09 January 2023

NHS Providers Hewitt Review – evidence submission

About NHS Providers

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in England in voluntary membership, collectively accounting for £104bn of annual expenditure and employing more than 1.2 million staff.

Our submission

We welcome the opportunity to submit evidence to the Hewitt Review into the oversight and governance of integrated care systems (ICSs).

The Secretary of State for Health and Social Care has appointed the Rt Hon Patricia Hewitt to consider the oversight and governance of ICSs. The review considers how the oversight and governance of ICSs can best enable them to succeed, balancing greater autonomy and robust accountability. It has a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement.
On 13 December 2022, NHS England published a call for evidence to support the review. More information about the objectives and scope of the review can be found in the Hewitt review terms of reference.
The evidence request was tightly structured, with 13 questions to answer and a strict word limit of 250 words for each question.

NHS Providers submitted the following evidence on behalf of our members on 9 January 2023.

Question 1: Please share examples from the health and care system, where local leaders and organisations have created transformational change to improve people's lives. (250 word limit) This can include the way services have been provided or how organisations work with residents and can be from a neighbourhood, place or system level.

- NHS Providers has collated a variety of case studies of place-based collaboration, provider collaboration at scale and how trusts are working with system partners to deliver change for patients.
- Given that transformational change often takes many months or years to achieve, much of the evidence of improvement is drawn from collaboration that predates current structures and will be

further developed under ICSs. However helpful indicative examples, including of work to invest in upstream prevention, include:

- In 2021, North West Ambulance Service NHS Trust (NWAS) piloted sharing its data on hypertension with a primary care network (PCN) in Greater Manchester. As a result, the PCN was able to identify and treat patients with undiagnosed or under-treated high blood pressure as a preventative measure.
- Somerset ICS has brought together system partners to develop a shared strategy and framework for change with extensive ambitions for improving lives through collaboration across health, social care and the voluntary sector. This page details their achievements to date – many of their programmes are still in progress.
- Central London Community Healthcare NHS Trust (CLCH) is taking an inclusive approach to working with partners to establish multi-disciplinary teams (acute, community and primary care clinicians working with voluntary sector partners) to provide their approach to virtual wards.

Question 2: Do you have examples where policy frameworks, policies and support mechanisms have enabled local leaders and, in particular, ICSs to achieve their goals? (250 word limit)
This can include local, regional or national examples.

- The Act establishes a flexible framework enabling collaboration and integration. Guidance, policy and support – and indeed the culture expected and modelled within the NHS from ministerial leadership, through NHS England, regions and systems – should mirror this legislative basis in terms of an enabling focus and also importantly in recognising the roles of statutory organisations (including trust boards) and their legal accountabilities as standalone organisations and proactive partners.
- Trust leaders understand the need for a manageable set of national priorities and appropriate standardisation of data, accompanied by sufficient flexibility to meet local needs. They prefer a clearer articulation of the 'what' in terms of ministerial and NHS England priorities, and less prescriptive focus on 'how' initiatives should be delivered.
- Examples of frameworks which trust leaders tell us they welcome tend to promote autonomy and local flexibility:
  - Code of Governance adopts a "comply or explain" approach, allowing boards to institute local solutions if core principles and statutory requirements are met.
  - Work underway on ICBs' self-assessment framework.
  - Core20PLUS5 supports systems to focus their efforts around nationally determined priority areas, adaptable to local needs.
  - The CQC's adoption of risk-based inspections and joint work with NHSE on a shared approach to the well led framework.
  - NICE guidance because it is evidence-based: e.g., their recent compiling of evidence on inequalities. Yet oversight and regulatory frameworks do not typically build on empirical evidence.

Question 3: Do you have examples where policy frameworks, policies, and support mechanisms that made it difficult for local leaders and, in particular, ICSs to achieve their goals? (250 word limit). This can include local, regional or national examples.

- Given constraints on leadership time, statutory guidance must be clear and actionable locally. An NHS culture of compliance can inadvertently discourage innovation when there is a genuine case to diverge from proven models of delivery.
- Trusts support the collaboration driven by systems. The new delivery landscape is complex and ICSs vary considerably in geography, population size/need and provider make up. The relationships underpinning ICSs and their capacity and capability to deliver also varies. System guidance and policy making must acknowledge this and support all ICSs to develop.
- More specifically, trusts have flagged the following challenges:
  - NHSE's Oversight Framework delegates day to day oversight of NHS providers to ICBs, risking undermining the equal partnership within ICSs between ICBs and trusts.
  - Partners in local systems must work through the governance models required to manage risk in a series of new collaborative partnerships, and to test new models of delegation from ICBs to trusts.
- ICBs' composition (ICB model constitution) creates governance challenges. The following could be addressed via guidance or small amendments to statute:
  - The chair's appointment/removal by the SoS could undermine local accountability by members of the ICB as a unitary board (as we would expect local action to appoint, and if needed, remove a chair).
  - Decision-making and scrutiny can be hampered by the numbers at ICB board tables and too few independent NEDs.
  - The ICB trust partner member role builds in conflicts which could be managed with national guidance, locally applied.

