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Integrated Care Systems: autonomy and accountability

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Contents

Summary 3

Introduction 5

1 Autonomy 7

New ways of working: the relationship between DHSC, NHS England and ICSs 7

Setting and pursuing priorities: protecting space for local priorities 9

Shared Outcomes Framework 9

Ensuring a focus on the long-term challenges 10

Short-term funding pots 12

Developing from an organisational to a system leader 13

2 Accountability 15

What are ICSs expected to achieve? 15

Partnership working: at the heart of ICS design 16

The 'voice' of social care 16

Which skills and specialities make up Integrated Care Boards? 18

Supporting the involvement of patients, their carers and representatives 19

What will CQC assessments look like? 22

Conclusions and recommendations 24

Formal minutes 28

Witnesses 29

Published written evidence 30

List of Reports from the Committee during the current Parliament 33

Summary

There is a lot of optimism about the 42 new statutory Integrated Care Systems (ICS). These systems are partnerships of organisations that are intended to offer a refreshed way of working across health, social care, wider local authority functions and voluntary, community and social enterprise organisations, to facilitate integration and to offer the flexibility to focus on the priorities that matter to local people. We have been encouraged by the commitment to, and positivity about, the potential of ICSs. However, alongside the optimism are concerns that this potential will not be realised, and that, in a number of areas, there is a serious lack of clarity. We share these concerns, particularly when it comes to the balance between accountability and autonomy that was the focus of our inquiry.

Collaborating well with partners will be the make-or-break factor in determining the success of ICSs. It is vital that social care is not forgotten, and that ICSs do not become too NHS centric. To support this, NHS England and the Department of Health and Social Care (DHSC) need to adapt their approach, with NHS England in particular needing to move away from its centralised "command and control" approach. There also needs to be a recognition that accountability in the NHS is different to that in local authorities, and an effort made to ensure they work well together. While it is well established how ICSs will be held to account for NHS services, it is currently unclear how they will be held to account for partnership working. We recommend that DHSC and NHS England provide more clarity about this and what action could be taken to resolve poor partnership working. Partnership working needs to be about more than just collaboration if there is to be true integration within ICSs.

In a national, taxpayer-funded service, it is right that the Government and NHS England set out the outcomes that ICSs should be working towards. However, to protect the intended flexibility of ICSs, it is vital that the Government and NHS England do not dictate how ICSs should deliver the outcomes. We recommend that any targets are outcomes-based and that any greater prescription is done sparingly.

ICSs have been designed to support a focus on longer-term issues, like population health and tackling health inequalities. In reality, they will need to balance this with the often intense short-term, operational challenges. The nature of such challenges means there is a risk that they will dominate ICS capacity and resources. This tension needs to be recognised by DHSC and NHS England, and they must make active efforts to ensure ICSs have the capacity they need to focus on public health and prevention. It needs to be clear to ICSs, at this early stage of their development but also as they evolve, that they will get the necessary national support to pursue longer-term work. A refreshed version of the NHS Long Term Plan would be a good opportunity to provide that confidence. We recommend that any update to the Long-Term Plan, and the pending Major Conditions Strategy, put prevention and long-term transformation at its heart. We also believe that all Integrated Care Boards must include a public health professional or public health director.

Given the enthusiasm for ICSs, and the challenges currently facing the health and care sector, it would be disappointing if the opportunities for real change were missed. ICSs are still in their early stages and so, if the opportunity is to be taken, it is important that

the issues we have identified are addressed promptly. We share the enthusiasm for ICSs, and we do not want the opportunities they present to be wasted. We are aware that, after our ministerial evidence session, NHS England told ICBs that their Baseline Running Cost Allowance will be "subject to a 30% real terms reduction" by 2025/26[1] and we are conscious of the impact this will have on ICSs' ability to meet their aims and objectives.

1 NHS England, Correspondence to ICB chief executives, 2 March 2023

Introduction

1. Integrated Care Systems (ICSs) are "partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area".[2] Their four key purposes, to be delivered by bringing organisations together, are to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.[3]

2. Each ICS includes two core statutory elements:

- Integrated Care Partnership (ICP): a statutory committee bringing together the NHS, local authorities and other organisations, including those from social care, as equal partners to focus more widely on health, public health and social care. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.[4]
- Integrated Care Board (ICB): a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the budget and arranging for the provision of services in the area. The ICB must have regard to the ICP's integrated care strategy when planning and delivering services.[5] The ICB has taken on many of the roles of clinical commissioning groups, which were abolished when ICBs were legally established.[6] ICBs will be directly accountable to NHS England for NHS spend and performance.[7]

3. Under provisions in the Health and Care Act 2022, 42 ICSs were established on a statutory basis in England on 1 July 2022. This followed a number of years of locally led development and many ICSs existed on a non-statutory basis prior to July 2022, albeit in a different form. As Sir David Nicholson, Chair of Sandwell and West Birmingham NHS Trust and Dudley Group NHS Foundation Trust and former Chief Executive of the NHS, told us, ICSs are "not the kind of dreamt up idea of politicians or an NHS manager … It is actually coming out of reality. The difference with [ICSs] is that it has grown out of people's experience".[8]

4. We have followed the development of statutory ICSs closely and in May 2021 we published a report on the Government's White Paper proposals for reforming health and social care.[9] We launched the current inquiry into ICSs in July 2022, to scrutinise the

2 NHS England "What are integrated care systems", accessed 08 March 2023
3 NHS England "What are integrated care systems", accessed 08 March 2023
4 The King's Fund, "Integrated Care Systems and social care", 8 December 2021
5 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 5), 14 October 2022
6 NHS England "What are integrated care systems", accessed 08 March 2023
7 DHSC Factsheet "Health and Care Bill: Integrated Care Boards and local health and care systems", 10 March 2022
8 Q23
9 Health and Social Care Committee, First Report of Session 2021–22 "The Government's White Paper proposals for the reform of Health and Social Care", HC 20

way that those proposals had been realised. We appreciate that all ICSs are different and are at differing levels of maturity. As Miriam Deakin, Director of Policy and Strategy at NHS Providers, said "If you've seen one ICS, you've seen one ICS".[10] Realising their full potential will be a matter of evolution over time.

5. During our inquiry, the Government announced an independent review of ICSs, led by Rt Hon Patricia Hewitt. The review is considering similar themes to our own inquiry, in particular "how the oversight and governance of ICSs can best enable them to succeed".[11] We welcome the commissioning of this Review and were pleased to see DHSC shining the spotlight on ICSs early in their development.[12] We hope that this attention, and the awareness of the impact of oversight arrangements, is maintained so that potential issues are ironed out early on. This focus is vital at this stage, before ways of working are entrenched and while systems still have the ability to change. It is in that spirit that we have completed our inquiry.

6. We are keenly aware of the difficult landscape that ICSs find themselves in, with challenges around workforce, funding, care backlogs and pressures on acute and social care services. Nicholas Timmins of The King's Fund described this well when he titled a recent article "The first days of statutory integrated care systems: born into a storm".[13] The challenges themselves were beyond the scope of this inquiry, but the impact that those challenges will have on the level of autonomy that ICSs will have, in reality, is key to whether they will succeed in being a new and improved way of working. We believe that DHSC and NHS England will need to be constantly mindful of how immediate pressures might crowd out longer term work.

7. We are also conscious of the variety of partners that will ultimately need to come together to ensure ICSs are successful, beyond those that fall under the responsibility of the Department of Health and Social Care and are addressed in this report. Estimates suggest that 80% of health outcomes are determined by non-health related inputs, such as education, employment, housing and the environment.[14] As Councillor David Fothergill, Chair of the Local Government Association's Community Wellbeing Board, told us, "local government controls many of" those wider determinants[15], which highlights the important role of local authorities within ICSs and the role of the Department for Levelling Up, Housing and Communities. If there is to be true integration, rather than simply improved collaboration, policymakers need to always be aware of the importance of all partners.

8. Fundamentally this has been an inquiry about balance, principally, as the name of the inquiry suggests, between autonomy and accountability. ICSs have been deliberately designed with flexibility at the forefront: the flexibility to focus on the needs of local populations and on the specific local drivers of ill-health, for example. However, it cannot be forgotten that ICSs exist within a national health service, funded by national taxes and available to all. It therefore follows that there needs to be a level of accountability and performance management, but this has to be done in a way that does not infringe on the flexibility at the heart of the design of ICSs.

