Good Governance Institute

# Hewitt review

**A response from the Good Governance Institute**

**January 2023**

www.good-governance.org.uk


The Good Governance Institute exists to help create a fairer, better world. Our part in this is to support those who run the organisations that will affect how humanity uses resources, cares for the sick, educates future generations, develops our professionals, creates wealth, nurtures sporting excellence, inspires through the arts, communicates the news, ensures all have decent homes, transports people and goods, administers justice and the law, designs and introduces new technologies, produces and sells the food we eat - in short, all aspects of being human.

We work to make sure that organisations are run by the most talented, skilled and ethical leaders possible and work to build fair systems that consider all, use evidence, are guided by ethics and thereby take the best decisions. Good governance of all organisations, from the smallest charity to the greatest public institution, benefits society as a whole. It enables organisations to play their part in building a sustainable, better future for all.

www.good-governance.org.uk

| | |
|---|---|
| Document name: | Hewitt Review – a response from the Good Governance Institute |
| Date: | 09 January 2023 |
| Author: | Simon Hall, Principal Consultant |



Good Governance Institute

info@good-governance.org.uk

www.good-governance.org.uk

# 1. Introduction

In his Autumn Statement on 17 November 2022 the Chancellor, Jeremy Hunt, announced a review of integrated care systems (ICSs) to be undertaken by former Secretary of State for Health and current Chair of Norfolk and Waveney Integrated Care Board Patricia Hewitt. The review considers how the oversight and governance of ICSs can best enable them to succeed, balancing greater autonomy and robust accountability with 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. It covers ICSs in England and the NHS targets and priorities for which integrated care boards (ICBs) are accountable, including those set out in the government's mandate to NHS England.

The review has been designed to consider and make recommendations on:

- how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending
- the scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England 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.

This paper summarises the Good Governance Institute's evidence to the Hewitt Review,

# 2. Our response

**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.**

GGI has experience of working with the majority of ICSs across England, and we have observed many examples of effective transformational change, at a variety of levels and across very different geographies. We feel that an easily accessible way for sharing of these experiences should be encouraged and supported as local systems develop in different ways. Whilst we are aware of the NHS Futures platform, a more accessible central repository of case studies would be a useful resource for many across all partner agencies and organisations that are involved in ICSs or in supporting ICSs.

The new ICBs have brought together around one board table NHS commissioners, providers and local authority leaders and we are seeing how this is changing the DNA of decision taking. We are seeing the signs of more rapid decision taking too, with tacit understanding of differing perspectives being gained through systems working.

**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?**

One of the most difficult issues that we are finding for local leaders is navigating the line between organisational and system risk in order to achieve their goals. Whilst working as a system is the most beneficial approach for patients, the NHS and the wider economy, it remains the case that each organisation within an ICS is an individual statutory body, including the ICB. As such, each has a regulatory framework that it must operate within, which may be explicitly at odds with the national policy direction for ICSs. If a point of conflict arises, each organisation must ultimately meet its own statutory requirements, even if that is to the

detriment of the wider system. ICSs are not statutory organisations and therefore any joint goals are effectively voluntary, and there is no requirement for the different organisations within an ICS (or on an ICB) to adopt and work to mitigate system risks or support system population health outcomes.

ICSs are in their early stages and in much of the country there still needs to be a significant cultural shift to enable effective system working. The development and application of policies and frameworks must acknowledge the huge variety in ICSs, in terms of geography, demography and stage of maturity. These differences are to be expected, meaning that any national approach should set out a clear minimum expectation which can then be built on in a sensible way for a local area, supporting local autonomy and decision making.

Early guidance was clear that local definition of places was required, to ensure that places were meaningful to the populations which they serve. This means that places look very different across the country, and don't always match local government designations. Later guidance set out expectations of how places should be organised and structured, attempting to create a more homogenous approach, contrary to the initial expectation, and this has created unnecessary tensions. It is essential that differences are recognised and encouraged where they make sense, as place-based working and the associated provider collaboratives are key delivery vehicles for the success of the ICS model.

There also remains a tension between place-based working and provider collaboratives where places have been seen as smaller local entities and provider collaboratives cover a much wider area. ICSs need to be encouraged to work out what this tension means for them locally, and put in place mitigations so that places are reflected positively within larger provider collaboratives.

There is also a fundamental governance point that can be a barrier to system working, as there is no single process for transparently moving funds between NHS bodies, meaning that funding flows can be a barrier to system working. The most effective solution to this has been for provider collaboratives to pool budgets under a lead provider, or to utilise Section 75 arrangements, both of which already were in place prior to the new legislation. Now that there is clear guidance on the role of procurement within ICSs going forward, we believe the time may be right to think about formalising a more flexible way of budgetary pooling either via provider collaboratives or properly constituted place committees.

