THE HEWITT REVIEW

An independent review of integrated care systems

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Appendix B

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Background and Context

In December 2022, the government asked the Rt Hon Patricia Hewitt to conduct a review of Integrated Care Systems (ICSs). The Hewitt Report was published on 4 April 2023 and the government is now considering its response to the 36 recommendations. The review considers the oversight and governance of ICSs (terms of reference) and makes recommendations on:

- How to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending.
- The scope and options for a significantly smaller number of national targets for which Integrated Care Boards (ICBs) should be held accountable for and supported to improve by NHSE and other national bodies, alongside local priorities reflecting the needs of communities.
- How the role of the Care Quality Commission (CQC) can be enhanced in system oversight.

ICSs provide the best opportunity in a generation to transform the health and care system. Effective change requires a combination of new structures with changed cultures.

The review has identified six essential principles for ICSs to thrive:

- Collaboration within and between systems and national bodies;
- A limited number of shared priorities;
- Allowing local leaders space and time to lead;
- The right support;
- Balancing freedom with accountability;
- Enabling access to timely, transparent and high-quality data.

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Chapter 2 -From focusing on illness to promoting health

The review specifically looks at how to empower local leaders to focus on improving outcomes for their populations; giving them greater control while making them more accountable for performance and spending; and having high quality and transparent data.

- ***Enabling a shift to upstream investment in preventative services and interventions***
- ***This should be in place by autumn 2023.***
- ***Embedding health promotion at every stage***
- ***ICS's role in embedding population health management***
- ***Role of data & digital tools to support the prevention of ill health***
- ***Empowering the public to manage their health***

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Chapter 2 –Recommendations

1.	The share of total NHS budgets at ICS level for prevention should be increased by at least 1% over the next 5 years. To deliver this the following enablers are required: a) DHSC establish a working group of local government, public health leaders, OHID, NHS England and DHSC, as well as leaders from a range of ICSs, to agree a straightforward and easily understood framework for broadly defining "prevention". b) Following an agreed framework; ICSs to establish and publish their baseline of investment in prevention.
2.	That the government leads and convenes a national mission for health improvement. It also supports the Health and Social Care Select Committee's recommendation that DHSC should publish, as soon as possible, the proposed Shared Outcomes Framework.
3.	That a national Integrated Care Partnership Forum is established.
4.	The government establish a Health, Wellbeing and Care Assembly.
5.	That NHS England, DHSC and ICSs work together to develop a minimum Data Sharing Standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers.
6.	DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the *Data Saves Lives Strategy* (2022).
7.	NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs -including from local government, social care providers and the VCFSE provider sector -to join the Data Alliance and Partnership Board.
8.	Building on the existing work of NHS England, the NHS App should become a stronger platform for innovation, with code being made open source to approved developers as each new function is developed.
9.	The government should set a longer-term ambition of establishing Citizen Health Accounts.

Chapter 3 –Delivering on the promise of systems

Every partner and sector within an ICS operates within its own financial, regulatory and accountability framework therefore ICBs and ICPs should create the environment to support '*mutual*' or '*collective*' accountability. To enable this, NHSE national oversight and accountability must respect and allow space for local accountability to develop.

- ***Approach***
- ***Place***
- ***Embedding a balance of perspectives***
- **Local accountability and priority setting**
- ***Self-improving systems***

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Chapter 3 –Delivering on the promise of systems

Accountable relationships at the heart of system working –clarity is needed on where accountability lies for NHS organisations and partners. The new NHSE operating framework states the role of ICBs includes: first line oversight of health providers; to co-ordinate and help tailor support for providers; assurance and input to regulators' assessment of providers; liaison or escalation to NHSE.

Acknowledging that systems are at different stages of development, the following principles are clear:

- Trust chief executives are accountable for what goes on inside their trust and are statutory accountable to their board
- Trust chief executives and boards are accountable to system partners -within a provider collaborative or Place Partnership where appropriate, but also with and through the ICB.
- Trust chief executives and boards are accountable to partners across the ICS (including the ICB) for their part in shaping and helping to deliver the ICP strategy and JFP, including their focus on prevention, population health and health inequalities
- as the organisation accountable for the state of the local NHS, the ICB is well placed to understand connections and inter-dependences between providers. The ICB has a crucial role as the convenor of the NHS, as the statutory partner with the upper-tier local authorities in forming the ICP
- ICBs are accountable for performance and financial management of the NHS in their area. ICB CEOs are accountable to their boards, to system partners and to NHSE for delivery of agreed priorities and plans
- the role of all system leaders is to challenge and support each other to meet agreed objectives. This can be through a distributed leadership model where different system members at system, place and neighbourhood level all have defined responsibilities and accountabilities and provide appropriate support to enable transformational change
- the ICB is the vehicle to coordinate activities of provider collaboratives and the NHS's contribution to place-based partnerships.
- ICBs have a direct interest in and commitment to the success of NHS providers within their system

Chapter 3 –Delivering on the promise of systems

- ***ICSs develop their own improvement capacity***
- ***High Accountability and Responsibility Partnerships*** **-**NHSE should work with ICB leaders to co-design a clear pathway towards ICB maturity, **to take effect from April 2024**.
- ***The right skills and capabilities for ICBs***
- ***The role of the regions***
- ***Organisational development***
- ***National planning guidance***
- ***Enhanced CQC role in relation to systems***
- **The role of data for system accountability**

