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Health and Social Care Committee

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

Tuesday 17 January 2023

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Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Paul Bristow; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris; Taiwo Owatemi.

Questions 103 - 153

Witnesses

I: Louise Ansari, National Director, Healthwatch; Sarah Walter, Director, NHS Confederation ICS Network; and Nicholas Timmins, Senior Fellow, The King's Fund.

II: Kate Terroni, Chief Inspector of Adult Social Care and Integrated Care and Interim Chief Operating Officer, Care Quality Commission; and Zina Etheridge, Chief Executive, North East London ICS.

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Examination of witnesses

Witnesses: Louise Ansari, Sarah Walter and Nicholas Timmins.

Q103 **Chair:** Good morning. This is the Health and Social Care Committee, and the third session of our inquiry into integrated care systems: autonomy and accountability. We have two panels this morning. We will try to change over at about a quarter to or 10 minutes to 11.

On our first panel, in their seats, we have Louise Ansari, who is the national director of Healthwatch; Nicholas Timmins, who is a senior fellow at the King's Fund; and Sarah Walter, who is the director of the NHS Confederation ICS Network. Thank you very much for coming in to join us as part of this ongoing inquiry.

Obviously, there are lots of very live and topical issues in the health service at the moment. Those watching could think that this is rather dry and rather a rabbit warren, and that we are talking about structures of the NHS. Yes, we are, because this is an ongoing piece of work and Select Committees are able to step back and be a little more reflective. I think that that is important, but how the NHS commissions services and how that works is also important to how the NHS operates and treats patients. That is the context for those watching, which all of us in this room know.

Perhaps I might start with you, Sarah. Are ICSs working out, or is it too early to tell?

Sarah Walter: I would say both. The progress that we have seen to date has been encouraging. We need to recognise that it is very early days for systems—they have been in existence for just over six months—given their ambitions, the intention around ICSs and what they have been set up for, which is around their four core purposes. When they were established, they set out to improve population health outcomes, to look at reducing health inequalities within their population, to improve productivity and efficiency, and to enhance the NHS's contribution to social and economic regeneration. Those are all long-term ambitions.

After six months, we are not in a position to be able to judge whether they have made progress in each of those areas, but there are encouraging signs of greater integration and connection across the different parts of the system. ICSs have been set up as a partnership in order to support greater cross-working between the NHS, local government, voluntary sector partners and the wider health economy. From the conversations that we are having with our members and some of the examples that we are seeing across the country, we see progress in those areas.

That relates both to some of the longer-term objectives around, say, social and economic regeneration and to the here and now. Nottingham and Nottinghamshire ICS is doing some work around discharge hubs and supporting improved discharge from hospital with wraparound care for

patients. There is work in Gloucestershire around supporting ambulance handover delay and helping people to move through the system. They are having practical impacts now, but I do not think that we have seen, and would not expect to see at this point in time, the kind of long-term, sustained progress and improvement that we want over the long-term horizon.

Q104 **Chair:** You mentioned Nottinghamshire and Gloucestershire. They are the apple of your eye. One of the purposes of your network, through the Confed, is to spread the love. Who is on Sarah's naughty step at the moment? Who is not making good progress? Please name names.

Sarah Walter: I do not have a naughty step, and I would not put myself in the position of naming names. Integrated care systems are interesting. Across the 42, every system is good at something. One of the things we do within the NHS Confederation, through our ICS network, is help to spread particular areas of improvement, or where innovation is taking place within particular systems, across the wider community. We would not say that any particular system has everything sussed. Equally, I do not think that there is anyone who does not have something positive to show, but it is differentially spread across different systems, as you would expect, because they are different and have had a very different evolution. Some are much more well established and have been operating as a system for longer, so you would expect them to be showing more progress.

Q105 **Chair:** Yes. They are six months old in legal terms, but they are not all six months old in terms of their work.

Sarah Walter: That's right.

Q106 **Chair:** Mr Timmins, would you concur with that, that they are all good at something, but none of them is the finished article yet? Are you content that we are on the right journey with ICSs?

Nicholas Timmins: Conceptually, yes. Absolutely. The idea of better-integrated care is not a uniquely British proposition. Everywhere, all around the world, is trying to do it, and nobody is finding it terribly easy, but conceptually it has to be the right thing to do.

Has there been progress? Yes. More in some places than in others. I would not want to try to give you a list or a league table, but it is clear that relationships with local government have been better in some places than in others. More progress has been made when that has happened. This is much more about behaviours and relationships than about rules and legislation. It is about mindsets and how people go about agreeing that they need to do the right thing, and then trying to work out how to do it within the constraints of the funding flows and what have you.

Q107 **Chair:** It is very interesting that you put it in those terms. Yes, it is about relationships and behaviours. Another word for that is leadership. Are the ICSs well led?

Nicholas Timmins: By and large, yes. I have not spoken to every chair and chief executive, but the ones I have spoken to are impressive people.

Q108 **Chair:** If you were the up-and-coming talent in a particular local health economy, is where you would want to be leading an ICS or would you want to be the chief executive of a trust?

Nicholas Timmins: That is one of the interesting questions we will discover the answer to over the next few years.

Q109 **Chair:** That is why I asked it.

Nicholas Timmins: If ICSs succeed considerably—they are never going to succeed perfectly—in doing what they do, it will become a very attractive job to do, won't it?

Chair: Yes.

Nicholas Timmins: When I talk to some of the people who are doing this, it is interesting to hear that they have rediscovered why they went into health in the first place. They are starting to worry about population health and health inequalities, not just—I do not mean this belittlingly—churning through the waiting list, if you see what I mean. For some of them, it has fired up what brought them into health in the first place. There is a possibility for that, but for it to happen the ICSs have to be effective, and, one might argue, be allowed to be effective.

Q110 **Chair:** What do you mean by "be allowed"?

Nicholas Timmins: Members of this Committee know that the NHS is famous for a central command and control approach to everything. The concept of an ICS cuts across that to a considerable degree, so a new balance has to be found. On one level, ICSs have to be accountable through to the Secretary of State, but they also have to work very closely with local government, the voluntary sector and what have you. Those are different accountabilities that cut across each other and are in tension. To put it very crudely, if the centre cannot let go up to a point, ICSs will not flourish.

