HOUSE OF COMMONS

Health and Social Care Committee

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

Tuesday 7 February 2023

Ordered by the House of Commons to be published on 7 February 2023.

Watch the meeting

Members present: Steve Brine (Chair); Paul Blomfield; Mrs Paulette Hamilton; Rachael Maskell; James Morris.

Questions 154 - 182

Witnesses

I: Helen Whately MP, Minister of State, Department of Health and Social Care; Mark Cubbon, Chief Delivery Officer, NHS England; and Matthew Style, Director General of NHS Policy and Performance Group, Department of Health and Social Care.

Examination of witnesses

Witnesses: Helen Whately MP, Mark Cubbon and Matthew Style.

Q154 **Chair:** This is the Health and Social Care Select Committee, on a very sunny Tuesday morning in London. We are in Committee Room 16 in the House of Commons, and we are concluding our long work on integrated care systems and an inquiry looking into their autonomy and accountability. As is traditional with these sessions, we end the inquiry with something I looked forward to greatly as a Health Minister, as I am sure Minister Whately does, too. It is like an end of term party, otherwise known as the ministerial session, when we ask the Minister questions. She has a couple of officials with her.

Today we have Helen Whately MP, who is Minister of State at the Department of Health and Social Care. We also have Mark Cubbon, who is the chief delivery officer from NHS England—hello, Mark—and Matthew Style, who is the director general of the NHS policy and performance group at the Department. Hello again, Matthew. Thanks very much for being here.

I am sure that you have followed some of our work on this subject. You know that ICSs and ICBs are very much the new kids on the block in the health architecture. They are something that was envisaged when I was in the Department back in 2017 to 2019. In more recent times, post the 2019 general election, they were legislated for through the Health and Care Act. They have now bedded in and will start getting a CQC lookover from this April. We are going to explore some of those issues with you. To kick off, in the Government's view, what does a successful, high-performing ICS that is doing apple of your eye things look like?

Helen Whately: That is a good question. I would take a step back on that and say, "Overall, what do we want our health system to do?" Clearly, what we care about are the health outcomes for people, healthy life expectancy, reducing inequalities, tackling health disparities, making sure that there is good patient and public satisfaction with the health and wider care system and, on the other side of the equation, making sure that it is affordable, sustainable and good value for money for the taxpayer.

We have those aspirations in the context of what we know are huge pressures on our health and social care system in the UK and, within that, in England. Very similar pressures are being felt across many other countries in Europe, in Canada and elsewhere as we come out of the pandemic, with the extra pressures, stresses and strains of that on the health service. It goes beyond that. It is a consequence of the changing needs of our population; people are living longer, with multiple health conditions. There are now many more people over 85. In fact, the number is expected to increase by more than 50% in the next 15 years or so. I know that the Committee will be very well versed in the kinds of health challenges that we and similar countries face.

Against the backdrop of those health challenges, we cannot just keep doing more of the same. The traditional way of operating a health system, where you have your hospitals and your primary care and you have your social care separate, and you have those things relatively siloed, is not a system that works in a world where people are living a long time with multiple health conditions. We know that the determinants of health are much broader than just what happens in a hospital. They include housing, wider care and education. Joining up is an imperative, both for improving health outcomes and for having a sustainable, affordable health system to get what we want.

Then the question is, what is the best way to join up? People have talked about integrating healthcare and health and social care for decades. I remember people talking about the holy grail of integration and the right way of doing it when I was working in healthcare, before I was a Member of Parliament, and there have been various attempts. The thing that I see as different about integrated care systems and the institutions within them is the extent to which they are bottom up. While we have 42 integrated care systems and integrated care boards and a framework that has been put in place by legislation, it was very much driven by parts of the system saying that that was what they wanted. It is a framework that allows a significant amount of local variation. It is not one size fits all; it is adaptable for the context of a local area.

Q155 **Chair:** Let's pick that up. You are right. That was the vision. If you think back to the Health and Social Care Act 2012, the top-down reorganisation, as it was badged, there was a lot of unhappiness and wrestling within the system about that. Something about integrated care systems feels different. That could be for the reason you give, Minister—that it has come from the system and that, in the wider sense, that is what people want. We have heard evidence about the timing of change and that is what I want to explore with you.

I know that you and the Secretary of State are ambitious and that you are impatient, and rightly so. You should be. When Patricia Miller, who is the chief executive of the Dorset ICB, gave evidence to us, she definitely said that the changes that ICSs were designed to deliver may not happen quickly enough. The National Audit Office said, "of senior ICS staff, 57%…expect it will take between three and ten years for their ICS to…improve outcomes in population health and healthcare."

As you know, we are doing a big piece of work on prevention. We have just kicked that off. Surely, we have to scale demand that is coming into the system. How can we move this on more quickly? If they are to manage population health, which is very different in my area from what it is in yours and in Rachael's up in York, there are different priorities. How can they deliver meaningful change quickly enough? How long do you give them before you start interfering?

Helen Whately: We will come to how long you give them and the oversight point in a moment. Things can be achieved quickly and are

being achieved here and now. You also need to look at ways of working over the next year or two and at the longer term five or 10 years out. I do not think it is an either/or. You need to do all those things.

If you are looking at overall population health and want to tackle things like obesity and children growing up into healthy adults, of course you will look at that over a long timeframe and it will take time for those kinds of changes to work. Some of the potential of an integrated care system is where it brings together healthcare organisations and local authorities and looks at housing and education or even joining up with crime and policing. Of course, those meaningful changes, which you can get really excited about, require a level of patience, but we are already seeing in the short term the impact where integrated care systems are joining things up.

