The Hewitt Review

Introduction

In November, the Rt Hon Patricia Hewitt, chair of NHS Norfolk and Waveney integrated care board (ICB) and deputy chair of the integrated care partnership (ICP), was commissioned by the chancellor, the Rt Hon Jeremy Hunt, to lead a review into the role and powers of integrated care systems (ICSs).

The terms of reference of the review were:

- 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 ICBs should be both held accountable for and supported to improve by NHS England (NHSE) and other national bodies, alongside local priorities reflecting the particular needs of communities.
- How the role of the Care Quality Commission (CQC) can be enhanced in system oversight.

The review was conducted with significant engagement with leaders from across health and social care and we had a welcome and constructive relationship with the review team on behalf of our members. NHS Providers has contributed throughout the review including: a submission during the formal call for evidence, discussion sessions with workstream leads, several meetings with Patricia Hewitt, and written feedback on various drafts of the report. Members' views were sought throughout and we are grateful to all who contributed their perspectives either through NHS Providers or directly to the review team.

Overview

- The Hewitt Review is an ambitious and extensive review which seeks to maximise the opportunities ICSs bring to improve population health and wellbeing.
- There is welcome recognition throughout of the issues hindering progress and placing unhelpful burdens on system players. The report recognises that without investment, workforce and leadership development, recurrent and multi-year funding, reduction of duplicative or unnecessary data requests, and effective planning (centrally and locally), systems will be unable to achieve their potential.

- The report makes the case for reducing the number of national targets to give local leaders the 'time and space' to lead. Hewitt suggests that there should be no more than ten national priorities, and that local priorities should be treated with equal weight.
- The report suggests high performing ICSs should have fewer national targets – it recommends establishing an initial cohort of 10 "high accountability and responsibility partnerships" (HARPs).
- The report clearly explains the fundamental need to join up heath and social care in numerous ways, and the challenges of doing so. It also emphasises the need to shift the focus to prevention and health improvement, including through more joined up central government, an increase in prevention spending, and a focus on inequalities and discrimination.
- The review recognises the importance of collaboration and co-design as drivers of improvement. It emphasises the need for improvement support to be the focus of most intervention, espousing a 'one team' approach to system development and oversight.
- The report aims to set out clearly the responsibilities and accountabilities of the different players in systems locally, regionally and nationally. We are concerned that it falls short of providing the clarity we believe is necessary to enable more effective collaboration (see NHS Providers View below). We are also concerned that ICBs are positioned as system overseers, rather than equal partners of trusts.
- On finance and capital, Hewitt recommends reviewing the entire NHS capital regime, reducing the use of short-term funding pots, and learn from good practice (including internationally) around payment models.
- The political appetite for such significant change (and necessary investment over the longer term) has yet to be seen: the Department of Health and Social Care (DHSC) has so far only committed to "review [the report's recommendations] in due course."

The Hewitt Review report has four main chapters. This briefing sets out the main findings and recommendations for each, and gives NHS Providers' view.

From focusing on illness to promoting health

This chapter describes the main health challenges facing the nation. It highlights the impact of health inequalities and promotes the importance of addressing the wider determinants of health, including education and housing, to enable people to live longer and healthier lives.

It also discusses about the role of ICSs in delivering a more holistic approach to improving populations' health, and the need for local leaders to be empowered to do this, while ensuring they

remain accountable for performance and spending. Data and digital is framed as a key enabler to driving this shift forward.

Key recommendations

- An increase in the public health grant to local authorities.
- A framework on what constitutes spending on prevention, decided by a working group of local government, public health leaders, Office for Health Improvement and Disparities, NHSE and the Department of Health and Social Care, and a cross section of ICS leaders.
- The government, NHSE and ICS partners, through their ICP, should commit to increasing resources going to prevention. In particular, the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next five years.
- A "national mission for health improvement" led by the government.
- A health, wellbeing and care assembly should be established to complement the activity of the NHS assembly, reflecting the need to bring in other systems partners.
- Population health, prevention and health inequalities should be part of the training and continuing development for all professions and embedded in the national workforce plan to help develop the skills needed to improve health equity.
- ICSs should be supported to establish an integrated view of population and personal health and wellbeing.