10 Q48
11 DHSC, Hewitt Review: terms of reference, 06 December 2022
12 At the time of writing, Patricia Hewitt's report has not been published.
13 The King's Fund, The first days of statutory Integrated Care Systems: born into a storm, 01 December 2022
14 NHS England, Anchors and social value, accessed 27 March 2023
15 Q27

1 Autonomy

New ways of working: the relationship between DHSC, NHS England and ICSs

9. In our opening evidence session, we heard from three current ICS leaders: Rob Webster (West Yorkshire and Harrogate), Patricia Miller (Dorset) and Rt Hon Patricia Hewitt (Norfolk and Waveney). All were positive about the opportunities that ICSs present to work differently and more collaboratively. For example, Patricia Hewitt explained how the new statutory framework has supported Norfolk and Waveney ICS to secure agreement from all NHS providers and county councils that their new director of nursing would lead on discharges across the health and care sector. She said that this "had the full backing" of Trust chief executives and senior local government officers. She described this as "a big breakthrough" that would not have necessarily been possible before July 2022.[16]

10. However, witnesses cautioned that the success of ICSs is in part dependent on the way that NHS England and DHSC work with them. As Sir David Nicholson, Chair of Sandwell and West Birmingham NHS Trust and Dudley Group NHS Foundation Trust, and former Chief Executive of the NHS, said, "it is the culture of the system that will drive whether it is successful or not, not the way the mechanics work".[17] Nicholas Timmins, Senior Fellow at The King's Fund, described NHS England as having a "central command and control approach to everything"[18] and suggested that "the concept of an ICS cuts across that to a considerable degree, so a new balance has to be found".[19]

11. Witnesses also highlighted the differing cultures and accountabilities between the NHS and local authorities[20]. As Councillor David Fothergill, Chair of the Local Government Association's Community Wellbeing Board, told us, it will not be possible to resolve these differences, but "both sides need to recognise the difference" and "make sure that the differences work together".[21] Without this recognition and effort to make the differences work, we are concerned that it will be difficult for ICSs to move beyond collaboration towards true integration.

12. A recurring theme in the evidence we have gathered has been the desire that NHS England and DHSC avoid "micromanaging" ICSs.[22] As The King's Fund wrote, "the historic approach of NHS top-down performance management can be useful under specific circumstances, but it is not an approach that will allow ICSs to flourish".[23]

13. The ICS leaders we spoke to shared this view. Rob Webster suggested that a "top-down performance management approach on national targets only" would "get in the way of

16 Q4
17 Q23
18 Q110
19 Q110
20 Q33 and Q110
21 Q35
22 Q12
23 The King's Fund, (ICS0013) para 12

people working collaboratively".[24] Patricia Hewitt told us that if ICSs are "micromanaged" and attempts are made to "impose one size fits all", this would "destroy the unique opportunity of statutory ICSs".[25]

14. Miriam Deakin, Director of Policy and Strategy at NHS Providers, explained that ICSs and Trust leaders are "comfortable" with central priority setting "up to a point" but would like "more freedom to determine how" they deliver those priorities.[26]

15. In October 2022, NHS England published its operating framework, which set out how NHS England will operate in the new statutory ICS structure.[27] Patricia Miller said that NHS England is "trying very hard to get [the] balance right" in the new framework. She did caution that this requires a "big change for [NHS England] …in how they operate, not just from a transactional perspective, but culturally".[28] Chris Hopson, Chief Strategy Officer at NHS England, acknowledged this point, telling us that the new operating framework "recognises that NHS England needs to change how it leads the NHS on giving ICSs and local leaders the space to lead".[29]

16. Witnesses were cautious about the new framework, suggesting that for it to deliver what it promises, there would need to be cultural change within the NHS. Sir David Nicholson told us that while it is a "helpful step forward", the issue for him is "whether the culture of the organisation and the culture of the way we do things will trump that".[30] Similarly, Professor Sir Chris Ham, Senior visiting fellow and former Chief Executive at The King's Fund told us that the framework is "a good starting point" but "we need more than what is in the operating framework".[31]

17. **It is clear that Integrated Care Systems offer a new way of working across health and social care. They encourage collaboration with a range of partners and a focus on what matters to their local populations. This fundamental premise needs to be balanced within a national service, funded by taxpayers and accountable to Parliament. It is therefore right that DHSC and NHS England set some of the priorities that ICSs should be working towards.**

18. **However, if ICSs are to realise the ambitions that have been set for them, and move beyond collaboration towards true integration, it is vital that DHSC and NHS England do not dictate how ICSs should deliver those outcomes. NHS England will also need to be conscious of its organisational culture and make concerted efforts to not revert to overly restrictive ways of working.**

19. ***Targets for ICSs set by DHSC and NHS England should be based on outcomes. There may be times when greater prescription around how targets are achieved is needed, but we believe this should be done sparingly.***

24 Q10
25 Q12
26 Q50
27 NHS England, Operating framework for NHS England (12 October 2022)
28 Q13
29 Q29
30 Q31
31 Q32

Setting and pursuing priorities: protecting space for local priorities

20. As The King's Fund told us, "one of the strengths of ICSs to date is that they have developed in a largely organic fashion in response to local needs and circumstances". They say it is "vital that this continues to be the case".[32] Likewise, the NHS Confederation told us that "a permissive framework which allows local flexibility to make decisions and measure progress is needed for ICSs to deliver against their four statutory objectives and continue to make a difference to communities".[33]

21. It is therefore encouraging that in guidance relating to ICSs, both the Government and NHS England have recognised the importance of leaving space for local priority setting. NHS England's Oversight Framework describes how the oversight of NHS trusts, foundation trusts and Integrated Care Boards will operate. It is built around five national themes, "high-level oversight metrics" aligned to those themes, and a sixth theme: local priorities.[34]

22. In their report *Introducing Integrated Care Systems: joining up local systems to improve health outcomes*, the National Audit Office (NAO) found that "there is an inherent tension between the local needs-based ICP strategies and a standardised service delivering the national NHS mandate target". They highlight that "Government intends ICSs to set out local priorities and make progress against them, but there are fewer mechanisms and no protected budget to ensure this happens".[35] They commented that this situation increases the risk of national priorities crowding out "attempts at progress on local issues", especially when contrasted with the "rigorous oversight mechanisms in place to ensure [national priorities] are delivered".[36]

23. We discussed the NAO's comments with Matthew Style, Director General of NHS Policy and Performance Group at DHSC, and he told us that, rather than protected budgets, he believes it is more important "to maximise the flexibility that ICB leaders have locally to determine how their resources are deployed". He said that DHSC's 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, and holding ICBs to account for good stewardship of those resources".[37]

Shared Outcomes Framework

24. In February 2022, the Government published *Joining up care for people, places and populations* setting out its proposals for health and care integration.[38] This signalled the Government's intention to develop a shared outcomes framework for ICSs, and DHSC told us that it is "committed" to publishing a framework "with a focused set of national priorities and an approach for developing local outcomes". DHSC said it intends to set out the framework in April 2023.[39]

32 The King's Fund (ICS0013) para 23
33 NHS Confederation (ICS0051)
34 NHS England "NHS Oversight Framework", 27 June 2022
35 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 12), 14 October 2022
36 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 12), 14 October 2022
37 Q167
38 DHSC "Joining up care for people, places and populations", February 2022
39 DHSC (ICS0030)

25. The idea of this framework has been broadly welcomed. The King's Fund told us that "this is the right approach to take"[40] and the Local Government Association (LGA) said they "support the proposed national shared outcomes framework".[41] The LGA suggested that the proposed framework "could herald the start of a national paring and rationalisation" of existing frameworks with the aim of "moving to a single, outcome-focused, light-touch and permissive framework". This would allow ICSs to pursue the priorities that will have the most impact on their populations.[42]

26. However, caution was expressed about the implementation of any shared outcomes framework. The King's Fund highlighted the example of the outcomes framework developed as part of the 2012 health and care reforms. They said these "were a laudable effort but in practice took second place to other (often process-based) targets in terms of the relative weighting placed on them by national bodies when holding local organisations to account".[43] The LGA also suggested that there is potential for the new framework to "add another layer of complexity to an already complex national framework for health, care and public health partners".[44]