Q111 **Chair:** It is like parenting. You have to let them go to the rec occasionally, don't you? Thank you for that. Finally, Louise, broad brush, are ICSs half full or half empty?

Louise Ansari: Actually, we think that 50:50 is about right, looking through the lens of being accountable to patients, the public and communities, and having the right structures in place, the right people in governance and the right support for the voluntary sector.

You and Nick mentioned leadership. We definitely think that there needs to be a culture of leadership where chairs, chief executives, the whole board and all the staff and bodies in the ICS genuinely believe in listening to their communities, and that then feeds through into what their priorities and actions are. There also needs to be a letting go of some of

the statistical-only or quant-only culture that perhaps pervaded CCGs. We must value people's experience and stories as much as the quant analysis. Those are some of the principles that are needed for all ICSs to succeed and be accountable to their public and communities.

Chair: Thank you for that as a start.

Q112 **James Morris:** I want to probe a little around what the Chair was saying about the tension between local and central. Does it matter that there is variability in what ICSs do?

Louise Ansari: We think that there should be fewer central targets and certainly more local autonomy, because the priorities should be set largely by the people in the area. It depends on who lives there. We see across the country that, obviously, some areas have different levels of deprivation and different groups that suffer greater inequalities, and that some local people have different priorities for health and care. At the same time, there are common themes such as access to primary care, particularly dentistry and GP services, mental health provision at all ages, women's health and children's health. Of course those are common themes across the country. It is a bit of both. There needs to be variability in local priorities.

North East and North Cumbria ICS is a good example for us. When they were setting their priorities for the integrated care strategy, they had an idea. The 14 local Healthwatch on the patch of North East ICS did a big listening exercise. People said, "You're not putting enough emphasis on our children and young people," so they shifted the strategy. That is a good example of listening.

Q113 **James Morris:** Further to Mr Timmins's point, how do we stop the centre crushing this interesting new structure that is evolving, which seems to be working in different ways? How do we stop that happening?

Sarah Walter: We probably need a range of things. Some of it comes down to how national targets and expectations are set, to what extent they take up all of the ICS activity, and the balance between national, centrally set targets and the ability to set local priorities. What that balance looks like is definitely part of it.

There is also something about how the system around ICSs operates. We have seen some promising progress from NHS England in the operating model that it published recently and its expectations of how NHS England as an organisation will need to change to adapt to and reflect the role of ICSs. I know that you are seeing CQC later on today. That part of the regulatory landscape is important.

It is about recognising that ICSs, as they have been conceived and with the intentions that they have been set up to deliver, should have almost a ripple effect across the rest of the system and how that operates, whether that is in the provider landscape, in the relationship with local government or in what we see through the NHS regulatory model. It is

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not just about targets. We talked about behaviours. It is also about the behaviours that exist outside those systems and the extent to which that support enables ICSs to be successful, rather than dampening down that energy.

Q114 **James Morris:** Mr Timmins, what do you think?

Nicholas Timmins: I suppose the short answer is behaviour. It must be very difficult at the moment, because the service is under a lot of pressure and you can understand the Secretary of State wanting to get his hands on all the possible levers to try to improve things. It is a question of whether you can recognise that a lot of activity from the centre does not necessarily produce improvement on the ground. If you are digging everything up, and looking at the spreadsheets for the way every hospital operates, to try to work out what to do about delayed discharges, you are probably not helping.

Q115 **James Morris:** On that point, interestingly, on the Floor of the House the other day, in response to a question that I asked about ICSs, the Secretary of State said that he thought that they were fundamental to the resolution of the problem of health and social care integration and that they should be the platform for achieving that. That strikes me as being a major role, but is it the right role? Doesn't that butt against the other, longer-term things that they are attempting to do? He is giving them a very strong operational role in resolving these issues, but is that really their function, or should that be their function? Does it matter?

Nicholas Timmins: It is their function in that day to day they are the bodies through which a lot of this flows. A lot of this stuff now takes place at a much lower level than the ICS. It is down on the ground, with social care teams and hospital care teams. They have a responsibility to do that, but they operate within a context, don't they? The context they operate in, as the Committee well knows, is one where social care is seriously underfunded, so they do what they can but only within the context. You could argue that the larger context is the one that the politicians need to sort out. Social care funding and applications are matters for politicians. They are not things that ICS chief executives or ICB chairs can do on their own, are they?

Q116 **James Morris:** Sarah?

Sarah Walter: If we think about the ICS role in the here and now and the extent to which they are able to be as effective as they could be, we could take the example of the adult social care discharge fund. We all knew that this winter was going to be very difficult. As an organisation, we had been calling since the summer for Government support in anticipation of a very difficult winter. The discharge fund was confirmed in the autumn. The funds did not come through until December. It was incredibly rigid as regards what ICSs were allowed to spend those funds on. We saw the same with the additional funding that was announced last week.

That is not to say that the funding is not welcome, but it feels like it is too little, too late. These small slivers of funds come out with a very rigid set of expectations of how they need to be used, which may be different from what ICSs would want to use them for, given the options and their understanding of the opportunities for different models of delivery, utilising and working alongside voluntary sector partners, for example, and thinking about things more creatively. The constraints mean that they are not able to do that. It does not create the maximum bang for your buck, in a way, because of the way those funds are delivered, the rules that are set around them and the reporting requirements that go alongside them, which are incredibly onerous.

Q117 **Rachael Maskell:** I want to start with you, Louise, if I may. What has been Healthwatch's engagement with ICPs and ICBs? In the context of having your ear to the ground in local health communities, are you successful to date in getting that voice heard within the system? If not, what needs to be done to improve it?

Louise Ansari: Thank you for that question. There are 152 local Healthwatch around the country that are commissioned by upper-tier local authorities. What we have found to date is that around 45% of integrated care systems have the local Healthwatch somewhere in their governance, either on their boards or in their committee structures. Around 18 integrated care systems have funded groups of Healthwatch to feed in insight across the ICS patch.

It is quite a complex picture because there is not a neat geographical match between local Healthwatch and ICSs. North East has 14 Healthwatch on the ICS footprint, whereas Healthwatch Essex covers two ICSs. Because it is a statutory duty in the "Working in partnership with people and communities" guidance, we would absolutely like to see representation of Healthwatch or, indeed, other patient representative or VCSE bodies, within the governance of integrated care systems. Because those bodies were never funded to feed in insight on this level and do the kind of community connection that they do, we would like to see ICSs step up further to support the infrastructure and to fund groups of Healthwatch and voluntary sector organisations on the patch.

