

The Hewitt Review

An independent review of integrated care systems

Rt Hon Patricia Hewitt

Published 4 April 2023

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Foreword

It has been a privilege to carry out this review. Although the invitation to do so came as a complete surprise, it was an opportunity I could not turn down. As chair of the Norfolk and Waveney NHS integrated care board and deputy chair of its integrated care partnership, and previously one of the first independent chairs of a sustainability and transformation partnership, I have no doubt that the decision to put integrated care systems onto a statutory footing was the right one, widely supported across the political spectrum.

I stepped down as Secretary of State for Health over fifteen years ago. The biggest contribution I helped make to the health of the nation was the smoke-free legislation: an important reminder in the context of this review that we should never mistake NHS policy for health policy. And one of the most creative was the nation-wide public engagement through 'Our health, our care, our say' that confirmed public support for a health and care system that would enable them to be as healthy and independent as possible.¹

ICSs have been born in difficult times. The answer is not simply more money, although of course that is needed, particularly in social care. Unless we transform our model of health and care, as a nation we will not achieve the health and wellbeing we want for all our communities - or have the right care and treatment available when it is needed.

ICSs bring together all the main partners - local government, the voluntary, community, faith and social enterprise sector, social care providers and the NHS - in a common purpose expressed in 4 main aims: to improve outcomes in population health and healthcare; to tackle inequalities in outcomes, experience and access; to enhance productivity and value for money; and to help the NHS support broader social and economic development.

This report shows how they are already making a difference and explains what needs to happen next to accelerate that progress.

As Secretary of State myself, I was a 'window-breaker' rather than a 'glazier'.² Like today's ministers, I was impatient for change - and rightly so. But my preferred style as a leader remains collaborative: bringing people together to understand each other's perspective, learning from and challenging each other, and working through disagreements or conflict as honestly and openly as possible to agree the best way forward. That is how I have carried out this review, and as a result I believe that most of my recommendations will command widespread support. But there is a wide range of passionately held views and it would be surprising if there was unanimity on all points. Indeed, an independent review with which everybody agreed would be pointless.

Given the scope of my terms of reference, and the tight timescale, it is hardly surprising that the review has been an intense and sometimes challenging process. I am hugely grateful to the many hundreds of people who have been involved through engagement events, town hall meetings and the 5 review work streams as well as in preparing over 400 submissions in response to the call for evidence. I have also drawn upon the many preceding important reviews and papers, including the work of the King's Fund, Professor

¹ [Our health, our care, our say: a new direction for community services.](#)

² Nicholas Timmins, *Glaziers and Window Breakers: Former Health Secretaries in their own words*, Health Foundation, May 2015

Sir Chris Ham, the Fuller Stocktake and the Messenger Review to name but a few. It has been a privilege to work with so many inspiring colleagues: every conversation has taught me something more. To all of you who have contributed to these rich discussions, thank you.

The time comes, however, when the drafting has to stop. I am painfully aware that it has not been possible to do justice to every insight and recommendation, or work through every issue raised in our discussions. Nonetheless, I hope everyone will feel that their efforts have been worthwhile, and that this report provides all of us committed to the success of ICSs with a platform for the next stage.

Many of my recommendations are designed to shape how we work together in the coming months and years, not only strengthening collaboration at local level but ensuring the breadth of partnership within ICSs is mirrored nationally. Real partnership starts with real work and I have made a number of recommendations for how the way we are learning and creating together within systems, should be embraced and embedded nationally: for instance, with DHSC, DHULC, NHS England, HM Treasury, ICSs and others working in concert on important areas of change including much-needed reform to the financial framework.

This review could never have happened without many people's exceptionally hard work. I am grateful to the Secretary of State for commissioning this review and his ministers, advisers and departmental officials for their support throughout. I am equally grateful for the active engagement of Amanda Pritchard and many senior colleagues at NHS England. Without them all, the review would not have been possible.

I am particularly grateful to the co-chairs of the 5 work streams: Sam Allen, Rt Hon Paul Burstow, Felicity Cox, Dr Penny Dash, Adam Doyle, Sir Richard Leese, Dr Kathy McLean, Patricia Miller, Cllr Tim Oliver and Joe Rafferty.

I want to thank Matthew Taylor, Annie Bliss, Ed Jones and others at the NHS Confederation whose ICS, primary care, mental health and other networks were invaluable and who provided additional policy and engagement support throughout. My thanks go equally to the Care Providers Alliance, the County Councils Network, the Health and Wellbeing Alliance of VCFSE sector representatives, Healthwatch, the Local Government Association, National Voices, NHS Providers, the Patients Association, the Social Partnership Forum, and the many others who have contributed and facilitated this work. I was also exceptionally fortunate in my DHSC Secretariat: Jason Yiannikou, Jonathan Walden, Georgina Connah, Laura Bates, Alexandra Kirsima, Haleema Nazir and Thomas Savage, all of whom deserve immense praise.

As the review concludes, and despite the very real challenges that lie ahead, I am even more optimistic about what we can achieve together than I was when this process started. I look forward to working with you all on the next stage of our exciting journey together.

Rt Hon Patricia Hewitt

April 2023

Terms of reference

The review's terms of reference were published on 6 December 2022 and are set out below.

Objectives and scope

The review will consider how the oversight and governance of integrated care systems (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 will cover 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.

In particular it will 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

Engagement

The review will draw upon the expertise of ICSs, local government, the NHS, the voluntary sector, patient and service user representatives and other subject experts including in academia, government departments and relevant thinktanks.

Governance and timing

The review will be led by Rt Hon Patricia Hewitt and will be independent of government.

Secretariat support will be provided by the Department of Health and Social Care.

The review will report to the Secretary of State for Health and Social Care, with interim findings by 16 December 2022, a first draft by 31 January 2023 and a final report by no later than 15 March 2023.

Executive summary

Integrated care systems (ICSs) represent the best opportunity in a generation for a transformation in our health and care system. Effective change will require the combination of new structures with changed cultures. Everyone needs to change, and everyone needs to play their part.

The review has identified 6 key principles, that will enable us to create the context in which ICSs can thrive and deliver. These are: collaboration within and between systems and national bodies; a limited number of shared priorities; allowing local leaders the space and time to lead; the right support, balancing freedom with accountability and enabling access to timely, transparent and high-quality data.

From focusing on illness to promoting health

Delivering these principles will require genuine change in how the health and care system operates. While there will always be immediate pressures on our health care system, shifting the focus upstream is essential for improving population health and reducing pressure on our health and care system.

This will require a shift in resources - the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. It will also require cross-governmental collaboration to embed a national mission for health improvement and the establishment of a new Health, Wellbeing and Care Assembly.

Our use of data must also support this mission, with improved data interoperability and more effective use of high-quality data. Alongside this we need to empower the public through greater use of the NHS App and further long-term commitment for the development of citizen health accounts.

Delivering on the promise of systems

ICSs hold enormous promise, bringing together all those involved in health, wellbeing and care to tackle both immediate and long-term challenges. To do this effectively, national and regional organisations should support ICSs in becoming 'self improving systems', given the time and space to lead - with national government and NHS England significantly reducing the number of national targets, with certainly no more than 10 national priorities.

We should encourage and deliver subsidiarity at place, system, regional and national levels. We are currently one of the most centralised health systems in the world, and ICSs give us an opportunity to rebalance this.

The most effective ICSs should also be encouraged to go further, working with NHS England to develop a new model with a far greater degree of autonomy, combined with robust and effective accountability.

For every ICS, increased transparency is vital to enabling local autonomy. The availability of timely, transparent and high-quality data must be a priority, and NHS England and the Department of Health and Social Care (DHSC) should incentivise the flow and quality of data between providers and systems. The Federated Data Platform can provide the basis for a radical change in oversight, to replace situation reports (SITREPS), unnecessary and duplicative data requests.

Both the Care Quality Commission (CQC) and NHS England will continue to have a vital role to play in oversight and accountability, but they should ensure that their improvement approaches are as complementary as possible, and complementary to peer review arrangements between systems.

Finally, it will be vital to ensure the right skills and capabilities are available to ICSs as both systems and national organisations manage through a period of challenge for the nation's finances. There needs to be consideration given to the balance between national, regional and system resource with a larger shift of resource towards systems.

Unlocking the potential of primary and social care and their workforce

In order to make the promise of ICSs a reality, we also need to pull down some of the barriers that currently exist for primary care, social care and the way we train health and care workforce.

Given the interdependence of health and social care, the government should produce a complementary strategy for the social care workforce. More should also be done to enable flexibility for health and care staff, both in moving between roles and in the delegation of some healthcare tasks.

National contracts present a significant barrier to local leaders wanting to work in innovative and transformational ways. I have recommended that work should be undertaken to design a new framework for General Practice (GP) primary care contracts, as well as a review into other primary care contracts.

Work also needs to be done to ensure that there is the flexibility to competitively recruit and train more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialised analytical and intelligence.

Resetting our approach to finance to embed change

We are currently not creating the best health value that we could from the current investment in the NHS. Instead of viewing health and care as a cost, we need to align all partners, locally and nationally, around the creation of health value.

NHS funding remains over-focused on treatment of illness or injury rather than prevention of them and ICS partners struggle to work around over-complex, uncoordinated funding systems and rules in order to shift resource to where it is most needed.

Instead, it is important to identify the most effective payment models, nationally and internationally, with an aim to implement a new model with population-based budgets, which will incentivise and enable better outcomes and significantly improve productivity. There should also be a review into the NHS capital regime to address the inflexibility in use of capital and the layering of different capital allocations and approvals processes.

NHS England should also ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.

1. Introduction

- 1.1 Across the developed world, healthcare systems are facing the challenge of increasing pressures, public expectations and opportunities (including those opened up by new digital and data technologies). As other healthcare systems are finding, no matter how much money is invested in treating illness, unless we transform how we deliver health and care, we will not achieve the health and wellbeing we want for all our communities - or have the right care and treatment available when we need it.
- 1.2 In England, integrated care systems (ICSs) represent the best opportunity in a generation for that urgently needed transformation of our health and social care system. They provide the opportunity to break out of organisational siloes, enabling all partners to work together to tackle deeply rooted challenges, drawing together their collective skills, resources and capabilities around their 4 core purposes, to:
- improve outcomes in population health and healthcare
 - tackle inequalities in outcomes, experience and access
 - enhance productivity and value for money
 - support broader social and economic development
- 1.3 If we allow the development of ICSs to become “just another NHS reorganisation”, we will let down patients, the public and everyone working in the health and care system.

Integrated care systems (ICSs) are partnerships that bring together local government, the NHS, social care providers, voluntary, community, faith and social enterprise (VCSFE) organisations and other partners to improve the lives of people who live and work in their area, in line with their 4 core purposes. Each ICS includes a statutory integrated care partnership (ICP) and integrated care board (ICB).

The ICP is a statutory committee jointly formed between the ICB and the relevant local authorities within the ICS area. The ICP brings together the broad alliance of partners and is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

The ICB is the statutory NHS organisation responsible for bringing NHS and other partners together to plan and deliver integrated health and care services and accountable for the finances and performance of the local NHS as a whole.

Why we need a new approach

- 1.4 There are 3 main reasons why we need a new approach for the health and care system. First and foremost are the immediate pressures upon the NHS and social care, already visible before the pandemic, but greatly exacerbated as a result of it. The public's immediate priorities for the NHS - access to primary care, urgent and emergency care, cancer, other 'elective' care, and mental health services - are just as important to ICSs as they are to ministers and NHS England.
- 1.5 Second, there is a growing number of people living with complex, long-term physical and mental health conditions, often associated with serious disabilities or ageing.
- 1.6 Third, as a nation, we are becoming less, rather than more healthy, both physically and mentally. More people spend longer in ill-health and die too young, particularly the least economically advantaged and those most affected by racism, discrimination and prejudice.

“Against the backdrop of those health challenges, we cannot just keep doing more of the same. The traditional way of operating a health system, where you have your hospitals and your primary care and you have your social care separate, and you have those things relatively siloed, is not a system that works in a world where people are living a long time with multiple health conditions. We know that the determinants of health are much broader than just what happens in a hospital. They include housing, wider care and education. Joining up is an imperative, both for improving health outcomes and for having a sustainable, affordable health system to get what we want.”

Helen Whately, MP, Minister of State for Social Care

- 1.7 ICSs are designed to tackle all 3 problems. As the examples throughout this report illustrate, many are already succeeding in doing so.
- 1.8 They are already starting to tackle immediate and often intractable problems - including ambulance queues and delayed discharges - which cannot be solved by any one organisation alone or by continuing to work in the same old ways. These problems require close partnerships between many parts of the health and care system - primary care, community health, mental health, acute hospital trusts, local government and social care providers - working together in different ways.

Dorset ICS has halved the number of A&E and emergency admissions among elderly people through its Ageing Well programme, improving anticipatory, preventative care by integrating community, primary and social care teams at neighbourhood level. ICB investment enabled the anticipatory care programme to undertake upstream interventions for patients with long term conditions. Interventions were developed for specific risk groups

by a multi-agency partnership. The ICS is now using data to predict who might be a frail patient at risk of falling, and intervene to help prevent falls and promote self-care. A digital programme supports an out of hours clinical team to respond to care homes and prevent admissions. The ICS is also expanding the use of virtual wards and is piloting the use of Age Care Technologies which support independence in the home. This is saving approximately £33,000 per person per year in care costs.

- 1.9 Despite many impressive examples of innovative working, the NHS in general is not yet currently configured to optimise the management of complex, long-term conditions. The result is a system that is fragmented rather than integrated, making it frustrating, inefficient and often challenging for patients and families as well as staff. ICSs, by integrating health and social care services, and working more closely with VCFSE providers, should aim to ensure that services are joined up, pressures are actively managed, and the interests of patients and the public are prioritized.
- 1.10 It has also long been recognised that the NHS is, in practice, more of a National Illness Service than a National Health Service. Despite important and continuing efforts by NHS England, the reality is that we are a very long way from devoting anything like the same amount of time, energy and money to the causes of poor health as to its treatment. That cannot be done by the NHS alone and ICSs - established as equal partnerships between local government, the NHS, the voluntary, community, faith and social enterprise sector, social care providers and others - are the right vehicle to build on and reinforce existing work.
- 1.11 Faced with these challenges, but also with many inspiring examples of success, it is not surprising that throughout this review I heard such strong commitment from leaders in ICBs and ICPs, local authorities, providers and national bodies, to the core purposes of ICSs. As so many ICS leaders - both non-executive and executive - said: "This is why I applied for this job."
- 1.12 At the same time, however, I heard real concern that the transformational work of ICSs and specifically the opportunity to focus on prevention, population health and health inequalities might be treated as a 'nice to have' that must wait until the immediate pressures upon the NHS had been addressed and NHS performance recovers. That is what has always happened before, and must not happen this time.
- 1.13 Prevention, population health management and tackling health inequalities are not a distraction from the immediate priorities: indeed, they are the key to sustainable solutions to those immediate performance challenges.
- 1.14 For too long, we have talked about the challenge of moving resources upstream to enable people to live independently for as long as possible, build more resilient communities and reduce health inequalities. This is how we can sustainably tackle

the causes and not just the symptoms of an over-burdened NHS, moving away from the constant cycle of ‘winter crisis’ management. Furthermore, the partnership working that is at the heart of ICSs is, itself, an essential means to tackle those symptoms of ‘winter crisis’, including delayed ambulance arrivals, handovers and delayed discharges. These and many other challenges do not just affect one organisation; they can only be effectively tackled by many organisations working together, integrating care across the entire pathway and making the best use of available resources to achieve better, safer outcomes.