27. **We welcome the clear references to local priorities within NHS England guidance for ICSs and DHSC's proposed shared outcomes framework. We hope that, in the years to come, this focus on local priorities will be maintained. However, we share the NAO's concern about the tension between local needs-based strategies and a national standardised service. Experience shows that locally determined priorities may become the poorer relation to priorities driven nationally.**

28. ***DHSC should explain the mechanisms that will ensure that progress is made against local priorities. It should set out how this compares to mechanisms used to measure progress against national priorities, alongside an assessment of whether this balance will support ICSs to meet their four main objectives.***

29. ***DHSC should publish, as soon as possible, the proposed shared outcomes framework and more information about how and when ICSs should expect it to be implemented.***

Ensuring a focus on the long-term challenges

30. ICSs present an opportunity to address immediate operational pressures, while also looking to the longer term: improving health outcomes, addressing health inequalities and ensuring, as Chris Hopson said, "that we actually prevent illness and encourage health and wellbeing as opposed to just treating illness".[45] We absolutely agree about the need to prevent illness. In January 2023, we launched a new, wide-ranging inquiry to consider what prevention should look like, how to promote it and what action the Government should take. We believe that prevention offers the biggest opportunity to improve quality of life and keep our NHS sustainable.[46]

40 The King's Fund (ICS0013) para 6
41 Local Government Association (ICS0016) para 2.2
42 Local Government Association (ICS0016) para 4.5
43 The King's Fund (ICS0013) para 6
44 Local Government Association (ICS0016) para 4.5
45 Q22
46 For more about the prevention inquiry, see here

31. The NHS Confederation told us that given the pressures that the health service faces, there needs to be "smarter use" of resources on the demand side (by preventing ill-health) and on the supply side (by "delivering the right care in the optimal setting through a more integrated approach to planning and delivery"). They suggest that this is in fact the role of ICSs and, while they "will not be a panacea" they are well-placed to work towards the smarter use of resources by bringing "all the relevant partners together to make decisions collectively".[47]

32. However, the evidence we have received highlights the scale of the challenge that ICSs will face if they are to balance immediate pressures with longer-term work. The Care Quality Commission (CQC) told us that this is "an inherent challenge of working at system level".[48]

33. As the NHS Confederation said:

> the need to meet performance targets (particularly reducing waiting times and the elective care backlog) and balance budgets in the short-term risks undermining investment of time and effort in the transformation ICSs need to deliver to improve patient care and make the health and care system sustainable in the long-term.[49]

34. As an example of the challenge ICSs face, Professor Jim McManus, President of the Association of Directors of Public Health, told us about one director of public health whose ICB papers "always" have "400 pages of [acute] performance data". They "struggle to find time to talk about" the value of other parts of the system.[50] This speaks directly to what The King's Fund has told us. They told us that, in principle, there are opportunities for a preventative approach to work in parallel with efforts to tackle current pressures. In practice, however, capacity in ICBs to "think creatively about longer-term solutions is likely to be highly limited currently".[51] Indeed the NAO, in their report on the introduction of ICSs, found that only "31% of senior ICS staff responding to [the NAO's] survey consider their ICS has the capacity to improve prevention" despite 77% reporting their intention to invest in prevention.[52]

35. Oversight and performance management methods could also have an impact on an ICS's capacity to focus on the longer-term issues. The NAO found that while NHS England's ask of ICSs is to take a long-term approach, "its oversight of NHS bodies over the past year has focussed on short-term improvements, principally elective care recovery" and "the NHS Oversight Framework focusses on current performance rather than longer term population health management".[53] Their report highlighted that the indicators in the oversight framework for preventing ill-health and reducing health inequalities "relate to delivering NHS interventions (screening, vaccinations, managing long-term conditions) and not the challenge that NHSE has set for ICSs to work with partners to address the

47 NHS Confederation (ICS0051) para 3
48 Care Quality Commission (ICS0035) para 45
49 NHS Confederation (ICS0051)
50 Q49
51 The King's Fund (ICS0013) para 25
52 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 11), 14 October 2022
53 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 66), 14 October 2022

wider determinants of ill health".[54] We strongly agree with The King's Fund when they say that "national bodies need to be aware of the risk of prevention being de-prioritised if there is highly directive performance management of short-term targets".[55] Likewise, we agree on the importance of the NHS long-term plan refresh and its role in keeping prevention and longer-term transformation "front and centre". As NHS Confederation told us, it is important that ICSs and NHS England and DHSC, "don't let today's challenges crowd out tomorrow's vision".[56]

36. **Unfortunately, there is a clear risk that short-term, acute pressures will dominate ICS capacity, resources and leadership headspace, limiting the true flexibility of ICSs. Active effort from DHSC and NHS England is needed to ensure ICSs retain the space they need to focus on matters like public health and prevention. This will be especially necessary at this early stage of development for ICSs but should be maintained as ICSs evolve.**

37. ***NHS England should provide an update on whether they intend to refresh their 2019 Long-Term Plan and, if so, when. Any update to NHS England's Long-Term Plan must put prevention and long-term transformation at its heart, empowering ICSs to pursue these priorities and giving them the confidence that they have the necessary backing from the Government and NHS England. This should also apply to the Government's pending Major Condition's Strategy.***

38. **Improving outcomes in population health and healthcare is one of the four core purposes of ICSs. Despite this, there is no mandated representation for public health professionals on Integrated Care Boards. Without that voice of expertise driving the public health agenda on ICBs, we are sceptical that ICSs will succeed in addressing longer-term priorities and fear that the move to ICSs will, once again, result in a sickness service, not a health service for the future.**

39. ***To guarantee a continual focus on the prevention agenda, all Integrated Care Boards should ensure they include a public health representative, such as a public health director or public health lead. In 12 months, DHSC should conduct a review to understand the extent to which this is happening. If necessary, further steps should be taken to mandate the inclusion of a public health representative so the focus on prevention is not lost.***

Short-term funding pots

40. One of the key challenges that impacts on an ICS's ability to look to the longer-term relates to Government funding cycles. Funding to support the health and care system during the winter has been welcome. However, we have heard criticism of the method behind these payments and the resulting limitations caused by the short-term nature of the funding. Patricia Hewitt explained:

> The biggest problem is that it only lasts for six months … We talk to providers, but we have to tell them: "Everything you bring onstream on 1 October or 1 November, you will have to get rid of on 31 March." Not surprisingly, a lot of them do not want to do it. Some of them agree and then pull out. We find

54 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 25), 14 October 2022

55 The King's Fund (ICS0013) para 25

56 NHS Confederation (ICS0051)

> somebody else and then have to get approval for the somebody else from NHS England regional centre. This is, frankly, nonsensical. What we could do is build some modular capacity that could be flexed as demand pressures come and go, although frankly winter pressures are now a 12-month phenomenon. Putting in a modular unit takes five months, so we cannot do it with money that only lasts for six months.[57]

Sarah Walter, Director of NHS Confederation's ICS Network, also raised this with us and highlighted the "rigid" nature of the adult social care discharge fund confirmed in autumn 2022. She told us that expectations were set about how the funding should be used, "which may be different from what ICSs would want to use them for" and reporting requirements alongside that funding were "incredibly onerous".[58]

41. While funding is therefore welcome, we note that the nature of its allocation and monitoring may lead to the unintended consequence of restricting the autonomy of ICSs and, as Sarah Walter said, may not deliver the "maximum bang for your buck".[59] We were therefore encouraged that the Minister of State for Social Care, Helen Whately MP, clearly recognised these challenges. She explained that there is a challenge for DHSC about how it can provide greater certainty about future funding, while considering the way in which the Government sets budgets and the need to be accountable to taxpayers. She told us that this is something that she is working on.[60]

42. **The four key purposes of ICSs are all dependent on taking a long-term approach. In order to fulfil them, ICSs need to be supported to make long-term decisions and have as much certainty as they can about upcoming funding.**

43. ***We welcome the Minister's comments about giving ICSs information about the funding that will be available to them further in advance. DHSC must set out how it intends to do this, and any decision to give that information must be made in plenty of time to support ICS preparations for winter 2023/24.***

