HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: Integrated care systems: autonomy and accountability, HC 587

Tuesday 6 December 2022

Ordered by the House of Commons to be published on 6 December 2022.

Watch the meeting

Members present: Steve Brine (Chair); Paul Bristow; Chris Green; Dr Caroline Johnson; Rachael Maskell; James Morris; Taiwo Owatemi.

Questions 39 - 102

Witnesses

I: Miriam Deakin, Director of Policy and Strategy and Deputy Chief Executive, NHS Providers; Professor Jim McManus, President, Association of Directors of Public Health; Dr Linda Patterson, Chair, Bradford District Care NHS Foundation Trust; and Sarah McClinton, President, Association of Directors of Adult Social Services.

II: Professor Vic Rayner OBE, Chief Executive, National Care Forum; Dr Trudi Seneviratne OBE, Registrar, Royal College of Psychiatrists; and Dr David Wrigley, Deputy Chair, British Medical Association GP Committee.

III: Rob Darracott, Editor, P3 Pharmacy; and Andrew Lane, Chair, National Pharmacy Association.

Examination of witnesses

Witnesses: Miriam Deakin, Professor McManus, Dr Patterson and Sarah McClinton.

Q39 **Chair:** Good morning. This is the Health and Social Care Select Committee and our second session looking at integrated care systems: autonomy and accountability. In this session, we are going to look at some of the partners that make up the partnership working component of the ICSs—the working bodies—to see how they are functioning and how it is hoped that they will function going forward.

We have three panels today. The first panel is made up of Professor Jim McManus, who is the president of the Association of Directors of Public Health; Dr Linda Patterson, who is chair of the Bradford District Care NHS Foundation Trust; Sarah McClinton, who is the president of the Association of Directors of Adult Social Services; and Miriam Deakin, who is the director of policy and strategy and deputy chief executive of NHS Providers. You are all very welcome. Thank you for coming into Westminster and joining us as part of our ICS inquiry.

When we get under way on the topic that is before us today, I will start by asking a couple of questions about prevention. We will then move on, and members will ask their various questions as we cover the ground, but first I would like to ask Miriam about something. We are expecting strike ballots today from some more ambulance trusts. How concerned should the public be about this wave of strikes affecting the national health service?

Miriam Deakin: Thanks for having me. The NHS is in unprecedented times. We are facing the most challenging winter that trust leaders have experienced in their careers. It is certainly the case that strike action, if it goes ahead and we cannot reach a negotiation beforehand, will be disruptive, but trust leaders have been planning for strikes for some time. They have experience, on the back of the pandemic, of redeploying workforce and changing plans. We will have and have had notice to let patients know if a planned and less urgent procedure will need to be scheduled for a different date.

The picture is quite complex. As you will have seen in the news, certain services will be exempt, but a lot of the arrangements will vary locally and be subject to local negotiation. That is where trust leaders are putting their efforts at the moment. They have patient safety front of mind and are focused on negotiating the best set of services that they possibly can with their local union reps and on the wellbeing of their staff, both those who have taken the difficult decision to strike, because trust leaders understand the set of circumstances that have brought this action about, and those who are not striking and will be working in quite pressured circumstances.

Q40 **Chair:** Is there enough visibility for the public as to which parts will be

exempt and which parts will be most affected? Do you think there is enough visibility from the providers?

Miriam Deakin: At the moment, all of that is still being worked through. We have been in touch with our members, who are very actively in negotiations with their local union reps at the moment. Although it is quite frustrating, it is probably a bit too soon to be crystal clear on what services can be available in every locality. Not all sections of the workforce are striking, and not in all hospitals, so it is quite a complex picture. At the moment, trusts are most focused on managing the risk to patient safety ahead of the strikes and getting the best possible set of services running on those days.

Q41 **Chair:** Finally, on the wider question of "Agenda for Change" and the independent pay review process, what is your view on the independent pay process? The process exists and everybody, to a greater or lesser extent—I am guessing that it is now a lesser extent—buys into it. Are we in a situation now where we have an independent pay review process that reports and the Government accept it, as happened in this case, and it is in place until it is not in place? Do we believe in that process or not? What is NHS Providers' view on that?

Miriam Deakin: The Government are facing some challenging questions. We are in a cost of living crisis. For different groups of staff, it is accurate to say that their pay has not kept pace with inflation, and that is clearly one of the arguments for industrial action. The set of circumstances and the context we are in are slightly separate from the question whether an independent pay review process is a valid thing. I would say that an independent pay review body process has many merits. It is there to provide an objective and independent judgment.

Q42 **Chair:** Isn't that what we want? Otherwise, what you are talking about is Ministers doing pay negotiation, which Ministers are not qualified to do. Do you really want pay negotiation for NHS staff sitting on the desk of a Minister, who is appointed through the preference of the Prime Minister of the day?

Miriam Deakin: That is why we have this independent process, isn't it?

Q43 **Chair:** But is it worth the paper it is written on? That is what I am asking. It seems that everything is agreed until nothing is agreed.

Miriam Deakin: I think that is right. I suppose what I am saying is that it seems to me that the process is valid, but the question is whether the process has been able to connect effectively with the context, particularly around the cost of living and how pay has kept pace with inflation over the years. The process has suffered and confidence in the process has clearly fallen away. That will have to be addressed. I think that the principles of having that independent, objective view on pay are still valid, but it has to connect with the broader context and the challenges that staff are facing, as otherwise it falls down, as we have seen.

Chair: All right. I am going to rewind briefly. I wanted to get to that with you before we talk about what we are doing. Before we do that, we have members here who want to make a couple of declarations on the record because of memberships that they have with trade bodies. Caroline, do you want to put your interests on the record?

Dr Johnson: I am a member of the British Medical Association and the Royal College of Paediatrics and Child Health. I am a practising consultant paediatrician at Peterborough City Hospital.

Chair: Thank you. I am sorry I did not do that at the start. Taiwo, do you want to declare your interests?

Taiwo Owatemi: I am a member of the Pharmacy Defence Association and a pharmacist at UHCW.

Chair: Caroline, do you want to put a question to Miriam Deakin?

Q44 **Dr Johnson:** Yes. It is with regard to the strikes. There are millions of people waiting for treatments, both urgent and relatively non-urgent. You talked about the processes that you are putting in place in advance of these strikes and the fact that some people who potentially have been waiting a long time for treatments may find they are postponed. The history of strikes is that quite often they are called off at the last moment. Is it the case that if that happens this time we will be able to reinstate those processes and treatments, or is it the case that, because you planned to postpone them, that time will be wasted anyway?

Miriam Deakin: That is a really good question. If the strikes are called off or postponed, as everybody very much hopes that they will be, trusts will pull out all the stops to make full use of the capacity that they will then have returned to them. They will do their very best to fill lists and to get as many patients as possible through the door.

However, if it is a very last minute call-off, you would be correct to assume that, regrettably, we will still see some disruption. That will be the practical reality of it in terms of reaching patients, patients' own availability and the admin and logistics that need to go behind getting processes back running. People will pull out all the stops to make best use of surgery time and to fill lists, but if it is a very late notice call-off we may still see disruption, unfortunately.

Q45 **Dr Johnson:** So even the threat of strikes will delay patient treatment.

Miriam Deakin: Absolutely. That is part of the process, isn't it? Strikes are a powerful tool. That is absolutely part of the process.

Q46 **Chair:** Yes. It is a good point. Are the trains in the wrong places? That is the purpose of Dr Johnson's question. They will not be able to write to patients, because they will not have time. Even if they did write, the postmen and women will probably be on strike as well. It is a happy Tuesday, isn't it?

We turn to our ICS inquiry. I will bring in James Morris in a second, but I want to ask you about prevention in the context of ICSs. The Committee is going to do a piece of work on prevention in the new year. We hear a lot about ICSs improving health outcomes and a lot about the structure of ICSs—who is on the board and who is represented in the system. The National Audit Office talked about the ICSs' role in prevention and how much they are set up to do that. There is no doubt that they have the capacity to improve prevention, but are they going to realise that potential? Are they yet realising that potential? Dr Patterson, you might be a good person to start on that.

Dr Patterson: As you say, the commitment is there very strongly in the ethos to try to reduce health inequalities, which will certainly be a wider forum than the NHS, but it has to be all the partners together. Even within the NHS, you can focus your services on those who are most disadvantaged. I think you have heard of Core20PLUS5, which is trying to segment your population. That is certainly something we are thinking about in my trust.

The thing about prevention is to try to keep people well and healthy at home, where they want to be, for as long as possible with healthy lives. We know that there are great disparities in health, and some of those will take a long time to tackle. We know that there is sometimes a difference of 15 years in life expectancy between the most deprived and the more affluent. I sometimes wonder why the public are not marching in the streets with their placards, saying, "Give me back my 15 years of life," because there is such a stark difference. People are accumulating chronic conditions, which are causing their reduced life expectancy.

The work of the ICS, which is the NHS with its partners, social care and the voluntary sector, is about health and wellbeing in the round. It is about intervening and helping to support communities to find their own solutions. We have to look to our communities and the voluntary sector. We need to look to early years. There is the whole issue of whether we are looking after our nought-to-fives well, because that is where a lot of this deprivation starts. We must then continue that. In my own trust, in our community services, we are very committed to trying to keep people at home for as long as possible, and keeping them well and supporting them, so that they do not go into hospital, because their chronic conditions can be managed in the community. That needs a lot of effort and partnership working between the NHS and primary care, with general practice. Of course, there are then the wider determinants, which my other colleagues can speak to.

Q47 **Chair:** Professor McManus, Dr Patterson is talking about management of a list, effectively. You have a slightly bigger list because you are an integrated care system. Are they too focused on managing existing conditions, rather than preventing conditions in the first place, really getting upstream of ill health?

