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Summary

Integrated Care Systems (ICSs) are the latest attempt to bring NHS and local government services together, to improve services and health outcomes for people in their area.

The Department of Health and Social Care (the Department) took an evolutionary approach to their design, testing different models before bringing in legislation, and this is likely to have contributed to the introduction of ICSs being more widely welcomed by those in the health and care sectors than previous reforms. ICSs have the potential to improve the health of the populations they serve by better joining up services and focussing more on longer-term actions and preventative measures to address the causes of ill-health. However, they will not succeed unless the Department addresses the multiple longstanding challenges facing the NHS and social care, which this Committee has repeatedly highlighted, and which remain unresolved. These include an elective care backlog which recently breached seven million cases for the first time, high workforce vacancy rates in both the NHS and social care, increasing demand, a crumbling NHS estate, and a very difficult financial outlook. These challenges require national leadership, and it is the Department and NHS England that are accountable to Parliament for addressing them, but plans to do so (such as the crucial NHS Workforce Plan) are repeatedly delayed. Until the Department has properly addressed these issues, including a trend towards 'paralysis by analysis' in formulating plans, it is difficult to see how ICSs can fulfil their potential.

There is a risk that ICSs will struggle to make progress on local or longer-term priorities such as increasing healthy life expectancy and reducing avoidable ill-health given the national focus on shorter-term challenges such as the elective care backlogs and A&E waiting times.

At national level, not enough is being done to focus on preventing ill-health: there do not appear to be effective arrangements for joint working between government departments to tackle the causes of ill-health, and NHS England's failure to ensure adequate NHS funded dental care risks creating more acute dental health problems.

The 'Integrated' element of ICSs as well as their accountability arrangements appear under-developed: there is a concerning lack of oversight for ICSs. NHS England's core responsibilities for overseeing the delivery of healthcare in the NHS absorbs most of its focus. The lack of leadership from the Department on the relationship between health and social care is worrying and could mean ICSs become a missed opportunity to make meaningful progress on how the NHS and local government work together. It is not clear who will intervene if joint working between the NHS, local government and other partners breaks down, and local health bodies' responses to concerns raised by MPs on behalf of their constituents have been very patchy. In short, on ICSs, the jury is clearly still out.

Introduction

Integrated Care Systems are new organisations joining up NHS bodies, local authorities, and wider partners involved in providing health and care in local areas. Forty-two ICSs in England serve populations ranging in size from around half a million to three and half million people. They were introduced into legislation in July 2022 through the Health and Care Act 2022, although many had been operating in shadow form on a non-statutory basis for several years prior to this. The Department has overall policy responsibility for health and social care in England. NHS England leads implementation of national policy and strategy for the NHS elements of ICSs which it oversees through its regional teams. ICSs have four key aims: improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience, and access; enhance productivity and value for money; and help the NHS support broader social economic development.

Conclusions and recommendations

1. **It is not clear what tangible benefits for patients will arise from the move to ICSs, nor is it clear by how much or by when things will improve.** We are still unclear on what specific benefits ICSs are expected to achieve and are concerned it would take another three to ten years for ICSs to significantly improve population health outcomes. ICSs' capacity to progress longer term objectives such as preventing ill-health is at risk from shorter term pressures. While 77% of senior ICS staff consider their ICSs intend to invest in preventative measures, only 31% feel they currently have the capacity to. The Department is yet to publish its response to its consultation *Advancing our health: prevention in the 2020s* which closed in October 2019. We were encouraged when the Department told us that the leading indicators around prevention, such as smoking and obesity, are well-understood and should show measurable difference as a result of the move to ICSs. We look forward to hearing what level of measurable improvement the Department expects, and by when.