Developing from an organisational to a system leader

44. Leadership of and within ICSs is a theme that was raised repeatedly. Professor Sir Chris Ham told us of the need to support existing leaders to be system leaders and not just organisational leaders, creating the behaviours that will "make ICSs succeed or indeed fail".[61] He said that these behaviours include "learning how to create partnerships", such as between health and social care, and how to "look out more [towards partners and communities] and not look up [towards NHS England and DHSC]". He highlighted a need to ensure expertise can be shared more widely to "create a different generation of leaders building on the very good ones we already have".[62]

45. Rob Darracott, Editor of P3 Pharmacy magazine, told us of conversations he has had with pharmacy colleagues about whether they were ready to engage with ICSs, which presented a varied picture. He pointed out that some of those he had spoken to

57 Q17
58 Q116
59 Q116
60 Q178
61 Q36
62 Q36

had suggested that it was not having a seat on an ICB that was important, but whether pharmacists were able to participate at the relevant levels of decision making.[63] Rob Darracott suggested that the pharmacy sector would particularly benefit from support around leadership development in order to "prepare people" to "think about how the system fits together and how they might play a role".[64]

46. We welcome DHSC's recognition of the importance of strong leadership. As Matthew Style, Director General of NHS Policy and Performance Group, told us, this is the best way of overcoming "some of the slightly inevitable barriers that accountability arrangements put in place". We were glad to hear of DHSC's focus on supporting strong leadership locally, through the role of the CQC and NHS England's development work with ICBs.[65] We look forward to seeing the results of this work.

47. **System leadership is different to organisational leadership and ICS leaders, as well as leaders at other levels, need support to develop skills to make the most of the opportunities and to ensure ICSs do not become too NHS centric. Systems need leaders that will work collaboratively and not be tied to the existing institutional instinct in healthcare to look upwards rather than outwards.**

48. ***The Government and NHS England should set up and fund an ICS leadership development programme, specifically targeted at supporting leaders of and within ICSs to develop the skills required to be successful system leaders.***

63 Q91
64 Q92
65 Q163

2 Accountability

What are ICSs expected to achieve?

49. While the four core purposes of ICSs are important overarching aims, it is unclear what specific benefits will be achieved within these purposes and how ICSs will be measured on progress. The NAO's report on ICSs ranked 10 elements for effective integration in health and care and then assessed ICSs' implementation against them. A "high-risk" element is one where the NAO considered it was likely to be important to the success of ICSs, but where they "could not see it had been considered and fully addressed in establishing ICSs".[66] "Clarity of objectives" was ranked as "high risk".[67] The NAO explained:

> It is not yet clear what ICSs are expected to deliver. NHS England has set out four high level purposes for ICSs but not articulated what improvement it expects to see against these objectives or by when it expects to see them. It has set out detailed expectations for the performance of NHS organisations against NHS priorities.[68]

50. Professor Sir Chris Ham wrote a report for the NHS Confederation about Patricia Hewitt's independent review of Integrated Care Systems. He welcomed the emphasis on transparency which he said suggests that more attention will be given to publishing data on ICS performance. However, he said questions still remain about how to assess that performance data. He argued that "now is the time to address this question and define what a high-performing ICS looks like".[69] While Minister Helen Whately MP spoke conceptually about what success looked like, we noted the lack of specifics in her descriptions.[70]

51. In January 2023, the Secretary of State, Rt Hon Steve Barclay MP, told us:

> One of the things I am very keen to do is empower parliamentary colleagues more through giving transparency on the data on their ICBs so that Members of Parliament can be more engaged in those conversations, rather than being on receive mode from health leaders, and being a bit more able to look at variation in performance and ask why their trust is in a different place from others.[71]

52. **We share the concern expressed by the NAO about the lack of clarity around what ICSs are expected to deliver within their core purposes. While we are conscious of, and agree with, the need to avoid micromanaging ICSs, we believe that DHSC needs to provide additional clarity about what exactly ICSs are expected to deliver. Only then can the public, and parliamentarians, begin to assess the success of ICSs.**

66 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 65), 14 October 2022
67 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 66), 14 October 2022
68 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 66), 14 October 2022
69 Professor Sir Chris Ham, "Accountability and autonomy in the NHS in England", January 2023
70 Q154
71 Oral Evidence taken on 31 January 2023, Q26 [Steve Barclay MP]

53. ***Following engagement with ICSs, and being conscious of the space required for local priorities, DHSC and NHS England should issue guidance with additional detail on what ICSs are expected to achieve within each of the four core purposes. As we have said previously, the focus here should be on outcomes and not dictating to ICSs how they achieve the goals.***

54. **Members of Parliament should be supported to directly hold their local ICSs to account for the service they provide to constituents, without having to rely on an assessment provided by local health and care leaders. We believe this is an integral part of the role of an MP. We therefore welcome the Secretary of State's desire to empower parliamentary colleagues to hold their local ICSs to account through transparency on ICB performance data.**

55. ***The Secretary of State should set out further detail about how he intends to empower MPs to hold their local ICSs to account and what performance measures he envisages being available to support this.***

Partnership working: at the heart of ICS design

56. ICSs have been designed to be a partnership of organisations, driving improvement through collaboration and a focus on places and local populations. Given that only 10–20 per cent of health outcomes are determined by NHS care,[72] to meet their duties, ICSs need to reach beyond the NHS to bring together local authorities, Voluntary, Community and Social Enterprise (VCSE) organisations and other local partners.[73] As Sarah Walter, Director of the NHS Confederation ICS Network, told us, "the ambition of ICSs will not be delivered if it does not have effective local authority engagement". She said that "partnership between the NHS and local government is at the heart of this and is going to be fundamental to its success".[74]

The 'voice' of social care

57. Evidence we have taken has raised some concern about the exclusion of adult social care in new systems, and the risk of ICSs becoming 'NHS-centric'. For example, Care England wrote: "The concern for [Adult Social Care] providers is that ICBs will merely be a reworked version of CCGs [clinical commissioning groups]; suffering from an NHS-centric focus that excludes the needs and concerns of the care sector".[75] The LGA wrote that "'parity of esteem' between partners is crucial to the ICS being seen as 'everyone's business' rather than the new and latest structural reorganisation of the NHS".[76]

58. We have heard both optimism and concern about the extent to which ICSs are truly partnerships of equals. For example, Sarah Walter told us that there are "encouraging signs of greater integration and connection across the different parts of the system".[77] The Minister told us that a short-term impact of the new structures is already being seen and "relationships are stronger". She said that ICB and ICP Chairs and local authorities that

72 NHS Confederation (ICS0051) para 5
73 The King's Fund, "Integrated Care Systems Explained", 19 August 2022
74 Q124
75 Care England (ICS0017)
76 Local Government Association (ICS0016) para 4.3
77 Q103

she has had conversations with have reported that "things feel different".[78] However, Sarah McClinton, President at the Association of Directors of Adult Social Services, told us that this is "subject to variation" and "overall it does not yet feel like an equal partnership".[79]

59. Given the concerns about exclusion, some of the evidence called for ICSs to be held accountable to a greater extent for partnership working, in particular with the social care sector. For example, the Surrey Care Association suggested that "the implementation of [Government guidance in July 2022] on the inclusion of adult social care providers needs to be assured through the CQC's new inspection arrangements for the system".[80] The National Care Forum recommended that there needed to be "clear requirements set out in guidance and regulation for adult social care involvement in their ICSs".[81]

60. The NAO's report explained that NHS England "intends to look at the ICBs' contribution to partnership working as part of an annual assessment of ICBs".[82] The NAO recommended that NHS England should "ensure its annual assessments of ICBs' performance include an evidence-based assessment of the effectiveness of joint working and delivery with partners beyond the NHS".[83] It is unclear whether NHS England are intending to take this recommendation forward.

61. The CQC also has a role in assessing ICSs, which will be discussed later in this report. On the subject of partnership working, Kate Terroni, Chief Inspector of Adult Social Care and Integrated Care at the CQC, told us that if a partner is not involved in an ICS in the way that would be expected, the CQC would want to know what efforts the ICS is making "to bring that partner to the table and engage them". The ICS would not, however, "be penalised".[84]

62. **Partnership working is fundamental to the design of ICSs and will be the make-or-break factor in their success. As we have discussed, the monitoring and evaluation of NHS priorities and structures is well established but it is unclear how partnership working will be monitored. It is also unclear how ICSs will be held accountable for partnership working, particularly if problems arise.**

63. ***NHS England should provide more clarity about what ICSs should expect in terms of the monitoring of partnership working and how this will be assessed in ICB annual assessments.***

64. ***DHSC, working with ICSs, should clearly set out what action could be taken, be that by the CQC, NHS England or others, to resolve issues of poor partnership working, in particular with adult social care.***

78 Q155
79 Care England (ICS0017)
80 Surrey Care Association (ICS0012)
81 National Care Forum (ICS0027)
82 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 25), 14 October 2022
83 National Audit Office "Introducing Integrated Care Systems: joining up local services to improve health outcomes" (Page 14), 14 October 2022
84 Q143

Which skills and specialities make up Integrated Care Boards?

