability to change the way they work and to deliver on a number of local outcomes and a small number of national ones. If we do not have those things, we will not have the capacity and capability to deliver everything.

Chair: Paulette, sorry. This is totally my mistake. You wanted to put an interest from your previous life on the record.

Mrs Hamilton: I do some work for the King's Fund independently around training. I am also a vice-president of the LGA. I wanted to put that on the record.

Q11 **Chair:** It is on the record. Patricia Hewitt wants to come in on your question.

Mrs Hamilton: Hello, Patricia.

Patricia Hewitt: Paulette, it is very good to meet you, particularly because I was a very old friend of your predecessor, the wonderful Jack Dromey.

I want to supplement the points that Rob Webster was just making. First, I think that sometimes we talk as if national and local priorities are completely different. Particularly in relation to the NHS, they are often identical. Our residents are increasingly unhappy about the difficulty of getting access to a GP, even though our GPs and their wider primary care staff are seeing far more people than they were before covid. The demand has gone up even faster. It is similar with ambulance queues or the shocking waiting lists for elective operations. Those are all things that



HOUSE OF COMMONS

are of very immediate concern to local residents. We hear those directly, from local councillors and from local Members of Parliament. They are shared priorities.

Of course, we also have our local health and wellbeing partnerships, which are led by our district councils. They are looking both at particular needs in their own local communities—particular health inequalities and particular priorities—and what local social and community assets they can build on. It is very noticeable, and very welcome, that all of our partnerships say that for them and their communities mental health is a critical priority.

We must have the freedom to work on those wider issues and local priorities. We know that only about 20% of our own health and wellbeing as individuals is the result of NHS treatment, even though that is vital. The rest of it is all of those much wider issues, where we can only make a difference if we work in the very different ways that people are describing. That absolutely means NHS England and the Department of Health doing—as I think the new operating framework suggests—much less of the micromanagement and multiple target setting. If you have 106 priorities, none of them is a priority. If you have three, you can really focus on them and have space to respond to local priorities, where those are different.

Chair: Thank you very much. All of those priorities are great, but they have to be accountable to somebody. We will move on to talk about that with Taiwo Owatemi.

Q12 Taiwo Owatemi: Good morning. It is a pleasure to meet you all. I am particularly interested in how the balance between autonomy and accountability within the new NHS structure will be assessed. It is a question to all three members of the panel, but I will start with Patricia Hewitt.

Patricia Hewitt: For quite some time, we have been wrestling with the inevitable tension between the national, or vertical, accountability and the horizontal accountability that Patricia Miller was describing. Key to that is being held accountable for outcomes, rather than micromanaged on an enormous series of inputs, detailed action plans and lists that say, “Have you done this? Have you done that?” We should focus on outcomes. For instance, over a longer period, are people themselves reporting that they are getting better treatment and care and feeling better? In the shorter term, are you reducing the ambulance queues, only seeing at the acute hospitals the people whom you need to see and ensuring that they stay there only for as long as they medically need to? There is a very limited set of data points that let you know whether you are achieving those outcomes.

Hold us—in this case, the “us” being the integrated care board, which is the NHS part of the wider partnership—accountable from the centre for outcomes. Don’t micromanage every little bit. If you do that and try to



HOUSE OF COMMONS

impose one size fits all, you will destroy the unique opportunity of statutory ICSs, which is to say, "Hang on. If we do things differently here, we can crack this problem." We need greater freedom and accountability nationally for a limited set of outcomes. That autonomy and local freedom to solve problems is how you achieve the national priorities as well. Micromanagement will not achieve them.

Q13 **Taiwo Owatemi:** Patricia Miller, do you agree with that?

Patricia Miller: Yes, I do. I think that NHS England is trying very hard to get that balance right in the new operating framework. It requires a big change for them as well in how they operate, not just from a transactional perspective, but culturally. If ICSs are to deliver what they need to deliver—for me, the real prize is the much broader relationship with local government, the third sector and communities, to really improve the health and wellbeing of communities and drive down health inequalities—we need to be able to be agile. We need to find local solutions. As Patricia said, that means being tasked with delivering outcomes without the detail about the how. The how is what we need to design with local people. Then we can focus on the things that we need to that will add value to people's lives.

Q14 **Taiwo Owatemi:** Rob, what support would you like to see from Government and the NHS to help achieve that autonomy and those outcomes?

Rob Webster: First, I agree with Patricia and Patricia on a small number of national outcomes supplemented by local outcomes for which we can be held to account. That is entirely consistent with the Government White Paper on integration. The new NHS England operating model is good. It says that we will have a system by default approach and we will allow systems to collaborate together in pursuit of the things that they are required to deliver through the mandate.

From central Government we need a clear mandate. We need to ensure that there is cross-government working on things that will make a difference. As Patricia Hewitt said, 80% of our own health and wellbeing is nothing to do with the NHS. It is to do with housing, education, employment, the environment and having somewhere to live, someone to love and something to do. That is critically important. That is why the partnerships at local level of councils and the NHS, third sector and communities, are so powerful.

Working across Government on issues like education, levelling up and housing, to give councils and ourselves a chance to ensure that we are delivering for the public, would be good, and then having a good, strong mandate for the NHS that is agreed and set. Alongside the micromanagement, I think we often get lots of requests for information at short notice over and above what we have already agreed to do or we are tasked with doing additional things that were not in the original mandate. Some discipline around that would be good.



Finally, it is just recognising that this is a novel construct. We have not had this kind of partnership working before. We should not try to impose old thinking about strategic health authorities or their predecessors on what is a new model. Obviously, I can talk about social care, funding for councils and all sorts of other policy matters, but that might be outside the scope of what we are talking about today.