    Recommendation: ***The Department should write to us within six months and set out:***

    - ***What specific measurable benefits it expects from the formal move to ICSs, including a clear description of the benefits, relevant metrics, and the timeframe for achieving them.***
    - ***What barriers have been overcome between the NHS and social care to support the integration of their objectives and funding.***
    - ***What action it took as a result of its 2019 consultation on prevention, and whether and when it expects to finally publish a response. In publishing its response, it should set out the known drivers of better health outcomes, how they are measured, and which improvements ICSs will be specifically accountable for, which are the responsibility of NHS England and the Department, and which are wider government responsibilities.***

2. **We remain very concerned about the critical shortages across the NHS workforce and the Department's repeated delays in publishing a strategy to address them.** Workforce shortages are widespread across the NHS, and particularly acute in some specialisms, for example midwifery. This can result in unsafe care for patients. This is a long-standing issue which pre-dates the pandemic and which has continued to worsen: NHS vacancy rates increased from 8.3% in December 2021 to 9.7% by June 2022. The NHS *Long Term Plan* committed to producing a Workforce Implementation plan by late 2019, and in September 2020 the Department told us that it expected to publish it following the 2020 Spending Review. It still has not done so. The Department's ongoing failure to publish the workforce plan is extremely disappointing. It is unclear how ICSs are supposed to plan for workforce shortages when the Department has not published a national plan, or the analysis underpinning it. We are encouraged that, not long after our evidence session, the Department committed to publishing a full NHS workforce plan during 2023, and we hope it is finally able to meet its own deadline.

Recommendation: ***The Department should make good on its commitment to publish a comprehensive NHS workforce plan and the forecasts underpinning it in 2023. That plan should set out the assumptions it is based on, including what the NHS will achieve if it is staffed to the target level. If the Department intends for NHS staffing levels to remain significantly below OECD comparator countries, it should explain why. The Department should write back to us a year after the plan is published to provide a progress update on what the plan has achieved, including changes in NHS staff numbers.***

3. **The Department has started taking some action to address workforce challenges in social care, but vacancies have increased by 50% in the last year and the number of people working in social care fell in 2021/22 for the first time in at least 10 years.** The NAO report sets out a very high level of social care vacancies in ICSs of up to 13%, and high turnover rates ranging from 23% to 37%. The Department has taken some action to improve the situation, including adding care workers to the shortage occupations list and launching a national advertising campaign. It told us that numbers of both domiciliary workers and care home staff are now increasing. However, as written evidence to this committee sets out, there are now 165,000 vacancies in social care, compared with 110,000 in 2020/21, and the workforce has decreased by 3% in the last year. We challenged the Department on what the £500m it has committed for social care reform would achieve, and it stated this money would be used to support discharge to assess and other measures for domiciliary care.

Recommendation: ***Alongside its Treasury Minute response, the Department should:***

- ***write to us by the end of March 2023 and provide a breakdown of how it spent and what impact it achieved, in terms of health outcomes as well as operational improvements, from both the £500m committed to workforce reform in December 2021, and the £500m announced in September 2022 to tackle delayed discharge.***
- ***The Department should also write to us within six months setting out the underlying reasons for social care vacancies, its forecasts for them, and its further plans to address them.***

4. **These reforms do nothing to address the longstanding tension caused by differences in funding and accountability arrangements between the NHS and social care. The Department, which has policy responsibility for both health and social care, is showing a worrying lack of leadership, and it is not clear who will intervene if relationships between local partners break down.** The interdependency between health and social care services is well established. However, we are concerned these reforms will be a missed opportunity to make meaningful progress on how the NHS and local government can work together. The NHS and social care continue to maintain separate budgets despite the ambition of integrating services through these new reforms. NHS oversight is focused on the NHS's objectives and while the CQC can identify problems in joint working, it is not clear how the Department intends to resolve them when they do arise. It is

essential that MPs can support their constituents when they encounter problems with health and social care services, but the arrangements for doing so within ICSs are very patchy.