65. The Health and Care Act 2022 sets out the minimum membership of Integrated Care Boards (ICB).[85] During the passage of the legislation, Members of Parliament put forward various amendments to expand the minimum membership.[86] The Government said that it sees the ICB membership in the legislation as the "baseline" and it does not want to "over-prescribe".[87] However ministers have also said that the minimum membership requirement could be expanded through regulations if needed at some point in the future.[88]

66. We heard calls for additional mandated representation, in particular for clinicians and social care providers. The British Medical Association (BMA) raised concerns that the provisions in the Health and Care Act and detail of the ICS design framework "fall far short of ensuring strong clinical leadership" and "risk postcode lotteries developing".[89] The consequence of this, according to the BMA, is that an ICS's understanding of the challenges facing frontline services and staff is limited. They went on to say that to be successful, ICSs need to "embed the active involvement of clinicians and frontline staff, who know their local healthcare systems and patients best, at all levels".[90]

67. Dr Trudi Seneviratne, Registrar at the Royal College of Psychiatrists, told us that it is "critical that we get to a place where clinicians are at the heart of ICBs".[91] Following a Government amendment during passage of the Health and Care Act, ICBs are required to include a member with expertise and knowledge of mental illness. Dr Seneviratne told us that while it is "good" that there is a mental health expert on ICBs, it is unclear whether these are mental health clinicians, or other professions within the mental health sphere.[92] Dr Seneviratne said it is "absolutely essential" that the representative was a clinician because "there is a greater understanding of the holistic care of the patient" and it needs a clinician who has the necessary expertise to understand the flow of people through the system.[93]

68. Concerns were also raised with us about the representation of the adult social care sector on ICBs.[94] Care England and the National Care Forum highlighted the need for greater involvement of the social care sector, beyond local authorities and NHS commissioners. The National Care Forum wrote in evidence to the Public Accounts Committee that "simply involving Local Authority and NHS commissioners is not enough, as they cannot, alone, be the voice of social care and support and will lead to acute health dominated policymaking".[95] Professor Vic Rayner, Chief Executive at the National Care Forum, explained to us that there is not "full representation" of adult social care if that representation is only through local authorities as local authorities are "largely

85 Health and Care Act 2022, Schedule 1B, Part 1,
86 For example see Amendment 32 to Schedule 2 during Committee Stage of the then Bill: PBC Deb 14 September 2021 col 244
87 PBC Deb, 14 December 2021 col 251
88 House of Commons Library, Health and Care Bill Committee Stage Report, 18 November 2021
89 British Medical Association (ICS0046) para 1.2
90 British Medical Association (ICS0046)
91 Q69
92 Q69
93 Q75
94 See: Care England (ICS0017); Public Policy Projects, (ICS0045)
95 National Care Forum, Written Evidence (Public Accounts Committee), (ICS0013)

commissioners". She explained "as long as you look at the expertise in social care as part of 'what can we buy from them?' rather than 'what can we do together in order to plan and prepare for our communities' needs?' we are going to continue to fail".[96]

69. Fundamentally, the discussions we have had about representation on ICBs have been around whether the "right" people are on the Boards or whether certain specialities are "overrepresented".[97] Dr Seneviratne suggested to us that there is a need to "ensure accountability of the Boards to make sure that the right people are actually on [them]. That ultimately goes to asking the Secretary of State to look at the Boards".[98]

70. It is unclear whether DHSC or NHS England has an overall view of the skillset and roles of members of ICBs. While the Minister was able to speak anecdotally about this,[99] when DHSC was asked a written question about how many ICSs have a director of public health or public health lead, it did not have the information to be able to answer.[100] DHSC has also said that "no specific assessment has been made" of the adequacy of the level of clinical staff involvement in ICBs.[101]

71. **We have heard a range of compelling arguments for particular professions to have greater representation on Integrated Care Boards and are sympathetic to the concerns that have been raised with us about the exclusion of expertise. However, we are also sympathetic to the Government's intention to give ICSs flexibility when determining which professions are most relevant to their local needs. Our concern is that it is unclear how the Government will monitor and evaluate whether its approach is the correct one. If data is not held centrally on how many, for example, public health experts or social care providers or clinicians, are on ICBs and no assessment is made of the adequacy of the representation, it is not possible to understand whether the Government's flexible approach is yielding the results it intends. It will also not be clear whether there are any patterns of under-representation.**

72. ***DHSC should centrally gather information relating to the membership of ICBs, including the specific role of members and their area of expertise, by 1 October 2023.***

73. ***Once the data is gathered, DHSC should review it with a view to understanding whether the policy of keeping mandated representation to a minimum is producing the intended results and whether any specialties are especially under-represented. They should report the outcome of this work, and whether any further mandating is required, to the House.***

Supporting the involvement of patients, their carers and representatives

74. The involvement of patients and their carers is a key part of the new Integrated Care Systems, both in terms of their legal duties but also in the way that they are structured with an explicit focus on the needs of local populations. Given that ICSs are designed to

96 Q84
97 See Qq81–86 in particular
98 Q85
99 Q173
100 Q173 and PQ 1042 1
101 PQ 1042 8

address issues that are the most relevant to their community, it should be expected that those communities can hold ICSs to account for what they deliver and be involved in decisions that will impact them.

75. As set out in the Health and Care Act, each ICB has a duty to "promote involvement of each patient… in decisions which relate to the prevention or diagnosis of illness in the patients or their care or treatment". This also includes their carers and representatives.[102] ICBs must also make arrangements to ensure that service users, carers and representatives are involved in the planning of commissioning arrangements and the development and consideration of proposals to change those arrangements.[103] In October 2022, NHS England published statutory guidance on working in partnership with people and communities.[104]

76. We agree with Louise Ansari, the National Director of Healthwatch, that there "needs to be a culture of leadership where chairs, chief executives, the whole board and all the staff and bodies in the ICS genuinely believe in listening to their communities, and that then feeds through into what their priorities and actions are". She also highlighted the need to move away from what she described as "some of the statistical-only or quant-only culture that perhaps pervaded CCGs" and "people's experience and stories" should be valued as much as quantitative analysis.[105]

77. We were pleased to hear the commitment to patient involvement and examples of good practice demonstrated to us within the evidence we heard from ICSs. Rob Webster told us that his ICS (West Yorkshire) has "a compendium of all the evidence and all the conversations that [they] have ever had with people". This is published every year and it helps to drive the ICS's reflections on the work it is doing.[106] Sarah Walter, Director of the NHS Confederation ICS Network, told us about work ongoing in Staffordshire and Stoke-on-Trent to create a patient assembly and highlighted "good work" in Bristol, North Somerset and Gloucestershire.[107] Louise Ansari praised North East and North Cumbria ICS as a good example of "patient listening", which was used to inform their ICP's work to build its integrated care strategy.[108]

78. Healthwatch was established under the Health and Social Care Act to "understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf".[109] They are a statutory committee of the Care Quality Commission, and Healthwatch's main statutory functions are to:

- "Provide leadership, guidance, support and advice to local Healthwatch organisations.
- "Escalate concerns about health and social care services which have been raised by local Healthwatch to CQC. CQC are required to respond to advice from the Healthwatch England Committee.