Q15 Taiwo Owatemi: As parliamentarians and the Government look into acknowledging the fact that this is a novel construct, what do you think we should be using to measure successes of ICSs? It would also be great to hear from Patricia Hewitt and Patricia Miller as to how you think we can specifically measure the success of your individual ICSs.

Rob Webster: If we go back to what it says in the statute, we are here to address inequalities. We are here to improve variations. There is variation that is warranted, but there is too much unwarranted variation. We are here to deliver value for money for the public and the biggest social impacts and economic return that we can.

The NHS Confederation recently found that, for every pound you spend on the health and care system, you get £4 back in the economy. I think you could hold us to account against a small number of indicators and outcomes for each of those areas. The Core20PLUS5 framework gives strong clinical evidence about what you should be doing in your system. Value for money around levels of efficiency and delivery of our financial targets is very easy to measure, and so on. We can quite quickly come to a small number of outcomes that we would want all systems to be delivering. That requires a continuation of the good approach that NHS England and others have taken to co-producing that with the service and with the public.

I would like Patricia and Patricia to give you some examples of where we might go with some of that. I have some thoughts myself if you want to come back.

Taiwo Owatemi: Can we start with Patricia Hewitt?

Patricia Hewitt: I agree with everything that Rob said. Part of the challenge is recognising that this work on inequalities and wider determinants of health, by and large, takes time to show results. All health services and health systems in developed countries are moving in the direction of integration. Some of them have been doing it much longer than we have.

An issue like obesity, which is the product of many wider social factors, including poverty and inequality, is driving an epidemic of very urgent health problems, including of course diabetes but also many of the cancers, heart disease and so on and so forth. Finding ways of measuring over a longer period the impact on obesity and doing that with the partners we are working with, particularly in our most disadvantaged communities, is really important. Inevitably, there will also need to be



some shorter-term outcome measures, but they need to be consistent with the longer-term ones.

Earlier, I mentioned the whole issue of admissions to hospital and so on, looking not only at how quickly we discharge people from hospital but at how much difference we make by supporting people in the community through the voluntary sector, through peer group support as well as through primary healthcare, particularly on their mental health, which of course is very closely related to their physical health as well. We can start to measure the impact of that work, in particular simply through patient and individual reported outcomes.

We can look at that in our most disadvantaged communities. We can look, for instance, at groups of people who are the heaviest users of 999, or who arrive at emergency departments with mental health problems. We can look at the impact of that, but with a limited number of short-term, more intermediate measures that are consistent with the long-term measures. Many of us as systems have done a great deal of innovation with base-marked use of data to have measurable impact on population health management. We did it supporting vulnerable people through covid with something called covid PROTECT. We have now taken exactly the same approach to diabetes and we are having an enormous impact on the number of people at risk of diabetes who are getting the support they need, and indeed becoming part of expert patient programmes. The short term and the long term are being measured together.

Taiwo Owatemi: I want quickly to bring Patricia Miller in, and then hand back to you, Chair.

Patricia Miller: I agree wholeheartedly with the comments from my colleagues. When we look at the statute, there is a reasonably short number of things we can be measured on. For me, the really important one is outcomes, and it is around health inequalities. As well as the report from the confederation, we also know that pre-covid health inequalities cost the economy around £37 billion a year. If we look at the impact since covid, I have no doubt that that figure will be higher. There is a vested interest for us around economic growth as well in trying to tackle this, and supporting ICSs to do that.

The things I would ask for are making sure that Government policies on inequalities are aligned. As Patricia said, 80% of our health and wellbeing is dictated by wider determinants such as education, housing, the environment and employment. We need to make sure that those things are aligned to drive down health inequalities and encourage the NHS to play its part in that, and not just to focus on health issues. It is the biggest anchor institution in the UK, and we need to start to think more about the work we need to do with a wider partnership around the wider determinants, and what role we can play in the partnerships to tackle that.



HOUSE OF COMMONS

There is something around making sure that we get the best use out of the public pound and offer value for money to our communities. That is not just about health. It is about health and local government coming together, jointly commissioning solutions and making sure that they get the best value from every pound they spend because it delivers a significant return in health for the community.

My final point is where Patricia started. When we think about the small number of priorities, we need to be a bit braver and, rather than measuring activity, start to think about putting our capacity and capability into areas that are also going to reduce NHS spend. Currently, we use around 40% of the tax receipts. While health is an investment, I do not think we can carry on at that level because it means that we are not investing in other public services to the level we need.

There is something about us choosing things that will improve the overall health of our communities and will also drive down health spend. Obesity and type 2 diabetes are things that we need to focus on more consistently and more broadly across England.

Chair: We are going to move on in about 10 minutes, but before that Rachael Maskell has some questions.

Q16 **Rachael Maskell:** Thank you, Chair, and thank you, witnesses, for joining us. It is very good to see you. I want to ask a question about regulation. We all know that regulation often drives activity and focus. I have a simple question to start with, if I may, to Patricia Miller. Is there need for change in the regulatory framework?

Patricia Miller: In the new operating framework that NHS England produced, they have tried to make some of the changes that are necessary. The proof will be in how we now adopt that, going forward. It would be really helpful in the regulatory approach if we took more of an integrated approach with arm's length bodies. We are regulated by NHS England. We will be regulated at system level by the Care Quality Commission and a number of other organisations external to systems, and it would be really helpful if we started to think about a more joined-up, cohesive approach to that.

You can find yourself spending lots of time interacting with regulators on a regular basis when you really want to be getting on with the job. That is not to say that regulators are not important; they are an important part of the governance process. The external view about whether organisations and systems are doing what they should, providing the quality service that they should and getting best value for money is all-important, but there is a different way that we could do it which means that the approach is more integrated. It uses a lot more of the evidence already provided by external bodies, so the regulatory process becomes less burdensome.

