BMA briefing - The Hewitt Review: An independent review of integrated care systems (England)

This briefing provides an overview of the Hewitt Review into ICSs (Integrated Care Systems) and sets out the BMA's views on its key aspects.

Headline summary

The Hewitt Review has identified six key principles for supporting ICSs – and their ICBs (Integrated Care Boards) and ICPs (Integrated Care Partnerships) – to positively transform the health and care system in England:

1. **Collaboration** within and between systems and national bodies
2. A limited number of **shared priorities**
3. Allowing **local leaders space and time** to lead
4. The **right support**
5. **Balancing freedom with accountability**
6. Transparent and high-quality **data.**

On publication of the review, **the BMA released a press statement** recognising the potential of a number of its recommendations but also raising significant concern regarding the proposals relating to GP contracts. This statement also reasserted the critical importance of the BMA, GPs, and LMCs being central to any and all discussions about the future of general practice.

We broadly **welcome** various aspects of this review, including recommendations to:

- reduce top-down targets and directives
- support local leadership, including through changing financial incentive mechanisms, which aligns with the BMA's view on collaboration, integration, and the future of ICSs
- shift the focus of health and care services towards the prevention of ill health, including an emphasis on ensuring ICBs have sufficiently embedded public health expertise
- encourage multi-year funding and reduce uncertainty surrounding resourcing
- review of the NHS capital regime, in line with the criticism of capital investment into NHS buildings in our **recent report on NHS estates**.

We are **concerned** about several aspects of the review, including:

- the possibility of a 'buy-out' of failing GP partnerships, which risks opening the door to private companies strong-arming smaller practices into selling
- the pressure on budgets that could be caused by a shift in resource to prevention without the necessary injection of additional funding
- the responsibilities attributed to the Federated Data Platform, given **concerns** regarding its potential reach and responsibilities.

The BMA will be continuing to engage with the review and will be monitoring any application of its recommendations closely.

For more information on ICSs, **visit the BMA's dedicated webpage**.

The BMA view - in brief

The final report of the Hewitt Review is a long, wide-ranging, and complex document containing an array of ideas and recommendations – consequently, it is difficult to definitively judge or classify it. The BMA sees the merit in a large number of these proposals but also has concerns about others – notably regarding the future of general practice.

The positive aspects of the Hewitt Review include its messaging around ensuring ICSs have the time and resources they need to succeed – something which the BMA called for in its own submission to the Review and has demanded since ICSs were first introduced. This includes the Review's recommendations on reducing top-down targets and directives, protecting ICB funding, and allowing ICBs to set more locally orientated goals.

The recommended changes to support ICBs to be more be responsive to local need, including them being able to set some of their own targets based on local priorities and reform of financial incentive mechanisms, aligns with the BMA's view on collaboration, integration, and the future of ICSs.

The report's focus on the importance of prevention is also welcome, as is the emphasis on ensuring ICBs have sufficiently embedded public health expertise in their structures. Both are broadly in line with the BMA's views and the focus on the role of public health leadership shows that the Review listened to us, even if it is not perfectly aligned with our own specific ask for a dedicated public health specialist on every ICB.

We are happy to see recommendations to reform current funding systems, particularly the encouragement of multi-year funding and steps to reduce the uncertainty surrounding resources for ICBs and providers, which often stymies transformation.

The call for a review of the NHS capital regime – which, for example, dictates what investment in infrastructure goes where – is welcome and aligns with our own criticism of the way in which capital investment has been managed in recent years. This is particularly relevant in respect of the lack of investment into the NHS estate, which we examined closely in our recent report on the NHS estates and has left many NHS buildings in a poor condition.

We are more tentative in our response to calls for increased pooling of budgets across NHS bodies and local authorities. While we see the value of pooled funding in many situations, we remain concerned that given the longstanding damage done to local authority budgets under austerity – NHS funding may be used to plug budgetary holes in some circumstances. For pooling to be as effective as possible, the NHS, local authorities, and social care, should all be funded adequately.

While we agree with the need to emphasise the role of prevention, there is a risk that budgets across the NHS could be stressed if a shift in resource to prevention occurs without the injection of additional funding to allow for it, particularly given long-term restriction on public health budgets.

There are, though, a number of areas where we have real concerns about the proposals included in the Review.

We are particularly apprehensive about some of the Review's recommendations regarding general practice. We have repeatedly voiced our concerns regarding the existing GP contract and the need for its reform and agree with the recommendation to expedite this – but we remain absolutely clear that the profession, represented by the BMA, must be central to any and all discussions or negotiations about this contract, not merely consulted as a stakeholder.

