BMA Submission – The Hewitt Review

The BMA (British Medical Association) is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Introduction

The Association welcomes the opportunity to respond to the Hewitt Review into ICSs (Integrated Care Systems). As set out in a recent letter from Dr Phil Banfield, Chair of BMA Council, to Ms Hewitt, the BMA has a strong interest in the development of ICSs and in their capacity to drive positive change for our members and for patients.

While we have been sceptical of some facets of ICS development to date, we recognise that they and the shift in approach they bring to the NHS has the potential to deliver a better NHS, based around collaboration over competition.

However, as set out in this submission, we are clear that a number of critical issues continue to limit that potential and that steps must be taken at a national and ICS level to overcome them.

In brief, these include:

- ICSs are severely lacking in clinical leadership. A meaningful voice for doctors from general practice and secondary care, and for public health doctors is critical to ensure ICSs understand and account for the realities of doctors’ experiences at the frontline of services.
- The new structures often lack name-recognition and can feel like remote entities; ICSs must guarantee a strong patient and public voice, to root them in their local communities.
- ICSs need time to develop if they are going to embed the culture shift needed to make their collaborative approach work – they cannot be seen as ready-made cure-alls for the NHS and should not be overburdened with short-term, politically motivated targets that do not allow space for service transformation and the deepening of collaboration.
- NHS England and DHSC (Department of Health and Social Care) must support ICSs financially – including allowing them headspace to improve services without the constant and overriding pressure of savings targets.
- ICSs should be given clear accountabilities and national expectations, allowing for clarity about their roles while avoiding constant shifts in directives.
- While flexibility is important, key funding allocations must be protected in order to limit unwarranted variation – namely via ringfencing of primary care and general practice budgets.
- Public accountability for ICSs is a major benefit of the Health and Care Act, but this has to be delivered in practice, with ICSs ensuring transparency in decision making and allowing for meaningful challenge from organisations and communities within their systems.
- The full scope of an ICS’s role or authority remains opaque, but it is essential that no ICS overreaches its powers to interfere with the pay, conditions, or contract negotiations of doctors – all of which must be protected.

Additionally, we would also like to note our concern with the timing and timescales of this review. Conducting such a rapid review over the festive period and at a time of immense pressure on NHS services has restricted the ability of BMA members to engage with and contribute to the review, as it likely has for other stakeholders too.

We hope that our submission is useful – please do not hesitate to contact us for more information if required.
1 Empowering local leaders

1.1 Question 1:

What are the best examples, within the health and care system, where local leaders and organisations have created transformational change in the way they provide services or work with residents to improve people’s lives? Examples can be from a neighbourhood, place, or system level.

We believe that:

- To ensure ICSs have clear expectations but are also empowered to develop localised solutions to meet them, national bodies should set clear outcomes-focused goals for ICSs while also delegating resources and decision-making power to them.

- ICSs - as well as national bodies – must be explicit about what ICSs are doing across their footprints, share best practice and positive examples proactively, and root ICSs in their local communities so that doctors, NHS staff, and patients know what they are, who leads them, and what work they are doing.

One positive example of this balance between clear expectations and permissiveness has been highlighted by a doctor working in general practice in Yorkshire, regarding the implementation of the initial COVID-19 vaccination programme. This example saw a core target of vaccinations administered established, but funding allocated at a place-level to allow them to take their own approach to hitting it. This allowed for a permissive, flexible approach to vaccine delivery, with local leaders empowered to use the knowledge of their local workforce and residents to inform their specific programmes, and to tailor them to local needs and circumstances. The provision of simple guidance on the output and outcome required combined with freedom given to local leaders as to how to achieve it ultimately led to a positive result.

However, we must also note that feedback from our members has shown that many doctors are unaware of specific examples of positive work their ICS has undertaken. This reflects a longstanding view amongst BMA members in England that ICSs are often remote entities with little direct connection to the services or communities for which they are responsible. That is not to say that ICSs are having no impact, but more so that the impact they are having is not always visible or directly attributable to the ICS itself. Consequently, ICSs and national bodies must work to promote and spotlight the positive work they are doing within and across each of the 42 systems and, more fundamentally, ensure that doctors have a strong voice and role within ICSs.

1.2 Question 2:

What examples are there of local, regional, or national policy frameworks, policies, and support mechanisms that enable or make it difficult for local leaders and, in particular, ICSs to achieve their goals?