For instance, in the here and now, we have the challenges in hospitals of people who need to be discharged—people who are fit for discharge but are waiting in hospital due to either processes or social care delays. In many areas, integrated care systems are playing a really important part by joining up and helping the conversations between health and social care to work better to get people discharged. Often they are running a control centre function, where, literally, it is in the integrated care system that the data across hospitals, community health and local authorities is looked at to work out a better way, and how an individual person can be discharged. That is very much in the here and now.

We are already seeing impact in the short term, where relationships are stronger. I have been talking to many ICB chief execs and chairs and ICP chairs. Local authorities are part of that conversation. They tell me that things feel different. This is getting people together in a room in a way that they have not been before. They are doing things here and now, but they also talk a lot about their ambitions for prevention in the longer term. They are thinking about both in parallel, as you need to do in healthcare. You have to deal with the here and now and the longer term.

Q156 **Chair:** Can we bring in Mark and give you a chance to grab a drink, Minister? Mark, you are a chief delivery officer. What a great title. Are you delivering, sir?

Mark Cubbon: Good morning. You asked about where systems are grappling with the very acute day-to-day challenges around making sure that we have our access to urgent care services in an improved position. Where we have patients waiting for elective treatments, we are trying to bring down the waiting lists and the time of wait as quickly as possible. Those are the very acute issues that some of our ICBs are wrestling with right now.

Across the 42 systems that we have, they are also working with colleagues across all the different partners to look at the specific needs of each population. We want to make sure that all partners, regardless of who they are, whether in local authority, in health or in the voluntary

sector, are coming together to look at the needs of the population and how well services can be planned and aligned to support delivery and the improvement in outcomes that systems have been set up to deliver. It is a challenge for all our systems to wrestle with the day-to-day and here-and-now issues and at the same time make sure that they focus on the medium-term transformation that will deliver improvements for their populations.

Q157 **Chair:** Am I right in saying that this month, or is it next, all ICBs have to deliver their strategy plans to NHS England?

Mark Cubbon: That's right. We have already seen 35 of the 42, which are published. The remaining systems will publish their strategies as well. That is where all the partners, whichever part of the system they come from, come together to look at how their collective strategies align to deliver the improvements for their populations.

Q158 **Chair:** What are you doing with those strategies? Are you aligning them against some of your national priorities to see whether they go with those? Obviously, you are not interfering in local priorities. We will come on to that a bit more with Paul. What would you say about those that you have seen so far? Are they red, amber or green?

Mark Cubbon: We have not rated them in that way. What we have done is review them with each system. We will continue to do that until all the remaining strategies are published.

Q159 **Chair:** Why have those who have not published them not done so?

Mark Cubbon: They are still working through them. They are in the final stages of getting the strategies together. They will be published thereafter. We have been working with them. We want them to take account of some national frameworks for improvements—things like a long-term plan. We want people to recognise the previous commitments and direction of travel, but we recognise that partnership is more than just health. It is the collective strategies that exist locally to deliver the improvements for their populations, not just health.

Q160 **Chair:** That makes sense. Finally, Minister, before I bring in James Morris, I have a question on the CQC, which will start looking at ICBs from April. When I saw the CQC recently, they were concerned that the regulations to allow them to do that with legal effect have not yet been laid by the Government. Could you update us on that?

Helen Whately: The regulations will be laid in time for them to kick off in April.

As you have brought it up, I want to seize this opportunity to say that I see the CQC looking at integrated care systems as a really important part of the landscape. We have the CQC looking at hospitals, primary care and care homes—the individual institutions. Inevitably, and rightly, that means that institutions are focused on doing what they do well and safely

and on the things CQC looks at. It is a really important part of the landscape to have CQC looking at how the system works as well, and at how well individual organisations are plugging into the system, to get a balance. It is important for an individual hospital not only to do a good job as a hospital but to be a good member of the system. Having the CQC look at that is important in getting the focus on the system working alongside individual organisations.

I also see the CQC assurance process as an opportunity to gain very valuable insights, in a very constructive way, into what works better and what is not working so well. We have integrated care systems at a formative stage and, rightly, different ways of doing things in different places. We therefore have lots of opportunities to learn from one another. The CQC process can be a valuable part of learning and improving over time the way integrated care systems work.

Chair: Good.

Q161 **James Morris:** I want to come back to the issue of health and social care integration. Minister, you cited the operational initiative around trying to get datasets in the control centres and so on. Anecdotal evidence from my speaking to various ICSs is that one of the key challenges around those control centres is that they are not able to get the social care data seeded into them because the data and the structures are different. Notwithstanding any other considerations, how do we overcome those kinds of operational challenges, where it is not even possible to seed the right datasets?

Helen Whately: There are two lenses on it. One is local—the opportunity for local areas to work through these challenges themselves. Some areas are doing a really good job of sharing their data effectively. The other is national—the work that we are doing from a national perspective to support the social care sector to build its data and its data infrastructure, looking at units of care, for instance. Very practically, in social care there is a challenge of not having the same common language that we have in healthcare. In healthcare, we talk about beds. It is not a perfect measure, but people can talk about beds and compare it as a currency. In social care, we do not have the same currency of units of care. We talk about care packages, but how big is a care package? Everywhere talks about it differently. There is some work to do. We are looking nationally at what is a helpful currency so that there can be better, more consistent conversations between the health and care systems.

In practice, locally, I have heard about really good examples. For instance, in Bristol, which has some real challenges with A&E in hospitals, they are working a control centre that looks at exactly the point about where the capacity is. It is not solved, but it is very much a work in progress. We are seeing it joined up.