Recommendation: ***The Department should, within six months, publish guidance for ICSs setting out how it will support systems to resolve joint working issues when these are identified by the Care Quality Commission.***

5. **The NHS estate is in an increasingly decrepit condition, but the Department seems unable to make timely decisions to address these problems.** The NAO report found that the cost of tackling outstanding maintenance work on the NHS estate has now reached £9 billion, up from £5 billion seven years ago. Alongside this, there are long delays in making decisions on capital programmes. For example, staff and patients at the Queen Elizabeth hospital in King's Lynn have been waiting for years for a decision, now expected later this year, about whether it will be part of the new hospitals programme. At present the hospital has 3,000 timber and steel supports holding up a cracked aerated concrete roof. The Department has set an aspiration that Integrated Care Boards within ICSs can retain the proceeds of any asset sales, but it is not clear whether they will be able to retain the full value of proceeds given wider pressures on public sector budgets. The Department has still not published its long-term strategy for capital, despite telling us in September 2020 that it would be published in Autumn 2020, and in June this year that it would be published in Autumn 2022. It now tells us it expects to publish in early 2023.

Recommendation: ***The Department and NHS England should ensure the capital strategy is published in early 2023. This strategy should set out an analysis of need and plans to address this. The Department and NHS England should also provide an annual progress update against the strategy, to include progress on nationally determined commitments and priorities, such as the New Hospital Plan, and system-wide ICS-led issues such as addressing the backlog of maintenance work. The progress update should also include details of when the Department and NHS England expect to make decisions that affect current and potential capital projects, to enable ICSs to plan with more certainty.***

6. **NHS funded dental care is in crisis in some parts of the country, and NHS England's failure to ensure people can access routine dental care is leading to more acute dental health problems.** NHS England, rather than ICSs, remains responsible for most NHS dentistry but in some parts of the country it is impossible to find a dentist offering NHS treatment. At our evidence session in November NHS England could not tell us how much longer it expected these gaps in the provision of an essential service to remain. It told us about several changes it has recently made, including increasing payments for complex work, allowing dental health technicians to accept NHS patients for treatment, and increasing the activity cap for high performing practices. Following the session NHS England wrote to us to set out more details on these plans. We welcome NHS England's assurance that it sees restoring dental services as a critical priority. However even in December 2019, before the pandemic, more than 40% of children and half of adults in England had not received any NHS dental care at all in the previous two years. We were disappointed that NHS England is still unable to say by when it expects the changes it is making to result in more dentists offering NHS treatment.

Recommendation: ***Alongside the Treasury Minute response to this Report, NHS England should write to us and set out:***

- ***The funding intended for NHS dentistry in 2022/23 and 2023/24 and what coverage this provides, in terms of the proportion of adults and children who could access these services, and what services the funding will and will not cover.***
- ***Its understanding of the proportion of adults and children using non-NHS dentistry, and the proportion of people who do not access any dentistry services at all.***
- ***By when it expects to be able to consistently provide the target level of coverage, and***
- ***What patients should do if they require dental care and are unable to find a dentist offering NHS treatment.***

1 Improving services for patients

1. On the basis of a report by the Comptroller and Auditor General, we took evidence from the Department of Health & Social Care (the Department) and NHS England about the introduction of Integrated Care Systems (ICSs) in England.[1]

2. ICSs are new organisations joining up NHS bodies, local authorities, and wider partners involved in providing health and care in local areas. ICSs have four key aims: improve outcomes in health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money; and help the NHS support broader social economic development.[2]

3. ICSs were introduced into legislation by the Health and Care Act 2022 in July 2022, although many had been running in shadow form on a non-statutory basis for several years prior to this. There are 42 ICSs in England serving populations ranging in size from half a million to 3.5 million people.[3]

4. There are two new statutory structures in each ICS:

- An Integrated Care Board, which is primarily an NHS body and responsible for planning and delivering NHS services in the ICS area.
- An Integrated Care Partnership, a committee jointly formed between local authorities in the ICS, the Integrated Care Board, and relevant wider partners. It is responsible for creating a strategy setting how the health and care needs of the local population will be met by the ICB, local authorities and NHS England.[4]

5. The Department has overall policy responsibility for health and social care in England. NHS England leads implementation of national policy and strategy for the NHS elements of ICSs and maintains oversight of these elements primarily through its regional teams.[5]