Why it can be different this time

- 1.15 Many of us have talked over many decades about the need to focus on prevention, population health and health inequalities. We have called for a shift from a top-down, centralised system of managing the NHS to a bottom-up system responsive and responsible to local communities and engaging the enthusiasm, knowledge and creativity of staff along with patients, carers and volunteers. The creation of primary care trusts (PCTs) and then clinical commissioning groups (CCGs) were attempts to do exactly that, but each was reorganised and swept away in their turn.
- 1.16 There are many reasons, however, for believing it can be different this time. There is a welcome, and almost unprecedented, degree of cross-party support for ICSs, both nationally and locally. Although we often hear the plea to “take the NHS out of politics”, that is neither possible nor desirable: in any democracy, different political parties will have different views on priorities for public spending as well as how best to fund public services. However, the extent of policy alignment now provides the basis for changes that will last well beyond one parliament, government or minister, giving ICSs the time and space to embed the new model.

“Local leaders are best placed to make decisions about their local populations... with fewer top-down national targets, missives and directives and greater transparency to help us hold the system to account.”

Rt Hon Steve Barclay, Secretary of State for Health and Social Care

“There is no alternative to health and social care integration. Stakeholders and leaders across health, social care and wider public services know that pressing forward with broad-based integrated care systems and local partnerships in 2023 is the only long-term solution to creating a financially sustainable and successful NHS and social care system; improving the population’s health and reducing health inequalities.”

Annual report of the Health Devolution Commission, an independent cross-party and cross-sector body.³

- 1.17 By establishing ICSs in statute as broad local partnerships we now have the right structures for change. But there is also a growing understanding that while structures matter, culture, leadership and behaviours matter far more. The failure to recognise that in the past is one of the main reasons why previous attempts have not worked.

"Collaborative behaviours, which are the bedrock of effective system outcomes, are not always encouraged or rewarded in a system which still relies heavily on siloed personal and organisational accountability...the current cultural environment tends to be unfriendly to the collaborative leadership needed to deliver health and social care in a changing and diverse environment...a re-balancing towards collaborative, cross-boundary accountability is a pre-requisite to better outcomes."⁴

Messenger Review

- 1.18 NHS England has itself recognised the need for change and embarked on an important and welcome transformation in its size, focus and ways of working. The insightful review of NHS leadership by General Sir Gordon Messenger and Dame Linda Pollard, and the follow-up work, will help to accelerate that change. The Messenger Review stressed that although 'command and control' is occasionally essential, the most successful organisations need collaborative leadership, good management at every level and clear accountability for defined outcomes. In a similar spirit, when establishing this review, the Secretary of State for Health and Social Care himself stressed the need to reduce 'top-down national targets, missives and directives'.

"This requires a cultural and behavioural shift towards partnership-based working; creating NHS policy, strategy, priorities and delivery solutions with national partners and with system stakeholders; and giving system leaders the agency and autonomy to identify the best way to deliver agreed priorities in their local context."

NHS England, new operating framework, October 2022

- 1.19 The Health and Care Act (2022) has decisively changed the framework of policy and structures. Previous government policies over several decades have encouraged strong sovereign organisations, using competition to drive quality and

³ [Annual Report 'ICSs: a great deal done - a great deal more to do'](#)

⁴ [Independent report by Sir Gordon Messenger and Dame Linda Pollard "Health and social care review: leadership for a collaborative and inclusive future"](#)

outcomes - most keenly seen in the establishment of foundation trusts. There is no doubt that this has brought benefits: new models of care, greater clinical innovation and the creation of strong boards.

- 1.20 In many cases, incentives have encouraged leaders to think about their organisation's interests without regard for the wider system. The new, partnership-based structures for statutory ICSs, including the statutory duty to co-operate, recognises that problem and reinforces the need to place the interests of patients and the public first. The 2022 Act also includes significant changes in the procurement framework for healthcare services, giving commissioners more flexibility when selecting providers but retaining the freedom to use competitive processes in the best interests of patients and the public.
- 1.21 Finally, millions of people are becoming increasingly active in managing and improving their own health and wellbeing, often using ever more sophisticated digital monitoring tools and apps to assist them. This can provide the basis for a very different conversation with the public - including those who are disadvantaged or discriminated against - about what we need to do for ourselves and within our families and communities, and what health and care services can be expected to do for us.

How this review can help

- 1.22 The creation of ICSs, and the new approach they represent, is the right reform at the right time. But more is needed to enable them to succeed.
- 1.23 We have created ICSs but not yet the context in which they can thrive and deliver. We have a clear choice - either do what we have done before and create something only to almost immediately undermine its purpose, or back ICSs as part of a commitment to a different model of health policy and delivery.
- 1.24 This review has given all of us working within and with ICSs the opportunity to consider what needs to be done locally and nationally to create the conditions in which ICSs can succeed.
- 1.25 Critically, all of us need to change. Local partners within every ICS need to put collaboration and cooperation at the heart of their organisations. NHS England, DHSC and CQC need to support and reflect this new model in the crucial work they do; and central government needs to change, mirroring integration within local systems with much closer collaboration between central government departments and other national bodies.
- 1.26 In the first stage of this review, we agreed that specific recommendations needed to be based upon clear principles that would command widespread support and form a touchstone for all of us to use in considering how we behave within

systems, within national organisations and in the relationships between them. Six principles emerged clearly from our discussions:

- **Collaboration:** within each system as well as between systems and national bodies. Rather than thinking about national organisations, regions, systems, places and neighbourhoods as a hierarchy, we should view each other as real partners with complementary and interdependent roles and work accordingly. Subsidiarity within each ICS is therefore vital, recognising that particularly in larger systems, much of the work will be driven by Place Partnerships, building on the work of each Health and Wellbeing Board (HWB) within the wider system, as well as by Provider Collaboratives. Different local partners - notably local government itself, as well as the VCFSE sector - have different accountability and funding arrangements. Only ICSs can create mutual accountability between all partners around jointly agreed outcomes and targets for both the long-term health of the population and for immediate issues such as discharge and tackling the backlog. On the other hand, it is also essential to recognise that, while the role of national organisations should change, some things can only be done effectively and efficiently by them. NHS England's new operating framework and its emphasis on aligned support and collaboration managed by or with the ICS rather than direct to provider organisations is therefore extremely helpful.
- **A limited number of shared priorities:** the public's immediate priorities - access to primary care, urgent and emergency care, community, mental health and social care services and elective diagnostics and treatment - are priorities for all of us including ministers, NHS England and ICBs. The level of interest in these matters rightly makes them a central part of accountability for all ICBs and their partners in the wider ICS. Evidence-based guidance and best practice examples are, of course, invaluable to local leaders; but it is essential that those local leaders have flexibility about how they apply those lessons to their particular local circumstances.
- **Give local leaders space and time to lead:** effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support and regulation over several years. Adding new targets and initiatives, providing small funding pots (often with complex rules and reporting requirements), or non-recurrent funding makes it impossible to plan or even recruit, wastes money and time, and weakens impact and accountability. Multi-year funding horizons, with proportionate reporting requirements, are essential, as is recognising that statutory ICSs are less than a year old.
- **Systems need the right support:** ICSs require bespoke support geared to the whole system and the partners within it, rather than simply to individual providers or sectors. But there is considerable variety between systems, in maturity as well as size, geography, demographics, NHS configuration and

local government structures, relationships between partners and so on. Support and intervention from NHS England to ICSs, through ICBs, needs to be proportionate: less for mature systems delivering improving results within budget; more for systems facing greater challenges or with weaker relationships and leadership.

- **Balancing freedom with accountability:** with greater freedom comes robust accountability, including for financial spending and ensuring value for money. That accountability includes the local accountability that is hard-wired into ICSs - through Health Overview and Scrutiny Committees (HOSCs), local government, ICPs, Healthwatch, foundation trust governors and many other forms of patient and public involvement. Peer review, widely used in local government, should also have a much greater role for ICSs as a whole. Within the 2022 Act, accountability for NHS performance and finances within each ICS also involves the accountability of ICBs to NHS England. But the Act also includes a new role for CQC as the independent reviewer of ICSs as a system, as well as their existing functions in relation to social care, NHS and other healthcare providers. CQC is transforming its own working methods to meet these new responsibilities. This will need to be done hand in hand with NHS England's role in overseeing systems. It will also be essential to consider the vital, but different, role of supporting ICSs, ICBs and providers with great challenges to improve, particularly where there are major failings in care.
- **Enabling timely, relevant, high-quality and transparent data:** we recognize that timely, relevant, high-quality and transparent data is essential for integration, improvement, innovation and accountability. As high performing ICSs are already showing, high quality, integrated data collection and interoperable digital systems can initiate real change. NHS England, working in collaboration with DHSC and local government (including through the Department for Levelling Up, Housing and Communities (DLUHC), the Local Government Association (LGA) and other local government representative bodies or stakeholders) has a key role to play. By defining standards on data taxonomy and interoperability, and coordinating data requests to the system, they can create the conditions for wider transformation.

1.27 In the rest of this report, I set out how these principles can be translated into action.

2. From focusing on illness to promoting health

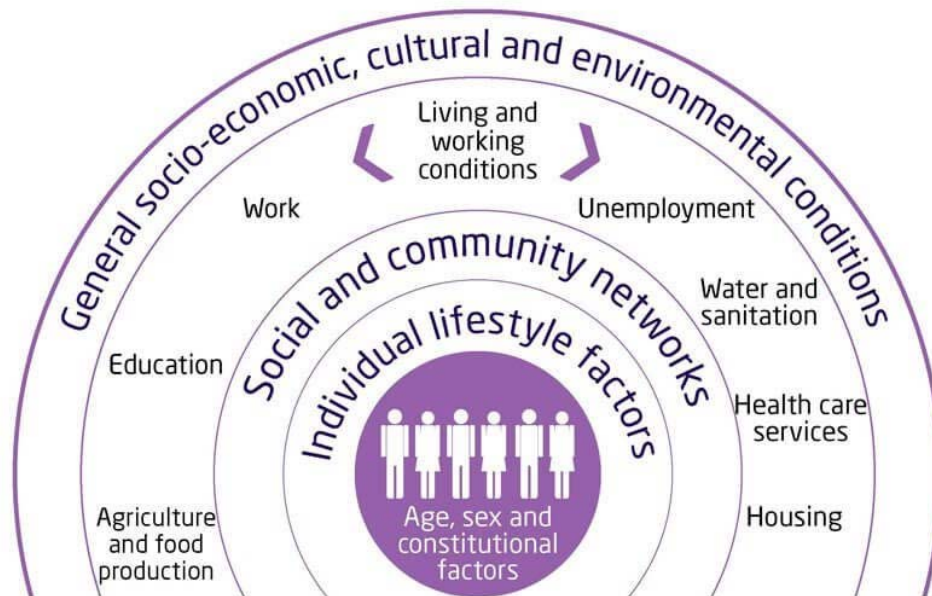
- 2.1 The review was specifically asked to look at how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending, supported by high quality and transparent data.
- 2.2 The ultimate objective of health policy is that more people live longer, healthier and happier lives. But too many of our nation's population do not live as long or as healthily as they could, with improvements in life expectancy stalled or even declining amongst some groups, and unhealthy life expectancy increasing, particularly amongst disadvantaged communities. The COVID-19 pandemic starkly highlighted the human cost of health inequalities, with the mortality rates from COVID-19 in the most deprived areas being more than double those in the least deprived areas and death rates being highest among people of Black and Asian ethnic groups.⁵
- 2.3 In England today, there is a 19-year gap in healthy life expectancy between people in the most and least deprived areas of the country.⁶ Those health inequalities, so damaging to the lives of individuals and their families, also impact on our society as a whole.
- 2.4 Both the Marmot review and the Dame Carol Black review highlighted the huge economic costs of failing to act on the wider determinants of health (see below for an illustration of the wider determinants of health).⁷ Even before COVID-19, health inequalities were estimated to cost the NHS an extra £4.8 billion a year, society around £31 billion in lost productivity, and between £20 to 32 billion a year in lost tax revenue and benefit payments.⁸

⁵ Public Health England. COVID-19: review of disparities in risks and outcomes. 2 June 2020

⁶ Tabor, D. (2021) Health State Life Expectancies, UK: 2017 to 2019, Health state life expectancies, UK - Office for National Statistics. Office for National Statistics.

⁷ Dahlgren, G. and Whitehead, M. (1993) [Tackling inequalities in health: what can we learn from what has been tried?](#)

⁸ Public Health England. (March 2021) 'Inclusion and sustainable economies: leaving no one behind.'



- 2.5 For too long, however, we have mistaken NHS policy for healthcare policy. In reality, the care and treatment provided by the NHS, vital and often life-saving though it is, only accounts for a relatively small part of each individual's health and wellbeing. Significantly more important are the wider determinants of health. In many parts of the country, partnerships led by local government, the VCFSE sector and residents themselves have been working over many years to create healthier, more resilient communities, often with strong engagement from NHS primary care. The response to the pandemic brought communities, statutory and voluntary partners together to support people in many inspiring ways.
- 2.6 The creation of integrated care systems (ICSs), with their 4 purposes and a strong statutory framework for partnership working, provides a real opportunity to build upon this approach and suggests a welcome recognition of the need for a more holistic approach to improving the nation's health.
- 2.7 Indeed, ICS leaders are enthusiastic about maximising the contribution of the NHS to wider economic, social and environmental objectives. From economic regeneration to life sciences, from net zero to local labour markets, the NHS has a crucial role to play in creating thriving places.
- 2.8 Designing and creating services together with local residents and communities leads to more actively engaged citizens, able to lead and support change within their own lives, with a corresponding reduction in reliance on public services.
- 2.9 The Wigan Deal - an informal agreement between the council and everyone who lives or works there to work together to create a better borough - is an excellent example of this. In Wigan, the council invested £13 million in a Community

Investment Fund which funded bottom-up prevention ideas from local communities that supported physical activity, addressed social isolation and loneliness and promoted positive mental health. As a result of this sustained approach healthy life expectancy in Wigan bucked the trend and an additional 7 years was added in the most deprived wards.⁹

- 2.10 Similarly, through PCNs and Integrated Neighbourhood Teams, primary care can play an important leadership role in working with local communities to tackle health inequalities. In Tameside, Greater Manchester, Healthy Hyde PCN employs 34 people across many different disciplines, all working to tackle health inequalities. It has 6 health and wellbeing coaches working in foodbanks, schools, allotments, and providing ESOL lessons to asylum seekers and refugees. The team has clinical leadership, managerial and administrative support, and works together to identify people via clinical systems, local knowledge and working with multiple agencies.
- 2.11 However, empowering local leaders to work with and through their partners and local communities to improve outcomes for their populations can only happen at scale if the broader environment in which they operate is aligned to enable them to do so - something that is heavily dependent on policies pursued across government.
- 2.12 Particularly in view of the fourth core purpose of ICSs, to help the NHS support broader social and economic development, all parts of Whitehall should feel they have a stake in the work of Partnerships and Places and should equally strive to replicate the same sense of partnership being forged across the country in ICSs.