**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?**

Partnership working beyond the boundaries of the NHS can be challenging due to differing financial and governance regimes, for example, different approaches to VAT in local government and the NHS, and non-aligned financial reporting timetables. We have found very few places where the use of Section 75 flexibilities is being used beyond the areas covered by the Better Care Fund. We would also note that the annual government budgeting cycle also impacts on revenue expenditure as some organisations seek to 'spend up' their allocations towards the year-end leaving the recipients with little time to invest that resource in transformational projects. A longer-term approach to public finances linked to a more longer-term focus on improved health outcomes would be helpful to help increase innovation and achievement of ICSs' goals. Learning from the New Models of Care Programme also suggests that innovation will be accelerated nationally by funding a number of pilot sites to try out innovative integrated care approaches in their local areas on the lines of the Vanguard and Pioneer programmes in the 2010s.

We have also observed the burgeoning of "low level" governance activity now that ICBs have been set up. We have seen many ICBs that have failed to move on from their previous CCG incarnations, which is not surprising as most of the staff were transferred across and have had no meaningful development. This is "stodging up" the ability to take action and do things differently. It is also losing credibility for ICBs from local providers,

who will be the ones who actually deliver the changes needed to improve integrated patient care. The solution here is to professionalise the corporate governance of ICBs themselves, and we would recommend strongly that this is a key theme for the first set of ICB external reviews. Through our work we feel the pain from both the ICBs themselves, from NHS providers, and from local government partners.

The other area that should be mentioned as critical under this question is workforce. There remain insufficient staff to deliver current services at the level required, with significant vacancies in all sectors. New initiatives and service models can sometimes draw staff away from under pressure services to a more attractive role, thus exacerbating the pressures on the day-to-day delivery of services. As the NHS seeks to implement integrated care plans, it is expected that more services and provision will move to community settings. This needs to be supported by making staff movement between organisations and sectors much easier.

**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 (VCSE) in integrated care systems?**

In order to achieve the aims that they were set up to do, ICSs need to nurture effective relationships and trust across sectors and between a wide range of partner agencies, and our experience shows that this cannot be fast-tracked. Partner member roles on ICSs/ICBs are difficult roles, and have inherent conflicts of interest, bandwidth issues, mis-alignment, differing cultures and governance systems. It is, though, very desirable to have partner members hard-wired into ICB governance. The trick that we believe has been missed is to also involve them in ICB executive teams, and there are multiple ways of doing this – and indeed a ready model with acute hospitals and how clinical directors are involved in trust management groups. Another option would be at place-based level, such as how some ICBs are embedding primary care leadership. Often, though, the NHS has traditionally insisted that such leadership roles have to be undertaken by chief executives alone and through oddly constituted committees, whereas in reality we would suggest that this is better done by senior provider leaders also holding senior executive portfolios within the ICB.

We also believe that it is vital that ICSs think about care home providers as partners and as separate from local authorities. We have found, working with Care England, a poor understanding of care homes by NHS leaders and trite, out of date assumptions. The care home market is so fractured it is often very hard to get someone to represent care homes in any ICS structure. ICBs need to bite the bullet and pay the voluntary, community and care home sectors for the time it takes to engage in ICB work, and there are some good examples of this starting to happen in some places across England. The real engagement an ICB can get from this exercise is well worth this investment, particularly as traditionally management structures have been inexorably thin in these sectors.

**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?**

The NHS has long suffered from a proliferation of national targets and a myriad of performance indicators all of which often claim to be "key". Our key recommendation here would be for greater clarity on what the national priorities are, to keep that number relatively limited, and to allow local systems to agree and develop how they achieve this. Moreover, it is vital that all priorities are understandable and realistically achievable within current funding and timescales. Ideally these would be focused on outcomes rather than outputs, although we acknowledge that the public often judge the health and care system on how long people wait for an ambulance, to get seen by a GP, or how long a waiting list for planned treatment is.

Ideally national priorities should be set in a collaborative way with local systems, who understand the realities of delivering services to patients and improving population health. It is essential that the impact is considered

across the whole system. In the past the NHS has found it is easy to focus on priorities around acute activity without acknowledging, or funding, the work that they may create for other sectors such as community, primary care, mental health, or ambulance services. Moreover when setting priorities, potential barriers to achieving them which are outside of the direct influence of the NHS, must be considered, and indeed this was one of the very reasons that ICSs were set up: the impact of social care capacity on the ability of the NHS to reduce waiting lists, or the impact of poor housing on improving population health, are good examples of this. It will be important for ICSs to set their own local targets, maybe phrased as joint agreements as a system to deliver X by Y.

**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.**

In his review of the banks Sir David Walker talked about the symbiosis of regulation and good corporate governance. He rightly identified that better control comes from the right balance between the two. In GGI we have often called a board 'the regulator of first resort'. In the NHS we would observe that CQC and NHS England as regulators are over-emphasised as the solution to problems, and nurturing good local corporate governance under rehearsed. Indeed when a trust is in trouble the local board is disempowered and their room for action significantly curtailed. We can see that ICBs, with their own strengthened corporate governance arrangements and direct relationships through partner members, could rebalance this and work to strengthen local boards – particularly when times are troubled. We have seen regulator intervention fail to achieve long-term resolution time and time again.