The Hewitt Review also proposes the introduction of a central fund to buy-out GP practices deemed to be failing. The BMA recognises that many GP practices are struggling to meet patients' needs, but

the emphasis now must be on supporting those practices. There is very little detail within the Review about how success or failure is defined and by whom, leaving many unanswered questions about how this would work. Rather than improving the community-based, holistic care provided by GP practices, we worry that this process may instead compromise the continuity of care that they have built over many years by forcing or heavily encouraging them to accept some form of buy-out.

Finally, the Review suggests that the role of the Federated Data Platform should be expanded. This is a source of unease, particularly due to our longstanding concerns about how the platform is protecting patient data. These issues have to be addressed before even considering broadening the role of the platform.

We will continue to closely monitor the review and any implementation of its various recommendations.

Background

In Autumn 2022, the UK Government announced that the Rt Hon Patricia Hewitt – currently Chair of the Norfolk and Waveney ICB (Integrated Care Board), and former Health Secretary – would carry out a review into ICSs (Integrated Care Systems).

The review considered a number of aspects of ICS development, focusing on the oversight and governance of ICSs, balancing autonomy and accountability, and data sharing.

The BMA submitted a detailed response to a public call for evidence in January 2023, stressing the BMA's longstanding calls to enhance clinical representation and voice within ICBs, as well as our broader argument that ICSs need to be given time, space, and resources to develop if they are going to be successful.

The Review's Findings

The final report of the Hewitt Review sets out six key principles to enable ICSs to thrive and deliver, these are:

1. **collaboration** within and between systems and national bodies
2. having a limited number of **shared priorities**
3. allowing **local leaders space and time** to lead
4. the **right support**
5. **balancing freedom with accountability**
6. transparent and high-quality **data.**

The report sets out the changes its authors believe are necessary in order to attain these principles, and a range of recommendations to Government and the NHS.

The key recommendations are summarised below:

From focusing on illness to promoting health

The Review stresses that in order to be successful, ICSs will need to place a larger focus on prevention and reducing pressures on the health and care system by improving population health.

This should be facilitated by changes including a shift in resources to increase funding for prevention, the creation of a national health improvement strategy, mandated public health representation in every ICB, and better use of data and the NHS App.

The Review also calls for an increase to the public health grant to local authorities, following years of real term 'squeezes' on funding.

This chapter also sets out four factors in shifting the focus of the NHS and the wider health and care system onto prevention:

- enabling a shift in investment toward preventative services and interventions
- embedding health promotion at all stages
- ensuring ICSs have a key role in embedding population health management
- empowering the public to manage their health.

The report's recommendations on how to address these factors and achieve the overarching change in priorities include:

1. increasing the share of total NHS budgets at ICS level going towards prevention by at least 1% over the next 5 years
2. the Government leading and convening a national mission for health improvement
3. establishing a national Integrated Care Partnership Forum to support ICP development
4. establishing a Health, Wellbeing and Care Assembly – this would bring together representatives from the NHS, ICSs, local government, social care providers, and the voluntary and charitable sector to support the shift in focus toward prevention
5. NHS England, DHSC and ICSs to work together to develop a minimum data sharing standards framework for ICSs, to improve interoperability and data sharing across organisational barriers
6. DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, to allow local authorities and the NHS to access appropriate patient information
7. NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs to join the Data Alliance and Partnership Board
8. the NHS App should become an even stronger platform for innovation, with the 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 – these would be based on a platform sitting outside of health and care IT systems and would allow patients to access all data held on them by NHS, local authority, or other health and care providers.

BMA view

The BMA is supportive of efforts to increase the focus on – and funding for – prevention, which is an important and positive pillar of the Hewitt Review. However, there are significant questions about how these recommendations would work in practice.

Notably, as the Review references, it is currently difficult to define exactly how much is spent on prevention within an ICS. Consequently, it is not clear how much a one percent increase in a given ICS' prevention budget would amount to, or whether it would be sufficient to facilitate the wider prioritisation of prevention called for in the Review. In addition, the BMA believes all parts of the health and public health system need to be properly funded, that does not mean robbing Peter to pay Paul, but funding both the NHS and public health and prevention properly.

The recommendations pertaining to data and digital are welcome, and broadly in line with past Government ambitions set out most recently in the NHS Data Strategy. The BMA has long called for minimum data sharing standards and welcomes calls to see them implemented, however, the burden must not fall exclusively to NHS organisations and work must be done to bring private sector software suppliers in line, so that they cannot sell products that do not meet these standards in a functional basic package to the NHS. The appointment of digital and data leaders to the Data Alliance and Partnership Board – which brings together a range of stakeholders to improve data collection – also holds promise, but care must be taken to ensure that these leaders come from a broad range of backgrounds, with a strong emphasis on clinical informatics and NHS-led innovation from clinical informaticians.