Question 4: What do you think would be needed for ICSs and the organisations and partnerships within them to increase innovation and go further and faster in pursuing their goals?

- To succeed all parties must see the benefits of the ICS and operate as equal partners. There is considerable variability in how equipped and established ICPs are, and in how ICPs and ICBs interact. National frameworks must allow for these different levels of maturity and offer all systems tailored support
- Trusts welcomed the strategic objectives established for ICSs under the Act and see an important role for them in helping to manage population health and invest in prevention.
- Questions however remain about how involved ICSs should be in overseeing operational performance. While providers understand that ICSs will be keenly interested in facilitating mutual aid, and new ways of working, it is important to avoid duplication between ICS, NHSE regional teams and other regulators and reduce the current burden of reporting.

- ICSs and trusts also need oversight and regulation encouraging local innovation. In line with its operating framework, NHSE should promote a learning culture, providing support.
- The NHS should support subsidiarity in decision-making, including clinician-led innovation/improvement.
- Greater clarity for community, mental health and ambulance trusts spanning multiple ICSs would be welcome. They face additional complexity, including challenges around resourcing effective partnership-working and potential lack of efficiency.
- Other factors which would speed innovation, beyond the remit of this review, include access to capital funding, workforce planning and reform of social care.

Question 5: What policy frameworks, regulations or support mechanisms do you think could best support the active involvement of partners in integrated care systems? (250 word limit) Examples of partners include adult social care providers, children's social care services and voluntary, community and social enterprise (VCSE) organisations. This can include local, regional or national suggestions.

- The two-part statutory ICS structure risks mirroring the divides between NHS and local government in some parts of the country.
- Clear shared priorities/outcomes in national policy frameworks would support better alignment for health and social care. However, unless both sectors are properly resourced and have clear, funded workforce plans barriers will remain in place.
- Place-based partnerships in many systems are also a key forum for a wider set of partners to come together to deliver better integrated care.
- The proliferation of strategic documents required by systems and places (produced by ICB, ICP, HWB, trusts etc.) could lead to lack of alignment. ICPs provide the current joining point for health and care partners: the mechanisms developed should therefore enable partners to follow the mandate created by integrated care strategies. In setting their strategies ICPs should build on the priorities and strategies developed by places and/or health and wellbeing boards, and ensure alignment with ICB/trust five year joint forward plans including delivery through partnerships/collaboratives.
- ICPs may struggle to operate as an inclusive forum for a diverse continuum of stakeholders while also ensuring they remain a workable size and are able to function and develop coherent strategies.
- We would urge the review team to ensure its outputs speak to a broad audience including the NHS and key partners such as social care.

National targets and accountability

Question 6: What recommendations would you give national bodies setting national targets or priorities in identifying which issues to include and which to leave to local or system level decision-making?

- Trust leaders understand and accept the importance of a small set of political priorities, agreed as part of a manageable set of national 'must dos.' We proposed five conditions for setting national targets as part of our input to the clinical review of standards, including that those responsible for delivering against them must be involved in co-producing them, and the NHS must be resourced and staffed appropriately for the task it is set.
- It is also essential that government/national NHS bodies reflect the interconnected nature of health and care services when setting priorities and targets. Currently, political/national focus is understandably on improvements to the UEC pathway (including ambulance handovers) and waiting times for planned procedures. However this may not be achievable, or sustainable, without fuller investment in preventative measures to improve population health and reduce health inequalities, or without holistic investment in mental health and community services (respecting parity of esteem) to ensure people can access the appropriate care at the right time.
- Government and national NHS bodies should:
  - hold ICSs to account for a set of outcomes-focused priorities, but leave ICBs, trusts and partners the flexibility to deliver these outcomes in ways that meet local population needs
  - recognise local leaders will shape delivery in many cases (subsidiarity) while in others system decision-making will add value.
- Better coordination when setting new priorities and far less frequent issuing of additional targets (by politicians or national bodies) would avoid disruption and frustrating progress against those already in place.

Question 7: What mechanisms outside of national targets could be used to support performance improvement? (250 word limit) Examples could include peer support, peer review, shared learning and the publication of data at a local level. Please provide any examples of existing successful or unsuccessful mechanisms.