**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 have seen examples of good practice across the country where data has been used very effectively to improve outcomes for populations. This has been particularly the case where the lead has been taken by Directors of Public Health to drive data sharing on a population health basis, with the ability to link this in with wider data available across Councils. We are encouraged by the New NHS Code of Governance that requires boards to look to their local populations as well as those that use their services. Some boards are setting up population health committees as an interesting first step, such as University Hospitals of Dorset NHS Foundation Trust.

There are also many examples of the use of flexibilities in the information governance regulations that systems used to empower their teams during the Covid pandemic. Examples of teams linking data with tools such as "SHAPE" to get breakdowns of which streets and types of individuals in individual postal code districts were less or more likely to be vaccinated helped target where to encourage community pharmacies to open additional clinics, where to sight drop-in vaccination facilities, or where to target local publicity campaigns. Many of these approaches have not continued following the re-imposition of harder-edged information governance regimes post-pandemic.

**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?**

Data collections are a perennial source of frustration for many in the NHS, and even reading this question will elicit strong reactions from those involved in data collection. There are national plans to draw down information from national datasets, but often these datasets are not completed as they should be, as guidance on completion is unclear. The NHS still has a myriad of different computer systems across acute trusts, primary care, community and mental health, although the success of the NHS App does show that

there is widespread public support for consistent data to be available both at an individual and collective level. More data focused on outcomes rather than outputs would help with service planning and population health improvement, and involving local organisations in agreeing data linked to fewer national targets would be helpful going forward. Additionally the use of such data is itself only helpful if it is timely, as often big national data sets end up being produced so long after the data collection that they are seen to be of little use locally.

**Question 9: What standards and support should be provided by national bodies to support effective data use and digital services?**

Learning from the New Models of Care Programme showed that sharing data across organisational boundaries is essential for the effective use of resources and improved patient care, enabling whole patient pathways to be reviewed and developing optimal value to the patient and the system. During the pandemic, data sharing rules were relaxed for the purposes of tackling Covid-19, and this clearly demonstrated the impact that sharing information can have on the ability of organisations to work together (as outlined in our answer to Question 8 above), which is a key aim of ICSs.

We would urge that the accent of national policy on data sharing should be altered to enable organisations to share data for the purposes of improving patient care through service development and transformation, on a newly robust legal basis. This should be supported by robust guidance on the key considerations, from a legal and information governance perspective, organisations should make when sharing data, but with the emphasis being upon the purpose of improving patient care. Investment also needs to be made nationally to improve the interoperability of systems both across the NHS and with adults' and children's social care.

**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?**

The NHS has traditionally been very inward thinking when it comes to thinking about how to improve performance or capability, and we believe that ICSs would benefit from adopting a much less cosy approach. ICSs, and ICBs in particular, need new thinking and skills to do very different roles from their predecessor NHS organisations, and we would suggest that looking to wider industry standards would be a useful start for NHS England, the CQC and the DHSC as they think about how to monitor the new bodies. To create a step change in the NHS around integration may require more radical steps, and a new regulatory and support regime should be designed to enable rather than hinder this. If performance monitoring focuses on activity in individual organisations, it will work against the wider desire to encourage and promote system working. There is a danger that a new oversight process designed in the same way as those in the past could rebuild the barriers that the Health and Care Act 2022 seeks to remove.

In other industries, the focus is increasingly switching to performance monitoring to value creation and we feel this is a useful addition to the pallet of language being used to describe what ICBs should be working to achieve. Value creation for an ICS would include performance, but also look at local populations having access to stable and sustainable care services, health literacy, established pathways of care, resilience within populations (ranging from knowledge about health and wellness through to high vaccination uptake), advocacy, established networks of carers, decent housing, high levels of employment and engagement, etc. ICBs should prosper a richness within populations of all those factors that contribute to maintaining health and wellbeing.

**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?**

In the past the NHS support, regulation and intervention regime was designed with the commissioning and providing system in mind. The emphasis going forward should be on a regime that supports, enhances and enables collaboration and partnership to improve health outcomes rather than a punitive regime designed to address failures in particular output indicators. We welcome the debate started by the CQC on how its regime can reflect partnership working going forward, but would note that the regulators themselves also need to change how they work to enable this to happen. Clarity of the respective roles of NHS England, the CQC, the DHSC, and ICBs in respect of performance and capability issues would be a useful start. ICBs have a clear responsibility to promote system working, so giving them the lead on system performance – without traditional "support" from the centre – would be a helpful test that the right parameters have been built into the new structures to enable ICBs to undertake their roles with success.

Simon Hall
The Good Governance Institute
9 January 2023