Professor McManus: Yes, partly. There is an awful lot of rhetoric and not a lot of outcome when you look across some parts of the country. One director of public health said to me that he really welcomes the ICS commitment to this, but where are the outcomes? It is a question of focus. Our NHS is precious and important, but it needs to focus on the things that are in its gift to address. If we really tackled hypertension in the patients we already know, we could reduce strokes and hospital admissions. If we did the same with diabetes, we could reduce amputations, but we could all point you to practices in the country where the needle has not changed on those things in 10 years. There is a big job for the NHS to focus on, with its partners.

There is another job for other partners to focus on. The local authority is a far bigger producer of health in children and young people, alongside the voluntary sector, than the NHS. It is a case of focusing on what will make the difference and motoring on that, and setting the outcomes that enable you to determine whether you are making a difference.

Chair: We will explore this more as the session goes on.

Q48 **James Morris:** Partnership working is at the heart of what ICSs were set up to do, but there is a trend with partnership working that I have observed over a number of years. The Government start by saying, "We don't want to prescribe how you go about partnership work. It is up to the local ICSs to determine that." Then somebody says, "Actually, don't we need some statutory regulations about who is on these partnerships?" We then end up with a bureaucratic regional structure that is enforcing partnership working, and people resist it. Is my analysis of how partnership working works in the NHS correct, or are you going to be different?

Miriam Deakin: I can make a start on that, if it would be helpful. At the moment, ICSs are very variable. They vary by population size, deprivation and need, and composition of providers within the ICS. I have heard a few people say, "If you've seen one ICS, you've seen one ICS." They are that different across the country. That means that, in order to manage through ICSs, we must have quite an enabling framework that is not too prescriptive, because you literally cannot get a really prescriptive bureaucracy to work in the same way in every ICS. They are all too different. At the moment, there is definitely a bit of a disjoint between that and an Act that has been quite enabling, which is all positive, and the NHS tendency to pull towards heavy performance management.

Q49 **James Morris:** Do we need heavy performance management?

Miriam Deakin: It is probably a little imbalanced at the moment. I think that systems and providers could probably have a bit more autonomy or come to an agreement with the centre about the "what"—the key priorities—but we could be less prescriptive about the "how" and leave the detail to local partnerships.

James Morris: Professor McManus?

Professor McManus: It is a good question for everyone to ask themselves, because what makes effective partnership is culture and commitment, not rafts of performance measures. That partnership will look different in different areas. If you look at 40 years' worth of empirical literature on partnerships—I am sad enough to have read quite a lot of it; I don't get out much—you see that it is about good culture, willingness to work together and a focus on the top must-dos.

One director of public health said that when her ICS board papers come through they are always 400 pages of performance data. It is all about acute performance, so they struggle to find the time to talk about the crucial value of pharmacy, for example. I know that you have pharmacists on later. Without pharmacists, we would be in massive trouble healthcare-wise in this country, but they are not always included in ICSs in the way I think they should be. Culture is the key thing.

James Morris: Sarah?

Sarah McClinton: As well as being president of the ADASS, I am responsible for health and adult services in the Royal Borough of Greenwich and lead the place partnership locally on our integrated care board. I absolutely agree with Jim. This is about culture. The ICSs have to do something different; they cannot just be another reorganisation of the NHS.

Building on Miriam's point about variation, from a local authority or DASS point of view, we have DASSs that have three ICSs on their patch, for example. At the other extreme, in Cumbria and the north-east, we have an ICS that has 11 local authorities. What is important is place-based leadership, building on the local partnerships that exist at place level, as a health and wellbeing footprint, and then aggregating up. Rather than a top-down performance management culture, it would be something that is much more connected to local communities and local place-based partnerships, that embraces subsidiarity and begins to build from the bottom up.

James Morris: Linda, do you have anything to add?

Dr Patterson: I work in West Yorkshire. That ICS was building partnerships for a number of years before the legislation came into force. I took up the position of chair of the trust on the same date as the legislation became statutory.

We in West Yorkshire have delegated down to place; to the partnership with the local authority, the VCS, social care providers and primary care. The money has gone down to place, too, which is a really important step. What I have found coming into the system is a strong level of trust that has been built up over time. You have to have trust. I agree that it is about the culture. You have to be able to trust that the strongest voices are not always going to win, that there is going to be a commitment to

parity of esteem with mental health, for instance, that the VCS will have a voice and that there is equal voice. It takes time, but it needs a commitment to distributed leadership, to voices being heard and, as I said, to delegation down to the lowest possible unit, where you can get on and actually do things.

Q50 **Rachael Maskell:** I will start with you, Miriam. Who is really setting the priorities? Clearly, you have your aspiration and are building your partnerships, but you have the Department saying A, B, C and D, you have 7.1 million people on a waiting list, and you have NHSE saying, "This needs to be done." Who is setting the priorities? Who do you feel accountable to?

Miriam Deakin: That is a good question. Given where we are post pandemic and the need to bear down on care backlogs, there is a broad feeling in the NHS that priorities are set centrally. People are comfortable with that, up to a point, but they would like more freedom to determine how, with their partners, they deliver against those priorities and perhaps have a little less duplicative regulation, bureaucracy and micromanagement on the "how", with multiple checklists to tick off. They accept that national priorities are important, but they would like less scrutiny of how they are delivered.

The aims of ICSs are quite strategic. They are around reducing health inequalities and population health management. The people I represent, providers, are keen that we do not lose sight of those broader aims, which speak to the prevention agenda, shifting resources upstream and doing things differently. We need somehow to focus on the operational imperatives, which are absolutely around reducing care backlogs, while retaining some leadership headspace to plan for the medium and longer term to do things slightly differently.

Q51 **Rachael Maskell:** Linda, can I come to you? What was the point of the reorganisation? What has changed? What is your message back to NHSE and other national bodies in light of the fact that, clearly, they are still pulling the strings?

Dr Patterson: I think this is a great opportunity, because it is the first time that we have had a legal basis to come together and work together on a level playing field, which is good. Competition was the way forward a few years ago. Some people ignored that and got on with building partnerships.

I think it is an opportunity. There are national priorities. We recognise that, because they are about people, aren't they? People do not want to be on waiting lists, to be waiting outside hospitals in ambulances and so on. In our ICS, we are committed to trying to deal with the backlog and the ambulance waits. That is a flow problem that all parts of the system have to be part of, my own trust included, as well as community services and so on. We would like to feel that we are not going to be micromanaged, even though we acknowledge those overall priorities. For

instance, our priority in Bradford is about children, because we are the youngest city in the UK and there is a lot of deprivation. We need to concentrate on children's services and children's health, laying things down for the future. We have taken that priority of place—"This is what we are going to do"—but we will also play our part in the other priorities.

Q52 **Rachael Maskell:** Can I turn to you, Sarah? We hear that social care is the one thing that we need to get sorted out in order to clear the backlog and sort out the back door of trusts. Do you now have the authority that you need to be able to deliver that agenda and to address all of the challenges in the NHS?

Sarah McClinton: It is probably an oversimplification to say that flow is just about social care. We have also seen that a lot of the data around that is not of the best quality, to put it politely. When we used to look at delayed discharges and have them signed off by the partnership, it showed that there are many other reasons why people may be delayed in hospital: access to district nursing, community services, mental health services, primary care and so on. There is a slightly oversimplified narrative that social care is the problem.

I agree that there is a real opportunity in ICSs to have a relentless focus on prevention and early intervention. Yes, there are people waiting for NHS treatment, but there are also half a million people waiting for social care. They tend not to be people waiting in hospital, because those people are prioritised, but that means that the health of people waiting in the community deteriorates and they are more likely to go into hospital. We are in a vicious cycle. We need to pay equal attention to how we stop people going into hospital, not just to flow and the back door.

Obviously, we want to work with our partners locally, but we need to see the impact on the whole system. The NHS and social care go hand in hand. We need good health services for strong social care services. Equally, we need the NHS to be doing its job. What is happening at the moment is that more and more activity is being generated in social care through NHS processes.

Q53 **Rachael Maskell:** Jim, can I turn to you? From hearing all of that, it is clear that, yet again, public health is being squeezed in that agenda. How are you ensuring that your priorities are heard? What would you want to see done differently?

Professor McManus: Given that about a third of the public health budget was taken out a few years ago and there is no more resource, many directors of public health are finding themselves servicing more and more meetings, which is not the best place for us to be.

The way I would like to see things done differently is this. You must have somebody setting outcomes, so let's agree the outcomes between national and local. There can be a negotiation about what are national and what are local outcomes. Other countries manage it perfectly well.

One of the challenges is a very top-down culture. We learned during covid that we can deliver and trust local areas without a top-down culture. We seem to have gone backwards on that. That is the first thing I would like to see.

The second thing I would like to see is clarity on whose job it is to do what. That will help on public health. For me, most directors of public health are pushing into their ICSs. I have a number of examples here. The really good ones recognise what their role is and recognise the best way to use the DPH. Sometimes that is advising, but sometimes it is leading programmes rather than sitting in meetings. Am I answering your question?

Q54 **Rachael Maskell:** Yes, that's great. Finally, how do you think that the focus can be switched on to public health, in the light of the pressures on the NHS?

Professor McManus: You need two things. First, you need a mindset that thinks both short term, to sort out current crises, and long term.

Q55 **Rachael Maskell:** But we are in permacrisis at the moment.

Professor McManus: Yes, but the only way we will get out of permacrisis is by changing our mindset and behaviour, rather than being driven by events. It is possible. We have done it before, and other countries have done it. I look back to the 1990 health and social care Act, which of course we have all read. That was a way of changing it. We absolutely have to do the short-term stuff, but that does not mean that we cannot start the long-term process of preventing people from needing social care by keeping their cardiovascular health good, preventing strokes, preventing diabetic amputations and getting public health to lead that action.