NHS Providers view

We welcome many of the proposals outlined in this chapter. It offers clear messages on the impact of inequality, racism and discrimination, and we welcome the focus on the wider determinants of health.

We agree that health improvement must be a key focus for central government, and welcome the recommendations around cross-departmental working to drive these ambitions forward. This mirrors the local collaboration that ICSs have been established to promote.

We welcome the focus on improved data and use of digital as enablers to addressing health inequalities. While recommendations around building on good practice and improving joined up working are important, we believe the report could go further in highlighting innovative, practical ways ICSs can progress this agenda.

We strongly support the call to increase the public health grant. NHS Providers has, over several years, called for this. Furthermore, we would argue that any increase in the allocation should reflect

and address the current inflationary pressures and years of underfunding that has effectively acted as a cut to the grant over the last decade.

While we welcome the proposed shift towards spending on prevention, we would welcome further clarity on the target to increase funding for prevention by 1%, including the evidence and baseline for this proposed increase. Upfront funding, including through an increase to the public health grant allocation, is key to delivering an increase in funding for prevention without diverting resources from elsewhere in the system.

Delivering on the promise of systems

Here, Hewitt addresses the need for substantial culture and behavioural change from all involved in health and social care if ICSs are to achieve the ambitions set out for them in the Health and Care Act 2022.

This section considers the roles and responsibilities of government departments, NHSE, the CQC, and the partners in ICSs, including the approach to oversight, assessment and performance management across health and social care. Acknowledging the different regulatory, financial and accountability frameworks that various ICS partners sit within, the focus here is on the NHS's framework of regulation and accountability, which NHSE and the CQC are already taking steps to change in light of the Act.

Stressing the need for strong ICS accountabilities, given the public funds at their disposal, Hewitt's starting point is that ICBs must be 'great partners' within both their ICS and within the overarching NHS structure – although it also positions ICBs as the bodies "with and through" which most regulatory activity is carried out.

Key recommendations

- The number of national targets should be significantly reduced, and total no more than 10.
- ICSs should set a limited number of locally co-developed targets which should be treated with equal weight to national targets and local outcomes.
- National Planning Guidance should be developed collaboratively with system leaders, and should focus on a small number of key priorities. This should be reflected in a streamlined Mandate for the NHS. To achieve this collaboration, NHSE and ICBs should agree a common approach to co-production, including working with organisations such as NHS Confederation and NHS Providers.

- Each ICS should define places and place-level leadership, transparently and accessibly for their communities.
- ICSs should be supported to become 'self-improving systems' and ministers, NHSE and ICSs should confirm the principles of subsidiarity, collaboration and flexibility to underpin this.
- Support and intervention in relation to providers should be exercised 'with and through' ICBs by default as per NHSE's Operating Framework. ICBs should lead in working with providers facing difficulties, supporting trusts to agree improvement plans, and calling on support from NHSE regions as required and depending on ICS maturity.
- An appropriate group of ICS leaders (including local government and other partners from outside the NHS) should work with DHSC, Department for Housing, Levelling Up and Communities (DHLUC) and NHSE to create new higher autonomy and responsibility partnerships (HARPs) - more mature ICSs able to take on advanced levels of autonomy and responsibility. Hewitt estimates around 10 systems will be able to work in this way from April 2024.
- 2023/24 should be a transitional year for the CQC as it works with NHSE and ICSs to co-design an effective long-term approach to their reviews of ICSs, and to develop the capabilities and skill sets to support the successful development of ICSs.
- The balance of resourcing between national, regional and system should be further considered in 2023/24, with a larger shift of resource towards systems.
- The required 10% cut in the ICB Running Cost Allowance for 2025-26, which will come on top of a 20% cut in 2024-25, should be reconsidered before the Budget 2024.
- NHSE should work with the Local Government Association (LGA), NHS Confederation and NHS Providers to develop a leadership support offer for systems, and a national peer review offer for systems should be developed, building on the LGA approach.
- NHSE regions should prioritise support for improvement over 'performance management'. Regional teams should support systems in translating national expectations to local circumstances, and ICBs should be involved in the work currently underway to design new regional teams.
- The role of data and its collection should be reviewed by DHSC and NHSE, working with ICS colleagues, to reset baselines, remove duplicative or unnecessary requests. This work should be completed within three months. In addition, data collection should be automated from the Federated Data Platform, replacing both SITREPS and additional data requests.