102 Section 25, 14Z36, Health and Care Act 2022
103 Section 25, 14Z45, Health and Care Act 2022
104 NHS England, Working in partnership with people and communities: statutory guidance, 10 Oct 2022
105 Q111
106 Q9
107 Q127
108 Q112
109 Healthwatch, Our history and functions (Accessed 10 March 2023)

- "Provide advice to the Secretary of State for Health and Social Care, NHS England and English local authorities, especially where we are of the view that the quality of services provided are not adequate. Bodies to whom advice is given are required to respond in writing. The Secretary of State for Health and Social Care is also required to consult Healthwatch England on the NHS mandate, which sets the objectives for the NHS".[110]

79. Healthwatch's statutory functions were not impacted by the changes within the Health and Care Act, but "additional burdens" and "accompanying guidance" set an expectation that Healthwatch would play an active role within the new ICS landscape.[111]

80. While the expectations placed on Healthwatch are the same across the country, Louise Ansari spoke of the variation in funding for Healthwatch. She told us that some are "chronically underfunded", and some are "funded to around £60,000 which is barely enough to run the organisation".[112] When asked what Healthwatch might need from the Government to support them to drive good patient accountability, Louise Ansari told us that the way Healthwatch is commissioned and funded at the moment "is not really fit for purpose". She explained:

> The money comes out of the Department of Health. It goes via local authorities. Some of it somehow gets reduced along the way, and then it leads to a huge variation in funding. When Healthwatch was set up 10 years ago, the funding was around £50 million for 152 local Healthwatch. It has reduced by around half; it is about £23 million to £25 million now. We need to look at the model and the funding.[113]

81. **The core purposes of ICSs, and the importance of addressing local needs, will not be met without good patient and carer involvement. ICSs cannot truly deliver for their local area without considering the needs of that area from the patient or carer's perspective.**

82. **Given the new expectations that have been placed on Healthwatch organisations across the country, we believe this is a good opportunity to consider their funding and commissioning arrangements.**

83. ***DHSC should therefore review the funding and commissioning arrangements for Healthwatch, with a view to ensuring they are fit for purpose within the context of new ICSs, and support Healthwatch to have a clear voice. The outcome of this review should be reported to the House.***

110 Healthwatch, Our history and functions (Accessed 10 March 2023)
111 For more detail, see: Healthwatch, Local Healthwatch Funding 2022–23 (page 13), 1 March 2023
112 Q125
113 Q126

What will CQC assessments look like?

84. Following a suggestion we made to the Government when considering their White Paper on proposals for reform of health and social care, Section 31 of the Health and Care Act 2022 places a new duty on the CQC to review, assess and undertake ratings of each ICS.[114]

85. Under the legislation, CQC assessments must consider leadership, the integration of services and the quality and safety of services. The legislation also gives the Secretary of State powers to set additional objectives and priorities for what the CQC assesses.[115] At the time of writing, there is still some uncertainty about the role of the CQC and what the specific outcomes of their assessments of ICSs will be. On 21 March 2023, CQC published interim guidance for assessing ICSs, which will develop through piloting and collaboration with stakeholders.[116]

86. The CQC has recently developed a new single-assessment framework, which they will use to assess not only ICSs, but also providers and local authorities. Kate Terroni, Chief Inspector of Adult Social Care and Integrated Care at the CQC, told us that the CQC will be looking at 17 areas of quality when assessing ICSs and, for each area, evidence will be collected, and a narrative will be produced.[117]

87. The CQC told us that each assessment of an ICS will consider the objectives set out in the Integrated Care Partnership strategy.[118] DHSC, in their written evidence to us, told us that "local and system planning and performance against those plans will be central to accountability in the new system".[119]

88. The methodology that the CQC has built does allow ICSs to be rated and CQC's interim guidance sets out how this could work[120]. However Kate Terroni told us that it is a "decision for the Government to make" as to whether ICSs will be provided with a publicly available rating.[121] From the CQC's perspective, they are focussed on producing a "report that is accessible and that ICSs can use to learn from best practice elsewhere, so that they have an independent analysis of view about how they are delivering against the two areas of focus [the CQC] will be looking at". These are improved outcomes for people and addressing inequality.[122]

89. We were also interested to learn of the CQC's approach when an ICS may include a poorly performing provider. Kate Terroni explained that ICS assessments would not be an aggregation of provider ratings. The CQC is "interested in how an ICS has oversight of support of every component of health and care provision" within their area. If there is a poor performing provider, the CQC is "interested to know how that ICS is working with the provider to support its improvement".[123]

114 Health and Social Care Committee, First Report of Session 2021–22 "The Government's White Paper proposals for the reform of Health and Social Care", HC 20, para 20–24 ; Section 31, Health and Care Act 2022
115 Section 31, Health and Care Act 2022
116 CQC Interim guidance on our approach to assessing integrated care systems, March 2023
117 Q139
118 Care Quality Commission (ICS0035) para 37
119 Department of Health and Social Care (ICS0030)
120 For more on how CQC plans to test ratings of ICSs, see: CQC Interim guidance on our approach to assessing integrated care systems (Page 12) March 2023
121 Q139
122 Q140
123 Q143

90. On regulation more widely, as NHS Providers told us, "It is not yet clear how quality oversight approaches from CQC and NHSE will align with DHSC's shared outcomes frameworks at place level".[124] With both CQC and NHS England assessments of ICSs, alongside other assurance work for local authorities and individual providers, there is a risk that assurance of ICSs may be subject to a degree of overlap. This could in turn create an unnecessary additional layer of bureaucracy for ICSs and result in ICBs in particular having too much of a performance management role.

91. Patricia Miller (NHS Dorset) told us that she would like to see a "more integrated approach" with regulators. She explained:

> We will be regulated at system level by the Care Quality Commission and a number of other organisations external to systems, and it would be really helpful if we started to think about a more joined-up, cohesive approach to that.[125]

92. **Given that the CQC will have the legal powers to conduct assessments from April 2023, it is concerning that there are still outstanding questions that the Government needs to provide clarity on. This is particularly around any priorities DHSC may have for the assessments, and whether the CQC will be expected to provide ratings. This absence of information limits the CQC's ability to prepare for these assessments and lengthens the time it will take for them to refine their approach to system assessment.**

93. ***DHSC should urgently provide the CQC with its decision on ratings and any priorities it would like the CQC to focus on. It should also communicate to ICSs what methods will be used to address any areas of concern that assessments might raise. ICSs should be given fair notice about this, and the CQC may need time to incorporate this into their approach, so it is imperative that this clarity is provided before the bulk of the CQC's assessment work begins.***

94. ***DHSC and NHS England should review existing regulatory assessments for ICSs with a view to ensuring there is as little duplication as possible. We recommend this work is done alongside the Department for Levelling Up, Housing and Communities given their role in local authority assurance.***

124 NHS Providers (ICS0034) para 21
125 Q16

Conclusions and recommendations

Autonomy

1. It is clear that Integrated Care Systems offer a new way of working across health and social care. They encourage collaboration with a range of partners and a focus on what matters to their local populations. This fundamental premise needs to be balanced within a national service, funded by taxpayers and accountable to Parliament. It is therefore right that DHSC and NHS England set some of the priorities that ICSs should be working towards. (Paragraph 17)

2. However, if ICSs are to realise the ambitions that have been set for them, and move beyond collaboration towards true integration, it is vital that DHSC and NHS England do not dictate how ICSs should deliver those outcomes. NHS England will also need to be conscious of its organisational culture and make concerted efforts to not revert to overly restrictive ways of working. (Paragraph 18)

3. *Targets for ICSs set by DHSC and NHS England should be based on outcomes. There may be times when greater prescription around how targets are achieved is needed, but we believe this should be done sparingly.* (Paragraph 19)

4. We welcome the clear references to local priorities within NHS England guidance for ICSs and DHSC's proposed shared outcomes framework. We hope that, in the years to come, this focus on local priorities will be maintained. However, we share the NAO's concern about the tension between local needs-based strategies and a national standardised service. Experience shows that locally determined priorities may become the poorer relation to priorities driven nationally. (Paragraph 27)

5. *DHSC should explain the mechanisms that will ensure that progress is made against local priorities. It should set out how this compares to mechanisms used to measure progress against national priorities, alongside an assessment of whether this balance will support ICSs to meet their four main objectives.* (Paragraph 28)

6. *DHSC should publish, as soon as possible, the proposed shared outcomes framework and more information about how and when ICSs should expect it to be implemented.* (Paragraph 29)

7. Unfortunately, there is a clear risk that short-term, acute pressures will dominate ICS capacity, resources and leadership headspace, limiting the true flexibility of ICSs. Active effort from DHSC and NHS England is needed to ensure ICSs retain the space they need to focus on matters like public health and prevention. This will be especially necessary at this early stage of development for ICSs but should be maintained as ICSs evolve. (Paragraph 36)