Q162 **James Morris:** But that is an operational point. Some of the evidence that we have had is about a feeling within the care world. For example,

Care England said, "The concern for" adult social care "providers is that ICBs will merely be a reworked version of CCGs; suffering from an NHS-centric focus that excludes the needs and concerns of the care sector." As you know, the care market is quite fragmented. There is a huge number of different players in it. How do you address the feeling among adult social services, for example, that their voice is not getting parity of esteem, if you like, on ICBs? That is a long-term strategic issue that needs to be resolved if we are to make any progress on integration.

Helen Whately: I recognise the concern. Clearly, as Social Care Minister, I speak to care providers and representatives a lot. There is a local authority voice on ICBs, yet I know from conversations with providers that local authorities can be seen to a greater or lesser extent as the voice of social care, because local authorities are the commissioner but generally not the provider.

There are some very interesting examples where ICBs and ICPs have gone further in having a care provider voice in the room as well. I do not mean to call on Bristol so much, but when I was there I had a meeting that involved the acute trust, ICB representatives and a care provider representative, and that was a valuable part of the conversation. It is an example of how integrated care systems can look around and learn from what other places are doing. The benefits of having a strong care provider voice in the room, as well as the local authority, are really important.

Matthew Style: On the issue of the local authority voice around the table, it is fantastic that at this early stage of ICS development the appointments to some of the critical leadership positions in ICBs are people who have had significant experience in local government and have moved across. That helps to ensure that the social care voice is heard, at least from the commissioner perspective. I hope we see more of that over time. That is really important.

At place level, below ICB level, in a number of areas senior executives are holding NHS roles and local authority roles simultaneously and being able to bring together trade-offs that ensure that the best possible use of resources is made locally. As the Minister said, that is exactly the sort of thing we would expect the CQC to take account of in its assessments. Are adequate arrangements in place to ensure that the full range of voices are being heard in the decision making locally?

Q163 **James Morris:** This is the final question from me. In a sense, it comes down to funding or commissioning power, as the fragmentation in health and social care is to do with the fact that local authorities hold the budget for commissioning care. We are not going to resolve this issue unless there is a single place where funding resides. For example, recently £200 million was provided for the NHS to commission beds in the care sector. The ICSs hold that budget. Does that indicate that, long term strategically, we might want to see a system where we do not have fragmentation between health and social care commissioning?

Helen Whately: Clearly, we have an ambition to join up health and social care so that it feels and operates much more as one system and you see the best possible allocation of resources across it. We sometimes have conversations about the fact that there are people in hospital who do not need to be in an acute hospital. They should not be in an acute hospital, as it is not good for them. They are waiting for social care, which would be better for them and better value, so don't we just need to shift the resources across? We all know that that is a difficult problem to solve, but the ICSs are a good place for those conversations to take place.

The reality is that the system we have has different lines of accountability for the NHS and for local authorities and social care, where they are accountable through local elections. That is the case, but this is about bringing the decision making together, about getting people in the room and having the conversations. I am told, "It feels different."

Although there is a simplistic description of accountability, which I have just given, the reality of accountability is more complex. Relationships between organisations are a form of accountability to each other, as well as accountability to their populations. It is a more complex but richer landscape. I see integrated care systems as a good place for that better joining-up to happen. Crucially, in every single conversation I have had with integrated care systems, we have talked about shifting care out of hospital and caring for people in the right place. That is so much part of the conversation that is going on that it feels like achieving that is much more likely to happen with the set-up that we have and the development of integrated care systems than before and without them.

Matthew Style: On the specific points that you made about the financial arrangements, Mr Morris, all my experience is that, wherever you draw the accountability lines, there are boundaries.

There are two things. First, the statutory framework around the pooling of resources is actually very permissive. We have set out that we will continue to support ICBs, both NHS and local authority partners, to make it easier for people to use the existing flexibilities. All my experience is that the most important thing in these cases is strong partnership arrangements and really strong leadership. That is the best way of overcoming, as it were, some of the slightly inevitable barriers that our accountability arrangements put in place. That is why we are so focused, as the Minister said, through the role of the CQC and through NHS England's own development work with ICBs, on supporting the development of strong leadership locally and on ensuring that, through the CQC, we have an eye on those partnership working arrangements.

Q164 **Paul Blomfield:** I want to explore some of the issues a bit further. My question is about the determination and implementation of local and national priorities. Clearly, there is a desire for whoever is in Government to drive national priorities. That is also true of the leadership of NHS

England, which is famous for its command and control approach, yet there is an ambition in the new integrated care systems to put local priorities to the forefront. I am interested in how that circle is squared.

Helen Whately: I think it is an "and" rather than an "either/or". You are almost asking whether there is a conflict between national and local priorities. Often, if you think about it, it is not so much, because what your constituents and my constituents want tends to be reflected in the national priorities in any event, whether it is access to a GP, not having to wait a long time for an elective procedure or quick diagnosis if you have cancer. Those sorts of things are national priorities, but they are also things that people want their local system to deliver. In fact, the national and the integrated care system level priorities would be very well aligned anyway, because what people want would be aligned.

That said, there are differences, particularly on population health outcomes, and there are different challenges for different populations. There will be some different priorities, but the integrated care system is set up to allow flexibility, with integrated care systems setting out their own strategies and ICBs setting out their own five-year forward plans. That includes the scope for them to say, "These are our priorities on things that we want to do locally for our population health." That is a really important thing that they are being not only allowed but encouraged to establish and work towards. I think you can do both. They are not necessarily in conflict. We very much want to support integrated care systems to do exactly that, and to define their own priorities.