Similarly, the idea of creating specific bodies to determine the parameters of prevention within the health and care sector may be positive, but serious effort will be needed to ensure these groups – like the suggested Wellbeing and Care Assembly – have both the authority and expert advice they need. To ensure that expert advice is available to this assembly and to any Government mission on health improvement, independent public health experts must be central to both, and to the ongoing work of ICSs.

Care must be taken with any expansion of access to NHS data or any changes to ownership of data within the health service – any changes must be made with the full involvement and meaningful consultation of GPs in particular.

Delivering on the promise of systems

The Review sets out a number of changes needed to ensure the effective operation of ICSs and to allow them to succeed in the long-term.

Decentralisation and a reduction in national targets are seen as lynchpins of this and are seen as necessary to enable ICSs to become 'self-improving systems', as well as to ensure that their senior leaders have the time and space to lead. This approach would involve the highest performing ICSs being designated as HARPs (High Accountability and Responsibility Partnerships) and given greater freedom over how they use their resources.

The Review also stresses that this local autonomy will only be possible if ICSs have access to timely, transparent, and high-quality data**,** which should be facilitated by NHSE, DHSC, and the Federated Data Platform.

In terms of oversight and accountability of ICSs, the Review argues that this should remain the responsibility of CQC and NHSE, who should use improvement approaches that are as complementary as possible.

To support the development of ICSs, the Review also sets out that there should be a shift of resource towards systems, including reducing cuts to ICB running costs, to ensure systems have the right skills and capabilities to deliver.

In partial recognition of a long-term BMA lobbying ask, this section includes a discussion of the crucial importance of public health involvement within ICSs, ICBs, and ICPs. This settles on calling on ICSs to consider whether they have sufficiently embedded public health expertise – which it stresses could be provided by local authority representatives – within their structures.

The specific recommendations for this chapter include:

1. HOSCs (Health Overview and Scrutiny Committees – which scrutinise the performance of health organisations on behalf of local authorities) and Joint HOSCs should have an explicit role as System Overview and Scrutiny Committees, scrutinising ICS performance

2. each ICS should be enabled to set a focused number of locally co-developed priorities or targets and decide the metrics for measuring these. These priorities should be treated with equal weight to national targets and should span across health and social care
3. ICBs should take the lead in supporting providers (e.g., trusts) facing difficulties, supporting them to agree an internal plan of action, and calling on support from region as required. To enable this, the default arrangement for provider support and intervention should be 'with and through' ICBs
4. NHS England and the CQC should work together to ensure their approaches to improvement are complementary and mutually reinforcing
5. a national peer review offer for systems should be developed
6. NHS England should work with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024
7. an appropriate group of ICS leaders should work together with DHSC, DHLUC (Department for Levelling Up, Housing and Communities) and NHS England to create new 'High Accountability and Responsibility Partnerships'
8. further consideration should be given to the balance between national, regional and system resource with a larger shift of resource towards systems in the 2023/4 financial year; and the required 10% cut in ICB running costs for 2025/6 should be reconsidered before 2024
9. NHS England and Government should work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries
10. ICS leaders should be closely involved in the work to build on the new NHS England operating framework to codesign the next evolution of NHSE regions
11. NHS England should work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer to ICSs
12. 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
13. ministers should consider a substantial reduction in the priorities set out in the new Mandate to the NHS - with no more than 10 national priorities
14. NHS England and ICBs need to agree a common approach to co-production working with organisations like the NHS Confederation, NHS Providers and the LGA
15. as part of CQC's new role in assessing systems, CQC should include ICS maturity within their assessment criteria
16. ICSs, DHSC, NHS England and CQC should all have access to the same, automated, accurate and high quality data required for the purposes of improvement and accountability.

BMA view

The BMA has been critical of many aspects of ICS development thus far and was opposed to the 2022 Health and Care Act, which enshrined them in law. However, despite this, we recognise the importance of collaboration within the NHS and between it, social care, and other services, and have called on DHSC and NHS England to ensure ICSs have the time and resources they need to succeed.

As a result, we welcome several of the recommendations made in this section, a number of which we advocated for in our submission to the Review. These include the call to allow ICBs to determine their own local priorities with equal weight to national directives, limit the number of national

priorities local bodies need to address, and an increase in peer support for ICBs. Likewise, the Review's recommendation to reverse cuts to ICB running budgets is also in line with our position on properly resourcing ICSs.

However, despite a recognition of the need to involve public health experts in the work of ICBs, the report is generally lacking when it comes to clinical representation within ICSs. This is a major omission, given the importance of ensuring ICS decisions and priorities are informed by those leading care provision on the frontline, and those with invaluable understanding of the health of the local population.