Chapter 3 –Recommendations

10.	Health Oversight and Scrutiny Committees (HOSCs) (and, where agreed, Joint HOSCs) should have an explicit role as System Overview and Scrutiny Committees. To enable this, DHSC should work with local government to develop a renewed support offer to HOSCs and to provide support to ICSs where needed.
11.	Each ICS should be enabled to set a focused number of locally co-developed priorities and targets and decide agreed metrics. These priorities should be treated with equal weight to national targets and should span across health and social care.
12.	In line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the Trust to agree an internal plan of action, calling on support from the region as required. To enable this, support and intervention should be exercised in relation to providers 'with and through' ICBs as the default arrangement.
13.	NHS England and CQC should work together to ensure their approach to improvement is complementary and mutually reinforcing.
14.	A national peer review offer for systems should be developed, building on learning from the LGA approach.
15.	NHS England should work with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024.
16.	An appropriate group of ICS leaders should work together with DHSC, DHLUC and NHS England to create new 'High Accountability and Responsibility Partnerships' (HARPs).
17.	During the 2023 to 2024 financial year, further consideration should be given to the balance between national, regional and system resources with a larger shift of resource towards systems; and that the required 10% cut in the RCA for 2025 to 2026 financial year should be reconsidered before Budget 2024.
18.	NHS England and central government should work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.
19.	ICS leaders should be closely involved in the work to build on the new NHS England operating framework to codesign the next stage of evolution for NHSE regions.
20.	NHS England should work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer.

Chapter 3 –Recommendations

21.	The implementation groups for the Messenger review should include individuals with significant experience of leading sustained cultural and organisational change in local government and the voluntary sector as well as the NHS.
22.	Ministers should consider a substantial reduction in the number of priorities in the new NHS Mandate -significantly reduce the number of national targets, with certainly no more than 10 national priorities.
23.	NHS England and ICBs need to agree a common approach to co-production processes with organisations like the NHS Confederation, NHS Providers and the LGA.
24.	As part of CQC's new role in assessing systems, CQC should consider within their assessment of ICS maturity, a range of factors (as set out on page 58 of the review).
25.	ICSs, DHSC, NHS England and CQC should all have access to the same, automated, accurate and high quality data for the purposes of improvement and accountability. In particular: a) NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking SITREP and other reported data directly from the FDP and other automated sources, replacing both SITREPS and additional data requests b) Data required in real-time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; where possible, without creating excessive reporting requirements, data should enable site-level analysis c) Data collection should increasingly include outcomes (including, crucially, Patient Reported Experiences and Outcomes) rather than mainly focusing on inputs and processes d) Data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government e) DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, remove duplicative requests, and those that are unnecessary or not used for any significant purpose. This work should be completed within 3 months

Chapter 4 –Unlocking the potential of primary and social care and building a sustainable workforce

- ***Primary Care***
- ***Primary care contracts***
- ***Social Care***
- ***Workforce***
- ***The digital and data workforce***

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Chapter 4 –Recommendations

26.	NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts.
27.	The government should produce a strategy for the social care workforce, complementary to the NHS workforce plan, as soon as possible.
28.	DHSC should bring together relevant regulators to reform processes and guidance around delegated healthcare tasks.
29.	Currently, the agenda for change framework for NHS staff makes it impossible for systems to pay competitive salaries for specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialized analytical and intelligence functions. Ministers and NHS England should work with trade unions to resolve this issue as quickly as possible.

Chapter 5 –Resetting our approach to finance to embed the change

- ***Financial accountability***
- ***Funding settlements***
- ***Financial flexibility for intra-system funding***
- ***Simplifying and broadening delegation and pooled budget arrangements***
- ***Ensuring efficient delivery of care***
- ***Payment mechanisms***
- ***Capital expenditure***
- ***Strengthening and embedding a culture of research and innovation***

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Chapter 5 -Recommendations

30.	NHS England, DHSC and HM Treasury should work with ICSs collectively, and with other key partners including the Office for Local Government and CIPFA to develop a consistent method of financial reporting.
31.	Building on the work already done to ensure greater financial freedoms and more recurrent funding mechanisms. Recommendations are: a) Ending (as far as possible) small in-year funding pots with extensive reporting requirements; b) Giving systems more flexibility to determine allocations for services and appropriate payment mechanisms within their own boundaries, and updating the NHS payment scheme to reflect this; c) National guidance should be developed to provide a default position for payment mechanisms for inter-system allocations.
32.	DHSC, DLUHC and NHS England should align budget and grant allocations for local government (including social care and public health and the NHS).
33.	Government should accelerate the work to widen the scope of s.75 to include previously excluded functions (such as the full range of primary care services) and review the regulations with a view to simplifying them. This should also include reviewing the legislation with a view to expanding the scope of the organisations that can be part of s.75 arrangements.
34.	NHS England should ensure systems are able to draw upon a full range of improvement resources to support them to understand productivity, finance, quality challenges and opportunities.
35.	NHS England should work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, drawing upon international examples as well as local best practice, to identify the most effective payment models thereby incentivising and enabling better outcomes and significantly improving productivity.
36.	There should be a cross-government review of the entire NHS capital regime, working with systems, with a view to implementing the recommendations from 2024.

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