Q165 **Paul Blomfield:** I take that point. In all the organisational charts that I have seen that try to picture the new system, arrows go in all directions. Who are ICBs accountable to?

Helen Whately: ICBs are accountable to NHS England, through the system regional directors, and have the NHS oversight framework to report against. That is the official, formal line of accountability, albeit that I would say—I alluded to this when answering James's questions—that accountability in practice is more nuanced than that. Whenever anyone talks about stakeholders, in part those are relationships where there is some sense of accountability. ICBs, chief executives and chairs are very aware of the importance of their relationships with other parts of the system, like local authorities, and their accountability to their population, for instance. While you can draw a simple line from the ICB, it is actually a richer dynamic.

Q166 **Paul Blomfield:** Can I push that a little bit further? As you said earlier, we are at a formative stage. The way the culture lands now will shape things for a long time to come. The National Audit Office talked about the "inherent tension between the local needs-based ICP strategies and a standardised…service delivering" to "national…targets." It went on to suggest that we need to make progress on that and highlighted the lack of mechanisms and protected budgets to bring life to that ambition. How do you feel about the view that the NAO took? How do we ensure that we

put those processes and mechanisms in place to ensure that we get the balance of relationships you talk about?

Helen Whately: One of the important points that you just made was that we are at a formative stage. ICSs were created in statute last summer, so they are not even a year in, although clearly some versions of them were in place before and they have evolved from that. It is early days for these things to be established.

Against that backdrop, Patricia Hewitt is doing her review, which it is helpful to do at a formative stage, and asking some of the questions about what is the right balance between oversight and autonomy and how we make sure, in a world where, inevitably, NHS England and Ministers want to be able to be confident about what is being delivered by parts of the system, that there is also the autonomy for local systems to do what they know and do best and get on with it. We want to get to the best place in that tension. One of the things that I think will be helpful coming out of her review will be some thoughts, having had all the conversations that she is having, about how it is working at the moment and how to get to the right place on that.

Q167 **Paul Blomfield:** I think Matthew wants to come in, but can I push any of you specifically on that NAO recommendation about the need for specific mechanisms and protected budgets to enable ICBs to respond to local priorities?

Matthew Style: If I may, Minister, I think that what is most important in supporting ICBs, to ensure that they have their appropriate balance between national and local priorities, and indeed ensuring that they have an appropriate balance between short-term objectives and longer-term population health improvement objectives, is that we maximise the flexibility that ICB leaders have locally to determine how their resources are deployed.

I do not think that protected budgets that would set proportions nationally would be helpful to the pursuit of either of those objectives. Our focus is on maximising the share of the overall NHS pot that is in local hands, giving ICB leaders maximum flexibility about how those resources are deployed, showing that there is transparency about how those resources are deployed, and holding ICBs to account for the good stewardship of those resources. I think that is a better way of helping people to get the balance right locally in their communities. As I say, there should be transparency about that, but we should be backing judgments made locally.

Sometimes there is a false dichotomy between national and local priorities. Patients across the country, in all of your constituencies, would expect, for example, that the commitments the Government have made about eradicating long waits for planned care are met in every community across the country. There is a lot of scope within that for ICBs to prioritise activity and the way they deliver those targets, in line with

their longer-term population health goals. For example, if an ICB has identified that health outcomes for particular conditions are a particular priority for them, they can have a particular focus on respiratory health pathways, or whatever pathways align with their overall population health strategy, as part of their focus on delivering the overarching national goals. With the right kind of framework in place, you can tick both boxes, as it were.

Q168 **Paul Blomfield:** I want to push one last question, using the practical example of dentistry, on which we have launched an inquiry. NHS England has had the responsibility for commissioning services, and that has not worked out very well. We have a crisis that is reflected differently in different parts of the country, although I am sure you will say, Minister, that you recognise it is a national crisis.

The ICBs take responsibility for commissioning in April. I am guessing that your response might be, "Well, we've put new contracts in place for dentists which will solve some of the problems in relation to access to NHS dentistry." I was talking to a member of our local dental committee on Friday—as she replaced one of my fillings—about how the new contract was landing. The view was, and it is just one person, that it was landing differently in different parts of the city, and actually was not addressing the problems in poorer areas where there was more acute need. As ICBs take over responsibility for commissioning dental services, what flexibility do they have in addressing those issues?

Mark Cubbon: We have been working with the sector to ensure that we have improvements in access for dentistry. As you know, it is a multifaceted issue. It was part of the system that was severely impacted through the pandemic because of the infection control challenges. We have stepped up the ability and the focus on contract management to align to the contract that is in place for dentistry providers. We have made the first changes in how that contract should work for 15 years. The new changes are being put in place right now. We are prioritising through those changes both access and what I think you suggest about patients who have more complex and higher health needs, to ensure that as the contract is fulfilled both of those groups of people are prioritised through the use of the contract.

From April and then in July, we will be transferring the commissioning role to ICBs, as you have set out, but we will not be leaving the ICBs alone just to get on and wrestle with some of the challenges around the contract, and also the transformation of pathways that will support earlier access to dentistry. That is something the national team will continue to do, working with local systems, so that they have flexibility to adapt the contract and the application of the contract to the needs of their local communities.