However, you need to back up the rhetoric with some money. We spend less than 2% of the healthcare budget, really, on prevention, not including the public health grant. If we are talking about prevention and reducing health inequalities, where is the money for pharmacists to improve vaccine uptake in older people to stop them going into hospital? Where is the money for GPs to visit populations like those where my mum lives, which is a quite deprived ex-industrial area where there are quite a lot of frail people? A lot of the people I went to school with have had heart attacks, stroke or cancer. It is the Celtic lottery. For me, there need to be multiple foci. They cannot be set totally nationally. Equally, they cannot be set totally locally either, because you get areas going their own way. Where is the aurea mediocritas—the happy medium—if I can quote Homer?

Chair: Very good.

Q56 **Chris Green:** Following what Rachael Maskell has been looking into, Miriam Deakin, if we look at the various issues that have been raised so far, there is a question about prevention having greater priority, or parity

of esteem between physical and mental health. Who actually holds the NHS providers to account for delivering those improved outcomes? Who holds them to account directly?

Miriam Deakin: It is a good question. Recent legislation has not changed the role and accountabilities of a trust board. Trust boards are still accountable to the populations they serve, to their commissioners, and to regulators like the CQC. In the case of a foundation trust, strictly speaking, it is directly to Parliament as well. I think those accountabilities are unchanged by recent regulation.

Our members tell us that it is not necessarily a bad thing, but something to navigate, that introduction of systems and new partnerships and collaboratives, while offering a lot of benefits, have created a more complex landscape in governance and accountability. As I say, it is not necessarily a bad thing, but it is a different environment, in which people are learning how to manage risk and how to make sure that the lines of accountability remain as clear as they need to be.

Q57 **Chris Green:** I can see the increased complexity. You have different bodies, going from the Secretary of State to the general public using the services, holding organisations to account for the delivery. As a Member of Parliament, I would think that it is very difficult for my constituents to have an influence. I can also see that the Secretary of State would not want to intervene if he could avoid it.

I am just reflecting on police forces. You have an integrated care system and, broadly speaking, there is a similar number of ICSs as there are police forces in the UK. Every so often a police force will be put into special measures. There are always a small handful in special measures. If an integrated care system overall was being considered for that special measure territory, how would they get put in it and how would that be marked out?

Miriam Deakin: Oversight of ICSs sits with NHS England, and CQC is also developing a new role. It had some new duties and powers under the new Act to look at how it assesses the performance of systems. When we are thinking about people and communities, that is where local institutions like a hospital brand that is recognised or a local authority name that is recognised, or a place, as Linda was saying, become more important. I do not think that the public are expected to, or will, relate to an ICS. I do not think we should expect that. What will be most important to the public and to communities are local services and knowing who to contact.

Q58 **Chris Green:** I appreciate the point about competition, but you need comparators between different systems around the country. Therefore, you need good-quality data being created and then being shared in—shall I use the term—a league table. You need a certain degree of clarity along those lines. Are we in a position at the moment to have that clarity in that data?

Professor McManus: The data is an interesting one. Ten years ago this week, I was diagnosed with a stage four cancer. Thank God, the NHS saved my life. They did a great job, and I lucked out because other members of my family got far worse cancers. What I wanted to know was how good the NHS trust was at treating the fairly rare type of cancer that I had. Actually, they were extremely good, which is great for me and a trial for everybody else who has to put up with me. But the data was there to compare performance.

The challenge with ICSs is that there are multiple routes for performance data to go in, and there is not a single version of the truth of what outcomes we are all after. You have to put that data forward. The ICSs that are doing really well are developing shared performance dashboards, with the local authority saying, "This is how social care is doing. This is how children are doing and this is how public health is doing." The NHS is saying, "This is how X is going." It is that kind of local stuff. Once you agree a set of outcomes, which has to some extent to be agreed nationally, let the local area grasp their performance. Am I answering your question?

Chris Green: Yes, that's fine.

Professor McManus: I don't want to go on too long.

Chair: We know each other well. We have looks to communicate with each other.

Professor McManus: Just hit me when I go on too long.

Q59 **Chris Green:** I have two brief points. The first is in a very different direction. On the one hand, you have existing care areas and existing treatments, but the integrated care systems' obligation to participate in innovation and the adoption of new treatments is going to be very difficult to assess and it will be difficult to hold them to account. Some ICSs will be very engaged in that; others will do the minimum. How do we get them to participate and make sure that the UK is a great destination for organisations from around the world and from the UK to engage and develop the next generation of treatments?

Miriam Deakin: We need to think about the right route for some of this activity. The ICS is going to provide a great infrastructure for learning from innovation and perhaps capturing that knowledge. I do not want to be too biased, but I think that a lot of that innovation—innovative treatments, equipment and so on, and investment in research—will be facilitated and take place via clinical leaders in providers. What is important is that the ICS provides an infrastructure such that we learn from that.

Q60 **Chris Green:** I have a final point. Perhaps it is not worth pursuing, but in terms of accountability a few years ago we had the devolution to Greater Manchester, where the Mayor had responsibility. I appreciate why it has not been taken forward as it could have been, but what potential is there

in that accountability and local leadership, not only from the top but from the patients as well? You ought to have that connection with your local health, and therefore perhaps it will be a mayoral responsibility as devolution advances. Does anybody want to comment on whether that is a positive thing?

Professor McManus: I think the Chair will probably realise that I would say this, wouldn't I? Local authority, local government and local elected leaders are often the glue that holds these systems together, along with their NHS partners and others. It is strong engagement from local government. For the most part, that is happening and is absolutely crucial. If you can talk to your politician on your doorstep, each year he knocks on your door, about the NHS performance, and then there is a route to talk about that with the NHS, as there is with social care, that is all to the good for residents.

Q61 **Dr Johnson:** I want to ask about the balance between local and postcode lotteries. On the one hand, you have a desire for outcomes to be even across the country and everyone to be levelled up to a good level. On the other hand, you have the desire for targets in healthcare to be set locally, depending on local priorities. But, if you do that, you end up with differences between local areas and then you get the accusation of postcode lottery. There is obviously a balance between the two. Do the ICSs offer the right balance between those two competing objectives?

Sarah McClinton: Setting those outcomes at national level is really important. ICSs are at different stages of development. They need space to develop based on their local relationships and partnerships and what their local assets are. Even within the NHS, which is seen as a fairly monolithic organisation, you get quite a lot of variation now. It is understanding what is warranted variation as to what is unwarranted variation, and how you understand the context of that particular ICS.

If we want to get closer to citizens, given that transformation and culture change is much more effective when it engages people, be that our local citizens or people who work on the frontline in the way that clinicians drive technical innovation, it has to be a much more bottom-up approach. By having that framework you can then begin to understand where there is variation. Sharing good practice is a tried and tested method in sector-led improvement approaches. It can be very effective. There are different ways that you can begin to make sure that best practice is spread nationally, but based on where systems are in their development.

Dr Patterson: I think we all look to benchmark our services—going back to the point made before—to compare how we are doing within an organisation with other people. If you look at a place, we need to be looking to see how we are doing compared with other places. It might be length of stays in psychiatric hospitals. It might be under-fives health measures that we can do. We are committed to learning from the best. We have provided collaboratives across the ICS at the moment, and that is one of the functions. We are about learning and sharing good practice,

and trying to benchmark within the ICS to say, "How are we doing?" It is to learn from the best. I do not think that means that there is necessarily a postcode lottery if you have local priorities. Each area is different and there may be particular health issues in a particular area that need to be tackled. I think that is justified.

Q62 **Dr Johnson:** My other question is about dentistry. In my area in Lincolnshire, access to NHS dental provision is not good for many of my constituents. I get a lot of letters about people who literally cannot find an NHS dentist. How will this change of organisation help, or will it not?

Dr Patterson: I agree with you; I think the state of NHS dentistry is pretty parlous. It needs a huge investment in both workforce and resource. Within my own trust we provide NHS dentistry for particularly deprived areas and for people with particular problems, perhaps with neurodiversity or disability. We have a very good dental service in the trust, but then we have to make the relationship back with NHS dentistry in the community, which is a bit thin on the ground, I would say. It is certainly one of the things that we have been agitating for within the ICS. If we are talking about resources, dentistry is absolutely somewhere that resources should go.

One of the successes, or not, of ICSs will be if there is a change of resource to services that have perhaps not had resources before. It is always the acute hospitals that get the resource, partly because they are developing lots of new treatments, which is great, but they are also the people who are actually having the pressure on them. That is partly because the other parts of the service are not keeping up. We need a shift of resource over time. That will be a success or not of the ICSs, but I absolutely agree on dentistry.

Dr Johnson: Miriam, do you have a comment on dentistry?

Miriam Deakin: Dentistry is slightly outside my area of expertise, so I can only really agree with Linda. Our members' trusts see the impact of the lack of investment and lack of attractiveness of the role for community dentists at the moment. I agree that ICSs will have a role in that, but it seems to me that it could need a national policy look as well, to look at why we are not attracting enough people into the role of community NHS dentist and why they are not finding their businesses viable, which seems to be part of the issue at the moment.

Chair: There are two speed-date questions to end this panel from Taiwo Owatemi and Paul Bristow.

Q63 **Taiwo Owatemi:** I am particularly interested in performance management. Given the fact that the ICSs are full of a range of different stakeholders, how do we effectively measure the success of an ICS? Do we focus on each individual stakeholder or should it be overall, based on how the organisations have performed together?

Professor McManus: There are multiple organisations that have got this more cracked than we have. You start by asking what outcomes you want, who is responsible for them and whether those outcomes are being achieved with what we call the four Es duty: economy, effectiveness, efficiency and equity. Intellectually, it is a fairly simple question. The issue is whether we have the will to actually put the system in place to do it.

Q64 **Taiwo Owatemi:** Dr Patterson, what happens if we have one stakeholder within an ICS organisation that is not pulling its weight, but the rest of the ICS is doing quite well? Is it fair to give that particular ICS an outstanding rating, even though there are areas for improvement?