Q17 **Rachael Maskell:** Thank you for that. Patricia Hewitt, I am thinking



about the outcomes framework and the role that has within the wider framework. What changes would you want to see to regulation?

Patricia Hewitt: I agree absolutely with everything that Patricia Miller said. We, and many systems, have been working with the CQC on developing their model of how they are going to inspect systems, not just individual providers. That is really important.

If I may, taking regulation in the widest sense, we need much less of what I have been calling micromanagement, and we need much more consistency in the long term. If you look at the £9 million of winter funding that we have been given as a system for this winter, we are glad to have it and glad to have it earlier in the year than it normally arrives, but it is a tiny proportion of our £2 billion NHS budget. It is hedged around with all kinds of rules and restrictions. The biggest problem is that it only lasts for six months. We are being asked, and told, to line up more beds and staff to deal with winter pressures. We talk to providers, but we have to tell them: "Everything you bring onstream on 1 October or 1 November, you will have to get rid of on 31 March." Not surprisingly, a lot of them do not want to do it. Some of them agree and then pull out. We find somebody else and then have to get approval for the somebody else from NHS England regional centre.

This is, frankly, nonsensical. What we could do is build some modular capacity that could be flexed as demand pressures come and go, although frankly winter pressures are now a 12-month phenomenon. Putting in a modular unit takes five months, so we cannot do it with money that only lasts for six months. Frankly, we need to get rid of that kind of regulation or micromanagement. That is an autonomy point. We need proper regulation focusing on the big outcomes and a limited number of intermediate and longer-term measurements.

Q18 **Rachael Maskell:** Rob, I want to ask a brief question about coterminosity. We have many providers, obviously, under the footprint of the ICS, but also some providers who are stretching themselves between different ICSs. Is it now time that we built greater coterminosity between the footprint in order to ensure that we get more focus on the delivery and outcomes?

Rob Webster: Before I answer the question, perhaps I could add something on the regulatory question. Providers now have a duty to collaborate, and regulators regulating providers on that will help across the country. I am not advocating foundation trusts here, but I believe we should be moving much more towards the approach in a foundation trust model where there was a regulator, and organisations were left to get on with it, with autonomy assumed. I think we need the kind of model that says ICBs get on with it and the regulator steps in only if there is failure. There should be much more sense of systems working together in collaboration to deliver outcomes and a licence to operate on that basis.



On coterminosity, I think this is one of those things where we would all love to tidy everything up, but life is not tidy, and things are not tidy. In a way, it does not matter that you have providers that span more than one ICB. A focus on structure will never, in itself, deliver improvements in service. You have to have good relationships, good governance, good rules, good incentives and good motivation.

I ran a trust that spanned two ICBs, and that was perfectly okay. We were able to manage across both and the slightly different needs of the different communities. We should resist the temptation to tidy up. Craven is part of West Yorkshire for administrative purposes, but if you ever said that to anyone who lives there you might not get out alive. It is important that we recognise some of that.

Chair: Thank you; that is very clear. Finally, on this panel, James Morris.

Q19 **James Morris:** A quickfire round from me. Mr Webster, you said that ICSs were a novel construct, which is an interesting use of words. There has been a history of the NHS having novel constructs and then disposing of them quite quickly when they do not appear to be operating well. For each of the witnesses, what is the one thing that would need to happen to stop the novel construct being just another novel construct that the NHS does away with?

Patricia Hewitt: A moratorium on NHS reorganisations—and I say that as a former Health Secretary who did one. This is a unique opportunity, as I hope we have all said, to work differently and get very different and better results for our residents, for the people you and we serve. Just don't change it. Please, no more huge reorganisations. We do not need another legislative change on this one.

James Morris: Mr Webster?

Rob Webster: I would come back to policy coherence and process discipline. This is a construct within a system. Everything in the system is changing. We have talked about: NHS England changing; its operating model changing; the Care Quality Commission changing; and the role of the DHSC and others changing. We need to be able to describe that and come back to the fundamental reason that we are doing this, which is that most people in hospital have, on average, three things wrong with them. The majority of people who come in more often have five or six things wrong with them.

We are trying to find ways to look after the mental, physical and social needs of people. That requires councils, the NHS, communities and the third sector to work together. We need to recognise that this is not an NHS construct. It is a partnership in places, planning for the medium term to meet those mental, physical and social needs. We need policy coherence to back that, and we need process discipline to deliver it.

James Morris: Patricia Miller?



Patricia Miller: I agree with much of what Rob said. The thing I would add is that this is going to take some time to start to bed in and work. Quite often, when we move to restructuring the NHS, we do not leave the system as it is for long enough to prove that it can deliver. We need to give this some time, because it will take time to develop the partnership. It will take time to start to see delivery of outcomes, particularly in health inequalities. It is not going to happen overnight. It is about collecting the evidence and being clear that it is not working, if it isn't, before we start to move to something different.

Q20 **Chair:** You have all given a very positive write-up of integrated care systems this morning, perhaps unsurprisingly. Finally, Patricia Hewitt, as a former Secretary of State, do you find yourself at moments thinking, "I wish I had done this when I was the Health Secretary"?

Patricia Hewitt: I look back on that time, Chair, and one of the things I am proudest of is a really important piece of public engagement we kicked off called "Our health, our care, our say". What the public were telling us was that they wanted exactly what this is. They wanted much more support to be as well, healthy and happy as they could be, and they wanted their care close to home wherever that was possible.

I remember Simon Stevens saying, when he was promoting integrated care systems, that actually "Our health, our care, our say" foreshadowed them. I think this is exactly the right policy framework. Yes, if we had done it earlier that would have been wonderful, but it is great that we are doing it now.