Matthew Style: It is a really good example of where ICBs can support better and more effective commissioning of services. As you say, Mr Blomfield, evidence shows that there are particular communities who face

particular access challenges in dental care. ICBs are best placed to identify those. The flexibilities that we have put in place, which Mark referred to, will allow ICBs in effect to re-base dental contracts to ensure that expenditure is targeted in the communities where it is most needed. What we have done nationally to support that is, again, to bring transparency about some of the challenges and make more information publicly available on where there are dental practices accepting new NHS patients and so on. I think that is where the national and local can best come together to address the challenges that we face in dentistry.

Q169 **Paul Blomfield:** Thank you very much. This is my last point, although I am sure we will come back to this in the dentistry inquiry. To be clear, you are saying that ICBs will have flexibility to adjust the contract to ensure that we keep dentists providing NHS services in areas of different need.

Matthew Style: They will have flexibility to target resources as the needs of their communities across their patch require.

Q170 **Chair:** Paul, I hope you were not discussing this with your dentist while she was replacing your filling. That would be quite a unique trick.

Minister, my colleague was referring to the Hewitt review. When do you expect that to be published?

Helen Whately: It is due to be published on 15 March. I caught up with Patricia Hewitt yesterday. The review is making really good progress. She has been having very helpful conversations with many parts of the system, with some fabulous people contributing to it. I look forward to some good insights.

Chair: That is the first time I have heard a date, so that is good to know.

Q171 **Rachael Maskell:** I have been listening carefully and I hear the theory, but on the ground I witness a very different story. On dentistry—I have an area of significant dental desert—I cannot quite see how that application comes about. What I see are different IT systems, different funding and different priorities. There are different lines of accountability and different workforces. We need integration of those key factors, but we are not going to see that because we have already heard that they have different routes and funding pots, and so on.

On the issue of the workforce, which we know is the issue, all the services are challenged at the moment. We have different pay rates, a different workforce and lack of supply. What I see on the ground is the secondary care sector reaching further into the community and saying, "We need to take our care there." I see the primary care sector reaching deeper into the secondary care area, having GP-run wards, but I do not see integration. I see a conflict, fighting for that space. How are we going to resolve that conflict? How are we actually going to see that settlement? At the moment it is not happening.

Helen Whately: You have set out the starting point, which as we know is exactly one of the challenges of our health and care system. Those separate organisations and entities often, as you said, have separate IT systems, separate funding streams and more or less distinct workforces, very obviously in healthcare compared with social care, for instance. That is the situation despite years of people talking about the importance of integrating health and social care, under different Governments. I recall those conversations going back to before 2010.

From conversations with people in leadership positions in integrated care systems, what I hear is that this feels like it is joining up health organisations and health and social care in a way that has not been done before. It feels better than any of the previous attempts. Nobody is suggesting that it is easy, but this does feel much better. There is a much greater sense of optimism about the joining up.

To pick up on some of the practical things that you are talking about, on the workforce front, integrated care systems have a remit to help join up the workforce, to look for opportunities to join up the workforce and plan across the workforce for the system to look at joint training and opportunities for joint roles, and we are seeing some of that going on. We see examples of joint health and social care teams coming together with staff who would traditionally have been in either one or the other, and forming joint teams. As you say, we have acute care being delivered more in people's homes. Virtual wards are one of the examples. There is closer joining up of community health services and the acute sector in some of the work to keep people out of hospital. We really are seeing the traditional boundaries being broken through in different ways and in different places.

One of the opportunities of integrated care systems is to try to crack another of the big challenges for our health system, which is not being as good as you would hope at learning from each other. Traditionally, you would have one hospital doing something fantastic, but the next hospital down the road being too busy with what they are doing to know what the other hospital is doing. There are 42 organisations and the scale of that is quite a good number to bring together. We are seeing really good sharing and communication across different areas about what they are doing to learn lessons from each other.

Q172 **Rachael Maskell:** I think what you are describing and what I am seeing is collaboration, not integration, and that is where the challenge sits. We need more unity of purpose, but also more control, so that we have national workforces, national targets and national determinations that then impress on local systems. Just monitoring the relationship between collaboration and integration will be the test of the new system.

I want to move on and look at the area of public health. We know that the health service will not be able to cope with future capacity if we do not pivot to looking at protecting people's health and wellbeing into the future. However, the budget spend from Government is significantly

smaller. If we look at the money provided, for instance, for the elective backlog it is £2 billion. If we look at prevention, it is £97 million. They are on a completely different scale, yet the demand for prevention to protect wellbeing in the future will stop the system being pushed even further into crisis. In looking at that, if the money is not flowing through for prevention, how are we going to see the ICSs being able to prioritise prevention over trying to deal with all of the other targets and priorities coming out of Government?

Helen Whately: I think I would look more broadly at prevention. You talked about the public health side of prevention, which has a budget of about £170 million for 2022-23. That is the population health side of things.

There is also a substantial amount of prevention in the likes of screening and vaccination, on which we are spending £1.5 billion. Prevention is broader. Clearly, tackling smoking cessation and obesity is a really important part of public health, but let's make sure that we are talking about the broader scope of prevention where early screening for potential breast cancer—mammograms as a specific example—is something that we are investing in and is life saving for many thousands of people who have access to it.

Actually, overall, the investment in prevention is broader. Part of every single conversation that I have had with integrated care system leaders, even at the height of the winter pressure period when we talked about pressures on A&E discharges and getting waiting lists down, has been, "Let's make sure we spend time thinking about prevention and looking further ahead as well." It is seen as so front and central to what integrated care systems are there to do that it gives me greater confidence.