As above, we believe that ICSs need to be given a robust set of core and outcomes-focused priorities they are expected to achieve, while being afforded flexibility on how they do so.

As we have highlighted consistently, the extent to which each ICS can diverge on a huge range of issues, policies, and priorities creates uncertainty. In part this is driven by the deliberately non-
prescriptive nature of the Health and Care Act as well as the permissiveness of NHS England’s approach to ICS development over several years.

We recognise the value of allowing ICSs flexibility and believe that this can create real advantages, particularly for the most advanced ICSs. However, we also believe that without a sufficiently robust set of core priorities the extent of this permissiveness has significant drawbacks. In particular, it can leave frontline NHS staff and patients unsure of the purpose of their local ICS, leads to doubt about what an ICS can or cannot do, risks overreach into areas outside an ICS’s competencies, and blurs lines of accountability between ICSs, NHS Regional teams, and national bodies.

- NHS England and DHSC need to go further to ensure that the fundamental roles of ICSs are clear – in terms of what they should, could, and should not do. The NHS Operational Framework, published in 2022, went some way to resolving aspects of this problem by providing the clearest overview yet of which element of the new NHS does what post-Health and Care Act.

- This list needs to explicitly set out what lies outside of ICS competencies. The BMA is already receiving examples of ICS overreach in several areas, most concerningly regarding local bargaining and negotiations over staff pay and conditions. A number of ICSs are looking to deploy system-wide policies in areas where responsibility still remains with local employers and national bodies – such as negotiating pay and terms and conditions directly with their recognised trade unions. This is inappropriate distracts from the primary role of an ICS - improving services. Likewise, NHS trusts must also recognise that they cannot fall back on ICS-wide positions on issues negotiated directly between trusts and doctors.

- Further clarity is needed on the role of NHS regional teams in the new structure, especially the degree to which they will be responsible for assuring ICS work. If ICSs are to be able to develop with relative freedom, the role of regional teams needs to be set out more clearly, to avoid overlapping responsibilities and management.

- ICSs need a longer-term vision and funding settlement if they are going to succeed. Policies, frameworks, and support mechanisms are too often reactive and overly focused on short- term goals or targets. This undermines the ability of ICSs to use their capacity to understand the specific needs of their area and adapt policies to them, by instead focusing funding and political pressure on narrow, activity-based targets.

Winter pressures are a particular example of this problem, where money to support services is routinely only made available late in the year and on an ad-hoc basis, preventing systems or providers from developing proper winter expansion plans in advance. More support needs to be given to ICSs to develop initial winter plans well before seasonal pressures begin in earnest.

- There should be a ‘bottom up’ approach, with ICSs assessing local circumstances, engaging with relevant stakeholders in their communities, and then using that understanding to guide national policy by looking at common needs or gaps across the country as a whole.

- ICSs should be enabled to monitor the differential impact of national policies on all parts of their system and, if necessary, adjust those policies accordingly. One example of this is the expansion of virtual wards, the use of which may lead to increased workload in general practice which needs to be monitored carefully.
ICSs require local estates strategies that are not solely focused on major projects, such as the New Hospitals Programme, but look at the needs of the whole system and the value of smaller-scale initiatives. These must enable NHS providers and GP practices to utilise, adapt, and improve available spaces rapidly without onerous administration. As the BMA’s report on healthcare estates, *Brick by Brick*, laid bare, the estates crisis across the UK is universal and this must be reflected in ICS strategies.

It is unclear whether ICSs have the analytical capability they need to make best use of the data and insights available to them. This situation risks limiting the effectiveness of ICS decision-making and reinforcing the overly reactive approach cited above.

Local data and information is essential to ICSs being able to properly plan for the future. In particular, GP leaders have told the BMA that they rarely, if ever, see ICS modelling on the needs of general practice or its capacity to support preventative medicine. Likewise, there is a significant role for public health doctors in the collection and analysis of ICS-wide data, which needs to be better utilised.

1.3 Question 3:

*What would be needed for ICSs and the organisations and partnerships within them to increase innovation and go further and faster in pursuing their goals?*

We believe that the most pressing changes needed to free ICSs to progress more rapidly are affording them greater time and resources, improved innovation funding, and ensuring a strong voice for doctors and patients.

- The shortage of recurrent, long-term funding for transformation and innovation remains a significant problem. Without this funding, ICSs are restricted in how far into the future they can look, or how far they can go in transforming services – instead, they are forced to look more at business-as-usual or short-term challenges. This is a particular challenge for less developed ICSs, which often are in most need of support. DHSC and national bodies must allocate sufficient, recurrent funding for transformation and innovation to ICSs to allow them to reach their full potential. These funds should also be made available to place-based partnerships and localities, to nurture local innovation and frontline service transformation.