Benefits of ICSs

6. ICSs are the latest in a long line of reorganisations of health and care services by government, in attempts to improve how they are delivered.[6] ICSs are intended to integrate planning and delivery of these services, and to focus more on longer-term population health management and preventative measures that address the underlying causes of ill-health.[7] The Department and NHS England took a more evolutionary approach to introducing ICSs than for previous reforms. They tested various models before drafting the legislation, so that the final approach could incorporate lessons from how local systems were working.[8] NHS England put in place support for ICSs as they became established.[9] The introduction of ICSs has been widely welcomed by those in the health and care

1 C&AG's Report, *Introducing Integrated Care Systems: joining up local services to improve health outcomes*, Session 2022–23, HC 655, 14 October 2022
2 C&AG's Report, para 1.6
3 C&AG's Report, para 1.2–1.3, 2.12
4 C&AG's Report, paras 1.9–1.12, Figure 4
5 C&AG's Report, paras 1.30–1.31, Figure 4
6 Q 27, C&AG's Report, paras 1.4, ICS0023
7 C&AG's Report, paras 1.4, 3.4–3.6, Figure 16
8 Qq 27–28
9 Q 28, C&AG's Report, paras 3.15–3.17

sectors.[10] However, it is unclear at this point what tangible benefits patients will see from the move to ICSs, and the timescales for any expected improvements are worryingly long.[11] The National Audit Office (NAO) reported that 57% of senior ICS staff it surveyed expect it will take between three and ten years for their ICSs to significantly improve outcomes in population health and healthcare.[12] We asked the Department how it would know the new ICS structures are working and delivering better outcomes. It told us the leading indicators that drive public health outcomes, such as smoking and obesity rates, are well-understood and easy to measure, and should show measurable difference as a result of the move to ICSs.[13] However, neither the Department or NHS England have set out what specific benefits they expect from the move to ICSs, or by when.[14]

7. We are concerned ICSs may struggle to make progress on their longer-term aims to prevent ill-health, given pressure for progress on immediate national priorities, for example, the need to reduce elective care backlogs and bring down A&E and ambulance waiting times.[15] We asked NHS England how ICSs can be expected to balance these two sets of pressures and how it would ensure that ICSs addressed them appropriately. NHS England told us it was critical that ICSs responded to both short- and longer-term challenges: in their five-year strategies ICSs must set out how they would meet their core purposes, including addressing more forward looking aims around preventing ill-health, and reducing health disparities. NHS England also described how its oversight framework for ICSs includes both short and long term metrics.[16]

8. We are also concerned about the lack of progress on preventing ill-health rather than simply treating it.[17] There also do not appear to be effective joint working arrangements between different government departments to tackle the causes of ill-health.[18] The Department began a consultation in July 2019, *Advancing our health: prevention in the 2020s*, seeking views on proposals to tackle the causes of preventable ill-health in England. Despite closing this consultation more than three years ago, in October 2019, the Department is yet to publish a response.[19] The consultation included questions where the responses would now be particularly useful for ICSs, such as on how local authorities and NHS bodies can work together, what more government could do to help people live more healthily, and views on the wider government policies that have the biggest impact on peoples' health and care. We challenged the Department on why it is taking so long to provide a follow-up and highlighted the risk of responses becoming out of date.[20] Without sight of the consultation's findings, it is impossible to evaluate any actions the Department subsequently took, or make a judgement on actions it could have taken but did not.[21] The Department told us the response to the consultation constituted a policy document and that its publication was therefore a matter for ministers.[22] We also challenged the

10 Q 27, C&AG's Report, paras 3.12, ICS0012, ICS0019, ICS0023
11 Q 35, ICS0048
12 Q 35, C&AG's Report, Figure 18
13 Qq 121–122
14 C&AG's Report, Figure 18
15 Q 113, C&AG's Report para 2.32, ICS0011, ICS0012, ICS0016, ICS0019, ICS0023
16 Q 113–114
17 Q 118–119
18 Qq 115, C&AG's Report, paras 3.24–3.27, ICS0012, ICS0019
19 Qq 123–127
20 Qq 123–124
21 Qq 125, 128
22 Qq 123, 129

Department on the long delay in publishing the results of the review it commissioned almost five years ago into pregnancy loss before 24 weeks. Again, it was unable to provide any information about when it might be able to make progress on this.[23]