8. *NHS England should provide an update on whether they intend to refresh their 2019 Long-Term Plan and, if so, when. Any update to NHS England's Long-Term Plan must put prevention and long-term transformation at its heart, empowering ICSs to pursue these priorities and giving them the confidence that they have the necessary backing from the Government and NHS England. This should also apply to the Government's pending Major Condition's Strategy.* (Paragraph 37)

9. Improving outcomes in population health and healthcare is one of the four core purposes of ICSs. Despite this, there is no mandated representation for public health professionals on Integrated Care Boards. Without that voice of expertise driving the public health agenda on ICBs, we are sceptical that ICSs will succeed in addressing longer-term priorities and fear that the move to ICSs will, once again, result in a sickness service, not a health service for the future. (Paragraph 38)

10. *To guarantee a continual focus on the prevention agenda, all Integrated Care Boards should ensure they include a public health representative, such as a public health director or public health lead. In 12 months, DHSC should conduct a review to understand the extent to which this is happening. If necessary, further steps should be taken to mandate the inclusion of a public health representative so the focus on prevention is not lost.* (Paragraph 39)

11. The four key purposes of ICSs are all dependent on taking a long-term approach. In order to fulfil them, ICSs need to be supported to make long-term decisions and have as much certainty as they can about upcoming funding. (Paragraph 42)

12. *We welcome the Minister's comments about giving ICSs information about the funding that will be available to them further in advance. DHSC must set out how it intends to do this, and any decision to give that information must be made in plenty of time to support ICS preparations for winter 2023/24.* (Paragraph 43)

13. System leadership is different to organisational leadership and ICS leaders, as well as leaders at other levels, need support to develop skills to make the most of the opportunities and to ensure ICSs do not become too NHS centric. Systems need leaders that will work collaboratively and not be tied to the existing institutional instinct in healthcare to look upwards rather than outwards. (Paragraph 47)

14. *The Government and NHS England should set up and fund an ICS leadership development programme, specifically targeted at supporting leaders of and within ICSs to develop the skills required to be successful system leaders* (Paragraph 48)

Accountability

15. We share the concern expressed by the NAO about the lack of clarity around what ICSs are expected to deliver within their core purposes. While we are conscious of, and agree with, the need to avoid micromanaging ICSs, we believe that DHSC needs to provide additional clarity about what exactly ICSs are expected to deliver. Only then can the public, and parliamentarians, begin to assess the success of ICSs. (Paragraph 52)

16. *Following engagement with ICSs and being conscious of the space required for local priorities, DHSC and NHS England should issue guidance with additional detail on what ICSs are expected to achieve within each of the four core purposes. As we have said previously, the focus here should be on outcomes and not dictating to ICSs how they achieve the goals.* (Paragraph 53)

17. Members of Parliament should be supported to directly hold their local ICSs to account for the service they provide to constituents, without having to rely on an assessment provided by local health and care leaders. We believe this is an integral

part of the role of an MP. We therefore welcome the Secretary of State's desire to empower parliamentary colleagues to hold their local ICSs to account through transparency on ICB performance data. (Paragraph 54)

18. *The Secretary of State should set out further detail about how he intends to empower MPs to hold their local ICSs to account and what performance measures he envisages being available to support this.* (Paragraph 55)

19. Partnership working is fundamental to the design of ICSs and will be the make-or-break factor in their success. As we have discussed, the monitoring and evaluation of NHS priorities and structures is well established but it is unclear how partnership working will be monitored. It is also unclear how ICSs will be held accountable for partnership working, particularly if problems arise. (Paragraph 62)

20. *NHS England should provide more clarity about what ICSs should expect in terms of the monitoring of partnership working and how this will be assessed in ICB annual assessments.* (Paragraph 63)

21. *DHSC, working with ICSs, should clearly set out what action could be taken, be that by the CQC, NHS England or others, to resolve issues of poor partnership working, in particular with adult social care.* (Paragraph 64)

22. We have heard a range of compelling arguments for particular professions to have greater representation on Integrated Care Boards and are sympathetic to the concerns that have been raised with us about the exclusion of expertise. However, we are also sympathetic to the Government's intention to give ICSs flexibility when determining which professions are most relevant to their local needs. Our concern is that it is unclear how the Government will monitor and evaluate whether its approach is the correct one. If data is not held centrally on how many, for example, public health experts or social care providers or clinicians, are on ICBs and no assessment is made of the adequacy of the representation, it is not possible to understand whether the Government's flexible approach is yielding the results it intends. It will also not be clear whether there are any patterns of under-representation. (Paragraph 71)

23. *DHSC should centrally gather information relating to the membership of ICBs, including the specific role of members and their area of expertise, by 1 October 2023.* (Paragraph 72)

24. *Once the data is gathered, DHSC should review it with a view to understanding whether the policy of keeping mandated representation to a minimum is producing the intended results and whether any specialties are especially under-represented. They should report the outcome of this work, and whether any further mandating is required, to the House.* (Paragraph 73)

25. The core purposes of ICSs, and the importance of addressing local needs, will not be met without good patient and carer involvement. ICSs cannot truly deliver for their local area without considering the needs of that area from the patient or carer's perspective. (Paragraph 81)

26. Given the new expectations that have been placed on Healthwatch organisations across the country, we believe this is a good opportunity to consider their funding and commissioning arrangements. (Paragraph 82)

27. *DHSC should therefore review the funding and commissioning arrangements for Healthwatch, with a view to ensuring they are fit for purpose within the context of new ICSs, and support Healthwatch to have a clear voice. The outcome of this review should be reported to the House.* (Paragraph 83)

28. Given that the CQC will have the legal powers to conduct assessments from April 2023, it is concerning that there are still outstanding questions that the Government needs to provide clarity on. This is particularly around any priorities DHSC may have for the assessments, and whether the CQC will be expected to provide ratings. This absence of information limits the CQC's ability to prepare for these assessments and lengthens the time it will take for them to refine their approach to system assessment. (Paragraph 92)

29. *DHSC should urgently provide the CQC with its decision on ratings and any priorities it would like the CQC to focus on. It should also communicate to ICSs what methods will be used to address any areas of concern that assessments might raise. ICSs should be given fair notice about this, and the CQC may need time to incorporate this into their approach, so it is imperative that this clarity is provided before the bulk of the CQC's assessment work begins.* (Paragraph 93)

30. *DHSC and NHS England should review existing regulatory assessments for ICSs with a view to ensuring there is as little duplication as possible. We recommend this work is done alongside the Department for Levelling Up, Housing and Communities given their role in local authority assurance.* (Paragraph 94)

Formal minutes

Tuesday 28 March 2023

Members present:

Steve Brine, in the Chair

Lucy Allan

Paul Blomfield

Paul Bristow

Chris Green

Mrs Paulette Hamilton

Rachael Maskell

James Morris

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

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

Summary agreed to.

Paragraphs 1 to 94 agreed to.

Resolved, That the Report be the Seventh Report 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 (Standing Order No. 134).