It is almost the USP of Healthwatch to talk to and get insight from communities that are seldom heard. To give you an example, in Kent, the local Healthwatch talked to a group of fishermen, who could not join the 8 am scramble for a GP appointment. When they got off the boats, eConsult was shut, so they were finding it extremely difficult to get a GP appointment in their area. The local Healthwatch fed this back into the system and the PCN changed, so I know the ICS is listening.

That kind of work is happening across the country. It happened in CCG world as well, but I hope that there has been a step change in listening in integrated care systems. Healthwatch is already playing a part in that, but needs to play a growing part.

Q118 **Rachael Maskell:** Sarah, what else needs to be done in the ICS framework to ensure that Healthwatch has a significant voice in the workings? Is it an issue of governance, or is it an issue of capacity and space for that voice to be very much integrated into the programmes and work of the ICS?

Sarah Walter: ICSs are strongly committed to the principles around patient and public engagement—that kind of citizen voice—and to making sure that it feeds into the new strategies that are being developed and their governance structures.

As Louise said, what that looks like in practice will be different because of the different ICS structures. That applies to almost anything you say about ICSs. The model that North East and North Cumbria, with 14 local authorities and 14 Healthwatch organisations, uses to engage Healthwatch in its local governance will be different from that in Gloucestershire or Somerset, with a different geography. What is important is the commitment to achieving the outcome and objective of a strong link to the community that the ICS serves and then working with Healthwatch colleagues to find the model that achieves that most effectively.

We must also recognise the role of place in all of this. In some of the bigger ICSs, in particular, which cover huge geographies, the place-based arrangements will be key. The role of the system will be to look at areas such as digital, workforce, inequalities across the patch or innovation and improvement. A lot of the day-to-day meaningful work around citizen engagement and what that means for integrating specific services will happen at place level. The ICS governance structure may not always be the right place if those place-based arrangements are where the action is.

Q119 **Rachael Maskell:** Nicholas, is there enough challenge within the system to ensure that the systems are saying, "Are we hearing the voice from the community?" Secondly, if Healthwatch or other bodies do not feel that their voice is being heard, where else can they go to ensure that they are not forgotten?

Nicholas Timmins: Where else can Healthwatch go?

Rachael Maskell: Yes.

Nicholas Timmins: That is a question for someone other than me.

Q120 **Rachael Maskell:** Within the systems.

Nicholas Timmins: If services do not listen to the patients—the customers—they will not be doing the right thing, so there is an obligation to listen. Do they listen? I don't know. Louise will tell you how far Healthwatch thinks they are listening.

On the variability point, it comes back to Mr Morris's question earlier. One of the more encouraging things about the STP/ICS process has been a

recognition that the structures do not have to look the same absolutely everywhere. I think that is the first time in the NHS's history. Previously, whether you had regions, areas, districts or PCTs, it was, "They have to look like this," whereas for this operation, there has been something much closer to saying, "There's a minimum that has to look like this, but after that you can work out what works best for you locally." That will not produce instant, overnight results, but I suspect that in the longer run it has a better chance of producing services that reflect what people want locally. That will include the views of patients. As has been said, the way that is done will vary locally, because the geographies vary locally.

Q121 **Rachael Maskell:** We are very much in the bedding-down period and still trying to work out how different bodies relate to one another.

Nicholas Timmins: That is absolutely true. One of the big tests will be patients. People look for very fast results. This will not produce very fast results. Will there be the patience to see it through, or will we dig it all up again in three or four years' time and say, "It's obviously not working very well"? I would not claim that primary care trusts were the greatest organisations ever, but the fact that they were dug up by the roots three times within a decade almost guaranteed that they were not going to succeed, whether they were the right idea or not.

Louise Ansari: May I add something?

Rachael Maskell: Please do.

Louise Ansari: We see some green shoots, and I would say that there has been a step change in listening. Later you will hear from North East London ICS. For some time, they have worked with the eight local Healthwatch to create what they call a community insights depository or bank, where they gather information from a range of sources to feed into the decision making of the ICB, so there are some areas. Recently, they did a specific piece of work on maternity. They have a very high birth rate, a high number of people from black and ethnic minority groups, and high levels of deprivation. They talked to women about their experience of maternity care and fed that back through into the decision making. There are some specific examples of what changed because of that. It is still very patchy, but we hear some really good examples of a bit more of a step change in listening.

The other point is that we want integration of listening. To the earlier point about trusts, people often get asked a lot of the time, by lots of different NHS bodies, about similar things. We need things like an insight bank or, at least, organisation of all of the insight so that it can feed through into the system as a whole and make more sense to all the leaders in the new system, which is supposed to be integrated.

Rachael Maskell: That is really helpful.

Q122 **Paul Blomfield:** To pursue the same theme from a different angle, Nick, you talked about local government's involvement being different across

the country. I am interested in exploring the nature of local government engagement. When we look at local accountability, the role of local voices expressed through our councils is important, but how far are councils engaging from that perspective, and how far are they engaging as providers, given the whole objective in relation to integrating provision of care and health?

Nicholas Timmins: The honest answer is that it is an extremely good question, but I do not know the answer. I just do not know enough about what is going on. All I can give you is an impression. You get quite a strong sense that different local authorities have different attitudes to this. Some are very sceptical, some are very engaged and some recognise absolutely that the new statutory duties of integrated care boards—population health and health inequalities—are actually the territory of local government far more than they are the territory of the NHS, in terms of having an impact. I think it varies a lot, but I cannot give you quotes, numbers or names. I just do not know enough, I'm afraid. It would be good to talk to the Local Government Association about that.

You can kind of see it in the funny structure we have ended up with. We have integrated care boards and integrated care partnerships, whereas previously, under the old arrangements, there tended to be one committee, which had no statutory power but acted as the ICS. We are now in the odd position where the ICS is actually a concept and we have one statutory board and one statutory committee. That is because local government as a whole could not agree on whether it was able to run a single committee when the NHS is run centrally and the money goes through that way, whereas it has its own separate funding and accountability.