Q173 **Rachael Maskell:** When I asked a written question about how many ICSs had a director of public health or a public health lead on them, the Department could not tell me. Clearly, it is not such a priority that the Department is looking at that particular issue. In fact, there is no reserved place for a director of public health or a public health lead on an ICB board. If prevention is of such importance, as I believe it is, why isn't it stipulated in the scope of the regulations that we should be looking forward as opposed to looking at crisis management now?

Helen Whately: One thing to say is that it should not only be the job of somebody who is the public health person to think about prevention. It is broader than that. It is an element of everyone's job in the system.

Specifically on boards, there have been arguments for there to be somebody from almost every possible bit of the system to be on the board. If the board was composed of everybody who had been put forward, you would not be alone; there are many other specialties and areas of health and social care where the argument has been made that that person should be on the board. At some point, you would get a

board that was too big to be able to have effective conversations and make decisions, particularly when you are trying to bring organisations together. That is why the set-up of the integrated care system boards has been intentionally permissive.

We also have the duo of the integrated care board and the integrated care partnership. The integrated care partnership has an opportunity to bring together a diverse range of organisations, but the board is intentionally at the starting position of 10 people who should be on the board bringing a range of knowledge to it, as stipulated. Then there is the opportunity, as particular areas see fit, to bring extra people on. For example, West Yorkshire has brought a Healthwatch representative on to their board. Somerset has indeed brought on somebody with specific public health expertise. Other ICB boards have brought on directors of adult social services. They reflect what they see as the right composition for their area. We are right to support that rather than stipulating nationally, "That is what you must have," for every single board member.

Q174 **Rachael Maskell:** Population health is one of the four key objectives of the ICSs. If that is of such importance, which it should be because we have to look forward, I think it is a derogation of duty not to stipulate that we should have somebody who is the expert. It is fair enough to say that everyone should be looking at this, but we need somebody who has the skills, understanding and expertise and who is driving that agenda.

As I have highlighted, we have reduced funding targeted at that area. Not having a voice at the table means that, once again, it is going to be a sickness service that we are creating and not a health service for the future. I think the Government need to look at that once again to ensure that we are driving forward and protecting health for the future. Clearly, we are falling back on many of the initiatives that should be taking place, but other demands, such as the elective recovery, are dominating the agenda and the current crisis.

Matthew Style: Ms Maskell, you referred to the fact that there is stronger weight put on population health in the regulatory and statutory framework under which ICBs operate. I think there is very significant power in bringing together the allocative powers and financial flexibilities, to which I referred earlier, in the organisation that has statutory responsibilities for safeguarding and delivering medium-term and longer-term population health goals. That gives us a better chance of targeting investment in the most effective ways, and ensuring that the balance is struck between the short term and the medium term, than nationally mandated pots of money for specific purposes to be spent over particular time horizons. The proof will be in the pudding, but I think the reforms in the Bill and the regulatory reforms made around it give us a better chance of delivering on that.

Rachael Maskell: I am not asking you to justify it. I am asking you to look at it carefully and closely. I think there is a significant risk that, once again, looking at population and public health could play second cousin to

the immediate demands and crises that the NHS has to address. Thank you.

Q175 **Mrs Hamilton:** Good morning, Helen. We miss you on this side of the table. It is good to see you.

My first question moves on from what you talked about in relation to the strategies of the ICSs. You said that the last five or 10 will be sent to Government in the next month or so. How will the strategies be measured? If the strategy is not working, will it be like a number of these different things where we leave it far too long, until we cannot even offer support? What we then have to do is go in and do immediate emergency action in the authority. What is the plan, going forward, once these strategies come in, to ensure that you are monitoring them and that they are acted on very quickly if something is going wrong?

Helen Whately: I will start and then Mark may be able to do more of the granularity of the answer. Thank you, Paulette.

Overall, the approach that we are taking, and certainly the way I look at it, is that these are early days for integrated care systems and for the institutions within them. We want to support them to do the difficult job of bringing different bits of their systems together and making good decisions about the allocation of resources, joining up services and those sorts of things.

The criticism over the years has tended to be that everything is too top down and too short term, and chief executives running NHS provider organisations are always asked to do what the centre is saying without the centre knowing enough about what is really going on on the ground. There is a call from the system to take a more supportive approach to help them with the challenges they face. It is trying to come with that mindset while, hand in hand—I feel it answering your questions today or whenever I am in the Chamber—there is pressure to make sure that the system is working and that people do not have to wait a long time in A&E or for ambulances.

Of course, we need to be leaning in on improving the performance in some of the real pressure points on the system, but to do it in a way that is supportive and learns from different bits of the system. I will give a very practical example, and then I will come to Mark to pick up on the oversight of the system. I have been working with our national discharge taskforce, led by a combination of Lesley Watts, who is chief executive of Chelsea and Westminster Hospital, and James Bullion, who is on the social care side, from Norfolk. They have been going round the country working with systems that are struggling with the pressures in A&E and the discharge side of getting flow through the hospital. They have said, "Well, these are the good things that you can do in a system," and then they go to the hospital and say, "Which of those things are you doing and not doing? How can we help you with doing the best practice?"

It is hard work. It is not just pressing a button and getting it all to work differently. It is a supportive approach: "We know those things work there; let's help you do those things in the context of your system." To me, that is the way to do it. It is by asking the questions. Transparency is a really important part of that, as well as having the data about what is going on. Rather than just saying, "That's not working," we will help the system to perform better. I will bring Mark in on the structural side and the oversight.