Chair: Very good. Very diplomatic. Thank you very much, Patricia Hewitt, Patricia Miller and Rob Webster for giving evidence. We will take a two-minute break while we change panels.

Examination of witnesses

Witnesses: Chris Hopson, Sir David Nicholson, Professor Sir Chris Ham and Councillor David Fothergill.

Q21 **Chair:** This is the Health and Social Care Select Committee and the second panel of our first session looking at integrated care systems, their autonomy and their accountability. We have had a very interesting first panel, which I know you have been listening to, including the former Secretary of State, Patricia Hewitt.

Our second panel consists of: Chris Hopson, chief strategy officer at NHS England; Sir David Nicholson from the Sandwell and Birmingham NHS Trust and the Dudley Group NHS Foundation Trust—Sir David is a former chief executive of the NHS; Professor Sir Chris Ham from NHS Assembly—welcome to you—and Councillor David Fothergill from the Local Government Association, chair of the community wellbeing board. Thank you very much, everybody, for joining us. We appreciate your time.



HOUSE OF COMMONS

I would like to start with you, Chris Hopson. We have heard about STPs today. I mentioned primary care trusts and CCGs earlier. How are the integrated care systems different? What three things?

Chris Hopson: Chair, I start by echoing Patricia Hewitt's congratulations on your election as Chair of the Committee. Obviously, all of us at NHS England look forward very much to working with both you and the Committee in the way we have always done.

The answer to the question is that they are different, in that they bring together on a statutory basis a partnership between the NHS and local government but also, as you heard from the first panel, between voluntary and community sector organisations. That is different in that it is on a statutory basis. As the two Patricias and Rob already outlined very clearly, it enables local systems to do things in a different way that they were not able to do before; you have a formal partnership that now exists between the organisations. That is the difference in terms of what ICSs bring that previous structures do not.

Q22 **Chair:** What is the biggest challenge?

Chris Hopson: Again, I thought the first panel set it out very well. It is the combination of the fact that the service, and the health and care sector more widely, is currently under a significant degree of pressure. I thought, again, that what was being outlined were some innovative solutions that bringing together the health and care sector on a formal basis allow us to do. Patricia was talking, for example, about looking at how we address the issue of between 10,000 and 13,000 medically fit patients who are ready to be discharged from district general hospitals but where we are struggling to do that. We are working very closely with our colleagues in social care.

It is the opportunity to address those immediate operational pressures but, at the same time, look longer term at improving health outcomes, address health inequalities and ensure that we actually prevent illness and encourage health and wellbeing as opposed to just treating illness.

Q23 **Chair:** Thank you. I remember sitting on the Bill Committee for the Health and Social Care Act, as it was back in 2012. Sir David Nicholson, you very famously said that the reorganisation of the NHS then was so big you could see it from space.

Looking at the ICSs, has all of the disruption that we had in creating the Lansley reforms—call them that—logically led to the ICSs that we have today? That seemed to be the message we were getting from Patricia Hewitt, certainly, in her evidence. Have they logically led to where we are today, and are you very comfortable with that?

Sir David Nicholson: To explain myself on that, one of the issues for me was that I do not think many people really understood the scale and nature of the change that was going on in structural terms. It is important to bring that to people's attention.



HOUSE OF COMMONS

Generally, part of the issue in the NHS is that we can be quite parochial. We sort of think that we are the only health system in the world that functions, and we do not necessarily look outside ourselves for how things might improve. Virtually every developed country in the world is currently going through some kind of process around integration. It is happening all over, and it is happening because the old way, the idea that competition would drive efficiency and quality of outcomes, simply has not delivered. The increasing evidence around how you bring people, organisations and services together to improve outcomes is the way to do it. It seems to me that that very strong impetus is driving it. This is not the kind of dreamt-up idea of a politician or an NHS manager in a place over here. It is actually coming out of reality. The difference with this is that it has grown out of people's experience.

Although I am a trust chair now, I was chair of an integrated care system some time ago. You could see how we were building, bit by bit, a much better way of working together—the integrated care system. The idea of mutual accountability and thinking about how we were going to deliver outcomes by working together has been a very powerful thing. It has taken many years to get us to the place where we are now.

To give you an example, I am in the Black Country, which is a fantastic part of the world, by the way. There are some very strong places within it—Dudley, Wolverhampton, Walsall and Sandwell—that have a very strong identity. They have a history in health terms of being quite competitive in the way that they function. We have broken most of that down over the last few years and things are much better. Building this reorganisation, if you want to describe it in that way, on the basis of that hard work gives it a really good possibility of success.

I know we will explore this issue, if I know anything about Chris Ham. The issue we have is creating that environment. It is the culture of the system that will drive whether it is successful or not, not the way in which the mechanics work.

Q24 Chair: Thank you. Professor Ham, many viewers will know you from running the King's Fund. You have done a lot of speaking. I remember you giving evidence to the early part of the Bill Committee on the Health Bill back in 2012. I have the same question to you as I put to Sir David Nicholson around the logical consequence of ICSs. Was the system always leading us to this?

Professor Sir Chris Ham: I think it has been since, if I may say, Simon Stevens picked up the baton from Sir David as chief executive of the NHS. He published his vision in the NHS "Five Year Forward View" back in 2014. What we are talking about today had its genesis in that vision and a belief that we would get more benefit by people working together rather than going down the route of competition, which was at the heart of the Lansley reforms and the 2012 Act.



HOUSE OF COMMONS

What has been important is that that vision has not just come from the centre. It has been moulded and shaped by people at local level who have been given permission, very unusually in the history of the NHS. It is not a blueprint laid down by clever people at the centre of NHS England. It has emerged by Patricia Miller, Rob Webster, Patricia Hewitt and many others, including Sir David himself, figuring out what it means to be a collaborative integrated care system, which is what we have now today in 42 areas of the country. It is very different from the Lansley vision. It is very much part of what Simon has been doing, but very much shaped too by the NHS itself and all the better because of that.