Enabling a shift to upstream investment in preventative services and interventions

- 2.13 There will never be a perfect time to shift the dial toward focusing more on preventative services and interventions. It is easy to argue - especially in the current climate of financial constraints and performance issues - that addressing these issues should be something we consider when the current pressures have died down. But that has always been the case.
- 2.14 The truth is, unless we make the change, the continual focus on improving flow through acute hospitals will simply channel more and more of an older and increasingly unhealthy population into acute hospitals, which will never be large or efficient enough to cope.

⁹ Source: Professor Donna Hall, CBE Chair New Local, Former CEO Wigan Council; and Wigan CCG, ICS Transformation Advisor NHS England, January 2023

- 2.15 Despite the current pressures, I have also seen through the course of this review a greater appetite to grasp the challenge of shifting our focus to prevention, proactive population health management and tackling health inequalities than at any other time I can remember. It acts as the glue that binds all partners in ICSs. There are many things we can do now - both nationally and at system level - to create the collective conditions for us to capitalise on this.
- 2.16 In order to achieve a decisive shift 'upstream', towards prevention, proactive population health management and tackling health inequalities, we need to establish a baseline of current investment in prevention, broadly defined, within each ICS from which progress can be measured. This baseline would include the £200 million allocated nationally towards tackling health inequalities. This must also be done in a way that enables ICSs to be benchmarked against each other, helping to spread best practice and strengthen both local and national accountability.
- 2.17 We also need a clear and agreed framework for what we mean by 'prevention', broadly defined. We all recognise that 'prevention' involves a range of activity including primary, secondary and tertiary prevention, much of it carried out by local government and VCFSE partners as well as within the NHS itself. Furthermore, much 'prevention' work is embedded within other services that are also directly concerned with treatment. DHSC should establish a working group of local government, public health leaders, DHSC (including OHID), NHS England, as well as leaders from a range of ICSs, to agree a straightforward and easily understood framework. As part of this work, the group should consider the guidance to local government on the use of the public health grant.
- 2.18 Once this agreed framework is developed, ICSs should establish and publish their baseline investment in prevention. This should be delivered through the ICP and include both NHS and local government spending on prevention. Especially within larger ICSs, it will also be important to establish the baseline at place level; indeed the ICS view might be built up from place level. Different ICSs will approach baselining in different ways; what matters is that it is done in all systems using a consistent framework.
- 2.19 By autumn 2023, we should expect the framework to be completed, with all ICSs reporting their prevention investment on a consistent basis by 1 April 2024. Both the initial framework, and the baseline measures, should be reported to and considered by the proposed cross-government arrangements on health improvement I outline below.
- 2.20 Finally, the government, NHS England and ICS partners, through their ICP, should commit to the aim of increasing resources going to prevention. In particular, I recommend the share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. Given the constraints on

the nation's finances, this is my most challenging recommendation; some ICSs will find it more difficult than others, depending on their current financial position as well as the strength of collaboration and common purpose between partners. But an ambition of this kind is essential if we are to avoid simply another round of rhetorical commitment to prevention.

2.21 As public finances allow, the public health grant to local authorities needs to be increased. The most recent government spending review represents the latest in 8 years of real-term squeeze on local authority funding for public health and other essential services. Investment in prevention and early help is essential if we are going to extend healthy life expectancy, reducing the financial burden to health and social care and strengthening local economies.

2.22 In addition, within the NHS itself, every opportunity should also be taken to refocus clinical pathways towards prevention. At the moment, pathways for different conditions often begin with diagnosis and focus on treatment. Instead we must shift the focus and resources towards preventing the condition occurring, diagnosing early and preventing avoidable exacerbation. I welcome the announcement of a major conditions strategy which seeks to address this issue. I also support the recommendation of the recent Health and Social Care Select Committee (HSCC) inquiry into the autonomy and accountability of ICSs that '... the major conditions strategy [should] put prevention and long-term transformation at its heart'. The prevention work done in secondary and tertiary care settings, rightly highlighted by NHS England as receiving increased priority and investment in recent years, must be seen within the wider work of an ICS on prevention. An example of this in action is the work being done under the Core20PLUS5 framework focusing on COPD, which has led to a reduction in unplanned respiratory admissions.¹⁰ Refocusing clinical pathways on prevention will be supported by my points set out below on primary care, which has a particularly important role in embedding prevention.

2.23 ICS leaders should also challenge themselves - and expect to be challenged - to work together to use existing resources as effectively as possible. The Joint Forward Plans (JFPs) that ICBs have been asked to prepare by 30 June 2023, reflecting the system-wide priorities established through the ICP's integrated care strategy, provide an opportunity for ICSs to set out their ambitions to shift the model of care towards prevention. The process for developing JFPs has been underpinned by a much more permissive and collaborative approach from NHS England, compared with previous CCG planning exercises. The collaborative work on the 2024 to 2025 planning guidance provides another opportunity to agree how a further shift on prevention should be achieved, year on year.

¹⁰ [Core20PLUS5 \(adults\) - an approach to reducing healthcare inequalities](#)

Embedding health promotion at every stage

- 2.24 There is currently no cross-government, national equivalent of the wide partnership involved in an ICS. To enable successful integration in systems, parallel integration across Whitehall is needed. I recommend that the government leads and convenes a national mission for health improvement designed to change the national conversation about health, shifting the focus from simply treating illness to promoting health and wellbeing and supporting the public to be active partners in their own health. To underline its importance, this could be led personally by the prime minister.
- 2.25 This new mission should be supported by appropriate cross-government arrangements, possibly including a revived Cabinet Committee that includes a senior minister from all relevant departments, as well as DHSC's Office for Health Improvement and Disparities, NHS England and the new Office for Local Government. An early priority should be the creation of a National Health Improvement Strategy, identifying priority areas and actions. I also support the HSCC's recommendation that DHSC should publish, as soon as possible, the proposed shared outcomes framework. This work should develop a small set of clear, high-level national goals for population health, with appropriate timescales and milestones for action. I would expect the government to consider how this framework could be used to consolidate current existing, fragmented outcomes frameworks to enable an aligned set of priorities across health and care.
- 2.26 These priorities should then be taken into account when setting the mandate for the NHS as well as developing NHS planning guidance and other material for systems.
- 2.27 It is not for this review to prescribe what this framework would look like, such a framework needs to be developed in collaboration with ICB and ICP leaders, as well as leaders from across the NHS, local government, social care providers and the VCFSE sector. It is vital that there is also full engagement and involvement with the public, patients, service users and carers (including unpaid carers), building upon the important work of Healthwatch, the Patients Association and many other patient and user advocacy groups. We should also learn from international examples, including the Australian Health Performance Framework which reports on the health of Australians, the performance of healthcare and the Australian health system, including health behaviours, socioeconomic factors and wellbeing as well as the safety, accessibility and quality of services. It provides an impressive, interactive online tool that allows the public to obtain information at national, state and local level, disaggregated by demographic and other factors.¹¹

¹¹ [The Australian Health Performance Framework \(AHPF\)](#) is a tool for reporting on the health of Australians, the performance of health care in Australia and the Australian health system

- 2.28 The NHS Assembly, established by NHS England in 2019, brings together a wide range of partners from within and beyond the NHS, providing an invaluable private forum for advice and challenge to NHS England itself. This should continue and will be complemented by the new arrangements proposed below.
- 2.29 However, in view of the establishment of statutory ICSs, there is also a clear need for government to have an appropriate forum to engage with integrated care partnerships (ICPs) - the convenors of ICSs as a whole - more widely. This would provide the opportunity for a 2-way exchange between ICP leaders and the relevant government departments and agencies, allowing ICP chairs to raise matters of priority directly with ministers and officials. I therefore recommend that a national ICP Forum is established. This could be convened by government itself, if my recommendation is accepted, or alternatively by the ICS Network and the Local Government Association together. It should include representation from DHSC, DLUHC (including the Office for Local Government) and, in the context of the National Health Improvement mission, the Cabinet Office as well as NHS England.
- 2.30 To support the shift to a new focus on prevention, population health and health inequalities, I also recommend that the government establish a Health, Wellbeing and Care Assembly, with a membership that mirrors the full range of partners within ICSs, including local government, social care providers and the VCFSE sector as well as the NHS itself. It would also be helpful for the Assembly to be supported by a secretariat drawn from OHID and the Office for Local Government as well as DHSC and NHS England.

ICSs role in embedding population health management

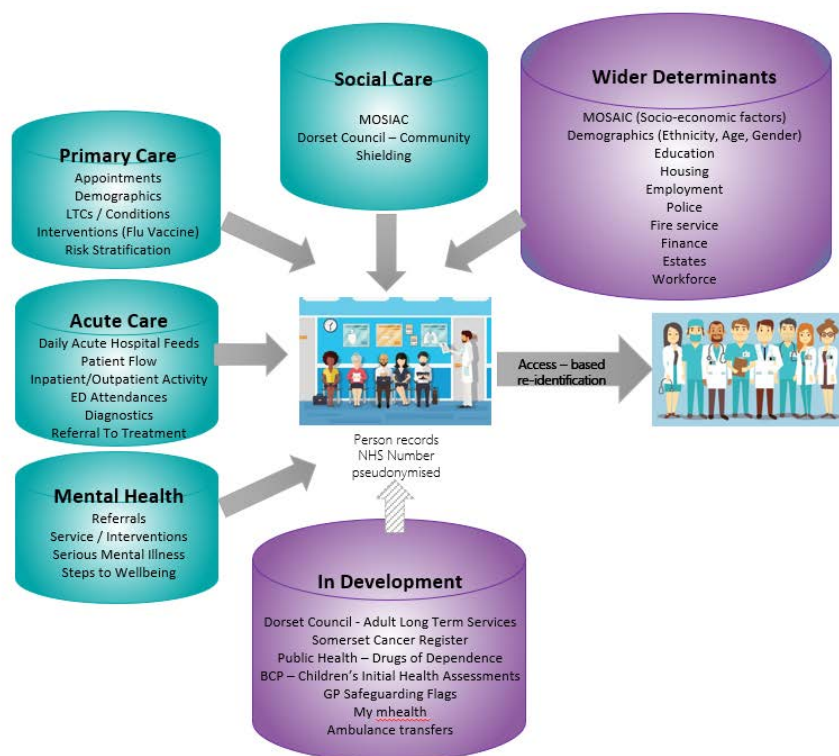
- 2.31 Improving population health and tackling health inequalities is a complex task. While public health leaders and other experts in the field play an important role, to affect change in all parts of the system requires awareness, knowledge and skills at all levels. Population health, prevention and health inequalities should also 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 themselves have the opportunity for health and social care professionals to learn from local communities, including VCFSE groups working with disadvantaged and marginalised groups, as West Yorkshire Health and Care Partnership is doing with its health inequalities academy and Cumbria and South Lancashire with their population health and equity academy.
- 2.32 Giving every child the best start in life, from pregnancy through to late adolescence, is crucial to reducing health inequalities across the life course. Starting with antenatal care, the first 1001 days provide a vital opportunity to support the health and wellbeing of the whole family. Barnardo's and the Institute

of Health Equity, are partnering to shape the way ICSs improve health and address health inequalities among children and young people. In several parts of the country, local government with responsibility for children's services has led the way in establishing a Strategic Alliance for Children and Young People that brings together all the relevant NHS, education, VCFSE, childcare and other services, partnering with parents and young people themselves to create the most effective and integrated support. Every ICS should ensure that both their ICP's integrated care strategy, and through it their ICB Joint Forward Plan, include a clear articulation of the needs of children and young people within their population, and how those needs will be met through collaboration across the system.

Role of data and digital tools to support the prevention of ill health

- 2.33 Shifting more of the focus onto prevention - underpinned by whole-system alignment on policy and funding - will radically improve our ability to do much more to tackle the determinants of poor health, with all of the associated health and economic benefits I have described.
- 2.34 That shift will be more impactful if we enable ICSs to connect data from multiple sources - while, of course, ensuring there are strong safeguards in place for individual privacy and confidentiality. This would transform their ability to accelerate their work around a whole suite of activity including improving individual care and outcomes; improving population health and wellbeing; tackling health inequalities; improving the wellbeing and engagement of staff; and, significantly, improving the productivity of the health and care system.
- 2.35 Many ICSs and partnerships within them are integrating data from multiple sources as the basis for integrated care and proactive population health management. Dorset ICS, for instance, has worked with its residents and partner organisations to establish a live linked data set, pulling in data from multiple sources, and using it as the basis for screening their fast-growing over-65's population, including for those at high risk of falls, and as a result significantly reducing the number of emergency hospital admissions. Norfolk and Waveney ICS has built on its award-winning COVID Protect approach, establishing Protect NOW, a GP-led collaboration that uses data analytics and risk stratification to

identify people at risk of undiagnosed or poorly managed Type 2 diabetes to improve patient engagement, care and outcomes.



*Dorset Integrated Care System*¹²

- 2.36 The North East and North Cumbria ICS is successfully joining up healthcare and social care data, using the OPTICA software, to streamline and simplify processes to effectively support discharge. Staff are using it as the single version of truth in hospital and community settings to help them understand where patients are in the discharge process, highlight blockages and provide actionable intelligence through comprehensive patient tracking and reporting modules. These and many other examples of excellent practice should be used both to support improvement and transformation across all systems and to contribute to work within DHSC and NHS England on wider policy development.
- 2.37 ICSs and NHS England need to work together to create a single view of population and personal health. To deliver this there needs to be a strong working partnership between ICSs, NHS England, local government, providers, and the VCFSE sector, which will enable systems and organisations locally to collect and utilise high-quality data. A strong partnership between different organisations locally and nationally will be vital for its success.
- 2.38 We welcome the proposed data framework for adult social care outlined in Care Data Matters, setting out what data the sector needs to collect, the purpose of

¹² Dorset ICS’s presentation on a population health management approach to place-based care delivery

those collections and the standard to which it is collected. Adult social care providers should be fully involved in finalising the new framework, reflecting the diversity of the sector, and including those who are already making transformational use of digital and data tools as well as those for whom digitisation will be more challenging. DHSC should work collaboratively with the provider sector, alongside local authorities and other ICS partners to develop the framework, which will set out how we will improve the quality of data and rationalise collections so that we minimise the collection burden.