Dentistry

9. The threadbare provision of NHS funded dental care is a further example of a failure to provide preventative or protective routine care leading to more acute health problems.[24] NHS England, rather than ICSs, remains responsible for most of NHS dentistry provision in England.[25] In some parts of the country it is impossible to register with a dentist offering NHS treatment and there is huge concern about lack of access. We raised concerns about children's dental health seriously deteriorating to the extent that they required hospital treatment.[26] NHS England told us it has begun implementing the first steps in a wider programme of dental reform that it announced in July 2022; that these represented the first major change to the profession in fifteen years; and that the changes had been widely welcomed. These reforms included changing the national dental contract to recognise and provide greater payment for more complex work; allowing dental therapists to accept NHS patients for treatment to free up dentists to do more urgent or complex work; and increasing the amount of activity high-performing practices could undertake by 10%.[27] NHS England is also, as part of its work with Health Education England on the NHS workforce plan, looking at ways to improve the pipeline into NHS dentistry, to make it a more attractive place for new dentists to come to do work and to stay.[28]

10. However, NHS England was unable to tell us how many more dentists it expected these reforms to produce, or by when they would appear. It told us that a sustainable solution required further engagement with the dental profession on the longer-term elements such as workforce and contract reform.[29] NHS England wrote to us following our evidence session to provide more details. It assured us that it sees restoring NHS dentistry services as a critical priority. However, it also confirmed that even before the pandemic when dentists were delivering "around 90%" of contracted care, that equated to only around 50% of adults and 58% of children receiving any NHS dental care at all over the two-year period to December 2019.[30]

23 Qq 25–26
24 Q 12
25 C&AG's Report, para 2.14
26 Q 12
27 Q 12
28 Q 15
29 Qq 16–17
30 Letter dated 26 November 2022 from Amanda Pritchard at NHS England to the Committee

2 Effective and sustainable ICSs

Funding and accountability arrangements between the NHS and Local government

11. There is a well-established interdependency between health and local government, with local authorities responsible for managing local social care markets. The stability and resilience of social services have a direct impact on the NHS. High-quality social care, if available, can keep people independent, healthy, and out of hospital.[31] Despite the aspiration for ICSs to better integrate health and care, we are concerned the underlying reforms do not address long-standing differences between the sectors and may be a missed opportunity to make more meaningful progress on how the NHS and local government work together. The NHS and social care continue to maintain separate budgets and we challenged our witnesses on whether this is the best way to ensure people receive the services they need.[32] NHS England highlighted pre-existing mechanisms such as the Better Care Fund, which has been in place since 2015, as a way for the NHS and local authorities to collectively pool budgets and agree how the money is then spent locally, and the Department wrote to us after the evidence session with examples of how the fund has been used and to what benefit.[33] However, the Department noted several times during the session that the ICS reforms are not intended to alter the funding that either the NHS or local government receives or change existing accountabilities and statutory responsibilities, but are instead intended to provide a forum for better decision-making to take place.[34]

12. The oversight of ICSs largely focuses on the NHS elements, and we are concerned the wider system is being overlooked. NHS England has established a very detailed performance regime to monitor Integrated Care Boards' contributions to NHS objectives. NHS England confirmed to us that it retains its power of intervention, and that if a provider or system was under performing it would expect to pick that up very quickly and provide appropriate support.[35] Arrangements for evaluating how the overall system is functioning, including ensuring that local partners are working well together, are less clear.[36] We asked the Department what happens in the event of a disagreement between the NHS and local partners, and it told us that while existing intervention powers across both health and social care remain unchanged, the Care Quality Commission will now have a new role to look at the effectiveness of partnership working locally.[37] However, as the NAO's report points out, the Care Quality Commission's role will focus on monitoring, assessing and reporting, and it will not have any direct enforcement powers over ICSs.[38] The Department has policy responsibility for both health and social care, and