Q25 Chair: Do you talk to people now that you knew in your King's Fund days—maybe they are still there—who say, "Do you remember when I said 10 years ago that this is what we should do?"

Professor Sir Chris Ham: Absolutely. I was one of those people at the time—

Chair: I know.

Professor Sir Chris Ham: —so you would expect me very much to welcome what we are talking about. I think you have heard some great examples so far this morning from people at the heart of all of this as to their vision around partnership working and working outside the NHS to help people keep healthy and drawing on all the assets in local government and the voluntary sector. That is real. I see it happening myself in the areas that I am still in contact with.

Let's be realistic about two things, if I may, Chair. One is the timescale for realising the potential benefits. In its recent report, which I commend to the Committee as a really good analysis of the current state of play, the NAO said it is going to take between three and maybe 10 years to see the benefits of true integration occurring right across England. I think that is a fair assessment.

The second thing is that ICSs, as statutory bodies, have been born in conditions of huge adversity. The financial challenges are unprecedented. The shortage of staff is a massive constraint on what ICSs are trying to do. Neither of those is insuperable, but you might say that ICSs have been established not as going concerns because of the underlying deficits they inherited and are taking forward.

I do not want to pour cold water on a positive discussion, but I need to be realistic myself in assessing their chances of success. I think that is what the NAO was saying in its recent report.

Q26 Chair: I have read it. There was lots of discussion at the Public Accounts Committee last week about it, with the permanent secretary and Amanda Pritchard, among others. Realism is good. We are not just all here to sing the praises; we are here to scrutinise. When you talk about 10 years, I can hear my constituents and the constituents of my colleagues here thinking, "How long?" What would be the measure of success of this



HOUSE OF COMMONS

brave new world? Would it be a reduction in demand on the service because they had truly dealt with diabetes prevention, being aware that that is a key challenge, for instance?

Professor Sir Chris Ham: I think there are two types of measures of success. One is the outcomes that we are all seeking to achieve, such as better health and reduced health inequalities across the country, which can only be delivered in partnership. That is why the timeframe has to be longer. If we are serious about those being at the heart of what ICSs are doing, it is not going to be weeks and months; it is going to be, frankly, a number of years because of the nature of the work involved.

Secondly, more short term, we are trying to bring about differences in behaviour and ways of working—culture, if you like—within the NHS, based much more on collaboration, mutual respect and trust. We saw that happening during the pandemic. It is a really important point. Because there was a common enemy—covid-19—it galvanised NHS organisations to come together and to use their resources collectively, for example, around what happened in intensive care. If we can do it in wartime, we need to do it in peacetime. We need to find a way of continuing that spirit of collaboration and commitment to partnership working on all the other challenges we are faced with. That would be a great sign of success for me as well, much more short term than the health outcomes.

Q27 **Chair:** I am going to bring in Rachael Maskell in just a second, but I want to open this up. Councillor Fothergill from the LGA, thank you for being here. How would you describe the response from local authorities? We talk about this being created in wartime. Local government thinks it is constantly in wartime, not least with its current financial challenge, and there is a lot of evidence to back that up. How do you feel local government has responded to the creation of ICSs?

Councillor Fothergill: On the point about wartime, local government played a full role during the covid pandemic. We worked very closely alongside the voluntary sector and the NHS, and actually delivered a lot of good solutions to people. That demonstrated just how well the system works when we work together.

As the Local Government Association, we welcome the ICS implementation. We have always welcomed it. There are a number of key aspects that we think need to be delivered. We do not want to see things being reinvented. We have quite a lot of good partnership working in a lot of areas already, particularly through the health and wellbeing boards, which I do not think have been mentioned so far today. They are absolutely fundamental to us. We must not lose the good work that is being done there.

Secondly, we, as local authorities, see it as a way to influence and to bring a different style to it. Thirdly, the important thing is that local government controls many of the other 80% of determinants of health



HOUSE OF COMMONS

that we talk about; 20% are within the NHS, and the other 80% tend to fall under local government, be it housing, leisure, public health or all sorts of things. We tend to control in those areas.

For us, the ICS is a really good opportunity. There are some shortcomings, which I am sure we will come to later in your questioning, but it provides a wonderful opportunity. We have to recognise that this is not a restructuring of the NHS. We must recognise that it is about changing the system in total: to change the system we have to be equal partners between local government, the NHS and the voluntary sector. We all have to make those changes and we all have to commit to them. If it becomes one-sided, it will not work.

- Q28 **Rachael Maskell:** I want to focus on priorities. If I may, I will start with you, Councillor Fothergill, leading on from that question. Obviously, if we are going to be pivoting to the future and focusing there, we need to see the injection of resourcing now into local government to bring about the changes that we all aspire to. However, the NHS is under considerable pressure at the moment and will be making serious demands on the budget. Local authorities are struggling financially. How do we make that change to ensure that we have a preventive first priority for the new system?

Councillor Fothergill: I think we have a wonderful opportunity. As the saying goes, you would not want to start where we are, though, in terms of finance. I can give the information in terms of how much we need to put in the social care system to make it much more effective.

The change to ICSs brings about a working together and a recognition of local priorities. We very much welcomed the flexibility and almost the ambiguity that is built into the system and the fact that local people and local leaders can lead. I think that is really effective, so that we can determine where budgets are going to be placed and where the priorities will be.

The big ask is: please do not make it too central. Do not make it too control-oriented. If you do that, you will kill the local place-led initiatives that are fundamental for improving the prevention agenda, which is really where we need to get to. That is what has to be delivered.