- It is also essential that ICSs are given the time and stable funding they need to develop. They cannot do so in a long-term, innovative, and transformative way if they are bound by persistent and short-term savings targets, constantly changing directives and targets, or only given piecemeal funding. If new ICS joint forward plans are going to be meaningful and successful, ICSs and their partners need to be given the confidence that they will be able to implement them in full.

- As the BMA has repeatedly argued, doctors from general practice, secondary care, and public health should all have a strong voice on ICBs and throughout ICS decision-making structures. This is essential if ICSs are going to better grasp the needs of the services for which they are responsible, and if they are going to truly understand the communities their serve.

- Doctors must also be supported to participate in ICS work, including by making funding available to provide cover and renumeration for those taking time away from work to do so.
Recently, BMA analysis of all 42 ICB constitutions has revealed the extent to which frontline doctors have been omitted from boards:

- None of the 42 ICB constitutions include a role for a representative of hospital doctors, or make any reference to LNCs (Local Negotiating Committees).
- 26 ICBs have the statutory minimum of one primary care representative, only 17 ICBs specify that their primary care representative will be a GP, and only one lists a local LMC (Local Medical Committee) as an observer (non-voting) member.
- Just two ICBs guarantee voting positions for public health specialists, seven ICBs establish that a voting member (from a Local Authority) should have knowledge and experience of public health, and 13 will offer non-voting roles to public health specialists.
- Disconcertingly, 20 ICB constitutions fail to mention any public health role at all.

In addition, it is essential that all ICSs include a strong patient and public voice. This is necessary to root them within their local communities, sense-check policies with those most impacted by them, and to ensure buy-in across the local area.

Question 4:

*What local, regional, or national policy frameworks, regulations and support mechanisms could best support the active involvement of partners, including adult social care, children’s social care services and voluntary, community and social enterprise in ICSs?*

We believe that:

- The potential of ICSs to actively involve partners from all sectors within their local systems is significant and we strongly believe that every effort must be made to maximise it, in order to better coordinate services, reduce duplication, and improve patient care.

One immediate step towards achieving this would be centring patient, public, and carer’s voices in ICS planning. Alongside clinicians, they have a unique understanding of local needs and service provision, as well as the various VCSE (voluntary, community and social enterprise) groups operating in their communities. Involving them from the outset will help break down organisational silos and give a patients-eye-view of the ways in which services overlap and interact.

- In order for ICSs to work more effectively with local non-NHS partners, they should seek to actively engage with doctors working in public health and primary care in particular, whose work frequently involves building relationships with the VCSE and social care sectors. Doctors working in these specialities/sectors often work across these boundaries already, coordinating care in MDTs (multi-disciplinary teams) and working with a wide range of NHS and non-health services.

- Clarity on role and capacity of ICPs (Integrated Care Partnerships) within ICS structures and ICB planning is essential. The role of ICPs remains unclear and, in theory, the joining-up of services and sectors across an ICS appears to largely sit with them. Serious thought needs to be given to the current roles and effectiveness of ICPs and whether they are currently in a position to facilitate the involvement of wider partners.
- There needs to be clear routes of involvement for VCSE groups without their needing to be involved at every layer. They need to be able to engage flexibly and offer their expertise in the right place at the right time, particularly given the lack of resources or staff many have available to them.

The place and neighbourhood levels of ICSs will be critical to achieving positive engagement with social services – particularly via MDTs in primary care – and VCSE groups. Many VCSE organisations operate on a hyper-local level, meaning system level may be too broad to appropriately engage them.

- We also recognise the increasing inter-dependency of NHS and social care services, as exemplified by the present challenges in discharge from hospitals. However, we believe it is imperative that NHS funding is not diverted to plug gaps in social care budgets. Both services must be funded fully but independently.

2 National targets and accountability

2.1 Question 5:

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?

We strongly believe that:

- A small set of achievable core targets is necessary, but widespread and politicised targets are fundamentally unhelpful.

- Targets that serve as indicators of patient safety – such as the four hour A&E target – are important and ICSs need to be sufficiently-resourced in order to meet them. More widely, though, activity-based targets such as on elective care need to be realistic and achievable. Setting new targets that are unachievable within present financial and workforce constraints is a pointless exercise.