- 2.39 Further, building on the Care Data Matters Strategy, I recommend that NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers, particularly focusing on GP practices, social care provision and VCFSEs providing health and care services (who will need additional support in this work).
- 2.40 I also recommend DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the Data Saves Lives Strategy (2022). This reform, already agreed in principle, is essential to allow local authorities and the local NHS jointly to plan and deliver support by accessing appropriate patient information.
- 2.41 The Shared Care Record (ShCR), now established in all ICSs, should be a priority for further development. To support care that is integrated around individuals, there is an urgent need to enable social care providers, VCFSE providers of community and mental health services and local authorities to access the ShCR on an equal basis with NHS partners. As soon as possible, the ShCR should enable individuals (and their carers where appropriate) to access as much as possible of their own data and allow them to add information about their own health and wellbeing. Finally, the ShCR should expand beyond individual ICSs to support people being treated by a provider in a different system or needing care elsewhere in the country.
- 2.42 As part of the development of shared care records and EPRs, patients should be able to access their hospital as well as their GP record, for instance updating information held on the NHS Spine, checking where they are on an elective waiting list and removing themselves if they have already had their diagnostic test or procedure and so on.
- 2.43 NHS England has a crucial role in supporting ICSs, particularly smaller systems, with vendor management of large suppliers (including vendors of population health systems) relationships with industry and ensuring supplier accountability for building systems that conform to NHS - and wider ICS - standards including compliant reporting and interoperability with other key national systems including

the Spine. National user-groups should be established with strategic suppliers to leverage and aggregate demand, coordinate any need for changes, and ensure compliance. As part of the national framework, trusts need to adhere to international standards and the data dictionary for nationally mandated metrics and data submissions and ensure coding rules are not open to local interpretation.

- 2.44 There is a shortage of skilled professionals, including those who are expert at the cultural change that underpins digital transformation. In line with its new operating model, NHS England should therefore develop in-house skilled teams who can be embedded within a provider or system to train front-line staff and grow the new local capability needed to ensure successful digital and data-driven transformation.
- 2.45 The Data Alliance and Partnership Board, within the Transformation Directorate of NHS England, has a central role in the development of NHS digitisation and will therefore have a significant impact upon the ability of ICSs to succeed. As an immediate measure, I recommend NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Board. The aim should then be to develop the Board into an Integrated Data Alliance and Partnership Board, creating a national equivalent of the ICS partnership itself. Both are essential to ensure that integration and the vital shift of effort and resources described in this chapter are not held back by an NHS-dominated view of the world.
- 2.46 Public support and trust for this approach is essential - without it the real transformation opportunities on offer by digital and data will not be fully realised. It is vital that national and local systems work with and engage the public continually to ensure that we can have a data-literate population that we can draw upon.

Empowering the public to manage their health

- 2.47 The democratisation and personalisation of data and digital tools has created a population that both expects and is able to use digital tools and data to support their health and manage their care and treatment. Equally, the effort to improve the nation's health can only succeed if we support people to become active and engaged partners in their own health, wellbeing and care.
- 2.48 Most people rely on increasingly sophisticated digital devices to support almost every aspect of their lives.
- 2.49 The nhs.uk website is the UK's biggest health website, with an average 23 million visits a week and the NHS app is a world leading solution in the hands of over 31 million people in England - nearly 7 in 10 of the adult population. But the public can also tap into multiple sources of information and advice, of varying quality,

reliability and cost, and use increasingly sophisticated wearable and other devices to monitor and support their own health and wellbeing. Increasingly, health and care are 'high tech' as well as 'high touch'.

- 2.50 At the same time, it is vital to recognise that many NHS patients and social care clients are amongst those least able to use digital solutions, whether because of frailty, economic disadvantage, language issues or physical, cognitive or other disabilities (including dementia). Their voice needs to be heard, within ICSs and nationally, to ensure that the design of digital and data solutions is as inclusive as possible. It is also vital for ICSs to provide digital support to people who cannot self-serve. From a high street pharmacy helping someone into a digital consultation booth and putting digital monitors on them for their remote outpatient consultation, to a dementia day centre supporting a carer to do a digital medicines assessment, digital patient engagement won't be real until it works for the NHS's most vulnerable users.
- 2.51 The response to COVID-19 rapidly accelerated digitisation, particularly in the NHS. The pandemic tapped into a deep sense of civic duty amongst millions of people who were willing to share data through real-time tracking systems in order to reduce the spread of the virus; to report their health status daily as 'citizen scientists', enabling faster identification of significant symptoms, the spread of the virus and new variants; and to participate in fast, large-scale and often world-leading clinical research trials to establish the most effective forms of treatment.
- 2.52 I therefore recommend that, building on the existing work of NHS England, 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. The NHS App is itself an open architecture, with 2 components already being open source. Extending this approach would allow innovators - including those with lived experience - to develop solutions to meet the needs of different communities, whether parents of a child with learning disabilities, adults supporting a parent with dementia or people whose first language is not English and so on. A national user group should be established for the NHS App, including people with lived experience and VCFSE groups supporting marginalized or overlooked groups, to ensure public involvement in future developments. With several ICSs developing 'carers' passports', an electronic version within the app would also be invaluable.
- 2.53 I also recommend that the government should set a longer-term ambition of establishing Citizen Health Accounts. This should be done by requiring all health and care providers (whether NHS or local authority funded or otherwise) to publish the relevant data they hold on an individual into an account that sits outside the various health and care IT systems and is owned and operated by citizens themselves. This should go further than just EPR data and should become a mechanism to enable people proactively to manage their own health and care.

Such a Citizen Health Account would need to be linked into the NHS app functionality and should receive information from sources such as NICE; it could also be a gateway into clinical trials and improving health outcomes. Digital tools and Apps can play a vital role in enabling ICSs to improve population health outcomes, a point emphasised in my terms of reference. A practical next step would be to trial this proposed approach in a limited format working with the NHS app team and suitable third-party vendors under the oversight of an appropriately recruited citizens' panel.

Chapter 2: recommendations

1. The share of total NHS budgets at ICS level going towards prevention should be increased by at least 1% over the next 5 years. To deliver this the following enablers are required:

a) DHSC establish a working group of local government, public health leaders, OHID, NHS England and DHSC, as well as leaders from arrange of ICSs, to agree a straightforward and easily understood framework for broadly defining what we mean by prevention.

b) Following an agreed framework ICSs establish and publish their baseline of investment in prevention.

2. That the government leads and convenes a national mission for health improvement. I also support the Health and Social Care Select Committee's recommendation that DHSC should publish, as soon as possible, the proposed shared outcomes framework.

3. That a national Integrated Care Partnership Forum is established.

4. The government establish a Health, Wellbeing and Care Assembly.

5. That NHS England, DHSC and ICSs work together to develop a minimum data sharing standards framework to be adopted by all ICSs in order to improve interoperability and data sharing across organisational barriers.

6. DHSC should, this year, implement the proposed reform of Control of Patient Information regulations, building on the successful change during the pandemic and set out in the *Data Saves Lives Strategy (2022)*.

7. NHS England should invite ICSs to identify appropriate digital and data leaders from within ICSs - including from local government, social care providers and the VCFSE provider sector - to join the Data Alliance and Partnership Board.

8. Building on the existing work of NHS England, 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.

3. Delivering on the promise of systems

- 3.1 The recommendation to place ICSs on a statutory footing was made following NHS England's engagement and then formal consultation with system leaders, partners and stakeholders, following a period of co-production and engagement in policy development that was widely welcomed. In making that recommendation, DHSC, NHS England and local government representatives all acknowledged that to deliver on the ambition for ICSs, the role of national government and national bodies, and the approach to oversight, assessment and performance management across the health and care system would also need to change.
- 3.2 I cannot emphasise too strongly the scale of the transformation involved in the establishment of statutory ICSs. Because ICSs are partnerships between all those involved in health, wellbeing and care, we can shift the dial on today's immediate and urgent problems, bringing people together to work in different ways. By doing so, we start to create a new virtuous circle of supporting health and wellbeing, and in the process reduce the pressures on NHS emergency care.
- 3.3 But the creation of ICSs also requires clarity about where accountability sits. Every partner and sector within an ICS operates within its own financial, regulatory and accountability framework, whether that is local government, a VCFSE organisation, a social care provider, or an individual NHS provider. ICBs and ICPs should - and in many instances already do - create the environment to support 'mutual' or 'collective' accountability: where system partners can, with mutual respect and transparency, support and challenge each other to deliver priorities they have agreed together, irrespective of where their statutory accountability sits. That local accountability can and should be strengthened in the ways described in this chapter.
- 3.4 The NHS, in particular, sits within a framework of national regulation and accountability that is already changing. The new and welcome NHS England operating framework reflects the move to system-based working, with NHS England expecting ICBs to identify the local shared priorities that sit alongside national NHS commitments and to play a key role in the support and oversight of NHS providers.
- 3.5 The framework also sets out further changes to NHS England's structure and operating model including the behaviours and values expected of all those within the NHS, with a 'One Team' philosophy and a clear expectation around behaviours - collaborative, trusting and empowering, transparent and honest, inclusive and diverse. Within each ICS, as part of their development, partners are working together to agree the values and behaviours for which they will hold themselves accountable; not surprisingly, they bear a striking resemblance in spirit, if not exact words, to those of the NHS England framework.

- 3.6 The need for faster, and in some cases further, change in the whole framework of oversight and accountability of the NHS itself and ICSs more widely, was a strong theme in my discussions throughout the review.
- 3.7 Although much of the following analysis and recommendations involve the NHS, this is not because I (or ICS leaders generally) believe the NHS is or should be the dominant partner in the new model. I believe quite the reverse. Instead, it simply reflects the fact that the necessary national oversight and accountability of the NHS needs to respect and allow space for local accountability within the whole ICS.
- 3.8 Integrated care boards (ICBs) have a particular position within this wider framework. They are a key partner within the wider integrated care system; with local government, they establish the integrated care partnership (ICP) that brings all partners in the system together to produce the integrated care strategy. As NHS statutory bodies, they have a statutory responsibility for arranging for the provision of health services for their residents; they take the lead in ensuring that all parts of the local NHS work together with each other and with social care and other partners; and they are accountable for the overall performance and finances of the local NHS.
- 3.9 They are simultaneously part of the 'one system' of an ICS while needing to see themselves - and be seen and treated as - part of the 'one NHS' team. Because ICBs are accountable for around £108 billion of the £150 billion made available annually by parliament for the NHS and for the performance of the local NHS, the need for accountability from the ICB to NHS England, and through NHS England to government, for NHS finances and performance is not in doubt.¹³ But the mechanisms for accountability need to be both effective in themselves and also proportionate so that ICB leaders have the space and time to be effective partners and leaders within the wider ICS. The improvement-focused work of NHS England with ICBs needs to take full account of the need for ICBs to be 'great partners' within their ICS and not simply within the NHS itself (see below).
- 3.10 Where an organisation has a clear responsibility for most or all of an issue and controls the resources to deal with it, accountability sits with them. Many issues are matters for the NHS partners in a system rather than a single organisation and one of the benefits of ICBs taking statutory form is that they can provide clear accountability 'upwards' to NHS England and the government for delivery of those things that are national must-dos and which are wholly or largely the responsibility

¹³ Data refers to CCG and NHS England spending for 2021 to 2022 financial year - [NHS Commissioning Board Annual Report and Accounts 2021 to 2022 financial year - for the period 1 April 2021 to 31 March 2022 \(england.nhs.uk\)](#) - to note £108 billion is the amount which ICBs were formally allocated in 22/23 the actual amount ICBs are responsible for is likely to be greater when considering funding streams from delegation or other one off in year funding packets.

of the NHS. It will be important to maintain clarity of accountability on these matters.

- 3.11 NHS England and the DHSC will continue to focus on the capability of the ICB and the effectiveness of all NHS partners, including the ICB, in ensuring clear accountability for NHS performance. The new role of CQC in relation to ICSs (see below) will include an assessment of how strong the mutual accountability between partners is within a system.

Approach

- 3.12 Conversations with system leaders towards the start of this review often focused on the need to reduce the top-down management of the NHS that reflects decades of hierarchical NHS management, a culture that NHS England's leaders are already changing. My recommendations build on, and are designed to deepen and entrench, their new approach. As the review progressed, however, the conversation moved from a negative view of autonomy ('freedom from') to a positive vision of self-improving systems ('freedom to') where partners work together, motivated by the common purpose of using the resources available to our communities to achieve the best possible outcomes.
- 3.13 It also became clear that the principle of subsidiarity must be embedded as part of this, enabling local leaders to make decisions at a level as close as possible to the communities that they affect.
- 3.14 In this chapter therefore, I set out the conclusions and recommendations I have reached from this review, starting with the need to work on the basis of subsidiarity, through strong, empowered Place Partnerships and neighbourhood teams.

Place

- 3.15 All ICSs are expected to define a clear role for 'place' level partnerships. As emphasised earlier, however, ICSs vary considerably in size and architecture, with corresponding differences in what 'place' means. At one end of the spectrum, there is a system covering around 750,000 people with a single upper tier local authority and one Health and Wellbeing Board. At the other end, there is a system covering over 3 million people, the ICS includes 13 places, 12 of which align with its own local authority area and Health and Wellbeing Board.
- 3.16 Although part of the impetus for this review came from concerns about top-down management of ICSs and the need for a new balance between greater autonomy and robust accountability, it is just as important that the principle of collaboration and subsidiarity is lived within systems themselves - and that the partnership

working and integration that is already delivering results locally is supported by further changes in the national framework.