- Q29 **Rachael Maskell:** Thank you. Chris Hopson, focusing on the centre and how we ensure that there is delivery of this wider agenda, where will the NHS release its grip on power in order to enable ICSs to really deliver for local communities?

Chris Hopson: We have been very clear in the operating framework that we issued recently that we recognise that NHS England needs to change how it leads the NHS on giving ICSs and local leaders the space to lead. I think David described it very well as, effectively, a partnership between us. The ICP element enables health, the NHS, local government and the voluntary and community sectors to come together and, based on local



needs, create a long-term strategy for exactly how you get the balance of, on the one hand, ensuring that you are delivering high-quality care, day in, day out, but at the same time a more preventive upstream approach that aims to help and ensure that we are not just treating illness but promoting health and wellbeing. There is now a statutory structure in place that enables that to happen.

The bit we need to be clear about though—I am sure that David would say the same thing—is that the underlying statutory responsibilities of local government and the NHS have not changed. You are held accountable, David, as a local councillor, as is your council, for the delivery of services to the NHS, which allocates £113 billion to ICSs every year. It is also held to account by you in Parliament. As you were saying, Chair, our chief executive was being held to account at the Public Accounts Committee last week, for the delivery of outcomes against that £113 billion local spend. That is the bit where we need to get the balance right between recognising that we have accountabilities that we need to account for, and that we set out clear priorities in the NHS planning guidance, and then there is the opportunity at local level to develop local plans and a longer-term strategy from the ICP, but the ICB element then develops a local plan that sets out how those priorities are going to be delivered, taking account of local needs.

I think, exactly as David was saying, that there is an opportunity in this new structure to get the combination of delivery of outcomes for a national health service but also health and local government working together in the long-term sense of a strategy that absolutely is about promoting health and wellbeing and more prevention.

Q30 Rachael Maskell: Finally, Chris Ham, may I turn to your work on this already? I was quite struck by your report where delivery people on the frontline said they believed that only 31% can deliver this kind of new agenda. Bearing in mind the consistent reports that we have seen—for instance, Michael Marmot’s report—focusing on the need to see this change, how are we going to deliver that wider piece to ensure that we address the issues around the environment, housing, employment and education to bring about the health changes that are needed?

Professor Sir Chris Ham: It is through the integrated care partnerships within the integrated care systems. Echoing what has already been said, my personal experience—I chaired the Coventry and Warwickshire integrated care system until the end of last year—is that we particularly benefited from strong relationships with the county council and from the city council in Coventry. The health and wellbeing boards, which David Fothergill mentioned a few moments ago, were vital in those arrangements. That is where a lot of the work around tackling health inequalities and improving the broader health and wellbeing of the population happened.

Through the integrated care system, we simply—if I can put it like that—built on the good work of the health and wellbeing boards on their local



health strategies. That was at the heart of what we were trying to do as an integrated care system. We do not need to reinvent some of the mechanisms where we already have well-functioning partnerships of that kind, and they are already beginning to make a difference around population health and wellbeing. That gives you a head start in what is now happening in every system, which is developing their strategies for the next five years.

Q31 Taiwo Owatemi: My questions are around accountability. Good afternoon, everyone. It is a pleasure to meet you.

Starting with Sir David, earlier you said that the culture of the system will determine success. How do you think the culture has changed since your time as chief executive of an NHS trust, particularly looking at health systems?

Sir David Nicholson: Well, obviously for the better, I would say. If you think about many of the things that we have said today, it will depend on the actions and work of individual providers. We are still the people who deliver healthcare, generally speaking, to people. You can see the difference that has been made through the development of the ICS.

Take, for example, the Black Country. There has been significant competition for both staff and services between the acute organisations. Under the auspices of the ICS, we have developed a provider collaborative which is now bringing clinicians together from all the various organisations across the Black Country, both to learn from each other about what best practice is and to think about how we can mutually support each other. That would never have happened 10 years ago. I don't think it would have happened five years ago, to be honest. That has a big impact and big potential for the population as a whole.

We are increasingly thinking about common approaches to the way we employ people. There has been competition for staff, with different organisations offering inducements for staff to move from one place to another. In fact, in the Black Country, we turn over about 10% of our staff a year. Most of them are moving to other places in the Black Country. Some of them have absolutely perfect reasons, but others do not. Increasingly now, we have a common set of approaches to the way in which we employ our staff. They are things that would never have happened before.

In the Sandwell and West Birmingham trust, we have adopted wholesale the idea of population health, how we can make a contribution to all of that and how we can develop economic growth with local government and employers. You can palpably see those things in providers going forward. I think that is a great opportunity.

Our anxiety as providers is that the ICSs get turned into a performance management system. Patricia Hewitt talked about micromanagement. We are concerned that they will essentially be treated by the NHS as another



layer. I agree that the operating framework is a really helpful step forward in all of this. It makes it much clearer, but the issue for me is whether the culture of the organisation and the culture of the way we do things will trump that as we go forward.

- Q32 **Taiwo Owatemi:** Thank you. In the interests of time, I am going to move on to Professor Ham. You spoke about the roles of NHS regional boards. What role do you think they can play in holding the ICSs to account? What do you think about their long-term future?

Professor Sir Chris Ham: It is a key question, and I am glad you have raised it. The structure we have in the NHS at the moment is quite complex and convoluted. We have overlaid integrated care systems on to the regions and on to the national arrangements. We need to ask, when ICSs bed down and demonstrate what they are capable of doing, what other changes are needed to the regions and the centre.