- Outcomes-based targets offer an important and more flexible and holistic alternative to activity-based targets and should be utilised more often. As set out above, this would allow ICSs the freedom to apply local solutions in delivering overarching outcomes.

- Local targets are also important, allowing ICSs and providers to focus on areas that are relevant to their patients and services, while also accounting for workforce availability and population demographics. This is an instance where it may be beneficial to have local variation to allow incremental gains, rather than set an unachievable national target.
2.2 Question 6:

What mechanisms outside of national targets, for example peer support, peer review, shared learning, or the publication of data at a local level could be used support performance improvement? Please provide any examples of existing successful or unsuccessful mechanisms.

We believe that:

- Building on existing work, the sharing of best practice and networking across ICSs and their place-based partnerships should be enhanced and deepened. This is especially important to ICSs still building local relationships and lacking the oversight and understanding held by the most advanced ICSs.

- Regulation and oversight of ICSs needs to be focused on support over sanctions. National bodies have to recognise that many ICSs are still very much in development and need assistance to build a stronger culture of collaboration, and to overcome decades of competitive behaviour. Regulation should be tailored to achieving this, not to punishing failures.

- ICSs need support to build their data analysis skills and capacity to evaluate interventions. Staff are needed to properly review commissioning gaps, and local service provision across the area. We recognise that ICSs and ICBs are working towards some of this, but progress needs to be faster. BMA members have advised us that, in many ICSs, the use of local data to evaluate services and shape investment is lacking. One cited the fact that their ICS has not undertaken any real analysis of the value ICS interventions or place-based partnerships have added so far, meaning that the ICS will only make minor changes based on what has been done before, rather than reflecting a deeper understanding of what is or is not working, or might work better.

- The development of clinical leaders is a vital part of improving performance. Surrey Heartland’s ‘Surrey 500’ is an excellent example of this, showing that investing in clinical leaders can provide an invaluable foundation of informed, engaged, and proactive clinicians with a collaborative and system-wide mindset. All ICSs should be considering implementing similar models and ensuring that they are utilising the insight and experiences of their local NHS staff. These programmes should also ensure they recognise the value of doctors as clinical leaders, as stressed in the BMA’s Consultant’s Charter.

3 Data and transparency

3.1 Question 7:

What examples are there at a neighbourhood, place, or system level, of innovative uses of data or digital services to improve outcomes for populations, improve quality, safety, transparency, or experience of services for people, or to increase productivity and efficiency?

We believe that:

- Providers need time and resources to utilise the data and information ICSs can gather meaningfully. This should include the utilisation of the skills and insight of public health
doctors, who have an immense amount to offer in the gathering, analysis, and use of this data.
- Our members have highlighted a number of positive examples of data being used successfully at GP practice level to highlight issues with abnormally high referral levels in certain areas and to adjust processes in order to address them. They note that GPs respond well to data and new ideas and like to adopt those that lead to service improvements, but that they are rarely given either the data or the time to use that information.
- ShCRs (shared care records - formerly local health and care records) enable rapid information sharing for direct care and their roll-out holds real promise. ShCRs are the closest approximation of a universal record, accessible by all care providers and represent a key part of the foundation needed for more integrated healthcare delivery.

3.2 Question 8:

How could the collection of data from ICSs, including ICBs and partner organizations, such as trusts, be streamlined and what collections and standards should be set nationally?

We believe that:

- Regardless of what specific national standards are introduced, they need to be applied uniformly across all ICSs and their services. This is necessary to avoid data gaps, to allow for comparison and learning across and between ICSs, and to ensure that ICSs are able to utilise and combine all service data to better understand the needs of their local systems.

- Similarly, all data collection should be automated. If computer systems are not in place to allow this – which we know in many areas of the NHS, they are not – they must be provided. Moreover, steps must be taken, including the coding and development of programmes, if necessary, to ensure that this data collection happens as easily as possible and does not create additional workload or distract providers from their core purpose – delivering care.

- Data sharing and access to data are complex issues, however, the BMA does believe that data sharing within ICSs is vitally important. While shared care records, for example, hold genuine promise, they must not substitute for a fully interoperable NHS, with all commercial suppliers mandated to provide only software that is fully interoperable with competitors at no additional cost, thus allowing staff anywhere in the NHS to access usable patient data seamlessly, safely, and instantly. Beyond this, more effort is needed to combine local authority data, particularly from public health and social care collections, with NHS data for the purposes of planning services and shaping population health strategies. Progress towards this goal appears to be slow in many ICSs and greater support needs to be provided to those struggling to achieve it.