NHS Providers view

This section sets out to tackle some of the thorny issues our members are raising with us as ICSs evolve, and seeks to resolve issues at the heart of the remit of the Review: clarifying the responsibilities and associated accountabilities of the partners in ICSs (including ICBs), NHSE regional

teams, NHSE centrally and the DHSC. This is no easy task, and there are welcome steps taken here to make real the ethos of partnership and collaboration.

The report strongly recognises the value of subsidiarity and effectiveness of co-design, and the counter-productive impact of numerous and unfocused national targets, ad hoc and duplicative data requests and invasive oversight. We agree with Hewitt's assessment of the burden created by excessive national targets, and support a shift towards more streamlined priority setting from the centre. We will be keen to ensure these fewer targets retain, and in some cases strengthen, a focus on community services and mental health.

Hewitt relies heavily on the existing NHSE Operating Framework and NHS Oversight Framework to describe the relationship between ICBs and providers. The review reinforces the role of ICBs in day to day oversight of providers, with NHSE working 'with and through' ICBs to support improvement and remedy issues. There is welcome recognition that not all ICBs will immediately have the capability to undertake this role and that support for their development from NHSE in these cases will be required.

However, the fundamental tension remains that ICBs are asked to be both system partners and overseers (in some cases performance managers) of trusts. This puts both ICBs and providers in a challenging position; one that may reinforce instead of moving away from a culture of command and control, and undermine the 'one team' approach that is well expressed elsewhere in the review. In this section, Hewitt also recommends that ICBs coordinate collaboratives' priorities and should be involved in appointing trust leaders. Increased autonomy of ICBs should not be achieved at the expense of the proper autonomy of trusts and collaboratives.

We fed back strongly during the review's development that clarity about accountabilities was required. The section on accountability relationships sometimes uses the term unhelpfully – for example without a statutory basis. The section ultimately does not add clarity who is accountable to whom within systems.

The inclusion of provider collaboratives as key drivers of improvements for the population is welcome, but the potential of provider collaboratives feels under-developed, and there is little recognition of the specific challenges for providers which straddle more than one ICS.

There is a logic to the evolution of health overview and scrutiny committees (HOSCs) to system oversight committees, but we are concerned that this (along with the proposed ICP Forum) adds

another layer of scrutiny and potentially bureaucracy in systems when the aim was the opposite. We also query whether the proposed Joint HOSCs might cut across the responsibilities of ICPs.

We would be pleased to work with the NHS Confederation and LGA on leadership support scoping and provision, and on developing co-design principles to improve National Planning Guidance.

Hewitt suggests "HARP" systems should be given greater financial freedoms and a radical reduction in the number of shared national priorities. We agree with these ambitions, which will afford more mature ICSs the bandwidth to drive forward local priorities. We will be interested to see whether and how these recommendations are taken forward by DHSC and NHSE.

We also share Hewitt's concerns about the impact of cutting the ICB running cost allowance in the context of the shift of resources from national to local. Systems will need adequate resourcing to deliver on the core ambitions of system working – especially as more is being asked of them than their predecessor organisations in overseeing trusts, for example.

Resetting our approach to finance to embed change

This chapter discusses the creation of value through the NHS, the need to focus on prevention and upstream funding to cut avoidable spending, and the importance of financial accountability.

It also calls for work to better understand ICS level prevention spending, greater financial alignment between the NHS and local authority partners, and greater flexibility for systems to determine allocations for different services.