It is not clear how the HARP model would work in practice, and it may be premature to introduce a new tier of ICS given they have only very recently come into force as legal entities.

Unlocking the potential of primary and social care and building a sustainable, skilled workforce

This section of the Review focuses on the ways in which the roles of primary and social care are central to the future success of ICSs and, alongside this, the need to maintain and build the workforce necessary to deliver high quality services.

The Review's focus on primary care is potentially its most controversial content, including a suggestion to radically reform GP contracting. It recommends the design of a new framework for GP primary care contracts and a review of other primary care contracts, with the aim of allowing local leaders to work in more 'innovative and transformational' ways. Importantly, it only states that the BMA should be engaged with as a 'stakeholder' in this process.

Additionally, the Review also argues that practices that are not delivering at a 'high enough' standard should be supported to improve or, if deemed necessary, be replaced. To deliver this, the creation of a centrally held fund for buying out 'struggling' GP contracts or premises is suggested. However, no clarity is provided on how this fund would be managed or by what body, on the process by which practices will be determined to be 'struggling', or on which body will make that determination.

Regarding social care, the Review stresses that the interdependence of health and social care should be acknowledged, particularly in respect of their respective workforces. This includes recommending the production of a strategy for the social care workforce that complements the upcoming Long Term Workforce Plan, as well as greater flexibility for health and care staff to work across both sectors.

The full set of recommendations for this chapter include:

1. NHS England and DHSC should convene a national partnership group to develop a new framework for GP primary care contracts
2. the Government should produce a strategy for the social care workforce, complementary to the NHS workforce plan, as soon as possible
3. DHSC should bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks – which, as per Skills for Care, are health interventions or activities that a registered healthcare professional delegates to a paid care worker
4. 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. Ministers and NHS England should work with trade unions to resolve this issue as quickly as possible.

BMA view

While we are generally supportive of efforts to better understand and account for the relationship(s) between the NHS and social care workforce – and pools of potential staff – we have serious concerns about other recommendations in this section.

While we agree that the GP primary care contract needs significant reform, this is and should be negotiated between DHSC and the BMA. Convening a new national group risks undermining this clearly defined approach. Furthermore, any suggestion that the BMA would not play a leading role in determining the future of the GP contract is one we would reject firmly.

Resetting our approach to finance to embed change

The Review focuses on the financial changes needed to transform the health and care system, rooted in the concept of perceiving health and care as generating value, as opposed to being seen as costs.

This revolves around a recommendation to create better 'health value' by identifying more flexible and effective payment models, making funding multi-year and recurrent to allow for better future planning, reviewing the NHS capital regime, and by providing systems with improvement resources.

The recommendations for this chapter include:

1. NHS England, DHSC and HM Treasury should work with ICSs and other partners (e.g., Office for Local Government) to develop a consistent method of financial reporting

2. building on the work already done to ensure greater financial freedoms and more recurrent funding mechanisms, the Review recommends:
    a. ending, as far as possible, the use of 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
    c. further development of national guidance to provide a default position for payment mechanisms for inter-system allocations.
3. DHSC, DLUHC and NHS England should align budget and grant allocation processes for local government, including social care, public health, and the NHS
4. government should accelerate work to widen the scope of Section 75[1] to include previously excluded functions (e.g., the full range of primary care services) and review the regulations with a view to simplifying them and to expanding the scope of the organisations that can be part of Section 75 arrangements, to include social care providers, the voluntary sector, and others
5. NHS England should ensure ICSs are able to draw upon a range of improvement resources to support them to understand their challenges and opportunities regarding productivity, finance, and quality

[1] This refers to Section 75 of the NHS Act 2006, which allows NHS bodies and local authorities to share a common fund through which health or care-related services can be commissioned.

6. NHS England should work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSs, to identify the most effective payment models to incentivise and enable better outcomes, and improve productivity
7. there should be a cross-government review of the entire NHS capital regime, working with systems, with a view to implementing its recommendations from 2024.

BMA view

There are several aspects of the recommendations in this section that we would support and that we called for in our submission to the Review. These include more consistent and long-term funding arrangements for ICBs, improving access to improvement resources for ICSs, and a review of the entire NHS capital regime – which aligns with our criticism of capital investment in our recent report *Brick by Brick*.

However, we are sceptical of other recommendations – particularly the suggestion to allow for wider pooling of resources between the NHS, local authorities, and other sectors, which we believe must only be done with significant protections in place to safeguard healthcare funding.

Stakeholder reactions

- NHS Confed: NHS Confederation responds to the Hewitt Review
- NHS Providers: NHS Providers responds to the Hewitt Review
- RCN: Royal College of Nursing responds to Hewitt Review