- 3.17 In many ICSs, place partnerships, aligned with Health and Wellbeing Boards and building on their work over many years, will lead much of the work to transform local services and models of care, support population health and tackle health inequalities.
- 3.18 Some providers, however, report that they are finding it difficult to navigate between different versions of 'place' in different systems. While 'place' cannot and should not be defined by the DHSC or NHS England, it should be agreed by partners at system level so that there is visible and accountable leadership at place, underpinned by an integrated governance structure. place-based leaders must be enabled to feed directly into system-wide conversations, plans and funding arrangements. Where provider trusts and foundation trusts provide services within different places or systems, there needs to be close collaboration between providers, place, and system leaders to ensure the best outcomes for residents. As every system establishes its place governance and leadership, taking into account relationships with different providers, this information should be transparent and accessible for their communities.
- 3.19 The same 'can do' culture described in the operating framework should equally apply to ICSs' relationship with their place partnerships and provider collaboratives. Indeed, we have seen examples through the course of this review where place partnerships are still 'looking up' to the ICB for permission and instructions instead of 'looking out' to the communities and neighbourhoods they serve. More mature systems are supporting their Place partnerships and provider collaboratives to drive initiatives and define their own priorities within the guardrails of the mutually agreed strategy of the ICB and ICP: this needs to rapidly become the norm across all ICSs.
- 3.20 In several systems, strong and mature provider collaboratives are an important engine of improvement and transformation. Collaboratives can bring together providers to improve access and reduce wait times, share best practice, staff and resources, and help overcome organisational barriers which can sometimes stop services being designed and delivered around the needs of patients and communities. While provider collaboratives, like ICBs, vary considerably in maturity and strength, they have the potential to become the core NHS delivery arm for achieving key system objectives. ICBs have an important role in convening, supporting and resourcing the development of effective collaboratives to help drive service transformation, increase provider resilience and embed a culture of collaboration across providers. It is also important for the relationship between provider collaboratives and the ICB to be clear within each system, with consistency between system objectives and the priorities of its constituent collaboratives.

Embedding a balance of perspectives

- 3.21 We have heard frustrations from a range of stakeholders at the limited number of mandated members of an ICB. Many feel it is impossible to have their voices heard if they do not have a seat at the table and that ICBs seem to be largely constituted from parts of the NHS rather than across the wider system; this is particularly felt by social care providers and public health leaders within local government.
- 3.22 It is important to remember that the 2022 Act created statutory ICSs with 2 separate, complementary bodies: an ICP bringing together the full range of partners through a statutory committee jointly created by the relevant upper-tier local authorities and the NHS, with members drawn from many other organisations and sectors; and an ICB, which is a statutory NHS body accountable for NHS performance and finances.
- 3.23 Given the variation in ICS constitution and size it was absolutely right that the government chose to be legislatively permissive. It was important to allow ICSs to create the architecture and governance for their ICP and ICB that enabled them best to serve their population. But as ICSs come towards the end of their first year as statutory entities, there is a valuable opportunity for them to learn from each other as well as from their own experience and adapt accordingly.
- 3.24 Crucially, regardless of membership, collaboration within an ICS should stretch wider than just those who are members of ICB boards. Wider partners, including social care providers, the VCFSE sector, and the independent healthcare sector should be fully engaged and their contribution better understood within the NHS.
- 3.25 However, I have heard a compelling case that social care providers should have a strong voice in every ICS. I agree, although reflecting the general principle of avoiding top-down directions, I believe that each system should decide how best that is done. Similarly, 20 of the 42 ICB constitutions do not specifically mention a role for public health. While public health is and should remain a crucial role of local government and may have been included through the recruitment of partner members on ICB boards, systems should also consider whether this expertise needs to be better embedded within their structures.
- 3.26 ICBs have been asked by NHS England to review their governance arrangements over the coming months, after their first year of operation. Each ICB should be encouraged to use this process (as many plan to do in any case) as an opportunity to engage with all system partners to consider how the ICB is operating within the overall ICS architecture. Many ICSs are using a process of self-assessment and mutual peer review to support their own self-development; this process should be actively encouraged while not forming part of any formal assessment. Within the governance review and its own self-assessment, each ICS should consider

whether it needs to do more to ensure that social care providers are involved in planning and decision making, that public health expertise is being effectively deployed within the system.

Local accountability and priority setting

- 3.27 Just as the care and treatment of individuals must be based on ‘no decision about me without me’, so local communities must be involved through a continual process of engagement, consultation and co-production in design and decision-making about local services. Strong and visible local accountability, recognising the principle of subsidiarity, also plays an important role in promoting legitimacy with the local population through empowering, accountable and transparent decision-making.
- 3.28 In many ways, local accountability is hard-wired into ICSs - through ICPs themselves as well as Health and Wellbeing Boards, Health Overview and Scrutiny Committees, Healthwatch, foundation trust governors and many other forms of patient and public involvement in system, place, provider and neighbourhood working. Health and Wellbeing Boards enable local councillors, alongside other partners, to set place-based priorities for improving health and wellbeing outcomes, to agree joint strategic needs assessments and health and wellbeing strategies for their residents. Where local government, healthcare and system boundaries do not coincide, it is particularly important that all concerned collaborate in the best interests of residents.
- 3.29 HOSCs are another important part of the local accountability framework, allowing councillors to scrutinise significant changes or issues in health and care provision and hold local NHS leaders to account. Although (like ICSs themselves) they may vary somewhat in effectiveness and maturity, it is important to the success of ICSs that they provide effective, proportionate scrutiny. In Greater Manchester, the HOSCs in all 10 unitary councils have already delegated this role of system oversight to a Joint Health Overview and Scrutiny Committee; a similar approach could be adopted in other equivalent systems. I therefore recommend recognising HOSCs (and, where agreed, Joint HOSCs) as having an explicit role as System Overview and Scrutiny Committees. DHSC should work with local government - through the LGA, the Office for Local Government and the Centre for Governance and Scrutiny - to develop a renewed support offer to HOSCs and to provide support to ICSs where needed in this respect. In assessing the maturity of ICSs, CQC should consider the effectiveness of system oversight provided by HOSCs or Joint HOSCs, or both.
- 3.30 In line with its statutory responsibilities, every ICS, through its ICP, has already developed an integrated care strategy, informed by Health and Wellbeing Board priorities (themselves reflecting their system JSNA) and co-developed by the ICP

ensuring engagement and involvement with those with lived experience, the wider local population, different tiers of local government and locally elected leaders, including elected mayors.

- 3.31 In response to the clearly expressed wishes of local leaders, I recommend that 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 should be co-developed with place leaders and adaptable to complement place level priorities, and should be a natural extension of the ICP health and care strategy. These priorities should be treated with equal weight to national targets and should span across health and social care.
- 3.32 A mechanism for achieving this recommendation lies with the Joint Forward Plans. NHS England has asked ICBs in their JFPs to reflect local priorities agreed with their ICS partners, ensuring these have equal weight alongside national NHS commitments. Building on the integrated care strategy developed by the ICP, the JFP should describe the outcomes the ICS is aiming to achieve. This should include short, medium and longer-term measures that will be used to track progress as well as how different partners will contribute to these and how they will hold each other to account for doing so.
- 3.33 NHS England itself consulted with local government and other colleagues to develop the guidance for JFPs; as noted earlier, this was very different in tone and approach from earlier, pre-COVID approaches to local NHS planning. I have heard from several colleagues, however, particularly those in local government, social care and the VCSFE sector, that it is confusing or even inappropriate for guidance relating to ICSs as a whole, and ICPs in particular, to come from NHS England when, by statutory design, the local NHS is only one partner amongst many within the system. Initially, at least, the reference to a 'joint' plan prompted some confusion about whether 'joint' referred to all local NHS organisations, the local NHS and social care, or the system as a whole. Concerns of this kind underline the need for clearer cross-government arrangements in relation to ICSs as a whole.

Self-improving systems

- 3.34 In any large, complex organisation, whether national or global, it is essential to find the right balance between 'national' and 'local'. ICSs, of course, are not a single organisation; they are a complex ecosystem. So is the NHS. As I have already described, the cross-sector partnerships of ICSs need to be paralleled by stronger cross-government working. But even for the NHS partners within each ICS, the 'national centre' is not a single entity: it includes NHS England, as the leaders and headquarters of the service, as well as DHSC and CQC. It is therefore essential

that the roles of each are clearly defined and delineated, in the way described below.

- 3.35 We know that high-performing organisations and systems combine high levels of autonomy with high levels of accountability. ICS leaders themselves increasingly want to create a self-improving system - empowered and strong enough to set strategy, agree plans and trajectories and to mobilise the collective time, talent and resource of system partners to realise them.
- 3.36 System leaders will succeed where they exercise the agency to define the 'how' and to deliver against agreed local and national priorities. The operating environment needs to allow system leaders the space to use their time and energy to collaborate, innovate, and tackle the problems their systems face and to determine together how improvement is best achieved in their local circumstances.
- 3.37 But recognising the considerable differences in maturity, relationships and strength of leadership across ICSs generally, and ICBs in particular, NHS England needs to reinforce the support it offers to the ICBs and other local NHS partners most in need of support. The goal should be to build the right leadership capability and partnership culture while recognising that, as a last resort, regulatory intervention by NHS England will be required.
- 3.38 I urge ministers, NHS England and ICSs to confirm the principles of subsidiarity, collaboration and flexibility that were set out when ICSs were being established and explicitly commit to supporting ICSs to become 'self-improving systems'. This clear goal would align all national priorities behind a dynamic, collaborative approach, informed by smart data-driven insights, enabling innovation and imaginative solutions.
- 3.39 As a system matures and is able to manage a wider range of issues more effectively, it should operate with greater agency. We should not see autonomy as a binary state; as something you do or do not have. For complex organisations in complex systems, the balance between what they do for themselves and what they seek or need further support in achieving is always likely to vary from issue to issue.
- 3.40 Mature systems and organisations are those which have the shrewdest understanding of where autonomy or support are likely to work best for them. Craving autonomy for its own sake can often be a sign of immaturity. It follows that we should think less in terms of 'earned' or 'assumed' autonomy and more in terms of a tailored combination of autonomy and support that produces effective agency. As systems mature, far more of that tailoring can be done by the systems themselves, with NHS England playing a stronger role in the less mature systems.

3.41 Inherent in this model, therefore, must be a commitment to organisational and leadership development, with a clear expectation on providers and ICBs in particular to work together and share resources to support the development of the right cultures and relationships.

Accountability relationships at the heart of system working

3.42 In the course of this review, several colleagues stressed the need for clarity within ICSs, and with NHS England, about where accountability lies for NHS organisations and partners. The new NHS England operating framework states clearly that the role of ICBs includes:

- first line oversight of health providers
- to co-ordinate and help tailor support for providers
- assurance and input to regulators' assessment of providers
- liaison or escalation to NHS England

3.43 That remains, in my view, a helpfully clear statement. Building on this, and acknowledging that different systems are at different stages of operationalising these roles and relationships, several principles are clear:

- trust chief executives are accountable for what goes on inside their trust, crucially, the quality and safety of the services they provide to patients. This statutory accountability is to their board (and in the case of FTs, also to their governors and members), as well as to NHS England
- trust chief executives and boards are also accountable to system partners - within a provider collaborative or Place Partnership where appropriate, but also with and through the ICB. They are accountable for their part in agreeing and delivering plans to improve patient outcomes and the quality, safety and accessibility of care, as well as to solve performance and productivity issues (including ambulance handovers and delayed discharges) that can only be solved by multiple organisations working together
- trust chief executives and boards are accountable to partners across the ICS (including the ICB) for their part in shaping and helping to deliver the ICS integrated care strategy and Joint Forward Plan, including their focus on prevention, population health and health inequalities
- as the organisation accountable for the state of the local NHS as a whole, the ICB is uniquely placed to understand the connectivities and inter-dependence

between different providers. They have a crucial role as the convenor of the NHS, as the statutory partner with the upper-tier local authorities that also form the ICP and leader and partner in the wider ICS

- ICBs are accountable for the performance and financial management of the NHS in their area. ICB CEOs are accountable to their boards, to system partners and to NHS England for delivery of agreed priorities and plans - including elective recovery, urgent and emergency care plans and so on. This is different from being accountable for the performance of individual trusts. As set out earlier, ICBs are accountable to both NHS England (through NHSE regions) and to their local communities
- it is the role of all system leaders collectively to challenge and support each other in relation to meeting the agreed objectives. In a growing number of systems, this is realised through a distributed leadership model where different system members at system, place and neighbourhood level all have defined responsibilities and accountabilities within their eco-system and providing appropriate support to enable transformational change
- the ICB has a critical role as the vehicle to coordinate the activities of provider collaboratives and the NHS's contribution to place-based partnerships. ICBs are vital to support and enable these partnership arrangements to deliver faster progress on service transformation, recovery, and wider delivery on long-term plan objectives
- ICBs have a direct interest in and commitment to the success of NHS providers within their system. This is partly because, as 'commissioners', they are properly concerned with quality, safety and productivity within individual providers. More fundamentally it reflects the recognition that none can succeed unless all succeed. Rightly, there is now a clear expectation that ICB chairs will be involved in the recruitment of trust and foundation trust chairs, with ICB CEOs similarly involved in CEO recruitment, helping to ensure that provider leaders understand and are committed to system working

3.44 I hope that these principles will be helpful to ICS leaders as they clarify and operationalise roles and accountabilities between partners across their system, and to NHS England as they support ICBs in making their contribution to shared local priorities.

3.45 NHS England should therefore work 'with and through' ICBs as the default arrangement. ICBs should be the first point of support for providers facing difficulties, supporting (and if necessary, challenging) the trust to agree a plan of action, mobilising system partners to agree action on wider issues that affect the trust and calling in improvement resources if required. As described in the NHS England operating framework, within their 'adult to adult' relationship, the ICB will

want to keep their NHS England regional team (and CQC if appropriate) informed on a 'no surprises' basis, and seek their advice on occasion, while retaining the initiative and 'first line' responsibility. NHS England should continue to evolve the NHS oversight framework and ensure it is being implemented as intended. There will also be times when an ICB asks the region to intervene directly. In all cases, this must be done collaboratively, with both the ICB and the region ensuring there are 'no surprises', whoever is in the lead.

- 3.46 Many ICBs will need time to develop the capacity and capability to lead all aspects of system risk management, particularly when performance pressures are so apparent in almost every part of the NHS. In less mature systems - for instance where relationships are poor or where the ICB has not yet developed the necessary capability - NHS England, in agreement with the trust and ICB, should take the lead in dealing with a trust facing serious difficulties or catastrophic failure. They should continue to involve the ICB, both so they can build insights into the trust's difficulties (including those caused by problems elsewhere in the system), and because working in this way will help to strengthen the ICB, improve the chances of success with the trust and help the whole system to develop more effectively.
- 3.47 Of course, there will be occasions when NHS England needs to communicate directly with providers on urgent or other specific clinical or operational issues. It is essential, however, for NHS England to avoid working directly with providers in a way that weakens or disrupts system working, for instance by bringing in support for a trust on delayed discharges without talking to or taking account of the partnership working tackling exactly the same problem.
- 3.48 I recommend that, in line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the trust to agree an internal plan of action, calling on support from region as required. To enable this and recognising NHS England's statutory responsibilities, support and intervention should be exercised in relation to providers 'with and through' ICBs as the default arrangement. Where relationships and leadership are less mature, ICBs will need more active support from NHSE regions.