Dr Patterson: That is a difficult one. We are each, as our own organisation, still responsible for our own performance legally. That is what we have to do. We have not given all that responsibility to the ICS. We are still legally responsible, so it is up to each of the organisations to make sure that they are meeting their way. If a particular organisation is struggling, one of the issues is whether the ICS will be able to give support and suggestions about how performance might be helped across the whole piece.

At the moment, as I understand it, the ICS will have to meet its financial responsibility to the NHS bit. Obviously, within that, there may be overspends and underspends. How we work that out is going to be a bit tricky. If my trust is actually in balance but somebody else's is not, am I going to have to give them some money? It is not clear at the moment. These are battles that are going to be fought over the next one to two years.

Q65 **Paul Bristow:** I have two very quick questions. First, ICSs are supposed to be a partnership at the top level with leadership from public health, the acute sector, primary care and social care. It is going to require a degree of flexibility beneath the top level for staff moving across. Do you think that is going to happen? How easy will it be for that to happen?

Professor McManus: There are some places where it is happening. It is a real struggle because we all have different mechanisms. There is "Agenda for Change" versus local authority pay, terms and conditions, and training.

What we must avoid is systems creating their own version of public health, clinicalising it and calling it "population health", which is a real risk, or ICSs creating their own social care structures inside the NHS. We have to get better. It does not matter who your pay and rations come from. What matters is your day job, who you do it for and how you do it. That is the culture we need.

Q66 **Paul Bristow:** I have a quick further question. I also have to declare that the company my wife works for provides secretariat services for the all-party parliamentary group on social care.

In an ICS, it is supposed to be public health, primary care, social care and the acute sector working together. Sarah McClinton, does it feel like an equal partnership?

Sarah McClinton: It is subject to a lot of variation. Overall, it probably does not yet feel like an equal partnership. Some systems are making a lot of progress. For me, parity of esteem is not just in terms of mental and physical health but parity of esteem in social care.

The purpose is to promote integration, but not integration for its own sake; it is a means to an end, not an end in itself. How do we get those partners to feel equal and make sure that we are using all the resources that we have in the best way possible across that whole system? That requires shifting resources. Maybe that is one of the ways to measure ICSs on how they make those shifts and how they actually see it as a whole system with equal partners around the table.

Chair: Brilliant. Thank you. Professor McManus, Dr Patterson, Sarah McClinton and Miriam Deakin, thank you very much.

Examination of witnesses

Witnesses: Professor Rayner, Dr Seneviratne and Dr Wrigley.

Chair: This is the second session of the Health and Social Care Committee looking into integrated care systems. On our second panel, we have Dr Trudi Seneviratne, Professor Vic Rayner and Dr David Wrigley. David is deputy chair of the British Medical Association's GP Committee; Trudi is the registrar at the Royal College of Psychiatrists; and Professor Rayner is the chief executive of the National Care Forum.

Thank you very much for your time. We will go straight to Rachael Maskell.

Q67 **Rachael Maskell:** Welcome. I would like to get to the nub of the development of the strategy. Do you believe that clinicians have had the opportunity to input sufficiently to that strategy, and also to innovate to bring about change to the health system? It is nice to see you, David. Would you start, please?

Dr Wrigley: Thank you. We need to think about what was there before with the CCGs, which came in through the 2012 Health and Social Care Act. That brought clinical leadership and clinical involvement down to the local level. What we see now with the Health and Care Act with the ICS is that the White Paper talked all about integration, but actually the opposite has occurred. Those local teams and the clinical leadership has been decimated. It has just disappeared.

Q68 **Rachael Maskell:** Are you saying that it is worse rather than better?

Dr Wrigley: Much worse, yes. This is what colleagues are telling me. Before, in CCGs, we had local leaders and clinicians who knew what was happening on the ground in their area. They were fully engaged and

involved in decision making, and they were involved in the workings of the local NHS. They have all been sidelined and left behind. They did not know for months on end what was happening with their roles. Often, now, they have just been left behind and they are not involved. The ICSs are now such huge structures. We have 42 across the country. It is very remote. The feeling now of a lack of accountability and transparency is significant. Yes, we have definitely taken a backward step.

Q69 **Rachael Maskell:** Trudi, is that also your experience for mental health?

Dr Seneviratne: I absolutely agree with that position, as my colleague has just said. We are at the very early stages of developing this new world of ICSs and ICPs.

As I look around the country, there are multiple different models of engaging with clinicians. One of the most useful things that happened was that we collectively insisted that there be mental health representation through the Health and Social Care Act process into the ICS and ICP structure. That was really quite important.

However, on the ground, thinking about the balance between autonomy and accountability, we have a long way to go to understand how that will pan out. Clinicians are being appointed to key roles in the ICP, which is good, but there are very few. I could count on my hand the mental health expertise currently. We have not yet seen the national picture. Even though it is good that we have a mental health expert in the ICB at that level, I have not seen the sorts of people being appointed to those roles, so we do not know whether they are clinicians or other folk in the mental health space. Who you get in that mental health role is very important.

A clinician is very different from a peer support worker or a voluntary sector—VCS—worker who might be appointed to that role. It is critical that you have everybody there. Everybody's voice is important, but it is so crucial to have somebody who knows and understands the entire mental health pathway, certainly from a mental health point of view, and to have a population-level approach right through from the fantastic work that NHSE has been supporting with their development of the new primary care mental health teams—the front-door service—through to our secondary care services.

We have far too much use of emergency presentations right across all ages. There are far too many, which means that people are using crisis as a way of entering the system because the actual services on the ground are not containing people or looking after people in the community. There is that element. I could go on for ages and ages, but the bottom line is that I do not think we are there yet. It is critical that we get to a place where clinicians are at the heart of the ICBs and in the thinking of how they are set up, ensuring that mental health has centre stage in the delivery of services and that the mental health story is not lost to the many other demands that there may well be in the ICSs.

There will be many demands around physical health, around other structures and around how the money is spent.

Q70 **Rachael Maskell:** We end up with a situation of management rather than creating strategy. Vic, what is the experience around social care?

Professor Rayner: I am delighted that you have us here. The terminology is really important. We do not have the group of people called clinicians that people want to bring round the table. Part of the challenge is that social care provision is not properly understood or recognised as a key driver around this. If you are asking me whether social care providers in the constituency I represent feel that they are part of any strategy development—not at all.

While we have some local authority representation at ICB level, what we do not have is the voice of social care providers. If we really want to change the dynamic and we want to do things in a very different way, we do not have the people who can start to think about developing services in different ways to support communities, focus on prevention and focus on all the key things that are part of the ICS agenda.

We will come on to talk about some of the kinds of structures and frameworks. I know that you talked about that in the previous session. One of the things that it is absolutely key to understand is that, where there is a description of the local systems being set up under a culture of permissiveness, it is fantastic if you are part of the group that can give out the permission, but if you were never part of that, and if the skills and expertise in your sector were never recognised in that way, it is very hard to get to that table.

Q71 **Rachael Maskell:** This is really interesting, and also quite worrying because we are starting to ask the question, "What is the point?" David, I will ask you this one question. How does innovation happen and what has to change to make sure that we have clinically led bodies to effect the changes that the health service desperately needs?

Dr Wrigley: It is very hard to see how that will happen under the ICS. As I say, it is such a large body. We could devolve back down to localities. In my area of north Lancashire and south Cumbria we were split in two. Morecambe Bay was making fantastic progress under the CCG. I led the vaccine campaign in my area. The support from the CCG was phenomenal; they were local people who knew what was happening. As I say, it has all gone. Innovation is almost a luxury. We want to get back to just being able to deal with our patients, which we cannot do at the moment given the huge pressures we face across the whole system.

The neglect of social care over the years has had a catastrophic effect on the NHS in hospitals, in my specialty of general practice and outside in the community. We are in a desperate situation. Innovation would be very nice but let's get the basics right first.

Q72 **Chair:** That goes to the heart of the first question I asked the first panel.

Getting the basics right first is where we are. We have to do that, but do we have time? We need to get on and prevent ill-health and get upstream of this because demand so far outstrips supply. Are you worried about that, David?

Dr Wrigley: Extremely worried. Yesterday, in my practice, was the busiest day we have ever had. It was a Monday in winter. We have strep A on the horizon with very little help or support. Pharmacists are running out of antibiotics. Patients are desperately worried about their children, and we are trying to deal with it with no additional help or support. No one came to my practice or contacted us saying, "Can we help? What do you need?" The structures are not there.

We have a workforce on their knees, who feel vilified day by day by the media, and by politicians who also sometimes take part in that. The workforce are thinking, "What is happening here? We are doing our best for our patients and we are trying hard." Today, in the media, it says that one in seven patients cannot get a GP appointment, as if that is our fault. We are trying our hardest to see patients, to deal with them and treat them, but when you do not have the resources and staff morale is at rock bottom, or the ability to deal with patients—

Q73 **Chair:** Is that one in seven story true?

Dr Wrigley: It probably is because we do not have the capacity. There is the complexity now of patients, with their illnesses, and 7 million people on waiting lists. Yesterday, I saw about five patients because they were on a long waiting list—12 months to see a neurosurgeon, with severe back pain—and they come back to see me time and time again. Someone else did not have that appointment because the system is not able to cope with the pressure. I do not see how the ICS will be able to deal with that. It is a problem about the lack of funding over 10 or 15 years and a workforce that has not been looked after, thought about or cared for, saying, "We just can't cope any more. This isn't working." It is the same in hospitals.

Q74 **Chair:** But the NHS has about £150 billion a year of our constituents' money. It has never had more money. Even in the autumn statement, which was not exactly a paradigm of spending, it had an increase in its budget. How much more could we give it?