- Developing a culture of improvement requires investment in creating safe space, avoiding blame and making connections with peers to share actionable insights.
- Systems must balance long-term sustainable improvement with rapid problem-solving around current concerns and responding to multiple improvement programmes, and often wholly different local authority agendas. It should be possible, if regionally led and coordinated, to cohere efforts to enable improvement. If nationally led, then reliable levers include targeted investment, such as in data.

- There is important learning about performance improvement from the attempt between 1997-2010 to reduce health inequalities. Achievements were due to:
  - Agreed change metrics
  - A focus on specific/priority areas driven by data
  - A focus on the wider determinants including early years
  - A national expert team which worked locally
  - Peer intervention models between local authorities
- Our members tell us similar things about what works
  - National consistency and clarity with aligned priorities
  - Supportive infrastructure, including realistic timescales and multi-year support/investment
  - Support with improvement methodologies and scalable change approaches
- Much evidence demonstrates how all elements driving in the same direction (including but alongside targets) is vital to achieving change in systems. For example: *The challenge of complexity in healthcare*, *Think of healthcare as an ecosystem, not a machine* and *The practice of system leadership – being comfortable with chaos*.
- Our Leading Integration Peer Support programme created space for Gloucestershire ICS to establish a Clinical and Care Professional Council (with stakeholders including AHPs, social care providers and the local authority).

Data and transparency

Question 8: Do you have any examples at a neighbourhood, place or system level, of innovative uses of data or digital services? (250 word limit) Please refer to examples that improve outcomes for populations and the quality, safety, transparency or experience of services for people; or that increase the productivity and efficiency of services.

- We know digital transformation can deliver a range of benefits, including improving outcomes, safety and quality of care. For example, in response to the pandemic, Leicestershire Partnership NHS Trust worked with partners across the system to establish virtual wards for heart and lung patients, supporting hospital discharges and containing infection rates. Annualised death rates fell by 42% as a result, with a 45% reduction in face-to-face appointments and higher user satisfaction.
- Digital transformation can also release efficiency savings. For example at Cambridge University Hospitals NHS Foundation Trust, electronic prescribing prevented 850 adverse reactions with allergy-related prescribing alerts, saving 2,450 bed days and £0.98m that year.
- To realise this potential the government should prioritise and properly resource basic digital infrastructure for health and care organisations within each ICS.

- Interoperability between health and social care also needs improving, so that systems can efficiently and securely share data between partner organisations.
- All partners in ICSs must be supported to apply the culture, process, business models and technologies of the internet era to health and care services. They need to be properly resourced and appropriately advised to recruit the right digital skills (often in competition with other industries which can pay more), invest in core infrastructure, and test new ways of working. Only then will systems be properly equipped to use real time data to improve services for patients and populations.

Question 9: How could the collection of data from ICSs, including ICBs and partner organisations, such as trusts, be streamlined and what collections and standards should be set nationally? (250 word limit)

- Trusts acknowledge the benefits of national data collection, e.g. consistency to make a case for national level investment, create meaningful benchmarks and deliver nationally applicable standards.
- Services benefiting from a national (programmatic) approach include:
  - mental health
  - elective recovery post covid
  - community services (move towards a more comparable data set)
  - national indicators can give profile to key services: trusts wish to ensure that mental health and community services retain due priority at all levels of the system.
- A better balance between national and local priorities, and a focus on outcomes, could streamline the data collection required by the centre and is appealing to trust leaders who often report concerns about the burden/duplication created by national, regional and system data reporting requirements. Better coordination between NHSE and CQC could significantly reduce risk of duplication and we are pleased to see the regulators now working together on the refresh of the well led framework for example.
- Going forwards, data requirements should be clearly articulated: why is the data being requested, who will benefit from accessing it?
- National, regional and system level leadership should work together to ensure data requested will be well-used, requests are not duplicated and submission processes streamlined.
- National datasets only ever tell part of the story, and the national focus should be on improvement (outcomes) not assurance around inputs.
- ICBs could usefully coordinate, and invest in the interoperability of, electronic patient records (EPRs) and shared care records to enable quick, automated responses to data requests.

Question 10: What standards and support should be provided by national bodies to support effective data use and digital services? (250 word limit)

- National investment and support is required to implement EPRs, which are essential to providing safe joined up care. This will enable accurate real-time data that can support clinical decision-making across the system.
- Digital transformation requires national investment/support in recruiting and retaining staff with the right skillsets. While some organisations are finding creative ways to share limited resource and digital skills, such as at Calderdale and Huddersfield NHS Foundation Trust where some IT support services are hosted and shared across partner organisations, support is needed from national teams to pool digital skillsets regionally.
- Data sharing agreements are time-consuming to negotiate locally and could be nationally agreed.
- National standards would be welcome in fast-moving highly specialist areas, such as AI, which are unlikely to be supported by local expertise. Clear national technical standards for interoperability would also be welcome, alongside support to enable systems, organisations and people to exchange and make better use of information.
- Given that digital maturity differs by place/organisation/partnership, digital strategies will naturally differ. Local autonomy over strategic decision-making must therefore be maintained. However central support is needed to help ICSs ensure that foundational building blocks for digital transformation (including interoperability and strong digital infrastructure) are in place. This will allow ICSs to join up data between their constituent parts, enabling data-led decision-making.
- Ensuring NHS and local authority datasets are connected, interoperable and underpinned by a strong digital infrastructure is key to enabling systems and places to develop data-led analysis.