ICSs develop their own improvement capacity

- 3.49 ICS leaders have the clearest view of what an ICS does, how it works, the interlinkages between different parts of the system and how best to craft solutions to meet the needs of their communities and resolve the challenges within local health and care services. It therefore follows that they should play a fundamental role in their own improvement.

- 3.50 Quality improvement should be supported by system leadership and at a system level, including through the adoption of common improvement methodologies across systems. However, this has often been deprioritised by other work and requires investment, capability building and drive amongst partners to accomplish. This will help ensure systems drive a learning culture in all system partners and enable future-focussed thinking.
- 3.51 The NHS Improvement Approach being developed by NHS England will ensure that the development and adoption of improvement methodologies is prioritised across each ICS. This improvement offer should align with the principle of self-driven improvement by establishing some overarching principles that can be adopted locally, rather than prescribing a 'template' for improvement (outlining the 'what' and the 'why' but not the 'how'). It should also build on, rather than duplicate, the work being done by various improvement focused organisations including the NHS Confederation, NHS Providers, Q Community, the Royal Colleges and Academic Health Service Networks (AHSNs), which should all be seen as leaders in driving and implementing this new approach.
- 3.52 CQC itself is committed to making its assessment of ICSs an opportunity to support and incentivise improvement, rather than a 'box-ticking' or compliance approach. Given the experience of many provider trusts who in the past have found themselves facing overlapping and sometimes conflicting requirements from CQC and NHS England, I also recommend that NHS England and CQC work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.
- 3.53 ICSs will naturally take different approaches to improvement - some driving this more directly through provider collaboratives and others in which ICSs are developing in-house capacity to support improvement initiatives or train provider staff. Cross-ICS sharing and learning via peer-to-peer networks and collaboratives will strengthen ICSs' approaches to collectively leading improvement. This work is happening - for example through the NHS Confederation's ICS Network - but there is great potential for the 42 ICSs to think of themselves and be supported to develop as a single learning system.

In West Yorkshire ICS, for example, there are clear arrangements for system improvement agreed between the ICB and the acute provider collaborative, the West Yorkshire Association of Acute Trusts (WYAAT), which leads on certain system priorities on behalf of the ICS including the planned care and diagnostics programmes.

WYAAT collectively has (and will continue to) reviewed and made interventions in specialities with workforce challenges to ensure that equitable access for patients continues. This is clearly led and owned by WYAAT as a collaborative, with ICB involvement for oversight of system risk where required and where changes to protect access may impact the way in which patients access services in the short, medium or

long-term. The oversight approach modelled by the NHS England regional team as well as the ICB is one of improvement support, trust and mutual respect, rather than top-down performance management. By adopting a clear, well-managed structure to facilitate partnership working on health inequalities and prioritising population groups' health at system level, the ICS has ensured it can deliver improved outcomes for key groups and maximise its effectiveness across a large population.

3.54 External peer review can be a powerful tool to incentivise and support improvement. The LGA's well-established local government peer review programme provides the basis for an equivalent ICS process for use by ICSs as a whole. Peer reviews should ensure the appropriate involvement of local populations and services users and have access to bench marking tools such as GIRFT and Model Hospital. I therefore recommend a national peer review offer for systems should be developed, building on learning from the LGA approach.

High Accountability and Responsibility Partnerships

3.55 As part of this work, I have heard a clear desire from ICBs and wider system partners to move towards a model with a far greater degree of autonomy, combined with robust and effective accountability. Such a model will need to balance a high degree of autonomy with the need to sustain and demonstrate both performance improvement and effective financial controls.

3.56 In order to make progress as quickly as possible, and reflecting what I have heard with ICB leaders, I recommend that NHS England works with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024. Reflecting ICB leaders' views, I expect that this new approach will include self-assessment of maturity supported by peer review mechanisms.

3.57 I have already urged all partners, locally and nationally, to commit to the goal of developing 'self-improving systems'. I have also heard a clear desire, both locally and nationally, for systems as a whole to set a high level of ambition, with the most mature systems being enabled to go further and faster in creating the transformation that, as we have argued throughout, is the most sustainable route to solving immediate performance pressures.

3.58 I therefore recommend that an appropriate group of ICS leaders (including local government, VCFSE and other partners as well as those from the NHS) should work together with DHSC, DHLUC and NHS England to create new 'High Accountability and Responsibility Partnerships'. These should start to operate from April 2024. To reinforce the cross-government arrangements needed to parallel the broad partnerships of ICSs as a whole, this working group should report regularly to DHSC and DHLUC ministers together with the chief executive of NHS England.

- 3.59 The design of HARPs will, of course, depend upon the work of this group. But to give an idea of the scale of ambition that I have heard from colleagues, I suggest that the framework for HARPs should include:
- a radical reduction in the number of shared national priorities and corresponding KPIs
 - a collective commitment by HARP systems, including the ICB, NHS providers, and, crucially, local government and other partners, committing themselves to a small number of priorities for which they would be held accountable both locally and nationally; with clear milestones and outcomes, and linked to Joint Forward Plans
 - significantly greater financial freedoms to enable partners to make best use of the resources available to them, including the public estate
 - an effective data-sharing approach across multiple partners, with linked data sets enabling proactive population health management, significantly improved outcomes for population groups and substantial reductions in demand for emergency and specialist services. These data sets would also, of course, provide appropriate warning systems to departments and regulators in case performance or finances begin to diverge significantly from agreed plans
 - a light-touch national accountability framework, for instance with 6-monthly reviews between NHS England, the ICB and other ICS partners
 - the process for ICSs to ask for additional support, and the support available to them
- 3.60 This approach also recognises that not all systems are ready for advanced levels of autonomy and responsibility, while allowing those who can go faster, to do so. It also recognizes that if circumstances change, and a system is struggling, there are processes in place to provide additional improvement-focused support and help.
- 3.61 Testing this approach in this way will not only provide crucial learning, it will mark out a clear path for all systems, showing what is possible, and what can be expected, from a high-performing system.
- 3.62 Although it would not be appropriate for this review to recommend how many ICSs should adopt these new arrangements, in order to test the approach, the scale of ambition needs to be clear. I would hope that around 10 systems would be able to work in this way from April 2024.

The right skills and capabilities for ICBs

- 3.63 This brings me to the capabilities needed for ICBs themselves.
- 3.64 As this review has confirmed, the 2022 Act gives ICBs a vital new role as convenors and catalysts for change. All ICBs need to work with their partners - including place boards, provider collaboratives and local government - as well as their own staff to establish and develop people in the roles that are needed in the ICB team to facilitate acceleration of and depth of performance improvement and wider transformation across the system - and to fulfil their multiple statutory duties - working in the new, collaborative ways required. ICBs are, of course, at different stages in this process.
- 3.65 On 2 March, NHS England announced that ICBs' running cost allowance - already frozen in cash terms for 2023 to 2024 financial year - would be further cut by 30% in real terms over the following 2 years, with at least 20% reductions delivered in 2024 to 2025 financial year, with no provision for redundancy payments.
- 3.66 Everyone I spoke to during this review is acutely aware of the intense pressures upon the nation's - as well as the population's - finances, and the stress upon VCFSE partners, social care providers and local government, as well as the NHS. Local government and NHS partners, including the ICB, need to work together within individual ICSs to share corporate services and other functions, create single teams and make better use of digital tools to improve productivity. Neighbouring ICSs need to consider similar arrangements, such collaboration helps to strengthen ICSs while achieving better value for public funds.
- 3.67 As the Wigan Deal demonstrates, financial constraints can and should be used as an opportunity for transformation. But the scale and timing of these reductions create a real threat to the successful development of integrated care systems (ICSs), with too much time and energy from all staff, including those most essential to improvement and transformation, diverted into a restructuring that is potentially too extensive and too fast. Instead, we need to focus on striking the right balance of capability between NHS England, NHSE regions and ICBs. As NHS England implements its new operating framework, I encourage a significant move of resource into systems, supported by smaller, more experienced and highly capable NHSE regions. Without that, the restructuring risks creating a new imbalance between the national, regional and ICB teams of 'one NHS', when the original intention was of course to rebalance resources towards ICBs and ICSs as a whole.
- 3.68 I therefore recommend that during 2023 to 2024 financial year further consideration is given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required

10% cut in the RCA for 2025 to 2026 financial year is reconsidered before Budget 2024.

- 3.69 Finally, delays and complexity with respect to the appointments process for ICB senior leaders have made it difficult for ICBs to build the right capability and governance to fulfil their statutory functions. In some cases, this has led to many months delay in approving the appointment of ICB medical directors, non-executive members and other senior roles. I therefore recommend that NHS England and central government work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.

The role of the regions

- 3.70 As the chair of an ICB in level 4 of NHS England's oversight framework (SOF4), with considerable challenges in performance, quality and finances, despite many achievements and real progress, I am particularly alert to the value of a senior NHS England regional team who can provide expert advice. Regional teams can help to mobilise, support and resource sustained improvement efforts across the whole system as well as in individual providers and challenge us, in the ICB and working with all NHS providers, to go further and faster. On occasion, of course, they may also need to exercise NHS England's statutory powers of regulatory intervention.
- 3.71 As 'one NHS', however, we need to make sure that there is the right balance of capability between NHS England, NHSE regions and ICBs. There are a number of fixed points in determining this balance - for example, NHS England will, and should continue to hold statutory regulatory functions in relation to ICB performance. However, there is also a clear need for flexibility - with different areas needing their regions to be structured in different ways, depending on the maturity, size and challenges facing them.
- 3.72 A region with a small number of large systems with mature relationships and effective, experienced leaders should work in a very different way from a region with several small, relatively immature systems - and both will be different from a region with a wider mix. For the North East and North West, NHS England has already established a single regional director and team in place of the previous 2. As systems mature, the regional arrangements will continue to change, with systems individually or collectively taking on the responsibility for system and regional leadership, with regional teams focusing on their statutory roles rather than on ICSs.
- 3.73 In other NHSE regions, particularly those with smaller and less mature ICSs, a small number of senior people at the region who know and understand each system (with its particular geography, history, demography, provider configuration and so on) and, crucially, have built strong relationships with the key people within

the system, will remain invaluable. Those NHSE regions should maintain a role as the collective agent for ICBs and the local NHS within ICSs, and should facilitate the resolution of particularly difficult issues, such as the best configuration of vital specialist resources.

- 3.74 In order to make this approach a reality, NHS England regional teams should work based on a collective set of principles to support systems in translating national expectations to fit local circumstances, brokering national support for ICBs with struggling providers, and supporting less mature systems to develop their own capacity and capabilities. If an ICB requires support or further escalation, or both, then this should be agreed between NHS England Region and the ICB. Only if further escalation is required should national NHS England be involved.
- 3.75 Improvement rather than 'performance management' should be the dominant approach and priority. NHSE regions should operate as equal partners with ICBs, aligned with the principles as described in its operating framework: "mature, respectful and collegiate, underpinned with effective lines of communication and a 'one team' philosophy".
- 3.76 There is good practice already of this with examples such as the Northeast and Yorkshire 4+1 scheme and a 'compact' in the South West. Arrangements should be agreed between NHS England and ICBs for the joint governance within NHSE regions.
- 3.77 Strong relationships and clear oversight arrangements in West Yorkshire are supporting the system to improve care for patients. West Yorkshire ICS has been a partnership since 2016 so has had several years to build up the trust and relationships between Place, providers, the ICB and NHS England regional teams. Within the wider region, they operate on the basis of a 4 ICSs + 1 region model, agreeing regional targets with NHS England regional team and other local ICBs which are then measured at a regional level. This approach helps facilitate peer learning between ICSs to compare local approaches to delivering regional targets. In line with this approach, I would expect all ICSs to continue co-designing arrangements for regional support that best support their continuing development.
- 3.78 An important part of the support that regional directors can mobilise sits within the many NHS England programmes focused on particular diseases, conditions and so on. The national cancer programme, for instance, is an example of the essential role for NHS England in convening leading clinicians and scientists, national cancer charities and patient advocacy groups to drive and support life-saving changes in prevention, early diagnosis, treatment, patient experience and access. Such work can only be done once, as NHS England's new operating framework explicitly recognises and it is a task for NHS England itself as the headquarters of the service.

- 3.79 But the multiplicity of national programmes has created real problems, with different national programmes reaching out directly to individual providers and systems, adding to the plethora of meetings, guidance, templates, demands for data and such like. It is helpful that NHS England is significantly reducing the number of national programmes, it is equally important that planning the future support and requests from these programmes will go through NHSE regions rather than directly to providers and systems.
- 3.80 It will be important for ICS partners themselves, working within NHSE regions, to reinforce this new and welcome way of working; as the Messenger Review underlined, these changes in culture and behaviours take time and sustained effort to bed in.
- 3.81 There is now an opportunity to build on the new NHS England operating framework to co-design the next evolution of NHSE regions. I recommend that ICS leaders should be closely involved in this work, to ensure that NHSE regions can operate as effective partners, and the collective agent of the local NHS within ICSs.

Organisational development

- 3.82 Real, lasting change happens because people come together around a common purpose. It is the job of leaders to create the culture and behaviours, backed by the right systems and processes, to enable that to happen. Realising the potential of ICSs - and the neighbourhood teams, place partnerships and other structures within them, including ICBs - needs substantial, sustained investment in organisational development, collaborative leadership and team working across different professions, sectors and organisations.
- 3.83 Local government and NHS leaders at place and system level can already draw upon the support provided in collaboration between the Local Government Association (LGA), the NHS Confederation and NHS Providers. NHS England has made some organisational development support available for ICBs, drawing upon a variety of change management partners and coaches.
- 3.84 Depending upon its starting point, each ICS needs to sustain, develop or create its own organisational development programme across the whole of the health and care system. This should include partners from neighbourhood, place and system level arrangements across the NHS, local government, the VCFSE sector and social care providers. Because of the fragmentation and siloed working between the NHS and social care, and within the NHS itself, there is a particular responsibility upon councils with social care responsibilities and NHS leaders - in foundation trusts, trusts and primary care, as well as the ICB - to work together as part of this process of creating a common culture.