Key recommendations

- NHSE, DHSC and HM Treasury should work with ICSs collectively, and with other key partners including the office for local government and the Chartered Institute for Public Finance and Accountancy to develop a consistent method of financial reporting.
- As far as possible, ending use of small in-year funding pots with extensive reporting requirements.
- More flexibility for systems to determine allocations for services and appropriate payment mechanisms within system boundaries, and updated NHS payment scheme to reflect this.
- National guidance should be further developed providing a default position for payment mechanisms for inter-system allocations.

- DHSC, DLUHC and NHSE should align budget and grant allocations for local government (including social care and public health which are currently allocated at different points) and the NHS so systems can more cohesively plan their local priorities over a longer time period.
- Government should accelerate the work to widen the scope of section 75 transfers, to include previously excluded functions (such as the full range of primary care services) and review the regulations with a view to simplifying them.
- Review of legislation with a view to expanding the scope of the organisations that can be part of s.75 arrangements to include social care providers, VSCE providers and wider providers such as housing providers.
- NHSE 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 most effective payment models to incentivise and enable better outcomes and significantly improve productivity.
- Government to commission a review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

NHS Providers view

We welcome the framing of this chapter, which clearly articulates the value the NHS creates in the wider economy. It also provides an important focus on lifting the financial barriers to prevention spending, and better understanding current spending by systems. These are important components in driving forward a successful prevention-based models. However, it is important to recognise that adding up, and effectively comparing, spending within and between systems, is a very complex task. This is particularly the case as much of this spending will be outside of the NHS, for example via local authority budgets.

We are pleased to see recommendations around the alignment of NHS and local government funding allocations and the removal of non-recurrent funding pots. These proposals will help to reduce burden on members and support a more effective approach to financial planning within system working.

We agree with the recommendation to remove hypothecation where possible, and afford systems greater flexibility to determine local allocations for services. However, the acknowledgement that we are not at the stage where we can remove all hypothecation is an important one and reflects the ongoing development of ICSs. We therefore strongly agree with the recommendation to retain the mental health investment standard, and to build on it to introduce a focus on delivering outcomes for populations within it. We also welcome the recommendation of a review of capital spending, which supports our ongoing campaigning on the importance of capital funding for providers.

Unlocking the potential of primary and social care and their workforce

This chapter focuses on both primary care and social care. It refers to the 2022 Fuller stocktake of primary care, and builds on its vision for integrated working, making recommendations around the contracting and commissioning of primary care services.

The report draws out the vital role of the social care sector. It suggests that in the longer term there must be a conversation about the funding and value of social care. In the meantime, it says social care must be a priority for investment and workforce development, and that ICSs can play a key role in supporting a more sustainable sector.

Key recommendations

- NHS England and DHSC should convene a national partnership group to develop a new framework for GP primary care contracts.
- Publication of a complementary strategy for the social care workforce as soon as possible.
- Investment in workforce development in social care should be longer term, as a minimum based on a three-year rolling planning cycle to support multi-year investment programmes.
- There should be a clear expectation that part of the training and development budgets within each NHS entity (i.e. primary care practices as well as trusts and foundation trusts) and within social care (at least commissioning and, ideally, provision) should be used for shared training and development of staff with other parts of the NHS and social care.

NHS Providers view

The report offers a clear vision for social care, and we support the view that social care should be a strategic priority for government. Many of the proposals support our view that social care plays an essential role in addressing key challenges facing the health and care system.

In particular, we welcome recommendations around a complementary strategy for the social care workforce, and long-term investment in the social care workforce. These proposals reflect our concerns about workforce pressures in social care, and our view that, where possible, joined up training and recruitment of NHS and social care staff is beneficial.

The recommendation that NHSE co-develops a framework for GP contracting, and that the national partnership group should discuss how primary care can be better supported and incentivised to work at scale, is also welcome. This is particularly important given the increased emphasis on this kind of working, including through vertical integration of primary and secondary care.