Dr Wrigley: Normally a 4% or 5% increase a year is needed to keep up with illness, innovation and new equipment. Since 2010, the increases have been minimal, so we are now way behind where we should be. We need that investment to keep up with services. That is why we now have hospital buildings in chaos. We do not have enough equipment. We have a workforce on their knees because investment stopped 12 or 15 years ago. That is a lot to catch up on. That is why we are in a really difficult situation now.

Chair: We could go a long way down that road.

Q75 **James Morris:** Trudi, I want to press you on a couple of things you said about the mental health issues. Obviously, a lot of us have been pushing to achieve parity of esteem between physical and mental health in the NHS for a long time. You said that across the country there were some mental health clinicians being appointed to ICBs and, in certain other areas, other folk—the way you put it—may be working in community mental health. Does it need to be a clinical person on the ICB?

Dr Seneviratne: I think that is absolutely essential. It needs to be somebody clinical because there is a greater understanding of the holistic care of the patient and of what could be managed, as my colleague was saying, at the primary care interface. The pathways are moving from what may be a universal provision for somebody who has a mental health need—a child, an adult or an older adult—to somebody who might perhaps need more secondary level input or indeed an in-patient stay.

It needs a clinician who has managerial expertise as well to understand the flow of people across the system. That is not to say one cannot have other colleagues and partners in there, but the knowledge of somebody who has clinical and managerial expertise is quite important or, if it is not there, to make sure that it is sought as part of the thinking.

Q76 **James Morris:** With all of the other priorities that we have been talking about in relation to the health system at the moment, do you think there is a danger that the mental health narrative, as I think you said, will be completely lost in these new structures that we are setting up? Will the aspiration to get parity of esteem be lost in this new world?

Dr Seneviratne: Yes. We are deeply concerned by that. It is important to state that, because parity of esteem for mental health has been talked about, and I have been a psychiatrist, for a long time. It is brilliant that there is funding in the NHS long-term plan for mental health services. It is fantastic that we are where we are with the long-term plan. It is the first time in my lifetime that there has been this level of investment for mental health. It is not all mental health services, though.

Even now, there is a real struggle to have people's mental health looked after and thought about in the same way that physical health is thought about and looked after. We have to move to a world where we talk and think about the whole person's health and mental health is not ignored. Sadly, this was all pre-covid but covid has unearthed an even bigger disparity for people's mental health.

I am a manager on the ground in an organisation, as well as a clinician. My in-patient ward is a psychiatric mother and baby unit. We are very proud because we fuelled the expansion of that particular specialism in the UK. We are the global leaders in perinatal psychiatry. It is brilliant, but we have had to close our unit which is a core unit—

Q77 **James Morris:** That is an interesting point. Do you think there is also a danger that, although the 10-year plan has significant uplift in investment

in mental health, not just as an aspiration but as a plan, that might get lost in the other decisions and priorities that we need tackle, and that we might not end up getting to the—

Dr Seneviratne: Yes, absolutely. That is a challenge for the ICS/ICB structures. We must ensure that the needs of those with mental health problems are properly looked after in all the care pathways in the ICS/ICB structure. We have to get the basics right for people with mental illness. There is an absolute crescendo of young people presenting in crisis to EDs and self-harming. It is criminal and terrifying. It is not acceptable. We have so many people presenting in crisis, as I said earlier. It is not acceptable. We have no beds to put people. Our estates are not fit for purpose.

Q78 **James Morris:** It sounds like you may need more than one mental health person on these ICBs.

Dr Seneviratne: It would be good, yes. I love innovating. I think innovation is absolutely the way forward. We want to do plenty more research going forwards in the space for mental health across the ages, with a cradle to grave approach, but we need people to be able to do that. We need a real governance structure, if you like, or a project management structure within the ICB that identifies all the areas within mental health. At the core of what is driving it, you have patients and families and the co-production within the ICB of the mental health agenda right across, from cradle to grave, so that we are looking at provision for children integrating with maternity health with the acute health trust and with primary care. It is looking at that holistic programme and the population-level programme, thinking about prevention. You cannot just have prevention, although that is good. We then have to have the basics and to be able to implement evidence-based treatments for people. At the minute we are not there.

James Morris: There is a lot to do.

Q79 **Paul Bristow:** I have a very quick question to Dr David Wrigley. We are here to talk about ICS structures and representation on ICBs. In your opening evidence, you mentioned lack of funding and investment in the NHS.

I thought I would put a couple of things on the record. First, the Institute for Fiscal Studies suggests that 44% of day-to-day Government spending—obviously not capital—is budgeted to be spent on the NHS by the year 2024-25. Secondly, as well as being the vice chair of the BMA and a very respected doctor in your area, you are also a member of the Labour party and Socialist Action for Health.

You said you have specific concerns about the low level of primary care representation on ICBs. What mechanisms do you think need to be put in place to ensure that primary care, or GPs in particular, are appropriately represented on these boards?

Dr Wrigley: First, on the lack of funding, my point was around not keeping up with the pace needed for 12 years.

Paul Bristow: It is 44%.

Dr Wrigley: As I said, it needs 4% to 5% a year. When you have 0% or 1% a year, it does not keep up, and there is a big backlog now. I have been critical of the Labour party in the past as well around what their policies have been, so it is not just about party politics.

Around representation, the BMA has analysed all 42 constitutions of the ICBs. None of them has a representation role for any secondary care clinicians. Just two ICBs are guaranteed a voting position for public health specialties, and 20 constitutions do not even mention public health. Do you remember that in the pandemic public health was at the forefront? We saw exactly how important public health is. They are expert in the commissioning of care. They are experts in prioritising care and focusing on deprived communities, but they do not have a voice there.

Under the Health and Social Care Act, they were moved to local authorities. They were promised that their funds were ring-fenced. That then slipped away. I used to have fantastic public health specialists in my area who I could talk to about moving funds around in the area for deprived communities. They have all gone now. There is very little public health input. As a specialty, it has been completely denuded and taken away from the system when, actually, it should be at the forefront in the ICBs because public health are the experts.

Local authorities now have a very powerful voice. We are concerned that, with the lack of funding in local authorities, the NHS budget will be used to block the hole there as well. In general practice, our budget is obviously utilised and is never overspent. We are concerned that overspends and the lack of funding in the whole system will feed into general practice and that we will see resources taken away, which will then threaten the viability of practices. We are now seeing that practices could well be on the brink of viability.

Q80 **Paul Bristow:** Dr Wrigley, what you said about public health is very interesting, but it flies in the face of what we heard earlier from Professor Jim McManus. He said he thought this was a real opportunity for directors of public health to work in partnership with other elements of the system. I asked earlier whether he felt it was an equal partnership. It seemed to be that it was a suck it and see operation. That is not what you are saying. You are saying that already you feel that public health is not adequately represented.

Dr Wrigley: Well, they are not on the board making the decisions directing how healthcare is utilised—

Paul Bristow: It is at odds with the evidence we heard earlier.

Rachael Maskell: I disagree. I think it is in line with it.

Chair: Okay. Dr Johnson, I should have called you earlier.

Q81 **Dr Johnson:** On the question of who is running these ICSs and whether it is a failure of the job description, you are saying that there is no clinician for social care, psychiatry, primary care or for secondary care in most cases. Who is running these organisations? Who got the jobs? What were the job description skills looked for, if it was not for any form of clinical expertise in any of the areas where the ICS was purporting to deliver services?

Dr Wrigley: I think people were appointed to the boards. The Secretary of State had a role in the chairs and who was on the board. Yes, there are clinicians involved but, as I said, not to the extent that we feel should occur. The BMA lobbied quite hard during the passage of the Health and Care Bill through Parliament for robust, clinical representation so that those who are working on the frontline, knowing day in, day out what is happening to their patients and what is needed for their communities, have a voice in the decision making of bodies with hundreds of millions of pounds of resources to direct care. That is the importance, we feel.

Yes, having local authorities working in partnership with social care, other colleagues, nurses and others, is very important. Having direct input from people on the ground is really important, and we do not feel that is adequate.

Q82 **Dr Johnson:** What effect do you think it has on efficiency? I was privileged both to work as a volunteer vaccinator with the covid vaccines and to see how the covid vaccines were being delivered and organised in different places. The most streamlined and efficient, financially and clinically, was one being organised in partnership between the local CCG and a group of GPs and nurses in practice. That had heavy levels of clinical input to its organisation. I saw others that had been organised in a much more top-down way that were delivering a visibly much more expensive and much more clunky sort of service. They were still delivering the vaccine, still being effective, but in a way that we cannot afford when resources are under pressure. What effect do you think the way the board has been appointed will have on the efficiency of the health service and, therefore, the clinical outcomes for our patients?

Dr Wrigley: On the vaccine service, I think 70% or 80% were delivered in general practice in the community under the primary care networks, the bolt-on to the GP contract. That is because GPs are experts in vaccinations. We do it every year. We are doing it now with the flu campaign and the booster vaccines. We knew that we could deliver it. That is why we stepped forward. We put countless weekends and evenings' work into setting it up. We saw the success of the vaccine campaign, which was phenomenal.

I should add that we had fantastic support from the CCGs. I really fear now that if we needed another vaccine campaign, without that local support I do not think we would be able to provide what we did back

then. It really worries me. It is vital that we have local support from the management and the CCG. It was phenomenal, and our local communities really pulled together. There was superb support from our local rotary club in Carnforth which we could not have done without. It was a real community effort and that was why it was so successful. Under the ICS, I really fear whether that could be replicated.

Professor Rayner: On your question about the job description and who are the right people around the table, part of the problem that we have in a lot of these discussions is that social care's provider contribution has not been recognised, even in the context of the discussion that Dr Wrigley has just had about vaccination. An absolutely critical partner at local level in the delivery of the vaccination was the social care sector. It was the care homes that were supporting people to be ready. It was the home care staff who were enabling vaccinations to happen.