Mark Cubbon: Thank you, Minister. With the strategies that are pulled together across our integrated care partnerships, we had some guidance issued to help support systems to pull their strategies together. This is where, as I mentioned earlier, there are all the common interests they have with the population; they understand the needs of the population and they build up a strategy that will respond to those needs. Implicit, and with each plan, I would expect there to be clear outcomes to be delivered and clear actions owned by each partner organisation.

There are different lines of accountability. There is clear accountability in each system for each partner to hold the other to account, to ensure their contribution to the delivery of the strategy and the delivery of better outcomes. It is to ensure that each partner is doing the bit that they signed up to deliver. Each partner is dependent on the other partners in the partnership doing their bit as well. That is where the local accountability sits.

From an NHS England perspective, we will do an annual assessment of integrated care boards. We will be looking to see how well the integrated care board has delivered against its contribution to the strategy that sits across the integrated care partnership. That is how we will play a role. It is to make sure that our integrated care boards are doing their part, but each partner will be making sure that some contribution from every single partner is making the improvement for their local population.

Q176 **Mrs Hamilton:** Could I push back a little bit? Let's face it, not all of them are working together. Say you have a system where the strategy is out there, and you then wait a year to review what is happening while, in the meantime, it is failing because the partners are not working together. The question I was trying to get at was whether you have anything in place so that you can go in at an earlier point if there is failure. This has to work. It went from an STP to an ICS and now the ICBs. Everybody is telling me that it is the only game in town. If it is the only game in town, how are we going to ensure that we do not have carnage out there where numbers of them are failing and you are only picking it up once a year?

Helen Whately: NHS England has already segmented the 42 ICBs into ones that, so far, are good versus ones that already look like they are in trouble and—I am trying to find the right language—need extra support to serve their population better. Even though it is early days, there is already identification of those that have greater challenges, shall we say.

Mark Cubbon: I was referring to how we have oversight of the effectiveness and the implementation of their strategy across the integrated care partnership. Across all of our integrated care boards we have an oversight framework with a set of clearly defined metrics, which we oversee for each system across the country. We categorise those systems in four different categories. Segment 1 has the lower-risk organisations or systems, where essentially they are delivering almost all the things that they are required to deliver. If you end up in segment 4, it is a group of systems that require more intensive support. It could be around some financial challenges that they have. It could be around some operational delivery challenges. It could be around some quality challenges that exist in their patch.

That is an ongoing assessment that we do, and we publish it on our website. It is an assessment based on the metrics, but it is also about judgment supplied through our daily interactions with systems. That sits alongside the annual assessment that we will do around the delivery of the strategy in each partnership.

Q177 **Mrs Hamilton:** Moving on swiftly, you now have your board. They are being trained. They have their strategy in place. How are we ensuring that the right level of training is going into that organisation? Remember, the actual ICS/ICB does not employ a lot of people. You have people from a wide range of different organisations, in and out of the NHS. How do we ensure that they get the right level of training so that they can deliver on things like prevention and population health?

Mark Cubbon: That is a really good question. This is something that we committed to do with systems, not that we are doing for systems; we are supporting systems to make assessments every year about the composition of the board and the composition of the groups and governance arrangements in each system.

Going back to an earlier point, we recognise that there are different types of skills and expertise that may not sit around every single table that the ICB and the system will need to draw on to support their delivery of improvements for their populations. Their annual assessment will look at the training needs. It will look at some of the skills that are required. It is good governance for all of our boards to make sure that they do an appraisal, to make sure that they have the right skills around the table to support the delivery of the improvements they want to make across their population.

Mrs Hamilton: Chair, you don't mind if I ask a further question?

Chair: I don't, Paulette. That's fine. I have a feeling that was a rhetorical question.

Q178 **Mrs Hamilton:** Let us move on swiftly. I have to be honest that this is an area I am absolutely passionate about. I have sat on it for years, and I declare an interest. I believe it can work if done properly.

The problem I see at the moment in the system that I know best is this. They have a pot of money for prevention. They have a pot of money to start some of the key work around prevention. The point is that it is just capital, which means that it is not ongoing. Once that pot of money is finished, a lot of the good work that gets started could die a death.

Is anything being put in place to look at some of these challenges? We have seen it in public health. In public health, they started off going into local authorities with proper pots of money. It then just got reduced and reduced until they could not deliver on what we said we wanted them to deliver. They do their best, but the money has been reduced so much.

With this particular system, I won't say the money is not there. In the system I know best, they have a pot of money. The point is that, moving forward, what are the plans to ensure that you support these systems to deliver on your objectives around prevention? It is no good saying population health and prevention, and then cutting them off at the knees.

Helen Whately: On the funding side, it is broader than that. I have so many conversations, whether it is with directors of adult social services on the local authority side or with the healthcare side, on wanting to have greater long-term visibility of funding, as opposed to short-term funding pots that mean you put something in place but you do not know how long it will be there, or where you might end up doing something that is the only thing you can do short-term but, if you knew you were going to have the funding longer term, you might do it differently and better. I have heard that from the system.

The challenge to us at the centre is how we can give greater visibility of funding and funding horizons in the context of the budgeting cycles that we have and the need to be clearly answerable to taxpayers on how their money is spent. For example, with the discharge funding, this winter we had the £500 million adult social care discharge fund followed by £200 million additionally for step-up care and then £50 million capital. One of the first things I heard with the distribution of the £500 million was, "Well, we want to know if we are going to get this money beyond March this year because then we can commission for the longer term."