You can see that mix, can't you? In some places, you discover that the chair of the ICB and the chair of the ICP are the same person. That has happened because some people see it as a commitment by the NHS to the broader ICP agenda of population health and what have you. In other places, they are separate because local government says, "We, as a separate organisation, cannot be tied into a more command and control, answering directly to Parliament, funding stream." You can see in those arrangements that there is a tension; there are different attitudes in local government to how this should be made to work.

Q123 **Paul Blomfield:** Sarah, you wanted to come in.

Sarah Walter: I agree with Nick's comments. We in the ICS network convene the integrated care partnership chairs as a group. Many of those are local authority leaders. Two colleagues I spoke to before coming here this morning were the ICP chair for West Yorkshire and the ICP chair for Surrey Heartlands ICS. Both of those individuals are leaders in their local authorities for those systems. They are strongly engaged in the work of the ICS and really see the opportunity to think about health in a much broader sense, in a way that very much appeals to local authority

ambition and thinking about the broader population, and recognising the different factors that impact on health, whether that is the role of housing or employment. Those are things that are outside the scope of the NHS. There is a role for it, but the local government perspective is hugely important. From the work that we are doing with ICP chairs, I am encouraged by the kind of engagement that we are seeing on that.

The place-based arrangements are important as well, particularly in systems where there is coterminosity with local authority boundaries at place level. We see strong local government leadership operating in that kind of place-based environment. Again, that is really encouraging.

It is easier in some system contexts than others. That is often to do with questions around coterminosity and the complexity of the local landscape. As Louise mentioned earlier, in Essex, where a single county council contributes to multiple ICSs or where the boundaries do not fit as neatly, that adds extra complexity. It is not insurmountable. There will never be a perfect set of boundaries, so I am not suggesting that we revisit all of that. We just need to recognise that some of those factors have an impact on how straightforward a question this is to answer.

Q124 **Paul Blomfield:** Given that the health system, or professionals within the health system, were prepared for the change, was there a sense in local government of thinking through, or does more need to be done to think through, the role of local authorities in how they contribute to integrated care systems?

Sarah Walter: We work closely with colleagues at the LGA. They co-convene their ICP Chairs Group that we run, and are strongly supportive of the ICS endeavour and the work of the network. I think that will continue to be really important. The ambition of ICSs will not be delivered if it does not have effective local authority engagement. It is all about creating a partnership between the NHS and local government, which is then complemented by the wider relationship with other organisations across the system. Partnership between the NHS and local government is at the heart of this, and is going to be fundamental to its success.

Q125 **Taiwo Owatemi:** I am particularly interested in patient involvement, so I will be circling back to some of the topics that have already been covered. Louise, you spoke earlier about the importance of involving patients, and the patients' voice and their carers and representatives being heard. From the perspective of your organisation, what does good patient accountability look like?

Louise Ansari: That is a great question. Obviously, day in, day out, that is what we think about. The principles in the guidance on working with people and communities talk about starting with the patient, the person, and thinking about local communities. It is about involving them right from the very beginning in what services should be provided and how they should be provided, using principles of co-creation if possible, thinking about whether or not people are going to be adversely affected

by decisions, involving people and communities all the way through in an ongoing dialogue with service providers.

I mentioned having them as part of governance, which is important. In relation to the last conversation, the NHS bits of integrated care systems probably have quite a lot to learn from the culture of local authorities, where public accountability is in their bloodstream, so to speak. Indeed, as I mentioned earlier, it is the actual experience of people and not just numbers on a spreadsheet. The experience of people needs to be listened to in order to make a difference.

Local Healthwatch do a great job in feeding a lot of that through, where they can. Some local Healthwatch are chronically underfunded. Some of them are funded to around £60,000, which is barely enough to run the organisation. The variation in funding is huge. There is a real problem in some ICS areas with a widespread culture of listening, constant dialogue and understanding communities. There is also a problem of funding and resourcing the infrastructure to listen. There is still a lot of work to go on in both those areas.

I see some excellent practice, going around the country. For example, I was in Salford last year where they organised for a group of health leaders to meet people from the deaf community who explained through BSL interpreters exactly what their experience was like. One of the trust leaders there said that they were ashamed at the poor quality of service. I was quite shocked listening to some of the stories. We will always open the door and try to wedge it open for people in communities to get into those kinds of powerful conversations.

I do not think it should be rigid. In governance, if you are making a decision about a service, you should have people there from the communities. If you are making a decision about maternity services, have people from a Maternity Voices Partnership in the room or have women and mothers in the room. It can be done, but it still needs to be embedded further.

Q126 **Taiwo Owatemi:** Is there anything that you would like to see from the Government in order for us to be able to achieve that?

Louise Ansari: Yes. We would need a couple of things. One is an assurance that, while there is this permissiveness, every ICS will embed not just the culture but, in governance and in funding, Healthwatch, voluntary sector or patient group representation in the governance of the system.

The second thing is that, from a Healthwatch point of view, the way it is commissioned and funded at the moment is not really fit for purpose. The money comes out of the Department of Health. It goes via local authorities. Some of it somehow gets reduced along the way, and then it leads to a huge variation in funding.

When Healthwatch was set up 10 years ago, the funding was around £50 million for 152 local Healthwatch. It has reduced by around half; it is about £23 million to £25 million now. We need to look at the model and the funding. I would love to talk more with Department colleagues about that.

Q127 **Taiwo Owatemi:** My local Healthwatch does a fantastic job despite the constraints. Sarah, I want to circle back to something you mentioned earlier. You spoke about the variations in the models in which patients engage with different ICSs. Are there any particular gold standard examples that you think other ICSs should be looking at? Also, how do you measure the success of each particular model to ensure that patients, regardless of where they are in the country, are getting access and that their voices are listened to?

Sarah Walter: I spoke to an ICB chair last week from Staffordshire and Stoke-on-Trent about some work that they have been doing on creating a patient assembly. It is not quite a citizens' assembly, but he was certainly proud of how that has been developed and the potential role it might have within the system, making sure that it has a strong voice as part of the ICS governance arrangement.

Similarly, I know that Bristol, North Somerset and South Gloucestershire has done some really good work in that area. There are models out there. As a network, we do what we can to support the sharing of those kinds of examples, and to enable different systems to learn from each other so that they do not have to reinvent things every time, although understanding that in many cases there will be quite sensible reasons why this might work in these kinds of contexts, but they might not be the right ones in others.