31 C&AG's Report, para 2.34, ICS0012, ICS0039
32 Q 53, ICS0039
33 Qq 53–54, Committee of Public Accounts, *Integrating health and social care*, Sixtieth report of Session 2016–17, HC 959, 27 April 2017, and letter dated 18 November 2022 from Chris Wormald at the Department of Health & Social Care to the Committee
34 Qq 108, 133, 139, 142,
35 Q 28
36 C&AG's Report, para 13, ICS0011
37 Qq 112, 147, C&AG's Report, para 1.32
38 C&AG's Report, para 1.32

when pressed on what it would do in the event of the Care Quality Commission flagging an issue within an ICS that cut across both sectors, it was unable to describe the steps it would take to support ICSs to get back on track.[39]

13. NHS England noted the importance of ICSs' Integrated Care Boards working constructively with the full range of local partners, including local government, elected members, community groups and the voluntary sector.[40] We highlighted the necessity of MPs being able to raise issues on behalf of their constituents who encounter problems with health and care services, but noted members' experiences of trying to engage their local NHS have at times been inconsistent and unsatisfactory.[41] NHS England offered to write back to us setting out who MPs can approach within their local ICS to resolve issues for their constituents, and how it will remind ICSs of the importance of working effectively with local MPs.[42] It has since written to us to provide information from MPs and we look forward to receiving confirmation that it has similarly communicated with ICSs.[43]

Capital investment in the NHS

14. ICSs must contend with the legacy of an increasingly decrepit NHS estate and infrastructure. The NAO's report highlights that the cost of the work needed to bring the NHS estate back up to scratch has increased from just under £5 billion in 2015–16 to an eye-watering £9 billion by 2020–21, of which £4.5 billion was assessed as high or significant risk repairs.[44] We have previously reported on capital expenditure pressures in the NHS and the Department's ongoing failure to publish a capital funding strategy, which was originally due in 2019.[45] The situation is exacerbated by the limited pots of capital funding in the NHS, and long delays to decision making for existing capital programmes. We highlighted the example of the Queen Elizabeth hospital in King's Lynn, which currently has 3,000 timber and steel supports holding up a cracked aerated concrete roof.[46] Staff and patients at the hospital have been waiting many years for a decision on whether they will be included in the government's new hospitals programme, and we were told they must now wait until later this year for a decision that was most recently expected in spring.[47]

15. We asked the Department about the limited extent of capital investment in the NHS. It told us that it had taken an explicit decision to reduce capital investment prior to the COVID-19 pandemic in the interests of managing budgets but accepted this has now put pressure onto capital programmes.[48] The Department highlighted how Integrated Care Boards now have more discretion to target capital resources towards local priorities than under previous arrangements, and will also have greater flexibility to retain and deploy proceeds from asset disposals. However, when we pressed on whether this meant they will be able to keep all proceeds from such disposals, the Department told us that further guidance on how this flexibility will be managed would be provided by government in

39 Q 147
40 Q 42
41 Qq 38–39, 43–47
42 Q 46
43 Letter dated 26 November 2022 from Amanda Pritchard at NHS England to the Committee
44 C&AG's Report, para 2.29
45 Committee of Public Accounts, *NHS capital expenditure and financial management*, Eighth report of Session 2019–21, HC 344, 8 July 2020
46 Qq 59–62, 66–67
47 Q 67
48 Q 61–62

due course.[49] In September 2020, the Department told us it would publish its long-term strategy for capital in Autumn 2020, and in June 2022 it told us that it would be published in Autumn 2022. The strategy remained unpublished at the time of the evidence session, and the Department has since written to inform us that it currently expects to publish the strategy in early 2023.[50] [51]

NHS workforce

16. We have been raising concerns about the lack of long-term planning for the NHS workforce since well before the COVID-19 pandemic[52]. We have noted that among comparable OECD countries the UK has relatively low numbers of nurses and doctors per 1,000 population.[53] The Department has repeatedly failed to make good on its commitments to produce a plan to address this issue, and now many areas of the NHS workforce appear to be in crisis.[54] This places significant constraints on ICSs' ability to deliver their aims and objectives.[55] These shortages appear to be particularly acute in some specialisms, such as midwifery, and we highlighted how this increases risks around unsafe care and patient safety.[56] Workforce pressures in the NHS predate the COVID-19 pandemic, and have continued to worsen: NHS England told us there had been increased numbers of staff leaving the NHS "since the pandemic ended".[57] The NAO's report highlights how the total NHS vacancy rate increased from 8.3% in December 2021 to 9.7% by June 2022, the latest date for which data is available, and NHS England told us that NHS vacancies were currently well in excess of 100,000 posts.[58]