Question 9:

What standards and support should be provided by national bodies to support effective data use and digital services?

As the BMA has argued consistently – including in our recent report Getting IT Right:

- Interoperability of IT systems is essential for the delivery of modern and effective digital services, and for coordination of care across providers. This is particularly important to the sharing of patient data between different services within an ICS and to the use of electronic
prescribing systems. As found in the aforementioned report, nearly 76% of doctors responding to a BMA survey ranked ‘interoperability of systems’ as a ‘significant barrier’ to digital transformation.

- Illustrating this, one BMA member, working in mental health services, pointed to a critical lack of interoperability between acute hospital prescribing systems – which are typically electronic – and those used in mental health facilities, which are typically paper based. This results in patient prescriptions needing to be re-written, duplicating work, risking clerical errors, and generating unnecessary tasks. Clear and enforceable interoperability standards must be applied to all commercial suppliers, at trust, ICS and national levels.

- A lack of investment into IT and digital services has a substantial and highly negative impact – including reducing the number of working hours spent on actually delivering care. Our Getting IT Right report also revealed that more than 13.5 million working hours are lost yearly in England alone due to inadequate IT systems and equipment, while almost 1 in 3 (29.8%) doctors working in both primary and secondary care responding to our survey stated that the software they use was ‘rarely’ or ‘not at all’ adequate and fit for purpose to perform their job role. This underlines the need for significant investment in and improvement of IT systems and equipment across ICSs – without it, they will be unable to deliver effective data use and digital services.

- Where third party providers of digital services or technology are being utilised, measures must be put in place to ensure that they are providing high quality, fast services and respond to issues in a timely manner – and that patient data is safe and protected to the highest standards.

4 System oversight

4.1 Question 10:

What 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?

In respect of regulation and assessments of performance and capability at ICS level, we believe:

- Patient safety is the single most important thing for national bodies to monitor and needs to be at the forefront of all performance assessments. Within this, there also needs to be an assessment of the specific reasons for any declines in or risks to patient safety – such as staffing levels, underfunding, and infrastructure problems.

- Given ICSs’ overarching perspective, workforce planning – including staff wellbeing, retention, vacancies, and development – must also be a key focal point for performance assessments of ICSs, to ensure ICSs understand and are addressing the issues facing the workforce. The present workforce crisis is a major limiting factor in all NHS activity and so must be a primary focus for all national bodies and ICSs. This should include assessments of ICS-level workforce plans and progress on their delivery.

- The strength of clinical leadership and patient and public involvement in ICSs should also be a consideration for CQC and other regulators. Both are essential elements to successful ICSs
and system transformation and need to be considered fully in any assessments of an ICS’s performance. They are also vital sources of information about service safety and quality.

- Regulators should also consider the quality and depth of collaboration within individual ICSs, as a pivotal marker of their performance. This should include assessments of the range of organisations actively involved across ICSs – including those from social care and the VCSE sector, the strength of relationships between NHS providers within the ICS – particularly between primary and secondary care, and the overarching culture of system-wide collaboration.

- The standard of communication of ICS planning and activity to partners, stakeholders, and the public should also be assessed. ICSs are now publicly accountable bodies and need to fulfil this, in part, by ensuring that they communicate proactively and openly with their constituents.

- As the CQC are currently exploring, system reviews considering the performance of an ICS as a whole and the various factors impacting its performance are an important step forward. This approach has the potential to provide a more holistic and less transactional form of regulation, which matches the system-wide and collaborative approach of ICSs over previous NHS structures. This should include examination and modelling of demand and capacity, too, to best understand why a given ICS is experiencing pressure in specific areas. ICS-wide reviews should also involve monitoring of commissioning gaps, to ensure patients do not fall between the cracks and the ICSs are providing an appropriate array of services for their local area.

4.2 Question 11:

What type of support, regulation and intervention would be most appropriate for ICSs or other organisations that are experiencing performance or capability issues?

As set out above, we strongly believe that ICSs should be supported to improve, not be penalised. This includes:

- ICSs should be connected with, or paired to, other more established systems to encourage peer support and review. This should extend to place-based partnerships and locality levels, too – support should not solely be targeted at system-level.

- ICSs should receive investment – both in terms of finances and assistance - to tackle problems proactively without waiting for formal regulatory intervention. This should be a function of NHS regional teams, in our view.