I support what has been said about the operating framework. It is a good starting point, but we need more than what is in the operating framework. The regions are already having conversations with their integrated care systems on working differently and working more effectively, trying to reduce the micromanagement that quite rightly has been criticised during the sessions today and recognising that there will be a continuing role for regions in holding ICSs to account. We need to devolve more responsibility for decision making to local level and give systems some of the freedoms that have been promised to them.

To your question, we need to think about what the added value of the region is in a world where ICSs are working even more effectively, and how they need to change. We are already hearing from Amanda Pritchard and her colleagues that there will be a reduction in staffing. That is welcome, but it is all about the changes in culture and behaviour that we are also discussing today.

I did some work recently where ICS leaders were quite critical of their experience of working with regions, feeling that they were in a parent-child relationship, ICSs being the children. They wanted to move much more towards an adult-to-adult relationship based on respect for each other and recognising the roles that people have. Regions will continue working on a smaller scale and, hopefully, working in a more mature way with the integrated care systems, giving them the time and the space to do the things that we have been talking about.

- Q33 **Mrs Hamilton:** Good morning. My question is quite straightforward. At the moment, local authorities are very cash strapped. We are working with a health system where, at this moment in time, none of the targets has been removed from what we are trying to do. We have talked about partnership today. We have talked about prevention. There are also many issues about equalities that have not even been looked at today and how you get equality into the sector.



HOUSE OF COMMONS

What are some of the early challenges that both the health system and the local councils are facing? I know that we have been on this journey for six years since the STP days, when Simon Stevens came in with his first report. Now that we have gone live, what are some of the challenges when you take on board some of the things I have just said? My concern is that unless you can pull real money out of the system, how are we going to start to move things forward? I will start with you, David, and then Sir David Nicholson. If Chris feels he can add anything, I would appreciate that.

Councillor Fothergill: Thank you, Paulette. It is good to see you again.

Mrs Hamilton: Thank you.

Councillor Fothergill: I won't beat around the bush. Local authorities' finances are under severe pressure. It is well documented that we need billions of pounds coming into the system if we are even to survive over the next few years as local authorities. That is well recognised. It is an argument we have made day by day by day and will continue to make.

What we have here is something different. It is an enabler to make changes without focusing on the cash. The cash will become part of the solution that comes out of it. We have to get the ICSs right. We have to get the way that we work together right because out of that will fall the opportunity to reallocate some of that funding, and that would be really welcome.

You talked about challenges. One is that we, the local authorities, have very different cultures from the NHS and from the voluntary sector. We have to ensure that we recognise that by coming together and working together. Our accountabilities are very different. Those of us who stand for public election know what accountability is at the very sharp end. I am afraid that the accountability to the NHS, from an outsider's perspective, seems to be upwards rather than outwards. We have very different accountabilities.

There are lots of challenges about how we work together, but ultimately I think this is the best opportunity we have to develop a new system and a new way of working and to build a very collaborative culture. Out of that will fall the right funding in the right places. I am sure that we will still argue for more, but at least we are starting with the right opportunity. We really welcome that.

Mrs Hamilton: Without adding to it, can I go quickly over to David, and then Chris?

Sir David Nicholson: I agree completely with what David just said. In my time as an NHS chief executive I said on a number of occasions, as people know, "Don't look up, look out. That was the thing we tried to talk to chief executives about. I said that, if people spent as much time working with their partners as opposed to trying to manage me as the chief executive, we would all improve. I absolutely get that. We are not



HOUSE OF COMMONS

quite there yet, clearly, but we have made quite a significant change over the period.

If you start the question by saying, "How can we move money from health to social care?", it will not help very much in the conversation. People will put up their barriers and all the rest of it. What I would say, and certainly my colleagues, my board and the people I work with would say, is that the biggest challenge facing us at the moment in running a hospital is hospital flow and discharge. That is crucial to getting the whole system working properly.

I absolutely agree with Chris that we need a 10-year time horizon to think about whether this way of doing things will be successful or not. If we don't sort out hospital flow and ambulance handovers relatively quickly, we are going to lose public confidence quite significantly. Getting that right is important. Most people I work with in the NHS would say that, if there is extra money for discharge, it should go to social care. We can see, both in terms of the amount of money social care staff are paid and in their ability to deliver care, that that is a massive issue, which is, in a sense, backing up through the healthcare system at the moment. It is a crucial thing in the short term.

Mrs Hamilton: I was very disappointed when the legislation came in around covid. I think we lost over 40,000 care staff, to add to what David said, which has not helped to unclog the system. Sir Chris Ham, do you have anything to add?

Professor Sir Chris Ham: Thank you. I have two brief points. First of all, it would be very helpful if there was a coherent cross-government policy supporting a lot of the local work on tackling health inequalities. Again, this is a point the NAO made very forcibly in its recent report. What I mean by that is getting all the relevant Government Departments together to create a strategy that can then provide the framework at local level for a lot of the great work that is already happening. If the Committee could lend its weight to that, particularly in relation to DHSC and other partners, it would be fantastic.

The second thing is that we have some really good local examples in local government of what needs to be done. Patricia Miller referred to the Wigan Deal and how that has been adapted in Dorset. Many of us will be aware that Donna Hall, Kate Ardern and colleagues in Wigan over 10 years or so, through the local authority, have shown the way. If we are willing to use all our assets and invest in the voluntary community sector, even as statutory services are being cut back because of austerity, you can still make some progress in tackling health inequalities and improving population health. It is being open to successful examples like that and making sure they are replicated as far as possible around the country. It was very heartening to hear that Patricia is doing that in Dorset.

Chris Hopson: I will add something very quickly, Paulette, if that's all right. It is interesting that we have got an hour and a half into the



HOUSE OF COMMONS

session and we have not talked about one of the four statutory purposes of ICSs, which is to enhance productivity and value for money. It is really important to identify that it is not just a question of the funding; it is also a question of making every single best use of the funding.