As to how you measure the impact of that, I would probably bow to Louise's expertise as to what that might look like in practice. Fundamentally, I guess it is whether you are able to demonstrate how you have engaged and what that has led to in terms of change. It is being able to clearly show the engagement process you have been through, and what that has led to in terms of action. Fundamentally, you can listen, but unless you are actually doing something in response, it will feel a little meaningless. It has to be demonstrable that it has changed, how an ICS or a place-based arrangement has chosen to approach delivery of services or how new services are being created to respond very clearly to need.

Chair: Paul Bristow wants to come in on the back of that conversation.

Q128 **Paul Bristow:** Thank you, Chair. I completely understand all of you saying that there is a balance between national targets and local priorities, and indeed structures. Nicholas, you talked about local structures this time. Where an ICS is producing poor outcomes for patients, what is the best way, in your mind, that it is held to account at a national level? Perhaps I could start with you, Sarah.

Sarah Walter: There has to be that kind of national accountability framework. ICS leaders understand that they have a responsibility and a duty on behalf of their population, and there is an understanding that they are the custodians of public funds and are responsible for delivering outcomes. There is an understanding that, where that is not being achieved, they might expect a different kind of relationship with the centre. We see some of that already being developed through NHS England's oversight framework, which assesses systems by the extent to which they are delivering. For those where there are more in-depth issues, and they are not achieving the outcomes that they want to achieve, there is a more direct relationship through the NHS England regional office to have tighter control in those system contexts.

Q129 **Paul Bristow:** Is there a fear that the NHS England oversight framework could get us back to the point where they insist on a one-size-fits-all model?

Sarah Walter: That is always a fear. It is something we would obviously want to ward against. One of the things that is really important for me is that in most systems where there is poor performance and there are issues at play, what will be fundamental is getting underneath it: what is behind that and what is causing those issues? Are there structural issues? Is there a particular kind of workforce problem? How you respond and how the ICS and the organisations in those systems respond to poor performance will vary because of what is behind that.

I live down in Devon. Everywhere across the country there is a workforce crisis, but it is particularly stark in my neck of the woods in Devon and Cornwall than it is in, say, London. Not all of the problems are caused by the same issues. It is having in-depth understanding, and translating that into what we need to do to respond may differ because of those fundamental factors.

Q130 **Paul Bristow:** Nicholas, do you want to say anything about that?

Nicholas Timmins: Yes. It is a taxpayer-funded service. In the last analysis, if things are going badly wrong, you would expect the Secretary of State to intervene, but you want a goodly number of steps before you hit that.

If an ICS is really struggling, it clearly needs support. That support has to come from NHS England, because there is nowhere else it comes from. It is from NHS England, and is probably drawing on the resources of ICSs that are doing better. One learns from what works better elsewhere. There has to be that, but the question is how far you are prepared to sit there and encourage people by various other forms of support to improve the service they are delivering, and how far you feel the direct need to intervene and say, "We're going to sort this out for you." The more you do that, the more you risk disempowering people across the piece, because that is what happens.

Q131 **Paul Bristow:** I will dig into that a little bit further, if I may. You talk about the NHS learning from other parts of the NHS, or ICSs learning from other ICSs.

Nicholas Timmins: Yes.

Q132 **Paul Bristow:** But the NHS has been notoriously bad at doing that over the past 20 years, I would suggest.

Nicholas Timmins: You could say since 1948.

Q133 **Paul Bristow:** Yes, since 1948. How do we embed a culture where that is encouraged and enabled? Where are we failing? Why doesn't it happen?

Nicholas Timmins: Why is it difficult? It is a very good question. The answer is that there have been times when some of these things work better. One of the things that struck me when I was talking to people in the summer was that ICS chairs and chief execs are talking to each other quite a lot, so there is clearly some common learning going on from each other.

There have been odd occasions when the centre has been quite good at encouraging learning. An organisation called the Modernisation Agency briefly existed in the 2000s, and particularly helped a lot with the initial drive to get A&E waits down to four hours. I don't think they invented anything, but they looked around the country at where it was working best. The answer was that the solutions were not the same everywhere, but there was a set of tools you could use to do it. They were able to go into places that were struggling and say, "Look, we're not going to tell you how to do it. You have to work out how to do it, because it has to work locally, but these are the tools that other people have used, so try some of them and get it to work." I think that contributed quite a lot.

There can be mechanisms where you spread good practice. The Modernisation Agency fell over because it was good at one thing, so it was given almost everything to do, got too big and collapsed, which is also an important lesson.

Q134 **Paul Bristow:** Sarah and Louise both want to say something.

Louise Ansari: I want to mention, on the other side of the coin, the role of the CQC. I know that you are talking to Kate Terroni later. We support the single assessment framework model that they propose for integrated care systems. For one reason, they are going to give equal weight to patient experience as well as the other domains. We look forward to working with them to see how that works. That may have an impact in bringing everybody up to a certain level.

Sarah Walter: I have a couple of comments to add. I certainly reiterate Nick's point about the sense of peer support that we are seeing among the ICS leadership. As an ICS network, we convene the ICB chairs and chief execs and the ICP chairs, as well as the broader exec and non-exec

teams. We see a lot of informal conversation and sharing between those individuals. People will put out a message saying, "We are trying to do this. Has anyone else got a good approach?" That is happening. In a sense, 42 is quite a nice number, and feels like a manageable community that is developing. We see some really good connections from an individual perspective in those leadership roles.

Secondly, on the support side of things, we talked about ICSs needing to listen to the population they serve. It is also important that, where there are national support programmes or initiatives being developed, they are developed in response to what they hear from ICSs. What is it that ICSs say they really need support on? That is the first question. Secondly, how might that best be delivered? That is rather than a default, "Here's a national programme that has to be delivered in exactly this way," without any sense of appropriateness in different contexts or an understanding—virtual care being an example—that there might be some ICSs where the appetite and energy for developing that approach exists in some specialties more than others. Maybe you go where the energy is to get that started, and then you look at how you spread it.

I think that kind of culture and behaviour from some of the national organisations that are potentially there to support some of this needs to reflect the sense of listening to ICSs and putting support programmes in place in a way that can work in different system contexts.

Q135 **Paul Bristow:** I want to ask one last question, which is about political accountability around performance and commissioning decisions. I know you said earlier that with local authorities involved there is an element of political accountability, and that local authority leaders are getting more involved in ICS or ICB boards, and so on.