Adjournment

Adjourned till Tuesday 18 April 2023 at 9.30 am

Witnesses

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

Tuesday 08 November 2022

Rt Hon Patricia Hewitt, Chair, NHS Norfolk & Waveney Integrated Care Board; **Patricia Miller**, Chief Executive, NHS Dorset; **Rob Webster**, Chief Executive Lead, West Yorkshire Health and Care Partnership Q1–20

Cllr David Fothergill, Chairman of Community Wellbeing Board, Local Government Association; **Professor Sir Chris Ham**, Co-Chair, NHS Assembly; **Chris Hopson**, Chief Strategy Officer, NHS England; **Sir David Nicholson**, Chair, Sandwell and Birmingham NHS Trust and Dudley Group NHS Foundation Trust Q21–38

Tuesday 06 December 2022

Miriam Deakin, Director of Policy and Strategy and Deputy Chief Executive, NHS Providers; **Professor Jim McManus**, President, Association of Directors of Public Health; **Dr Linda Patterson**, Chair, Bradford District Care NHS Foundation Trust; **Sarah McClinton**, President, Association of Directors of Adult Social Services Q39–66

Professor Vic Rayner OBE, Chief Executive, National Care Forum; **Dr Trudi Seneviratne OBE**, Registrar, Royal College of Psychiatrists; **Dr David Wrigley**, Deputy Chair, British Medical Association GP Committee Q67–89

Rob Darracott, Editor, P3 Pharmacy; **Andrew Lane**, Chair, National Pharmacy Association Q90–102

Tuesday 17 January 2023

Nicholas Timmins, Senior Fellow, The King's Fund; **Sarah Walter**, Director, NHS Confederation ICS Network; **Louise Ansari**, National Director, Healthwatch Q103–137

Zina Etheridge, Chief Executive, North East London ICS; **Kate Terroni**, Chief Inspector Adult Social Care, Integrated Care and Interim Chief Operating Officer, Care Quality Commission Q138–153

Tuesday 07 February 2023

Helen Whatley MP, Minister of State, Department of Health and Social Care; **Matthew Style**, Director General of NHS Policy and Performance Group, Department of Health and Social Care; **Mark Cubbon**, Chief Delivery Officer, NHS England Q154–182

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 Action on Smoking and Health (ASH) (ICS0037)

2 Age UK (ICS0023)

3 Association of Optometrists (ICS0022)

4 Bayer Plc (ICS0028)

5 British Association for Counselling and Psychotherapy (BACP) (ICS0056)

6 British Medical Association (ICS0046)

7 British Specialist Nutrition Association (ICS0026)

8 Cancer Research UK (ICS0050)

9 Care England (ICS0017)

10 Care Quality Commission (ICS0035)

11 Chartered Institute of Public Finance and Accountancy (CIPFA) (ICS0067)

12 Collings, Annie (Secretariat, Medical Technology Group) (ICS0064)

13 Coproduce Care CIC (ICS0052)

14 Cystic Fibrosis Trust (ICS0048)

15 Danone (ICS0042)

16 Department of Health and Social Care (ICS0030)

17 Diabetes UK (ICS0007)

18 Federation of Specialist Hospitals (ICS0024)

19 General Medical Council (ICS0018)

20 Gilead Sciences (ICS0019)

21 HFMA (ICS0010)

22 Health Devolution Commission (ICS0066)

23 Healthcare Safety Investigation Branch (ICS0033)

24 Holloway, Dr Mark (Senior Brain Injury Case Manager, Expert Witness and Post-Doctoral Researcher, Head First) (ICS0002)

25 Hospice UK (ICS0062)

26 Independent Healthcare Providers Network (IHPN) (ICS0041)

27 Keep Up With Cancer (KUWC) (ICS0058)

28 LDC Confederation (ICS0055)

29 Local Government Association (LGA) (ICS0016)

30 Local Optical Committee Support Unit (ICS0005)

31 Londonwide LMCs (ICS0001)

32 MS Society (ICS0009)

33 Mencap (ICS0043)

34 Mental Health Foundation (ICS0031)

35 Metabolic Support UK (ICS0003)

36 Motor Neurone Disease Association (ICS0015)

37 N-Able Services Ltd (ICS0021)

38 NHS Confederation (ICS0051)

39 NHS Providers (ICS0034)

40 National Care Forum (ICS0027)

41 National Pharmacy Association (ICS0032)

42 Norfolk Care Association (ICS0044)

43 Nuffield Trust (ICS0054)

44 Paediatric Continence Forum (ICS0025)

45 Petsoulas, Dr Christina (Research Fellow, London School of Hygiene and Tropical Medicine); Allen, Professor Pauline (Professor of Health Services Organisation, London School of Hygiene and Tropical Medicine); Sanderson, Dr Marie (Assistant Professor, London School of Hygiene and Tropical Medicine); Surgey, Melissa (NIHR ARC-GM PhD Fellow, University of Manchester); and Osipovic, Dr Dorota (Research Fellow, London School of Hygiene and Tropical Medicine) (ICS0020)

46 Pharmaceutical Services Negotiating Committee; Optometric Fees Negotiating Committee; and National Community Hearing Association (ICS0049)

47 Public Policy Projects (ICS0045)

48 RNID (ICS0036)

49 Radiotherapy, APPG for Radiotherapy (ICS0069)

50 Royal College of General Practitioners (ICS0029)

51 Royal College of Nursing (ICS0057)

52 Royal College of Psychiatrists (ICS0068)

53 Royal Pharmaceutical Society (ICS0039)

54 Service, Parliamentary and Health (ICS0065)

55 Specialised Healthcare Alliance (SHCA) (ICS0006)

56 Sue Ryder (ICS0061)

57 Surrey Care Association (ICS0012)

58 Tahir, Dr Waqas (Diabetes Clinical Lead , West Yorkshire and Humber ICS); Hannah Beba (Consultant Pharmacist , NHS Leeds CCG); Frizelle, Dr Dorothy (Consultant Clinical Psychologist and Head of Service, Mid Yorkshire Hospitals NHS Trust); Hadani, Dilesh (Company Owner , Home Clean Home); Kanumilli, Dr Naresh (Diabetes Network Lead, Greater Manchester and East Cheshire Strategic Clinical Network); Kotecha, Satyan (Chair, West Midlands Pharmacy Local Professional Network); Patel, Dr Dipesh (Endocrinology and Diabetes Consultant Physician, Royal London Free Hospital); Rayman, Professor Gerry (Diabetes Clinical Lead, Suffolk and North East Essex ICS); and Thomas, Derek (Chair and Member of Parliament , Expert Working Group on Diabetes Policy) (ICS0060)

59 Teenage Cancer Trust (ICS0040)

60 The Association of the British Pharmaceutical Industry (ICS0038)

61 The Health Foundation (ICS0063)

62 The King's Fund (ICS0013)
63 The LIFT Council (ICS0008)
64 The Neurological Alliance (ICS0047)
65 Tony Blair Institute for Global Change (ICS0004)
66 Urology Trade Association (ICS0014)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

Session 2022–23

Number	Title	Reference
1st	Pre-appointment hearing for the Government's preferred candidate for the role of Patient Safety Commissioner	HC 565
2nd	The impact of body image on mental and physical health	HC 114
3rd	Workforce: recruitment, training and retention in health and social care	HC 115
4th	The future of general practice	HC 113
5th	Pre-appointment hearing with the Government's preferred candidate for the role of Chair of HSSIB	HC 843
6th	Follow-up on the IMMDS report and the Government's response	HC 689
1st Special	Cancer Services: Government Response to the Committee's Twelfth Report of 2021–22	HC 345
2nd Special	Government Response to the Expert Panel's Report on Government commitments in the area of cancer services in England	HC 346
3rd Special	Expert Panel: evaluation of Government's commitments in the area of the health and social care workforce in England	HC 112
4th Special	The treatment of autistic people and people with learning disabilities: Government Response to the Committee's Fifth Report of Session 2021–22	HC 631

Session 2021–22

Number	Title	Reference
1st	The Government's White Paper proposals for the reform of Health and Social Care	HC 20
2nd	Workforce burnout and resilience in the NHS and social care	HC 22
3rd	Pre-appointment hearing for the Chair of the Food Standards Agency	HC 232
4th	The safety of maternity services in England	HC 19
5th	The treatment of autistic people and people with learning disabilities	HC 21
6th	Coronavirus: lessons learned to date	HC 92
7th	Supporting people with dementia and their carers	HC 96

Number	Title	Reference
8th	Children and young people's mental health	HC 17
9th	Clearing the backlog caused by the pandemic	HC 599
10th	Pre-appointment hearing for the position of Chair of NHS England	HC 1035
11th	Pre-appointment hearing for the position of Chair of the Care Quality Commission	HC 1091
12th	Cancer services	HC 551
13th	NHS litigation reform	HC 740
1st Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of maternity services in England	HC 18
2nd Special	The Health and Social Care Committee's Expert Panel: Evaluation of the Government's progress against its policy commitments in the area of mental health services in England	HC 612
3rd Special	Supporting people with dementia and their carers: Government Response to the Committee's Seventh Report	HC 1125
4th Special	Expert Panel: evaluation of the Government's commitments in the area of cancer services in England	HC 1025

Session 2019–21

Number	Title	Reference
1st	Appointment of the Chair of NICE	HC 175
2nd	Delivering core NHS and care services during the pandemic and beyond	HC 320
3rd	Social care: funding and workforce	HC 206
4th	Appointment of the National Data Guardian	HC 1311