There are two things going on now that were not happening before, as a result of ICSs. The first is that there is an opportunity for NHS providers inside a healthcare system, inside an ICS, to do things much more effectively now that they were not doing before, like sharing back offices or, for example, as David was saying, creating collaborative staff banks. I thought David set it out really well. We had individual providers competing on agency spend. Now, across a single ICS you can agree the approach that you are going to take to agency pay rates, for example.

What you also have is the ability for NHS organisations to collaborate much more effectively with local government. For example, if you look at intermediate care—the bit where you discharge people from hospitals but also potentially step up and step down—wherever you look in ICSs there is some really interesting work going on to create joint solutions that pool the budgets between local authorities and the NHS, and get best value for them. We should not lose sight of the fact that ICSs are a real enabler in a way that we did not have before.

Q34 **Chair:** That statutory pillar is important, and it is important that you mentioned it. Are you saying that the NHS has enough money?

Chris Hopson: There is clearly always a debate in a taxpayer-funded system about whether the NHS has enough money. It is Parliament's job to set the financial envelope. You know what the NHS's funding settlement is. We are waiting for the announcement on 17 November about what the forward budget looks like. We feel it is our responsibility in the NHS, once the Government have set the envelope, to obtain absolutely maximum value for money for that envelope.

Chair: Taiwo Owatemi wants to come back in on something.

Q35 **Taiwo Owatemi:** Councillor David, you spoke about how the NHS and local authorities have different accountability systems. How do you think we can resolve that so that we streamline it more effectively?

Councillor Fothergill: If you try to resolve it, you will spend a long time trying to resolve it. You have to recognise that there is a difference and make sure that the differences work together. Without being glib, I think that accountability upwards still has to be there. There are some important accountabilities that the NHS has, and continues to have, but ultimately the local authority is responsible to its population. You cannot resolve that. What you need to do is recognise the difference. Both sides need to recognise the difference.

In terms of measurement, some measurements have to be national—recognising what the ICS can do—and some very local. My population in Somerset have very different requirements, I am sure, from other areas



HOUSE OF COMMONS

such as the city of Birmingham. They are very different. We know what their priorities are. We understand our place locally and we can deliver on those priorities, but that is not to say that we are not part of a wider national system that has national targets.

- Q36 **Chair:** I have a couple of things, finally. Professor Chris Ham, you did a big piece of work "Governing the health and care system in England: creating conditions for success". One of the things that you talk about there is supporting leaders and staff to create leaders and thinkers who are able to take the ICSs forward in terms of system leadership. Is that a very polite way of saying that we do not have strong enough leaders at the moment in the NHS?

Professor Sir Chris Ham: No, it is not saying that. It is saying that we need to support our existing leaders, who are doing for the most part, in my view, a fantastic job, to be system leaders and not just organisational leaders. It is learning how to create the partnerships that we have been talking about today and to look out more and not to look up. It is about behaviours that will make ICSs succeed or indeed fail.

Some of that is being learnt very quickly on the job. I can think of a number of great examples. You heard from Rob Webster, who is one, to spare his blushes, and has been doing that for five or six years now with real success. We need to make sure that the expertise we are gaining can be shared more widely and create a different generation of leaders, building on the very good ones we already have.

- Q37 **Chair:** Thank you for clarifying that. I have a couple of points for Chris Hopson. In 2020, the Government created the health and care visa, as you know. The aim of that was to make it easier, cheaper and quicker for health workers to be recruited into the NHS. The Government have said that the Home Office and the Department are going to work together to encourage more GP surgeries to be sponsors for international medical graduates to come here and be retained as GPs.

We had a debate in Parliament last week, led by Matt Warman, the Conservative MP for Boston and Skegness. Robert Jenrick, the Immigration Minister, responded to that. He gave an undertaking to go away and look at the idea of ICSs being umbrella sponsors for those visas, because it is very bureaucratic, and it is challenging for individual GP surgeries and even primary care networks to do that. Has that fed through to you, and would you be warm to that idea?

Chris Hopson: One of the things that we are doing is working it out, now that we have ICSs. The point you are making is fundamental. We have the opportunity to operate primary care at scale, with support for what were previously individual practices that were trying to do exactly what you are suggesting on an individual basis. You can now do that in a supported way with appropriate resource at the ICS level. That is something I know we are looking at.

- Q38 **Chair:** Excellent. Your boss, the chief executive Amanda Pritchard, said



HOUSE OF COMMONS

last week that the NHS's challenges are greater now than they were during covid. What do you take that to mean?

Chris Hopson: I take it to mean that we know that the service before it went into covid had its challenges. Covid has now created, for example, backlogs in care in elective surgery as well as in mental health and community services.

The point she was really trying to make—it has come up before—is that when we were in covid there was an intense focus on a single, individual problem in terms of dealing with covid. What we are now seeking to do, as you have heard today, is not only to restore services but, for example, to improve access in primary care and urgent and emergency care, to deal with a series of operational pressures and, at the same time, not lose focus on the longer term while also building the partnership that we know we need.

The point she made—she has made it internally on several occasions—is that it is the multifaceted nature of that challenge, as opposed to the ability to just focus on a single thing, which makes it challenging. That is what public service leaders are here to do: within the context in which they are working, to provide the best policy of service possible to the citizens we serve.

Chair: Excellent. Thank you very much Chris Hopson, chief strategy officer, NHS England; Sir David Nicholson, chair, Sandwell and Birmingham NHS Trust; Professor Sir Chris Ham, co-chair of the NHS Assembly; and Councillor David Fothergill, chair of the community wellbeing board at the Local Government Association. Thank you for giving evidence to this first part of our inquiry into ICSs. There will be much more to come. Thank you.