That element of provision is not recognised. We have people sat around the table not understanding the fact that almost all social care is delivered outside the health trusts, health organisations and local authorities that are sat around the table. It is all delivered outside that. If you do not bring in that expertise, the sort of challenges that we are facing now are never, ever going to be resolved.

We had the Minister come to speak just last week, exhorting social care providers to come forward and support the challenges around discharge pre-Christmas. I completely understand that importance. I have been to those discussions for probably about 10-plus years. Every October and November, social care providers are brought together. It is not that people do not know where social care providers are, or what they can do or deliver; it is just that they are brought in at the point of a delivery relationship rather than as an equal partnership.

The problems that we are seeing in the workforce are completely exacerbated by that. We have people sat round the ICB table or the ICP, without social care providers there, who are thinking about how they will manage the kind of workforce challenges that are being faced. The parties at those tables are making decisions about their own workforce that are fundamentally undermining the ability of the social care workforce to address that.

We have local authorities potentially increasing the rates for their own staff. Of course, it is at their own behest to do so, but the automatic impact of that is that people who are trying to deliver care in the independent sector, who are funded by commissioned rates from that local authority, are unable to increase their salaries. We have hospital trusts who are putting in place terms and conditions to support their staff, as they rightly should, with the cost of living challenges, but all that does is to draw people out of the independent social care workforce and into the hospital sector, thereby leaving further challenges around workforce.

One of the Committee's challenges is around accountability. It does not feel as if there is accountability at the table when you do not have the full representation of those vital elements. Those are really important parts about who needs to be there. It is not local authorities because local authorities, in essence, are largely commissioners. As long as you only look at the expertise in social care as part of "What can we buy from them?" rather than "What can we do together in order to plan and prepare for our communities' needs?", we are going to continue to fail. I am afraid that the ICS will not change that at all.

The Chair mentioned the question of innovation. Social care has had to, and continues to, innovate on an almost daily basis in order to meet the very rapidly changing needs of the people that it sees. Sarah McClinton, a previous witness, talked about the 500,000 people who are currently waiting for assessment and waiting for social care. What that means is that people coming into social care services are frailer, need more support and need services to be delivered in different ways. Providers are having to innovate and change that. It would be so much better to have them at the table and see that as a strategic agenda implemented across the system. I am afraid that, unless we are clear that social care expertise and social care delivery is part of the job description and that an understanding of that is part of the job description, we are not going to see the kind of transformational change not just that we want but that communities desperately need.

You talked about the level of funding for the NHS. The level of funding for social care is not in dispute at this Committee, in the sense that this Committee has very effectively advocated year on year for much more money to be put into social care. The money that is being put forward is welcome, but it is absolutely not sufficient to transform social care and make it fit for now, never mind fit for the future.

Q83 **Dr Johnson:** In reverse, Professor Rayner, you have criticised the current composition of these boards on the basis of the skills that they do not have but you would like them to have. Have you analysed what skills they have on the board that are particularly crucial? Is it just that they are over-represented, or do you think that they have chosen the wrong people altogether?

Professor Rayner: They do not have the right people, in that they do not have some social care provision. I have been a bit broken record about that. Unless that is changed it will be a problem.

There are some very interesting principles that have been agreed or co-produced around the engagement of social care. In a way, they talk to some of the things that those boards need that many people here suggest are not being recognised in that way. There is not, particularly, a core understanding of how prevention needs to work in practice and how we can get that upstream expertise.

Q84 **Dr Johnson:** Without making the board get bigger and bigger, as each

person wants representation on it—I can see the strong and clear arguments for clinical representation; I completely agree with that—are the people composing the board at the moment the wrong people? Which skillsets would you take off in order to add the clinicians, without making the boards too big?

Professor Rayner: You probably need to make the boards bigger in that sense, to get some of them on.

Q85 **Dr Johnson:** What sort of people are on the board now? What skillsets do the people on the board have now?

Professor Rayner: What do they have? They have strategic skills, but they do not have the full picture.

Dr Seneviratne: I absolutely agree with everything that has been said so far. We should look at this as an opportunity. It is a fantastic opportunity. The system has to be grateful for the progress that is happening.

If we think of it as an opportunity, these boards are in the early stages. It is important that all of the boards have not been appointed. We know that they are operating in slightly different ways. The accountability point is important. Moving forward, we have to ensure accountability of the board, to make sure that the right people are actually on the board. That ultimately goes to asking the Secretary of State to look at the boards.

Moving to the mental health picture, it is important that whoever is appointed as the mental health lead for the ICS and ICP is able to be supportive, with patients and carers being at the core of what is being delivered. There should be a programme of activity that looks at all ages of mental health and the whole picture, including the prevention piece, with a programme that with the support of NHS England, because they have the data, is monitoring things like waiting lists, waiting times for treatment and all the figures that we can capture so that the programme is accountable. Whoever is the mental health lead should be supported in having a programme that is accountable year on year as part of the ICSs and ICPs progressing.

A helpful way to look at it is that this is a huge opportunity for transformation. I say that to my local teams all the time. Actually, shifting chairs around in the community for transformation for both CAMHS and adult services is a huge opportunity, as I keep saying to the clinicians and our managers. Clinicians are so disheartened. They think, "Oh my gosh, not again. What's going to be different this time round?" We say, "It is going to be different for people. It is going to be different for patients. It means that the children will be looked after differently. The older adult, grandma, will be looked after differently." I was on call two weekends ago. We had 31 people waiting for admission, with no bed in the organisation that I work in. That is not acceptable. It is simply not acceptable.

Q86 **Dr Johnson:** David, should there be a medical director on the board?

Dr Wrigley: From where, or just for the overall responsibility?

Dr Johnson: Overall.

Dr Wrigley: I feel so, but I feel we need broad representation. On your point about who is on the board, they are all excellent people. They have superb skills and are very senior, but in a way they have an impossible job. I would not want the ICSs to be blamed for what are almost impossible pressures in the system.

How does an ICS deal with a social care system that is grossly underfunded? We cannot discharge people from hospital. There are 200 people in my local hospital ready for medical discharge who have nowhere to go because there is nowhere in the community for them to go. If we focus on the logjams in the system, we can deal with the pressures across the whole of the NHS, but I do not know how an ICS could deal with that. It is almost an impossible role. My ICS is making people redundant. They had an all-staff meeting the other week with a mutually agreed resignation scheme because of the tens of millions of pounds system deficit where they have to plug a gap. They have been told that they have to sort out the deficit. Their laser focus is on the funding, the finances.

Q87 **Dr Johnson:** Of course, they should have a laser focus on funding and finance because this is 44% of the Government budget, and it is important that it is spent well.

You talked about the demand increasing. We see the population getting more elderly. There are more complex conditions and increasing demands. The population is getting larger. There was net migration of half a million last year as well as a general increase. That is increasing the demand for the NHS.

Do you think the issue is really money, or do you think it is a failure over a long time to recognise the number of extra doctors in particular, and nurses and other clinical staff that we would need? More money will not necessarily help instantaneously. I started my training as a doctor in 1996—I was terribly old—and the cap on doctors' numbers is what is causing much of the NHS problem at the moment. It is the fact that over generations of different Governments of different colours and coalitions and suchlike, we have under-invested in the number of doctors each year, which means that the number of doctors we need per capita, per condition and per demand has fallen.

Dr Wrigley: We have the lowest numbers of doctors per thousand patients in the western countries. That is something we need to focus on. It is about funding, as I have already mentioned. I will not go over that again. It is about morale in the workforce. That is a real issue.

There is also bureaucracy. In general practice we have huge amounts of box-ticking and chasing of funding, whereas we want to get on with

seeing patients. One of my clinical pharmacists probably spends a day a week chasing targets, chasing points and chasing bureaucracy just to allow the funding to keep the practice going, when they could be seeing patients.

We say, yes, have some checks in the system to ensure that we are providing good-quality care, but let us get on with our job. Trust us with the finances to run our practices in our localities. We should celebrate general practice because it runs in a locality working with patients on how they need their services. In a local practice to me in Lancaster they look after a university. They tailor their system to a completely different population. It needs that focus, but remember that we are a diverse population. That must be remembered, and we should focus on getting rid of the bureaucracy because that will free us up to see patients.

Q88 **Taiwo Owatemi:** I want to ask Professor Rayner a quick question about how we ensure that adult social care becomes a partner within ICBs. Does there have to be a statutory requirement for ICBs to include adult social care providers within the board?

Professor Rayner: Yes, I think that is where we are at. It would be enormously helpful to have that recognised as part of the statutory responsibility. Without it, that is where we are continuing to suffer.

It is interesting. The King's Fund did some recent research around the engagement of social care providers and said that there needs to be some proper structure around that. We have various mechanisms—care associations, national and regional bodies and things—that would need to be in there to do that. Alongside having it as a statutory role within the ICS, we probably need to look at some of the other areas where decisions are made that then have an influence on the ICB and ICS's ability to work at regional level—for example, ensuring that we have statutory representation of social care provision at that level. When there are workforce decisions about numbers of doctors and nurses, mental health support, and so on, we need to make sure that we are talking about what is needed across the whole system and not just for acute systems.

Q89 **Taiwo Owatemi:** Given the fact that there are so many adult social care providers, how do you decide which organisation is the most important?

Professor Rayner: I do not think that social care providers see that as a problem. As I say, we have local care bodies that bring together all those social care voices. They are an absolutely adequate and effective way of doing it. The principles that have been produced by the Government talk about adult social care providers being "encouraged, supported and, where appropriate, resourced to build sustainable networks and relationships." If an ICS is looking around and saying, "I don't know where to turn in terms of adult social care," that should not be the stopping point. Resourcing that so that there is an effective voice would be hugely important, but, yes, it has to be there because of those sorts of discussions, particularly around prevention.