Louise, you were right that local authorities have a strong track record of public accountability. I see lots of examples where leaders of local authorities—individual councillors—have really driven through system change because of their link with the public. We do not have that experience in the NHS. How do we create that?

Sarah Walter: We are starting to see more of that because of the greater connection now between the ICB leaders and their ICP counterparts, and the close relationship between the NHS and local government. When you look across the ICS leaders who have been appointed to those roles, many have come through the NHS management route, and quite a high number of individuals have come through local government and the voluntary sector. There is more diversity of experience. The kind of sharing that I described in that community is helping to drive some different behaviours.

Q136 **Chair:** Finally, Mr Timmins, you have recently worked on something for the King's Fund on integrated care systems, "Born into a storm." You are a senior fellow at the King's Fund. I was interested in your comments about primary care trusts and how they started, stopped and changed.

Obviously, there has been a lot of structural change. I think you wrote a piece, "Never Again," which was the story of the Health and Care Act 2012.

Do you have any reflections on ideas that are being mooted at the moment about patient referral? Basically, it is bypassing GPs and patient referrals straight to secondary care. This has often been talked about. Some would say it is a hypochondriacs charter. Do you have any thoughts about that because it would potentially be the biggest change to the patient journey in the NHS's history?

Nicholas Timmins: I would be quite cautious about it. There is capacity, which goes up and down over the years. Self-referral by patients involves self-diagnosis by patients. How good are patients at self-diagnosis? Sometimes, very. A lot of the time, they don't know. I think you would run the risk of an avalanche of demand to which the system would not be able to respond. You would get inappropriate referral.

There clearly are areas where a certain amount of being able to go direct would help—certain forms of physiotherapy, for example, for back pain and that sort of stuff. I would argue that, broadly, patients being able to self-refer to specialists is not a good idea. It is not a good idea.

Q137 **Chair:** In my experience of being a Health Minister, wading into the clinical decision process is a dangerous place. Lower back pain can be just lower back pain because you have been lifting small children all day. It could also be something significantly more serious.

Nicholas Timmins: Exactly. I agree. I think it would be a very rash decision.

Chair: That is very interesting evidence. Thank you very much, Louise Ansari, Sarah Walter and Nicholas Timmins. Thank you very much for giving evidence, and thank you, Sarah, for coming all the way from Devon to speak to us this morning. We very much appreciate it. Our report will be out in due course. We thank you for your time.

Examination of witnesses

Witnesses: Kate Terroni and Zina Etheridge.

Q138 **Chair:** Kate Terroni is the chief inspector of adult social care, integrated care and interim chief operating officer at the Care Quality Commission. Zina Etheridge is the chief executive at the North East London Integrated Care System. Thank you very much for coming into the House of Commons today. You have listened to the evidence in the first panel, so thank you for making time for doing that.

Kate, I am going to ask you about ICSs, inspection and CQC. You are meant to be taking up that role from April. My understanding is that the Government have not yet laid the regulations that are necessary to specify exactly how that will work. I am sure you have done some work in readiness. How concerned should we be about that timetable, given

that it is 17 January today?

Kate Terroni: Thank you very much. As you say, we need the Government to lay the commencement orders in order to switch on our powers to assess ICSs from 1 April. We have been working incredibly closely with the Department throughout the development of our new powers and the approach that we will be taking. They are confident that the right steps will be taken for the powers to go live on 1 April as planned.

Q139 **Chair:** Obviously, you are going to do the work. Will there be publicly available ratings following those assessments? What will they look like? Is it traffic lights? Is it something more qualitative than that? Do the public actually care?

Kate Terroni: We have built our way of assessing ICSs based on what matters to people. We have worked with Think Local Act Personal and National Voices to design our new single assessment framework. We will use the same assessment framework for health and social care providers as for local authorities and integrated care systems. The reason why that matters so much is that we will be assuring providers, local authorities and ICSs about what matters to people. Our focus throughout all of this work is, does this activity lead to improved outcomes for people?

We have designed a new methodology. We will be looking at 17 areas of quality when we go out to ICSs. For each of those 17 areas, we will collect evidence and produce a narrative about what we find. That narrative has the ability to be scored and rated. We have built something that can rate ICSs. As to whether we do or not will be a decision for the Government to make.

When I think about ratings for providers, we know that it is a currency that makes sense to people. We know that a lot of people use our ratings to make judgments on where they access services. We know that our ratings are simple to understand and that the public value them.

People use our ratings a lot when they are making decisions about social care providers—where they might move a loved one into a care home or where they might purchase homecare. Whether someone would look at a rating for an ICS to decide where in the country they would move to is, I think, more questionable. Ratings have huge value for providers, and we obviously will carry on rating them, but I am less convinced about whether it will inform the public about decisions that they make. We know that ratings can help drive improvement as well.

Q140 **Chair:** I don't see how it could. Obviously, yes, you are right that where a provider is getting a rating, people can look at that because, frankly, there is choice. It is a decision point that they can use. For an ICS, there is only one in the area. It may be that Kirsty and Phil on "Location, Location, Location" are going to add that alongside schools in an area. The big news is that the ICS in Gloucestershire is rated excellent, and

that is going to push up property prices, but it is unlikely, isn't?

Kate Terroni: It is unlikely. As I say, the decision about ratings will be one for Government. We are keen that we produce a report that is accessible and that ICSs can use to learn from best practice elsewhere, so that they have an independent analysis of view about how they are delivering against the two areas of focus we will be looking at, which are improved outcomes for people and addressing inequality. Ratings are a secondary question for Government to decide whether they want them or not, but we have built something that would enable us to deliver them if that is the choice made.

Q141 **Chair:** You have done the prep, basically.

Kate Terroni: We have.

Q142 **Chair:** Zina, welcome. What is your point of view on being ready for inspection? No school ever wants it and it is a lot of work for the senior management at trusts, so much so that the CQC has recently been asked to ease back on inspections of acute trusts due to the pressures they are under at the moment. What readiness have you, as a system, made in your part of London for this inspection regime beginning in the spring?

Zina Etheridge: First of all, thank you for inviting me today. It is a pleasure to be here. Secondly, we were, as a system, part of the CQC's test and learn process for trying out or developing the process in July. I guess we potentially have a bit more of a head start in our readiness for the inspection regime, when it comes in.