17. The January 2019 *NHS Long Term Plan* originally committed to producing a workforce implementation plan by late 2019. In September 2020, the Department told us that it expected to publish the workforce plan following the December 2020 Spending Review.[59] In July 2021, it finally commissioned the work from NHS England and Health Education England and expected to publish this in Spring 2022, but this date was again missed and the plan was still unpublished when we took evidence for this report.[60] NHS England informed us it hoped to complete and deliver this work to the Department before Christmas 2022, or by the end of the financial year at the very latest.[61] We asked the Department to commit to publishing the plan by April 2023, but it declined to do so and informed us key conclusions from the plan would be published by ministers in due

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49 Qq 63–65
50 HM Treasury, *Treasury Minutes, Government response to the Committee of Public Accounts on the Seventh to the Thirteenth reports from Session 2019–21*, CP 291, September 2020
51 Letter dated 15 November 2022 from the Shona Dunn at the Department of Health & Social Care to the Committee
52 Committee of Public Accounts, Sustainability and transformation in the NHS, Twenty-Ninth report of Session 2017–19, HC 793, 27 March 2018
53 Committee of Public Accounts, *NHS backlogs and waiting times in England*, Forty-Fourth Report of Session 2021–22, HC 747, 16 March 2022
54 Qq 75–76, C&AG's Report, paras 2.25–2.26, ICS0011, ICS0012, ICS0019, ICS0048
55 C&AG's Report, paras 2.25, ICS0048
56 Qq 97–98, 100
57 Q 80
58 Q 82, C&AG's Report, para 2.26, ICS0012
59 Committee of Public Accounts, *NHS capital expenditure and financial management*, Eighth report of Session 2019–21, HC 344, 8 July 2020
60 C&AG's Report, para 2.28
61 Qq 85–87

course.[62] Shortly after our evidence session, the Department committed to "publishing a comprehensive NHS workforce plan, including independently verified workforce forecasts" in 2023.[63]

Social care workforce

18. The social care workforce is in a similarly precarious position, against a wider backdrop of declining local authority resources.[64] Despite the Department's assurances that "the numbers are moving in the right direction", vacancies in social care have been on an upward trend over the last ten years at a national level, rising from 4.4% in 2012–13 to 9.2% in 2020–21.[65] Within ICSs, social care vacancies varied from 5% to 13% and turnover in roles range from 23% to 37% in 2020–21.[66] The Department told us it is taking several steps to address this situation.[67] These include recently launching a national advertising campaign to encourage people to work in social care; committing £500 million to the sector through its Adult Social Care Discharge Fund as part of the *Plan For Patients*; adding social care to the shortage occupation list, which it told us had resulted in between 10,000 and 15,000 new recruits from overseas; and working with the Department for Work and Pensions to better match jobseekers to social care roles.[68] The Department also committed £500m for investment in the social care workforce in December 2021, as part of its white paper on adult social care reform *People at the Heart of Care*.[69]

19. The Department told us numbers in the social care workforce were going in the right direction and that domiciliary care and care home workforces were expanding.[70] However, written evidence sent to us by the National Care Forum highlights that, as of October 2022, there were 165,000 vacancies in the sector according to Skills for Care's most recent 2021–22 annual report.[71] This is an increase of 50% compared to the 110,000 vacancies in 2020–21, and represents a 3% contraction of the social care workforce over the previous year in the face of increasing demand.[72]

20. We asked the Department what the £500 million Adult Social Care Discharge Fund would achieve. It informed us this funding would be used primarily for measures to support discharge from hospitals into social care, with an expectation that much would be focussed on the domiciliary care workforce.[73] The Department also noted this funding would be used differently in different places, and that it was for local authority and NHS partners within ICSs to decide, through place-based decision-making, how best to deploy resources for the greatest impact in their areas.[74]