We have to recognise the things that Dr Trudi was talking about in terms of people's access to mental health support. Of course, the bit they get from the clinicians is vital, but the rest of their time they are being supported by adult social care and support providers. That bit of the system will not work unless people have a safe place to live and people they trust caring for them and providing them with the support they need.

Dr Seneviratne: I entirely agree. That collaborative partnership is so essential. There are blockages in mental health. We cannot get people out of in-patient beds when they are ready because there is nowhere for them to go on to. That partnership is crucial in helping the flow back into the community and keeping people well in the community. It is essential that that is represented at ICB level, so that these conversations are happening at the highest level.

Chair: Just in the nick of time. Professor Rayner, Dr Seneviratne and Dr Wrigley, thanks very much for joining us.

Examination of witnesses

Witnesses: Rob Darracott and Andrew Lane.

Q90 **Chair:** Our third and final panel consists of Rob Darracott, editor of *P3 Pharmacy* magazine, and Andrew Lane, chair of the National Pharmacy Association. You have been here throughout the morning and have heard the evidence given by the various witnesses. Thank you for joining us.

Let me ask you about leadership, Andrew. You must see integrated care systems. You must interact with them. You must hear from your members about them. Are the right people leading ICSs? Are the senior people in local health systems running the trusts or are they running the ICSs? Are the right people where they should be?

Andrew Lane: I can talk with experience from my own particular involvement in Gloucestershire ICS. We have an excellent chair, Dame Gill Morgan, in Gloucestershire. I think the leadership from the top, in the system I am involved in, is absolutely right. She has the right vision. She understands that it is an inclusive operation and recognises, where perhaps CCGs have historically failed, that we now have opportunities to start co-creating locally.

In terms of the rest of the country, the feedback I am getting from my membership of the National Pharmacy Association who are involved in their local systems is that it is very patchy—extremely patchy. It is incumbent on community pharmacy particularly to make sure that our network of local pharmaceutical committees gets involved very early on, as we did probably two or three years ago, getting used to who the players were going to be on the local system.

We were already pretty well networked with the CCG. I certainly believe from pharmacy's perspective that it is incumbent on local pharmaceutical

committee leaders to make sure that they are involved in every part of the system. As you know, community pharmacy adds value to a whole range of—

Q91 **Chair:** We will get on to that a bit more. Is the leadership of ICSs good enough, Rob? Is it strong enough? Would they get through Sandhurst?

Rob Darracott: They may well be able to. They may already have been through Sandhurst, some of them. I would have to say that right now the jury is out. From a pharmacy perspective, you were very kind to mention that I spend a lot of my time these days editing a magazine and having a chance to talk about these things on a regular basis.

It may be helpful to know that I do a little bit of policy work. I did a bit of work on this about a year ago. I asked colleagues around the system whether they were ready to engage with integrated care systems at their eye level. I got a very interesting picture. Some very clearly said, "We don't really know where to start," or, "We haven't made a start."

There were some very interesting comments from the people that I would see right now as being the exemplars of how you can actually effect change. They said, "Rob, we don't want to go on about seats on the board right now. What I'm particularly interested in is: can I get into a position or am I talking to the people who will be sitting down and redesigning the pathways, who will be identifying how the system should fit together in a more integrated way? Am I at that table, because that is the point where they might want to hear what I can do rather than at the high-up level where people are making the ultimate decisions?"

Although the people who would say that they are in those positions are relatively few and far between, you can get there. It seems to me that if you then follow that through and see the kind of conversations they are already having, and I were to go back to them now and say, "How are you getting on?", they would say, "Well, actually, we're starting to see things happen now. We're starting to have the kind of conversations that are about the future of a more integrated and more joined-up system in which pharmacy plays a small part, but at least I feel I'm part of the conversation now. Two years ago I'd have struggled to be part of that."

Chair: Okay. Taiwo Owatemi, let's bring you in at this point. I know you wanted to ask the gentlemen some questions.

Q92 **Taiwo Owatemi:** Thank you, Chair. Rob, the point you just made is very interesting. We have so many pharmacists in this country. Many of them will say that they do not know where the table is or the process for being able to find a seat at that table. What work do you think needs to be done, especially for local pharmacists, to feel that they are playing a role and can have a seat at the table?

Rob Darracott: There are two gaps. I have been going on about this sort of thing for more than 30 years. One is getting the system to recognise the valid point that might be made by people that they do not

really think about it and do not know about it. You don't know what you don't know. That is a challenge in itself. All national organisations can do what they can to engage at that level and say, "Have you thought about this?" In fact, in your first evidence session, Chris Ham, in response to a question from Mr Morris, I think, said that there is a particular thing that pharmacy could be helped with a little bit, and that is to support leadership development.

Wherever the pharmacists are in the system, whether they are working as locums, managing a pharmacy or working in primary care, there is a difference between organisational leadership, however big or small the organisation is—it might be just them—and system leadership. There is a huge gap there. To prepare people to even think about how the system fits together and how they might play a role in talking about what might happen in the future, or where they might fit, that gap needs to be plugged somehow.

There are programmes around. The NHS has got better at engaging pharmacists, but the recognition that there is a gap is an important part of creating the conditions in which pharmacists think, "Do you know what, I could do that." You will know, more than I know from recent practice, that pharmacies are a very rules-based kind of thing. We do things in a certain way. We like the way all that fits. Therefore, to break out of that, people need to be challenged to think very differently and not to think that they are always in a particular box. That sort of thinking needs unpacking, encouraging and developing. Not everybody has that, so they need a bit of help.

Q93 **Taiwo Owatemi:** I agree with that. Andrew, I want to move to pharmaceutical commissioning. The ICBs are due to take responsibility for that in April. Do you think they are ready?

Andrew Lane: They are all going to be at different levels of readiness, depending on how far back they started on the journey to that readiness. Again, speaking from my own experience, even though we started on the journey a few years ago, we are still at the very early stages of understanding what that might look like. We are in the south-west. We were already looking at how the south-west might have a hub for delegation. Other regions are looking to have a similar sort of set-up. It is very difficult to see how that might work, bearing in mind that we are actually just finding our feet locally as well.

We are fairly fortunate, in a way, because we are coterminous with the secondary care trust, and coterminous with the council. We have 109 pharmacies in Gloucestershire. We are all engaged. There is a can-do attitude that comes from the top, Dame Gill Morgan. She has empowered the board for all the different parts of the system. It is now POD—pharmacy, ophthalmology and dental—and we had our first meeting of all those providers just last week. It is coming in April and we are having those early conversations, but to your point, it is going to take a lot longer to establish proper processes and proper governance

arrangements to make sure that everyone is working at the top of their licence, for want of a better word.

Q94 **Taiwo Owatemi:** How do you think we can assess the accountability of pharmacy services within the ICSs? How do we ensure that ICSs are accountable for the pharmacy services they are providing and assess how good they are?

Andrew Lane: To a large extent some of that accountability, as mentioned previously, comes through NHS England in its usual monitoring. More importantly perhaps, pharmacy has always had, as we heard earlier, a rules-based approach. We are very risk averse.

One of the current examples facing us now is this. I had a meeting with local GPs on the system a couple of weeks ago. They said, "Well, actually, you have this great service called GP CPCS coming. We would really like to make sure that we can get UTIs off our desks. At the moment, we do not have a PGD. That means we cannot have a regular pharmacist being able to prescribe antibiotics for UTIs." Some systems already have that. You would ask the question, for uniformity, why wouldn't all systems have the opportunity to allow their pharmacists to allow their GPs to get UTIs off their desk? That is going to shift, as we heard earlier, some of the value so that more important things can be done by GPs. The GPs want to get UTIs off their desk, so surely the system should be able to have PGDs for UTIs enabled. Our surrounding systems already have that in place. That is just an example. You have inconsistencies. How you provide for the accountability to make sure that that is covered across all systems is still a bit unclear.

Q95 **Taiwo Owatemi:** Do you think that inconsistency will start to change once pharmacy prescribers come into the system more in 2026?

Andrew Lane: I am not too sure whether the accountability will change, but the system needs to plan for that. What we have actually said is, yes, you can plan for independent prescribers coming, but they will not be ready with a pad or a budget on day one. Between now and then, you have time to plan for those coming and have a strategy for how you are going to deal with that workforce. In the interim, you can plug that gap with PGDs. In other words, you do not have to wait for a prescribing pharmacist to come along before you can prescribe antibiotics for UTIs.

We have some national anti-microbial stuff going on in the background that will perhaps slow some of that down, but going back to the risk piece, you can mitigate that risk. Your system can have the governance in place to mitigate that risk. Other systems are doing it. The system can work out, with the right people, how you fast-track some of the opportunities that are around to involve pharmacists in clinical service provision at a much earlier stage.

Q96 **Taiwo Owatemi:** Rob, as you said earlier, pharmacists like structure. We are risk averse, and change is something that we are very careful

about. We heard from Professor McManus earlier about the important role that pharmacists play in helping with improving patient outcomes.

Do you think that in the future it would be beneficial for pharmacy to move away from the traditional model of pharmacy, with one clinical pharmacist providing dispensary services, to a model where there is flexibility and better co-operation between pharmacists? For example, you have a pharmacist who is still providing that traditional service but another clinical pharmacist is providing diabetes support or smoking cessation support that is tailored to helping GPs and helping primary care address some of the public health outcomes it wishes to prioritise. Do you think that moving away from that model is achievable and how do you think that we can get pharmacists to think in that way and approach that model?

Rob Darracott: It is achievable because it is being done now, although the examples of it are few and far between. One of the things I do is to find out how people have done it and why they have done it. Why did they decide that they needed to move into that model? What is the benefit back to them, because the received wisdom will be, "We can't afford to invest at that sort of level," but I think it is happening.