Our experience of the test and learn when we did it, and one of the pieces of feedback we gave to the CQC, was that we did not have enough time to prepare. That was inevitable because of the situation; it was a test and learn. It was just at the point when we were formally setting up as an ICB, in the later stages of July. We had been concentrating on governance and things. Our experience was that the complexity of the system and the number of different people who potentially needed to be involved in order to give the CQC a rounded view of the system as a whole meant that you needed a reasonable run-in just in order, quite apart from anything else, to do the logistics around getting interviews with the right people, getting your staff focus groups set up and things like that. All of that is a baseline.

In terms of more general readiness, obviously there is still some detail for us to understand and work through and a set of wider pieces in the landscape that we collectively do not yet understand, such as how to provide ratings related to ICS ratings going forward. We would want to understand some of those things more as we got closer to when the inspection regime was to be brought in.

Q143 **Rachael Maskell:** I want to stick with the pilot assessments. I would be interested to hear a response to Zina on that last point, and about the internal challenges within the ICS between the different partner

organisations and how you are assessing the coming together of the agenda as opposed to remaining as separate bodies with separate priorities.

Kate Terroni: Our development over the last year or two has absolutely been in partnership with ICSs. That is why we were eager to get out and test with North East London and with South Yorkshire. It is absolutely critical that we make sure that we work hand in hand with NHS England, whose main focus will be on how the ICBs are performing. We are interested in how they are performing, and also in where they are coming together with the integrated care partnerships, and their formal coming together with local government, along with other key partners like the voluntary sector.

With regard to Zina's point about how provider ratings play into our view of ICSs, that is a very common question we are asked. We are clear that we are not aggregating provider ratings to form a view of the ICS. We are absolutely not going to be doing that, but we are interested in how an ICS has oversight of support of every component of health and care provision within their landscape, within their patch. If a provider was performing very poorly, we would be interested to know how that ICS was working with the provider to support its improvement. If it had a system partner that was not playing well and was not around the table in the way that it should be, again the ICS would not be penalised for that per se but we would want to know what efforts it was making to bring that partner to the table and engage them.

Our focus is around partnership working and the coming together of health and social care. We will constantly be going back to whether it has made a difference for people who live in that area.

Q144 **Rachael Maskell:** I guess subsequent inspectors, if improvements have not been brought about by the provider, will ask questions of the ICB as to exactly where it is getting its provision from and why it cannot bring about the change, which could have implications for the provider as to why it is not following what the ICB requires of it.

Kate Terroni: Absolutely. Our focus at ICS level with our ICS leaders is how they are coming together to understand their population, to address inequalities and to tackle issues around access. Where there are concerns about provider components of that system that need us to look further, we will continue to have our enforcement powers to go in and look at individual providers as well. We do not have that at ICS level, but we have it at individual provider level when needed.

Q145 **Rachael Maskell:** Zina, I have a couple of questions for you. From all the work that you have done, and from seeing the inside of the inspections, are you happy with where it is landing? Do you think it has the balance right?

You have an inspection, and you get a rating and a lot of recommendations that go with that. Do you think that is sufficient in light

of the fact that this is quite a new organisation, or do you think you need more of a process of continual improvement and support to be able to fulfil what the CQC requires of you?

Zina Etheridge: Those are really big questions. First, is it in the right place? It is difficult to give a single answer to that because there are so many different components. The CQC has been working really hard to get it into the right place. There has been, as Kate said, lots of work with the system to make that work as well as possible.

You talked collectively in your last session about the learning culture, and leadership and behaviours in ICSs. I guess that is true for regulators as well. It is just as big a change for regulators to move into regulating and inspecting a very different way of working together as it is for the systems themselves. Having the right framework is one thing. Having the right culture, leadership, and so on in your workforce is another component of the same thing. I am not well placed to judge how far the CQC has got with its workforce, but I would say that is another important aspect.

I am sorry, I have forgotten the second question.

Q146 **Rachael Maskell:** I was asking about continuous improvement versus getting requirements to improve.

Zina Etheridge: The answer, of course, is that we need both. They do not necessarily both need to be provided by the regulator. Do we need, as ICBs and ICSs, to continually improve and have lots of opportunities and mechanisms to do that? You talked earlier on about good practice, for instance. Sharing is one of those, absolutely.

One of the questions that I would want to know any ICB and ICS had a good answer to is, "Do you have a consistent approach to quality improvement and improvement in general?" Yes, there are lots of different methods by which you can do improvement. I am quite interested in peer reviews as one of those methods. My background is in local government, and peer reviews are used a lot there. That is not necessarily the same as periodically taking a slight snapshot view of a whole system and reflecting on all the different aspects of quality and leadership: "This is where we think you are at the moment."

Chair: Dr Caroline Johnson has something related to that.

Q147 **Dr Johnson:** Thank you. Reflecting on what has been asked about ratings and what the Chair said about "Location, Location, Location", I agree that I do not think people are going to move home based on the ICS rating, but, of course, people do not necessarily live and work their entire life within the boundaries that we have drawn for the ICSs.

I still work as a paediatrician at Peterborough hospital. We regularly see patients from Northamptonshire, Rutland, Lincolnshire and Cambridgeshire. We occasionally see problems where people want to

choose a particular service from a particular area because it is more convenient for them, but it does not quite fit with the grand plan and we have to make bespoke arrangements. To what extent do ICSs, for the people who live near the boundaries from one to another, make things more or less difficult for patients to choose where they receive their care?

Kate Terroni: Thank you for that question. It comes back to why it is so important that we regulate from the perspective of the person accessing health and social care. We create organisational silos, and we draw up boundaries, but if you are a member of the public it does not make any sense to you.

The way that we will be assuring ICSs, but also the way we have built our single assessment framework, will enable us to track pathways. We will not just be looking at how someone receives joined-up health and care in place X; if someone is on a cancer pathway or someone has a mental health breakdown and needs support, we have the ability to track what their experiences are if they move across boundaries. It is critical with the artificial boundaries that get created across health and social care that the way we as the regulator view the world is through the perspective of the person accessing care, who often does not see those distinctions when they are receiving treatment or seeking social care support.