62 Qq 74, 78, 88–90
63 HM Treasury, *Autumn Statement 2022*, 17 November 2022
64 Q 104, C&AG's Report, para 2.35–2.36, ICS0012
65 C&AG's Report, para 2.37, Q104
66 Q 133, C&AG's Report, para 2.37
67 Q 104
68 Q 104, C&AG's Report, para 3.9
69 C&AG's Report, para 2.38
70 Q 104
71 ICS0013
72 C&AG's Report, para 2.36, ICS0012
73 Q 134–136
74 Q 137

Formal minutes

Monday 23 January 2023

Members present:

Dame Meg Hillier

Olivia Blake

Sir Geoffrey Clifton-Brown

Mrs Flick Drummond

Mr Mark Francois

Mr Louie French

Peter Grant

Sarah OIney

Nick Smith

Introducing Integrated Care Systems

Draft Report (*Introducing Integrated Care Systems*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 20 read and agreed to.

Summary agreed to.

Introduction agreed to.

Conclusions and recommendations agreed to.

Resolved, That the Report be the Thirty-fifth of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjournment

Adjourned till Thursday 26 January at 9.30am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Thursday 3 November 2022

Sir Chris Wormald, Permanent Secretary, Department of Health and Social Care; **Matthew Style**, Director-General for NHS Policy and Performance, Department of Health and Social Care; **Amanda Pritchard**, Chief Executive, NHS England; **Edward Waller**, Deputy Chief Finance Officer, NHS England Q1–150

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

ICS numbers are generated by the evidence processing system and so may not be complete.

1 Age UK) (ICS0049)

2 Allanson, Dr Judith (ICS0042)

3 Alzheimer's Society (ICS0004)

4 Association for Young People's Health (ICS0008)

5 Barnardos (ICS0030)

6 British Association for Counselling and Psychotherapy (BACP) (ICS0001)

7 British Geriatrics Society (ICS0007)

8 Care England (ICS0032)

9 Chartered Institute of Public Finance and Accountancy (CIPFA) (ICS0050)

10 Chartered Society of Physiotherapy; Royal College of Physicians; Royal College of Occupational Therapists; British Society of Physical and Rehabilitation Medicine; British Geriatric Society; College of Paramedics; UK Active; National Care Forum; Royal College of Speech and Language Therapists; and UK Acquired Brain Injury Forum (ICS0043)

11 Company Chemists' Association (ICS0037)

12 Connolly, Professor Sara (ICS0036)

13 The Nuffield Trust) (ICS0048)

14 District Councils' Network (ICS0044)

15 Genetic Alliance UK (ICS0021)

16 HealthWatch England (ICS0017)

17 Huntington's Disease Association (ICS0009)

18 Local Government Association (LGA) (ICS0023)

19 London Councils (ICS0039)

20 MS Society (ICS0018)

21 Marie Curie) (ICS0031)

22 Medical Technology Group (ICS0045)

23 Mencap) (ICS0046)

24 NHS Confederation (ICS0011)

25 NHS Providers (ICS0012)

26 NSPCC (ICS0025)

27 National Care Forum (ICS0013)

28 National Children's Bureau (ICS0028)

29 National Network of Parent Carer Forums (ICS0020)

30 Norfolk and Suffolk Campaign to Save Mental Health Services (ICS0010)

31 Paediatric Continence Forum (ICS0005)

32 Royal College of General Practitioner (ICS0016)
33 Royal College of Paediatrics and Child Health (ICS0033)
34 Royal Osteoporosis Society (ICS0035)
35 Sebastian’s Action Trust (ICS0003)
36 St Mungo’s (ICS0027)
37 Stroke Association (ICS0026)
38 Sue Ryder (ICS0034)
39 Teenage Cancer Trust (ICS0014)
40 The Hepatitis C Trust (ICS0040)
41 The King’s Fund (ICS0019)
42 The Urology Trade Association (ICS0047)

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