To pick up your previous question, we are seeing some very small shoots of pockets of interesting activity. Some local system managers want to talk about a community service. Community pharmacy is community: they are embedded very deep in the heart of communities in neighbourhoods. They are often the only thing that looks vaguely retail that is left standing in some pockets of the country. They are investing in single services from single pharmacies. I heard of one the other day that is providing a service across a whole town. They are not the only pharmacy in the town, but they are providing a service because they have the experience. People recognise that they try to do things differently and they are developing.

There are some other examples where there are networks of pharmacies in local areas, often not the whole of the membership of the local pharmaceutical committee area but a group of pharmacies that have been commissioned to deliver a service. It can be targeted very geographically. There were some amazing examples during the first stages of the pandemic of community pharmacy delivering surge LF testing for local councils because they are in the communities where you need them.

There are some signs of that. That is meeting up with innovative models of provision, saying, "You know, if we think about our servicing in a slightly different way and then recast that to have capacity to deliver more of these things, we are seeing some of those things." They are also taking the opportunity to say, "What other staff do we have available? Do we have a pharmacy technician or another registered professional on the team? How do we use them effectively? How far can I push the rest of

the pharmacy team members to be part of the triaging system? How will they all react?"

We are seeing that being developed really positively. I was in a pharmacy earlier in the year in south London where they are supporting a local big trust that was having problems discharging patients into the community where the pharmacy was a blocker to providing a service there. The guy running that business said to me, "We give people more reasons to come to work because they feel they are more helpful. They are treating their own families and friends because they are from the locality. That is a benefit to me because we are seeing less turnover, and people want to stay with us and build."

There are models out there. You might have to find them, but I always used to say—I still say it now—that if you scratch the surface of most communities you will find somebody doing something and you will say, "Wow, I never knew they could do that. How did they fix that?"

Q97 **Taiwo Owatemi:** Should that model be implemented nationally across all ICBs?

Rob Darracott: England is a huge place, and that is always the challenge. I wrote a piece the other day as a result of a conversation I had with the chief pharmacist from Wales about some of the changes they have been making there. I think there is an interesting opportunity. NHS England have invested in pharmacists within NHS England at system level to have a chief pharmacist's role. They have also invested in part-time liaison pharmacists—it is still going on; they do not all have one yet—who will start to knit the whole system together and explore what is available.

That is an opportunity. That is why ICSs are, in one way, an opportunity. Instead of talking about the whole of England and whether we can do this nationally, which is a heck of a challenge, particularly right now, can we bite it off? If I am in, say, a small ICS like Frimley Health—geographically the smallest, and complicated because of the local authority functions—can we do something there? If I am the ICS chief pharmacist, could I effect some change locally that would start to make a difference, start to change the conversation, start to encourage people to do things slightly differently and start to implement some of the national services that are not quite as embedded as they perhaps ought to be but could relieve pressure on GPs? What is my role in that?

My suggestion, if you want to know how to effect change at a slightly smaller level in the geography of England, is to go to Cardiff and ask them how they did it. They are doing some of it there and it is a very interesting approach.

Taiwo Owatemi: They are indeed. Thank you.

Q98 **Chris Green:** I think the territory I was going to ask about has been covered. In terms of pharmacy representation at the ICS level, Mr

Darracott, you suggested that it is not necessarily having representation there, provided that they are listening to the right people and perhaps being incorporated in the structures and the advice. It does not need to be necessarily included, but where some ICSs take up that advice, and others do not, you are going to have variability of outcome.

Rob Darracott: I will try to give you a very brief answer. It would be nice, but we have already heard today that the boards are huge. The model I have seen work at a much lower level is where people suddenly realise, "Do you know what, that person is clearly connected. They've got something different to say. They've got a vital perspective." After all, pharmacists are clinicians and with that comes critical thinking and the ability to look at papers and say, "What is this saying to me?" There is a clinical perspective, wherever you are. There is a pharmacist who I think has been appointed to the integrated partnership board in Cheshire and Wirral, but he is there representing the primary care professions.

Yes, it would be nice, but there is also a case for saying that, if we got some of the leadership piece right, I would back people in some parts of the country to show what they can do. People would go, "Do you know what, it would be really great to have pharmacists around this table because they ask different questions."

Q99 **Chris Green:** That gets to my point. In terms of primary care, where you have GPs, social care, dentistry, pharmacists and ophthalmologists, you have a range of different people who would be interested in having a voice at the integrated care system level. My impression at the moment is that the GP voice is perhaps the dominant voice at that level and, therefore, perhaps drowns out the other voices, or they would seek to represent the broader voice but perhaps it is easier as a GP representative to represent the voices of GPs. When there is increasing interest in what, for example, pharmacies can do, in the overlap, in the question of whether it is the GPs or pharmacists who should be delivering it, that representation of interests is perhaps not reflected as well as it might be by the GPs. Mr Lane, would you like to answer that?

Rob Darracott: Andrew has practical experience of that.

Andrew Lane: My GP colleagues will understand this. Dr Claire Fuller set out her vision of how it was all going to come together. We are still on the Fuller journey of integration. It is really important that we use Fuller, because we have all got behind that, as a basis for how primary care integrates, not just with itself but with the other parts of the system. For too long, we have had secondary care in an ivory tower with a separate budget outside primary care. Now they are in the tent, and we are having really good conversations. I have another example. We have a discharge medicine service. We are now talking to the local hospital about how we can make the journey seamless for patients who come out with complicated meds. That would never have happened before this system.

If we stretch it a bit further to our colleagues in care, again we are having conversations that we never had with local councils. We get involved in the local flu campaigns and all the other things that a pharmacy does, but we were on the edge of the whole piece of care that we heard about from our colleagues earlier. Most of our delivery drivers in pharmacy, for example, are dementia-approved carers; they actually go in and spot people with dementia.

There is a lot more we can build on in that whole integrated piece. Historically, we have all been in different silos. I certainly see the system as an opportunity to pull all those bits of the siloed systems together for the benefit of the patient. In other words, we leverage the best value of the pharmacy pound for the taxpayer in the system. If we all focus on that, the money in the system will follow the patient. The process will end up being the right process for the patient, particularly because we have all the patient groups involved in that discussion as well.

Q100 **Chris Green:** This is actually quite positive. It is interesting that historically, perhaps, these relationships were not formed and now there is that opportunity. I do not seem to be getting the suggestion at the moment that there should be any compulsion. There should be flexibility in each ICB as to how representation is developed and formed, but there ought to be opportunity within the system so that if cost savings can be made in different places within that overall system, it ought to be retained in that area to save money and reinvest that money locally. You would actually have a system that incentivises efficiency and effectiveness.

Andrew Lane: And prevention. Our Professor mentioned that earlier; we can perhaps move that 2% of budget from where it is now to more about the prevention agenda. Pharmacy sits right slap bang in the middle of that opportunity.

Chris Green: Mr Darracott?

Rob Darracott: I have one other thing to add. There are certain low-hanging fruit levers that could be pulled, which do not knit the system together as they might do. It might not be the right cycle to do it, but the pharmaceutical needs assessment, which is currently done in each locality, is not formally connected to the joint strategic needs assessment. It could be. If you have a process over here which is thinking about what the pharmaceutical needs of the population are, and that is separate from a bigger strategic process considering the joint strategic needs of the population, inevitably there is going to be a disconnect between the two unless somebody is a genius locally at things and says, "Do you know? It would be great if we could join these things up." It may be that the time is not right to connect it now, but it seems to me to be odd, if we are talking about integration, that we do not also integrate things that look at the system and say, "Have we got what we need?", or, "Shall we flex it a bit?" and that is not then connected as part

of a bigger piece which says, in the totality of health and care, "Have we got what we need and, if not, how do we fix it?"

If you have people sitting slightly outside the rest of the system, as pharmacy has done historically with a national contract framework and everything else, it is another opportunity for people to say, "Hey, what about this lot? You know you're supposed to be responsible for this, so how do we connect it to this other bit that you are already responsible for?" They are both supposed to be looking at needs across the piece. There are things like that that could be done to help things along and get people to think, "Hey, we need to think about pharmacy."

Q101 **Chair:** Thank you very much. Finally, Andrew, you will be aware of the press stories at the weekend: "Pharmacy drafted in to break NHS strike." I can wonder what your response to that may have been, but I suspect it involved the words "Money. Show. Us. The." Would that be accurate?

Andrew Lane: It is interesting. Obviously, we have some sympathy with our NHS colleagues, doctors, nurses and ambulance workers who are at this juncture deciding that enough is enough. Our negotiator used those words—enough is enough—recently. I do not believe we are in a position to strike-bust. I think the press have got a hold of an opportunity that they believe we are in a position to do that. We are not.

Q102 **Chair:** That is a headline writer's take on it. The serious point was that the Government want to put more the way of pharmacies and allow greater prescribing powers, which will require a change to the write-in ability on the patient record. Do you welcome that, or do you think, "Yes, but we can't just keep doing this on good will"?

Andrew Lane: We welcome it in a properly costed, funded environment. That comes back to what I was saying to Chris Green about how the system can look at the money that is available in the system for the population and involve pharmacists in prescribing. That whole NHS economic model has not really been developed yet. It has a long way to go. The right health economists supporting us in community pharmacy at the moment—with bigger brains than we have—could probably get to that model. Certainly in the early stages, where we have seen pharmacists prescribe and get UTIs off doctors' desks, for example, we are starting to release capacity.

We are absolutely on that clinical journey, and we welcome that, but it has to be with the right level of funding. As we know, many pharmacies have to close early at the moment because they struggle to find pharmacists. I mentioned our workforce survey that the system did recently in Gloucestershire. It demonstrated that there are 85 pharmacists required just to meet the ongoing need. That is not in community; it is across the system, in hospital and in GP workload. There are 85 required in the next two years. We have a workforce issue to bust as well, but we are definitely on that clinical journey.

Chair: Thank you very much. That concludes our session. Rob Darracott and Andrew Lane, thank you for joining us to talk about ICSs and pharmacy.