System oversight

Question 11: What do you think are the most important things for NHS England, the CQC and DHSC to monitor, to allow them to identify performance or capability issues and variation within an ICS that require support? (250 word limit)

- The ongoing use of soft and hard local intelligence (derived from NHSE regions, ICBs and partners) will be more effective at alerting all partners to issues at an early stage and enabling improvement than reliance on rote periodic reports. This would not be limited to performance against targets: effective risk management for example should be central to system oversight.
- There should be a common well-led framework that reconciles assessments of the quality of leadership with outcomes for populations. Monitoring direction of travel should be integral to this. Peer review should play a central role in understanding performance and capability.
- Regulators should focus on assuring that agreed minimum standards of care are met and offer signposts for improvement.

- Regulators and the DHSC have different remits, but alignment between their approaches and clarity on accountabilities and responsibilities will help; sharing datasets, statistics and intelligence will avoid duplication, ensure greater efficiency and reduce the regulatory burden on system partners.
- Trusts are generally supportive of the NHS oversight metrics, but feel that there are too many metrics, and many overlap. They want a smaller number of meaningful, coordinated and measurable metrics/targets that stay the same for long enough to enable real progress, and a clear focus in these on outcomes for patients and local populations.
- Comments from our latest regulation survey noted the CQC remains predominantly focused on individual organisations, rather than pathways of care or systems.

Question 12: What type of support, regulation and intervention do you think would be most appropriate for ICSs or other organisations that are experiencing performance or capability issues? (250 word limit)

- Trusts generally welcome the NHS oversight framework and associated guidance's approach: with the ICB providing day to day oversight and seeking to support/informally resolve issues first before proceeding with formal action. However as noted this creates a tension for ICBs, in acting as both partners and overseers. It is appropriate that ICBs provide support, but regulation and intervention activities should sit with NHSE.
- Our regulation survey found:
  - 33% of respondents saw the oversight framework as a support tool, while 71% perceived it as a performance management tool
  - 14% agreed that CQC's approach to regulation encourages providers to be collaborative and integrate care, 58% disagreed
  - 63% of trusts felt the regulatory burden had increased over the last 12 months, 7% felt it had decreased
- There is considerable evidence from the provider sector as to what is likely to work:
  - creating a learning/improvement culture that encourages transparency and asking for help. This is critical at trust level is needed from national and regional leaders as well
  - well directed financial support from the centre/regional teams
  - offering improvement support, co-created with the trust – rather than its imposition
  - listening to self-identified issues
  - peer support/insight
  - enabling consistency of leadership and avoiding unnecessary or repeated removal of leaders in challenged locations if broader structural challenges rather than individual failure are at fault
- The NHS should operate to shared values and the behaviours of leaders at every level should live up to their stated intention of supporting improvement.

Question 13: Is there any additional evidence you would like the review to consider? (250 word limit)

- We appreciate the opportunity to work with the review team on this important review. Our key messages are:
- Trusts support the focus of the review, however given the extent of the challenges they currently face, it should first seek to clarify and consolidate the existing statutory context, rather than reopening debate about how the NHS is structured.
- Trusts drive delivery partnerships/collaboratives within ICSs. National bodies must be comfortable with subsidiarity shaping delivery, with local partners best placed to identify local population-health priorities.
- Trusts favour fewer national targets focused on outcomes, coordinated and aligned across priorities in underpinning policy/guidance. Alongside the understandable focus on UEC and elective recovery, this must protect progress to prioritise mental health and community health services nationally and locally.
- ICBs and their place-based partnerships/provider collaboratives should agree shared outcomes locally between partners and have space to drive forward longer-term cross-system objectives.
- The national oversight and performance management framework needs alignment between the CQC, NHSE and ICBs without duplication. It should be streamlined and enable useful collaboration and clarity about accountabilities. Regulators' behaviours need to match their stated intention: promoting autonomy while providing support.
- System governance and organisational forms should be as simple as possible to enable control of safe, effective activity. NHSE and government should resist attempts to define what effective partnership-working/collaboration looks like in terms of inputs/structures, and focus on outcomes.
- Policy and guidance should respect the roles of statutory organisations (including trust boards) and their legal accountabilities.