One of the good things about the autumn statement was the announcement of the £1.6 billion going into discharge funding, so there is visibility of the money coming for longer, although I have heard back from the system, "Okay, but what are the conditions going to be on that money and our allocation? Until we know our allocation and the conditions, it is hard for us to commission further ahead." One of the things I am working on right now is how we can give that visibility further ahead, while also recognising that we need to do some evaluation as to what has worked and make sure that that informs the choices that are made going ahead. That is a responsible thing to do with taxpayers' money.

The thing to grapple with is to do our utmost to try to give longer-term visibility while working within the constraints of not knowing many years out what the funding pot will be. Mark, do you want to talk more about some of the practicalities?

Mark Cubbon: On the prevention side, there are specific pots of money transformation support that go into the prevention activities. As the Minister said earlier, and indeed as Matthew said earlier, there is a much broader range of opportunity by bringing together the prevention strategies that exist across health and care. I expect that to be a cornerstone. Certainly, some of the strategies that have been reviewed already are a cornerstone for how systems are planning to use the collective resources to support the prevention priorities for their local communities.

Clearly, there are going to be different opportunities and different priorities if you live in Cornwall, Gloucestershire, Manchester or the north-east. There is a range of different priorities, but it is for local flexibility to use the collective resources and strategy to deliver the improvements that they want for their populations.

Matthew Style: You were asking about the training and support for leaders in ICBs in this area, Mrs Hamilton. It is worth being clear that ICBs have a statutory duty to seek advice from appropriate experts on public health and prevention. At the same time, there is a duty in regulations on local authorities to provide expert public health advice to ICBs. I think that gives us a strong framework for ensuring that they have access to the appropriate expertise.

Mark mentioned earlier the process of segmenting ICBs and the role of the NHS oversight framework in that. There are five themes in the NHS oversight framework. One of those is dedicated to prevention and population health. That helps to ensure that a light is shone on precisely the issues that you have been raising, and that they get taken seriously and appropriate emphasis is put on them in their allocative decisions and the priority-setting that Mark referred to.

Q179 **Mrs Hamilton:** My last question is around Healthwatch. We had Louise Ansari here. She told us that commissioning and the funding structure for Healthwatch was not really fit for purpose. She is not the only one saying that. I know you are going to say that to me. I am just using her as an example because she came to us and told us.

Again, I am passionate about organisations like Healthwatch. As you have said, Healthwatch sits on some of the boards around the country, but not enough of them. I think most of them sit at the ICP-type level, which I think is appropriate, but some of them do not even sit there. What are your views relating to funding, commissioning and how they are seen in the system?

Helen Whately: Broadly, the voice of patients and carers is really important at multiple levels in our system. It is very important at the provider level. It is very important at the integrated care system level in planning services, in decision making and in making sure that the system is responsive to what people want of it. That voice is absolutely crucial.

Specifically on the Healthwatch point and the funding model as it is, the Government are contributing £3.5 million annually nationally and then £14 million funding which goes via local government to Healthwatch. That is probably worth a separate conversation rather than being part of the ICSs.

As you said, there are different ways that areas are involving Healthwatch and/or patient and public involvement in their boards. We have Healthwatch representatives as observers. Sometimes they are part of the conversation and, as you said, on the ICP. It is not just about Healthwatch. There are often other groups who are very effective voices for local patients. In some areas, Mencap is a very effective advocate. Age UK is a strong advocate in the system, with others. One thing is to recognise the diversity, and that what is good in one area to give patients a voice may be different in another area. An important part of Healthwatch is that it is not only about the healthcare voice but the social care voice, and making sure that social care users have a voice.

From the national oversight point of view, there is a statutory requirement for integrated care boards to involve patients and the public in their decision making. An important part of CQC assurance will be to consider how well integrated care boards and integrated care systems are bringing in the public and patient voice, as well as the carer voice.

Q180 **Mrs Hamilton:** Do you plan to look at how Healthwatch is funded nationally at Government level?

Helen Whately: Let me take that one away rather than making policy here and now.

Q181 **Chair:** Cally Palmer, who is our national cancer director, was with us in November. It was one of the first sessions I did and one of our first topical sessions on our cancer services follow-up to that work. She said that she thought the NHS was "going in the right direction" on the target of reducing the 62-day backlog to pre-pandemic levels by March 2023. Obviously, that is one month away. We hope to have Cally back with us soon. Is the target going to be met?

Helen Whately: Amanda Pritchard, the NHS chief executive, has already gone on record about this. In fact, I am meeting Dame Cally tomorrow to talk about progress and how far the NHS can get against that target, knowing as we do the huge challenge in meeting it. As you know very well, one of the positive things we are seeing is a great increase in the number of people coming forward as cancer referrals from GPs. It went up around 130% in November. Overall, that is a good thing. The majority

of those people will be given the all-clear. A minority, around 6%, get a cancer diagnosis. The system is working hard. This is exactly what I am speaking to Dame Cally about tomorrow. There are various things that NHS England is doing to speed up the pace of seeing people, diagnosing them or giving them—

Q182 **Chair:** You will be pushing her on the 62-day wait.

Helen Whately: We will exactly be talking about that and where she envisages she can get to for March, and in fact beyond that. Let's look at the year ahead and how we can improve the performance.

Chair: As you know, March 2023 was the NHS's own target, which had already been pushed back. It is really important that that happens. It is something that this Committee takes very seriously, and we will continue to return to it.

That concludes the session on integrated care systems. In fact, it concludes the inquiry on integrated care systems. Thank you very much Mark Cubbon, Minister Helen Whately and Matthew Style for giving evidence to us. We will produce our report in due course. We hope, Minister, that you will ensure a prompt reply from the Government when it is produced. Thank you very much for seeing us today.