- 3.85 I therefore recommend that NHS England work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer. Investment of this kind is a necessity, not a luxury. But within each ICS, partners need to work together to make the best possible use of limited funds, including the training and development budgets of the ICB, individual NHS organisations and local council partners. The need for such support is echoed in the HSCCs most recent inquiry of ICS autonomy and accountability. Their recommendation calls for government and NHS England to set up and fund an ICS leadership development programme, specifically targeted at supporting leaders of and within ICSs to develop the skills required to be successful system leaders. Statutory partners in ICSs should consider how they support VCFSE and social care provider partners to be fully included in organisational development. Creating shared teams between local councils and the NHS (for instance, a single integrated health and wellbeing communications team) will help to build common purpose and understanding of the very different culture, governance and financial frameworks of different statutory organisations as well as making better use of scarce resources.
- 3.86 The previously described goal of self-improving systems also requires sustained investment in improvement capabilities. Quality improvement should therefore be supported by system leadership and at system level (or, in very large systems, at place level).
- 3.87 A few systems or place partnerships have already adopted a common improvement methodology. Others have started bringing together QI leads or teams across different organisations to create a QI community. Mutual understanding, sharing learning and building a common approach will be a powerful driver of improvement and transformation across the local health and care system. When assessing the maturity and effectiveness of ICSs, CQC should take into account the extent of collaboration around organisational development and quality improvement.
- 3.88 In further recognition of the need to sustain and deepen culture change, I recommend that the implementation groups for the Messenger Review should include individuals with significant experience of leading sustained cultural and organisation change in local government and the voluntary sector as well as the NHS.

National organisations

Relationship between DHSC, NHS England and ICSs

- 3.89 Consideration now needs to be given to the relationship between NHS England, the department and ICSs themselves. The 2012 Act separated NHS England from the department, placing operational leadership in an arm's length body. Policy

making, including setting the mandate for NHS England, remained with the department. That arrangement, confirmed by the 2022 Act, reinforced the position that NHS providers, and now NHS ICBs, are accountable to NHS England which is, in turn, is accountable to the Secretary of State and, through them, to parliament. NHS England has also taken on new functions from NHS Improvement, Health Education England and NHS Digital - making clarity of responsibility and accountability even more important than before. It is increasingly clear, however, that these arrangements are not working as intended. From the standpoint of providers and systems the apparently clear distinction between the department and NHS England can feel increasingly blurred in practice.

- 3.90 Everyone wants ICSs to succeed: the department and its ministers, NHS England and ICS partners and leaders themselves. The fact that all 3 can, at times, have quite different perspectives on the central issue in my terms of reference - the balance between greater autonomy and robust accountability - does not flow from any difference in the outcomes they seek. All want the best outcomes for patients and the public, improved working lives for staff and the most effective use of public funds. Their differences of perspective are driven by differences in position within the health and care system rather than different goals.
- 3.91 I have therefore sought to understand all 3 perspectives and reflect them here, starting with ICSs.
- 3.92 I have been directly involved in the development of ICSs over the last 6 years, as independent chair of a sustainability and transformation partnership (STP) and then an ICS, and now as chair of an ICB and deputy chair of the ICP. The views of system leaders are reflected throughout this report, including the clear desire for greater autonomy alongside effective accountability. They want to look outwards, not upwards. ICS leaders themselves recognise ministers' personal commitment to ICSs and welcome their increased interest. It is not only helpful but essential that ministers become as familiar as possible with how different ICSs are working, their real achievements and the challenges they are encountering. Ministerial attention can itself help to reinforce partnership working, highlight and spread excellent practice and innovation and challenge ICS leaders to go further and faster. On the other hand, many ICB leaders are concerned by the growing number of requests for detailed performance data or explanations of exactly what they are doing on a specific performance issue, duplicating or conflicting with clearly established lines of accountability. I am therefore not surprised to hear a growing number of system leaders say that "it feels as if we have 2 centres now."
- 3.93 In relation to NHS England, from the start of this review, I saw how easy it would be to frame the issue as "ICSs good, NHS England bad". Easy, but wrong. In the announcement of the review itself, I stressed that the review would 'build on the welcome work already done by NHS England to develop a new operating model'. Both before and since 2012, I have worked closely with what is now NHS England.

I value their clinical and operational expertise and have great respect for their many outstanding leaders. It is clear to me that the leaders and staff of NHS England are committed public servants who have a real dedication to supporting the NHS. As both the headquarters for the NHS and as an arm's length body of government they face daily challenges, but it is to the great benefit of the system and to government that they continue to tackle those challenges. NHS England deserve a good deal of credit for the changes they have already made and are continuing to make, referred to in other parts of this report. They themselves initiated STPs in the first place, giving them welcome freedom to develop in response to local circumstances. As the headquarters of our National Health Service, they continue to have a vital role in relation to the NHS as a whole that must be recognised and supported.

- 3.94 Nonetheless, in matters affecting the success of ICSs, including how they are regulated and held to account, NHS England needs to go further and faster in some respects. They also need to recognise that, as the headquarters of the NHS, they cannot also be the headquarters of ICSs where the local NHS is only part of a far wider partnership.
- 3.95 Turning to the Department of Health and Social Care: I have been Secretary of State for Health myself, working closely with the many exceptional officials who then formed the 'department' team. Both as an ICS leader and particularly through this review, I have leant on the policy expertise, insights and dedication of today's officials. It is clear that ministers are committed to lightening the load of 'must dos' and we have seen, for example, a welcome shortening of the mandate in recent years, a trend I am confident will continue this year. Personally, I have felt the same heavy weight of responsibility for the NHS and the social care system that ministers feel today. I know what it is like, being constantly summoned to the House of Commons to deal with urgent questions or facing media interrogations about serious problems in a particular area. Like ministers today, I held the NHS to account, seeking to understand and support them but also to challenge. I expected to have the information I needed to fulfil my role. For ministers, it can also often feel as if they are in a parallel centre that is being held publicly accountable for performance as well as policy.
- 3.96 Nonetheless, in matters affecting ICSs, including how they are regulated and held to account, it is essential that there is clarity on roles and responsibilities and clear boundaries between operational management and wider responsibilities. This makes alignment between the department, Secretary of State and NHS England vital. The department needs to accept that provider trusts and ICBs do not report to them, and maintain the distinction between operational performance management on the one hand, and accountability and challenge on the other. And, of course, there needs to be an open, trusting and respectful relationship between NHS senior executives and ministers themselves. Just as we should expect NHS England to work 'with and through' ICBs in their relationship with

providers, so we should expect the department to work 'with and through' NHS England in its relationship with systems and providers. In both cases that does not preclude direct engagement, but it does set a default expectation for how things should normally work.

- 3.97 My terms of reference specifically asked me to 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'. Although I had expected to find a broad measure of agreement on this point, this proved not to be the case. DHSC and its ministers are frustrated by their inability to get data that they want. NHS England itself has changed its stance on sharing data and information with DHSC, with automated data-sharing feeds updated regularly. ICB and trust leaders themselves are increasingly concerned about multiple requests for data and information, often extremely detailed and at very short notice. As the above account illustrates, however, what appears to be a duplicative request for information from one perspective can, from another point of view, be a reasonable action to ensure that parliamentary accountability is done properly. This helps to show why effective alignment can never be found solely in the rulebook or the legislation - it depends on building relationships of trust and on mutual understanding.
- 3.98 Digitisation of the health and social care system, together with the rapidly growing use of smart data analytics tools, will help to provide the 'single version of the truth' that is an essential part of aligning all partners, locally and nationally, around the same purpose and goals. I make recommendations on that and other matters that will help both ICSs and national bodies, including ministers.
- 3.99 The pandemic itself provides an example of successful data sharing between NHS England, No.10 and DHSC, integrating information from the NHS on cases, symptoms and outcomes as well as population and demographic data to create a 'single version of the truth', updated daily and used as the basis for ministerial press conferences as well as policy decisions. And this report provides examples of the impressive results achieved within systems from data-driven approaches to identify people and communities at risk and provide them with the early intervention that is both better for them and relieves pressure on health and care services.
- 3.100 In order to strengthen the alignment between the department, NHS England and ICSs, I suggest a rapid stocktake - potentially led by the No. 10 delivery unit - to assess data flows for timeliness and usefulness. Its conclusions should be shared with systems, Secretary of State and NHS England as a basis for agreeing actions for using data to further support the work of all 3.
- 3.101 As an ICS leader remarked to me 'real change comes from real work' and the more that systems, NHS England and ministers can do together to make sense of

the key issues and work through practical solutions, the easier it will be for partnership working to be sustained into future challenges. I therefore suggest that DHSC ministers (along with DLUHC colleagues) build on their work with NHS England and systems to undertake shared learning from this winter. This should take the form of shared conclusions and actions during this year, and should report to the Secretaries of State for DHSC and DLUHC and the chief executive of NHS England.

- 3.102 For the new system we have created to succeed, we need some honest conversations about what is working and what needs to change. There are many unsung examples of effective team working between the department and NHS England and systems in all and every permutation; but there are also examples of tensions, wasted time and needless frictional costs generated by uncoordinated pursuit of organizational goals that do not take account of their wider effects. This also makes it harder for vital partners outside of the NHS - including local government, the VCFSE and social care providers - to collaborate effectively with the NHS. It can often feel to them like looking in on a purely NHS conversation that absorbs enormous amounts of time and energy that could be devoted to joint working. Everyone needs to change, and everyone needs to give a little so that the system as a whole works better.

National planning guidance

- 3.103 As I've previously made clear the public's immediate priorities - access to primary care, urgent and emergency care, community, mental health and social care services and elective diagnostics and treatment - are priorities for all of us, ministers, NHS England and ICSs. The level of interest in these matters rightly makes them a central part of accountability for ICBs and their partners in the wider ICS.
- 3.104 However, effective change in any system - particularly one as complex as health and care - needs consistent policy, finances, support and regulation over several years. Adding new targets and initiatives, non-recurrent funding or small funding pots, makes it impossible to plan new services or even recruit staff, wastes money and time, and weakens impact and accountability.
- 3.105 The government of which I was part introduced national targets as part of a number of measures to improve NHS performance. Although controversial at the time, a small number of targets undoubtedly contributed to significant improvements in performance and productivity. Reflecting on that experience, 4 points stand out to me.
- few targets concentrate minds; the more that are added, the less effective they become

- the higher the performance standards (for instance on emergency department waits), the less they allow room for vital clinical judgement
- the combination of too many targets, performance standards that are not clinically supported and an excessive focus on hitting targets by managers or boards themselves can lead to 'gaming' of the targets or even a disastrous neglect of patients themselves¹⁴
- I also learnt that targets that focus on end-to-end pathways can be particularly powerful in joining up care between siloed organisations, such as the target initially set for patients with suspected cancer to be seen by a specialist within 2 weeks of referral by the GP

3.106 My terms of reference setting out that the review will 'consider the scope and options for a significantly smaller number of national targets' reflect the widely-held belief that national targets had become wholly excessive. This is exemplified with the 2022 to 2023 planning guidance expressing national NHS objectives in 133 asks across 10 domains. The 2023 to 2024 planning guidance, developed in close consultation with ICB leaders and this review itself, made welcome and significant progress, summarising national NHS objectives on a single page with 31 asks across 12 domains.

3.107 Further progress should be made in the planning guidance for 2024 to 2025. I recommend that ministers consider a substantial reduction in the priorities set out in the new mandate to the NHS - significantly reduce the number of national targets, with certainly no more than 10 national priorities. Given the need to integrate care around patients themselves, it would also be helpful if the planning guidance could focus on outcomes rather than individual NHS sectors (primary, community, acute and so on). In particular it would be helpful to focus even more rigorously on the 'what' and the 'why' rather than the 'how'. I therefore endorse the recommendation of the Select Committee that "Targets for ICSs set by DHSC and NHS England should be based on outcomes". There may be times when greater prescription around how targets are achieved is needed, but we believe this should be done sparingly.

3.108 In turn, we can expect the planning guidance for 2024 to 2025 to reduce further the number of 'domains' and 'asks'. Building on the approach taken last year, NHS England should continue to work closely with ICBs themselves as well as the

¹⁴The Francis report found that the failures in Mid Staffordshire was 'in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.' [Mid Staffordshire NHS Foundation Trust Public Inquiry. \(2013\). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary \(HC 947\). The Stationery Office.](#)

department to produce the new guidance. This focus on a small number of key priorities is particularly important in the current, highly-stressed circumstances.

- 3.109 I would also strongly urge that the necessary focus on reducing elective care waits be matched by an equal focus on reducing waiting times for acute mental health treatment.
- 3.110 I understand that the reduction of the number of 'domains' and 'asks' has itself caused concern, particularly amongst those whose area is not included. It is important to stress that national standards for clinical care, including those set by NICE, remain in place and will, of course, continue to guide the care provided to patients with different conditions.
- 3.111 I would also suggest harnessing the enthusiasm in both NHS England and systems for a more co-productive way of developing policy. In the development of its strategies and plans (for example the UEC strategy or the primary care recovery plan) NHS England works hard to engage a broad cross section of experts and stakeholders, with systems playing an increasingly strong role in the shaping of policy. Both NHS England and ICS leaders should build on this to deepen both the involvement of ICSs in shaping policy and the understanding within ICSs of that involvement. There should be very few 'degrees of separation' between an ICS leader and a new policy or strategy: either they or a peer should have had a hand in shaping it.
- 3.112 Building on the process of engagement used by NHS England in preparing the 2023 planning guidance, NHS England should commit to further deepening this collaborative approach in developing the 2024 planning guidance. Furthermore, where significant new plans and priorities directly impacting systems are added in-year to the planning guidance framework, these plans should also benefit from a process of collaborative co-design with system leaders.
- 3.113 Finally, I recommend that, to support this, NHS England and ICBs should agree a common approach to co-production, including working with organisations like the NHS Confederation, NHS Providers and the LGA.

Enhanced CQC role in relation to systems

- 3.114 Greater autonomy for ICSs - including, in particular, a radical reduction in central targets and top-down performance management together with an increase in financial autonomy and flexibility - will enable ICS leaders to deliver both short term performance and longer-term improvements in population health.
- 3.115 However, greater autonomy must come with more effective accountability to patients and the public as well as to NHS England and ministers.

- 3.116 Having started the review with a degree of scepticism about CQC, I now strongly support their enhanced role in relation to ICSs. This will build on their core mission to inform patients and the public about the quality of care and the effectiveness of services based on their oversight and inspection of health and social care providers.
- 3.117 The Health and Care Act 2022 included an important new role for CQC to review ICSs, alongside a further new role to assure local authority commissioning of social care. Once CQC has put in place arrangements to review systems, developing their approach and capability in partnership with a wide range of ICS leaders both from ICBs and ICPs, they should provide clear and transparent ratings on the quality of services within the ICS, across the key domains of care services - including primary care, mental health, community services, social care and both emergency and elective care at acute hospitals. They should also make an assessment of the level of maturity and effectiveness of each ICS as a whole, including a rating of the ICS leadership itself, based on an assessment of how far ICS structures (including of course the ICP and ICB) are adding value and enabling the system as a whole to meet its objectives and improve outcomes. CQC should then use these different ratings and assessments to inform an overall judgement on the achievement, challenges and areas for improvement for each ICS.
- 3.118 This work - which should be led by a Chief Inspector of Systems - should draw on multiple sources of quantitative and qualitative data, including CQC's existing inspections, as well as NHS England's information on ICB and providers use of financial resources. In its review of the ICS (effectively a 'well-led' review), CQC should assess how the ICS itself (including the ICP, ICP, place partnerships and Provider Collaboratives) adds value, enabling the whole to be more than the sum of its parts. Reporting should focus on helping ICS partners to improve more rapidly, as well as providing a basis for regulatory intervention where required. We know the most effective health and care organisations and systems are those where quality, performance and financial management go hand in hand, and so ratings must take account of all of these elements - and so we would not expect the highest ratings to be given to a system where the financial position is not being well-managed.
- 3.119 We recognise that this will be a significant shift for CQC, although building on the work that is already underway with ICS leaders to develop the right approach and capability for their new responsibilities. As a result, 2023 to 2024 should be a transitional year, allowing CQC and ICSs to co-design the most effective approach to CQC reviews, sharing learning as both CQC and ICSs embed system working and enabling it to generate ratings that the public, as well as ICS partners themselves, can trust.