Q148 **Dr Johnson:** If I am somebody—say one of my constituents—living in Barrowby and I compare, for example, Nottinghamshire and Lincolnshire and think I want my care in Lincolnshire, or Nottinghamshire depending on what I have got, which might be better or worse in the ratings, will I still be able to choose or will I be furrowed, "No, this is where you must go"?

Kate Terroni: When we look at ICSs we will be looking at how they understand their population and how they are designing services tailored to meet the needs of the people in their population. We would not be prescriptive in how they go about it. We know that patient choice—people having information so that they can be informed and make their own decisions—is absolutely critical.

Our starting point would be the outcomes that people are experiencing. You talked earlier to the chief executive of Healthwatch. Hearing the person's experience is going to be critical to how we form a view of an ICS. In the example you talked about, we would be asking how ICSs were hearing from people via Healthwatch and other routes. We would also seek our own view on how that ICS was listening to the public. We would be talking directly to members of its population. We might have an exchange with someone in the scenario that you talked about. Again, we would want to hear how they had experienced the information they were given to form a view about where they might receive that treatment as well.

Q149 **Mrs Hamilton:** I didn't have a question, but I will ask a quick one.

Regarding boundaries, you have talked a lot about population health. As you know, when the ICSs, the structures, were put together, some of them had nine or 10 local authorities attached to them. They are not really similar. They are quite different in the way they are made up. In future, especially with you looking at quality and especially with what is happening in social care right now, could there be a possibility that if you are to measure quality and rate particular ICSs, you may need to rejig the way you do the boundaries?

Kate Terroni: That would not be something that we—

Q150 **Mrs Hamilton:** As a recommendation, would that be something?

Kate Terroni: Again, I go back to my earlier point. Boundaries are something that we understand if we are in the health and social care business. I think that if you are a member of the public they are less relevant. You just want to make sure that your health and social care is joined up and that you understand the support you are getting and know the outcomes.

The point about the differences of ICS to local authority ratios is really important. We are keen that we see great place-based plans. When we go out to ICSs, we want to see how they are working with the 10 local authorities in their patch and understand what needs to be done at place level in hearing the population's voice and designing services, and then what needs to happen at the broader level, the ICS level, as well.

When we did our test and learn in Zina's patch, I think we looked at two of her boroughs. We will not be systematically looking at every place when we go out to ICSs. We will look at a few. The main focus will be on how, at ICS level, they are taking into account what matters at place level and what the particular inequalities issues are that need to be addressed there, and ensuring that that is reflected in the integrated care partnership strategy and plans that happen in that wider footprint.

Zina Etheridge: Can I add something to emphasise some of the things that Kate said?

Mrs Hamilton: Of course.

Zina Etheridge: The important building blocks of our ICS are the place levels. For us, it is our local authorities. We have seven, plus the City of London, and they are all very different places. The 10,000 residents of the City of London are a very different population from the 337,000 residents of Tower Hamlets, for instance, in my area. They have different health needs and access the health economy in a very different way, as you might expect from those resident populations.

The important thing for us is to make sure that those populations' needs are understood from all of the different levels in our system. Much of that will be at place level, but for specialist commissioning for instance—the provision of particularly specialist services—it might be on the level of the

whole of the ICS or even on the level of the whole of London. As Kate said, the importance in the regulation is being able to see that we are getting it right at all of those levels.

Q151 **Chair:** Zina, you just nailed it. You have a very diverse population and therefore a very diverse ICS with different population groups within it. You have the CQC sitting next to you. When they do their inspection, what are you doing really well? We heard earlier that the 42 ICSs are all doing something really well and other things not so well. As we know, there are no losers, but only winners and things from which you learn. It sounds like Prince Harry's therapist.

What are you doing really well at the moment? Where do you think there is room for improvement?

Zina Etheridge: What a lovely question, at least in the first part. What are we doing well? You heard from Louise earlier about the community insights programme that we are running with Healthwatch. That is really great. We have just agreed with our integrated care partnership our integrated care strategy, or at least the interim version of it. We have been able to do that collaboratively with the whole system. Although we did not have time to talk directly to patients and local people during the development of that strategy, we were able to use the community insights function really well to make sure that we were getting it broadly right. Then we will use the spring to have a conversation with our residents, to make sure that we have got it right from their perspective, particularly in terms of how we measure whether we are succeeding. I think we are doing that right.

We have really good relationships with our local authorities. I think it helps that I was a local authority chief executive before I came into this role. I think I have the advantage of some existing relationships of trust and being able to speak the same language. That helps. We have a set of constructive local politicians who want to engage strategically in the system and understand how to do it. That is really good.

Q152 **Chair:** It would be very strange if you did not say you had a good relationship with your local authorities. I imagine that every chief executive would say that to us, whether it is true or not. I am very sure it is in your case. Clinically, where do you think you are excelling? Is it diabetes care or the cancer pathway? Where do you think you are making a difference?

Zina Etheridge: On cancer standards, we are doing really well. That does not mean to say that we are doing as well as we would want to on everything. If you look at North East London ICS compared to the rest of the country, we are doing really well on cancer standards. That is fantastic. We have some fantastic diagnostic pathways. We have some really good specialist provision and a specialism in sickle cell, as you might expect from our population.

Diabetes is an interesting area. Although there are some good examples and some absolutely excellent pieces of provision, and interesting pieces of work on population health and trying to identify, using population health management techniques, people who are pre-diabetic and therefore getting at them quickly, diabetes is one of our biggest issues in north-east London. We have huge numbers of people with diabetes. Indeed, children as young as 12 are getting type 2 diabetes, which is really causing problems. There are areas where we know we have to make some further progress in urgent and emergency care. It is true across the rest of the country. We have some particular pressure points, particularly in outer north-east London. I will stop there before I give a litany of all the things that we are struggling with.

Q153 **Chair:** The system is very challenged in north-east London at the moment, is it, as it is everywhere else, and things are under extreme pressure. Do you think that is getting better with the influenza cases in the acute sector, for instance? Do you think that is peaking?

Zina Etheridge: It seems to be. The pressure seems to have eased off in the last couple of weeks, certainly compared to where it was over the mid-December to first week of January period.

Chair: Thank you very much for coming in and giving evidence to us. It was really interesting. Zina Etheridge and Kate Terroni, thank you so much for coming in for the end of our penultimate session on ICSs. We will conclude it shortly.