- 3.120 We also recognise that ICSs, and ICBs within them, are at different levels of maturity, and differentiation between them will continue to be both necessary and important. As explained elsewhere, a 'baseline' of increased financial autonomy and flexibility should apply in all ICSs, with further freedoms also focussed on the more mature systems and ICBs during 2023 to 2024, so that NHS England can concentrate its improvement work and financial performance management on those ICBs where it is most needed, as well as fine tuning the arrangements for financial autonomy and flexibility.
- 3.121 CQC have been clear that they do not want to carry out 'compliance' inspections and have seen the opportunity to capture and help scale innovation. It is vital that assessment of ICSs does not become yet another set of tick-box capability and competency requirements but is a useful tool for enabling each system to develop and improve. I welcome CQC's recognition of that risk and their commitment to understand the very different starting-points of each ICS, how each system stands in relation to its own stated ambitions and focusing on how each ICS is adding value and developing capability as a self-improving system.
- 3.122 In particular, as recommended in other parts of this review, CQC should include within its assessment of ICS maturity:
- how different partners - local government, the VCFSE sector, social care providers, other ICS partners and the local NHS including the ICB - themselves assess their engagement and relationships within the ICS itself, including the extent to which both public health expertise and the social care provider sector are involved in the leadership of the system
 - the strength of the system-wide integrated care strategy with Joint Forward Plans, clear priorities, outcomes and timescales, providing a local outcomes framework against which the system can be held accountable by local residents and others
 - the coherence, consistency and impact of arrangements at place and neighbourhood level within the ICS
 - how far the system is making progress in shifting resources towards prevention, population health and tackling health inequalities
 - how well systems work with and respond to support provided by the NHSE regions within the new operating framework, including the goal of supporting ICSs to become self-supporting systems
 - practical examples of ICS partners identifying priorities, agreeing a diagnosis of the problem as well as a plan of action and making progress towards agreed outcomes. This should include looking at specific pathways of care

from a patient and service user perspective. It should also take account of Ofsted's assessment of children's social care services and whether or not system partners have developed an effective strategy for prevention, population health and tackling health inequalities amongst children and young people

- whether system partners are developing a framework of mutual accountability, sharing performance and financial data transparently in order to agree a single version of the truth; developing an ability to learn from mistakes and respond effectively to problems without blame within systems (in other words, focusing on quality improvement and creating a learning and improvement culture, building on peer review, 360-degree feedback, measurement of staff engagement, role of HOSCs and psychological safety)
- whether the system is finding ways of shifting emphasis and resources towards prevention, population health and tackling health inequalities

3.123 Reviews should also share best practice and insight from other systems in suggesting recommendations for improvement and identify good practice to be shared. This would support continuous improvement and stronger relationships. CQC should be mindful to ensure their reviews can help foster stronger relationships and how they can impact fragile relationships in still developing systems.

3.124 CQC has reviewed international experience of integrated care and engaged with a number of ICSs to develop a methodology for ICS inspection. Given the scale of change this represents for the CQC itself, however, at a time when statutory ICSs are in their infancy, CQC and ICSs should work together over the coming year to develop a long-term approach to inspections and ensure that CQC develops the capabilities and skill sets needed to support successful development of ICSs.

3.125 In their first year the focus of CQC should be on calibration of their assessments and supporting improvement and sharing best practice amongst systems within their reports rather than assessment and rating.

3.126 This should be driven by co-design between CQC and systems sharing learning as both CQC and ICSs embed system working. This should include engagement with ICBs in forming a view about the ways in which clinical risk are held and managed within and between providers and other partners, incorporating this into their judgements of registered services.

3.127 I would also suggest investment in training for the CQC workforce to upskill staff and bring in colleagues with experience from systems, including where appropriate other system leaders.

- 3.128 While I appreciate work is beginning already on CQC's new inspection regime for adult social care and reviews of ICSs, CQC should use this year to work closely with and learn from local authorities and systems while they continue to refine and develop their methods.

The role of data for system accountability

- 3.129 Transparent, accurate and accessible information enables patients and the public to know whether the services they are receiving are high quality, efficient and effective. Equally, clear and effective engagement with the public builds confidence that individuals' data contributions are creating real benefits for themselves and wider society, thus underpinning further improvement and transformation. Transparent data is a powerful incentive and enabler of improvement, reflected for instance in the work of the National Joint Registry (NJR) over the last decade. Using cutting-edge data analytics, and as a globally recognised exemplar of an implantable medical devices' registry, the NJR has already helped to improve patient outcomes, inform clinical practice, ensure the quality and value of joint replacement surgery and support orthopaedic research.
- 3.130 To develop integrated care with timely, relevant and high-quality performance data, it is essential to ensure that there is a two-way flow between systems and national bodies.
- 3.131 The new Federated Data Platform (FDP), currently under procurement, should make a significant difference. The automation of data in real time will drive consistency, free systems from administrative burdens and enable effective benchmarking across providers and systems. Although the first stage of implementation is focused on NHS acute trusts, I recommend that work begins at the same time to build a close partnership between NHS England, the FDP developers, and appropriate colleagues from ICSs, local government and the provider sector including primary care, community and mental health, adult social care providers and VCFSE providers to ensure that the full benefits of the FDP can be realised in future, with all parts of the health and care system involved in its development. The strategic objective should be to create a unifying digital architecture across the entire health and care system, with the FDP itself helping to support local systems to address key challenges while also offering the opportunity to share and scale innovative tools and applications.
- 3.132 In particular I recommend:
- NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking SITREP and other reported data directly from the FDP and other automated sources, replacing both SITREPS and additional data requests

- data required in real-time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; and where possible without creating excessive reporting requirements, data should enable site-level analysis
- data collection should increasingly include outcomes (including, crucially, Patient Reported Experiences and Outcomes) rather than mainly focusing on inputs and processes
- data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government
- DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose. This work should be completed within 3 months

3.133 As I stressed earlier, I understand only too well the need for NHS England and DHSC to get up to date information from systems and providers. But it is essential that information-gathering itself does not distract senior leaders and their teams (including the scarce resource of digital and data experts themselves) from the key priority of actually improving performance. Given the scale of improvement required, the present manual reporting burden placed on providers and partners in ICSs is unacceptable. Notwithstanding the severe performance issues in December 2022, in one instance one ICS received 97 ad-hoc requests from DHSC and NHS England, in addition to the 6 key monthly, 11 weekly and 3 daily data returns.

3.134 Continuing automation of data provision, shared between NHS England, DHSC and No. 10, will itself improve matters. In the meantime, further action is required to reduce the number of uncoordinated, often urgent requests for data that can only be provided through time-consuming manual means.

3.135 Even high quality data needs to be supplemented by experience and insights to understand where investment and energy should best be directed, both within systems and between systems and national bodies. For instance, although data may show the same performance challenges in 2 systems or trusts, the causes may be very different (for instance, in one case a well-led trust or system struggling with a fundamental mismatch between demand and capacity; in the other, a combination of weak leadership, antagonistic relationships and poor culture). The support or regulatory intervention required would also be very different, despite the apparent similarity in performance. Insights from systems themselves, regional teams and CQC are vital in complementing performance and benchmarking data.

Chapter 3: recommendations

10. HOSCs (and, where agreed, Joint HOSCs) should have an explicit role as System Overview and Scrutiny Committees. To enable this DHSC should work with local government to develop a renewed support offer to HOSCs and to provide support to ICSs where needed in this respect.
11. 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.
12. In line with the new operating framework, the ICB should take the lead in working with providers facing difficulties, supporting the Trust to agree an internal plan of action, calling on support from region as required. To enable this support and intervention should be exercised in relation to providers 'with and through' ICBs as the default arrangement.
13. NHS England and CQC should work together to ensure that as far as possible their approach to improvement is complementary and mutually reinforcing.
14. A national peer review offer for systems should be developed, building on learning from the LGA approach.
15. NHS England should work with ICB leaders to co-design and agree a clear pathway towards ICB maturity, to take effect from April 2024.
16. An appropriate group of ICS leaders should work together with DHSC, DHLUC and NHS England to create new 'High Accountability and Responsibility Partnerships'.
17. During 2023 to 2024 financial year further consideration should be given to the balance between national, regional and system resource with a larger shift of resource towards systems; and that the required 10% cut in the RCA for 2025 to 2026 financial year should be reconsidered before Budget 2024.
18. NHS England and central government should work together to review and reduce the burden of the approvals process of individual ICB, foundation trust and trust salaries.
19. 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.
20. NHS England should work closely with the LGA, Confed and NHS Providers to further develop the leadership support offer.
21. The 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.

22. Ministers should consider a substantial reduction in the priorities set out in the new Mandate to the NHS - significantly reduce the number of national targets, with certainly no more than 10 national priorities.

23. 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.

24. As part of CQC's new role in assessing systems, CQC should consider within their assessment of ICS maturity a range of factors (set out on page 58).

25. 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. In particular:

a) NHS England and DHSC should incentivise the flow and quality of data between providers and systems by taking SITREP and other reported data directly from the FDP and other automated sources, replacing both SITREPS and additional data requests

b) Data required in real-time by NHS England and DHSC should be taken from automated receipt of summaries to drive consistency; where possible without creating excessive reporting requirements, data should enable site-level analysis

c) Data collection should increasingly include outcomes (including, crucially, Patient Reported Experiences and Outcomes) rather than mainly focusing on inputs and processes

d) Data held by NHS England (including NHSE regions) about performance within an ICS, including benchmarking with other providers and systems, should be available to the ICS itself and national government

e) DHSC and NHS England work with nominated ICS colleagues to conduct a rapid review of existing data collections to reset the baseline, removing requests that are duplicative, unnecessary or not used for any significant purpose. This work should be completed within 3 months

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

- 4.1 The review terms of reference specifically asked to look at how to empower local leaders to focus on improving outcomes for their populations and making ICSs more accountable for performance and spending, much of which can be delivered through primary and social care.
- 4.2 Strengthening local leaders' ability to have greater and more flexible decision-making in primary and social care, supported through a more joined up national policy approach, will not only better enable them to deliver improvements in immediate performance, it will be key to improving outcomes in the communities they serve.
- 4.3 In order to enable the kind of integration, collaboration and autonomy we want to see integrated care systems (ICSs) embody, we need to pull down some of the barriers that currently exist for primary care, social care and the way we train health and care workforce. Breaking down these boundaries will be fundamental to unlocking the potential of system working and reinvigorating the much-needed focus on prevention and early intervention.

Primary care

- 4.4 Dr Claire Fuller's timely stocktake of primary care has already set out a vision and route-map for integrated neighbourhood working where teams from across primary care networks (PCNs), wider primary care providers, secondary care teams, social care teams, and domiciliary and care staff can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.
- 4.5 My recommendations build upon the important work and recommendations of the Fuller Stocktake, focusing on what more needs to be done within ICSs to create integrated neighbourhood teams and integrate care across the whole patient pathway. I also make recommendations on the changes needed within primary care contracting (an issue not included within Dr Fuller's terms of reference).
- 4.6 On 1 April 2023, all ICBs will take on responsibility for commissioning community pharmacy, optometry and dentistry, through delegation of all primary care commissioning for the first time. Instead of each element of primary care being treated as a separate silo, ICBs now have the opportunity - and the responsibility - to work with all elements of primary care to achieve the accessible, high-quality

and integrated services that residents and local communities need. Much of this work, of course, will be led and delivered with local government and VCFSE partners through place partnerships and integrated neighbourhood teams, involving collaboration with community, health and social care services, and specialist acute services as well as primary care itself.

- 4.7 Despite currently being constrained by nationally negotiated and held contracts with care partners, ICBs through PCNs and place partnerships, as well as system-wide, can still consider the needs of their local population and determine the best use of resources for that population. They can support the joining up of different elements of urgent care, including 111, community pharmacies and walk-in centres and ensure the most effective provision of services to meet population need without focusing solely on one area of primary care when commissioning those services.
- 4.8 ICSs should also play a greater role in driving primary care transformation. The Fuller Stocktake included many inspiring examples of primary care organisations delivering at scale and through multi-partnership teams; others have emerged during this review, including Medicus in Enfield, North London.

Medicus Health Partners is the second largest primary care practice in England. Working in the London Borough of Enfield, it brings together 15 practices merged into a single PMS contract, with 34 partners, a managing partner, 23 salaried GPs and a multi-professional staff totaling 370. By working at scale to listen and respond to patients, provide development and support for staff and streamline administrative and digital support services, they have been able to improve the working lives of their staff while transforming the quality of care they provide. At a time when A&E attendances and emergency admissions of patients in care homes in other parts of Enfield were rising by around 30%, Medicus worked with care homes to reduce A&E attendances by over 10% and emergency admissions by 16%. Medicus have an estates strategy that consolidates fifteen surgery premises, some of them too small old and not fit for purpose to accommodate staff or patients properly, into 9 modern health and care hubs.

Primary care contracts

- 4.9 I have heard repeatedly that national contracts present a significant barrier to those within the GP partnership model who want to work in innovative and transformational ways, requiring a great deal of time, goodwill, ingenuity and workarounds from practice partners and ICBs. ICBs also lack effective levers to support and secure the services in practices where practices are facing difficulties in providing a good quality of service in their area.
- 4.10 With ICBs taking on responsibility for NHS dentistry on 1 April, it is essential that the next stage of dental reforms, which is currently being developed and builds on

the incremental reforms made last year, is implemented as soon as possible. Without this, ICBs are simply being handed the task of improving an unacceptable situation without sufficient tools to address this. The government has already made some welcome changes, giving ICBs some flexibility to create additional services where they are most urgently needed and announcing the first set of contractual reforms in July 2022 to support fairer remuneration for dentists and increase patient access to care.

- 4.11 Furthermore, the contract held by GP contractors for 'general medical services', which is negotiated nationally between government and the BMA, provides far too little flexibility for ICSs to work with primary care to achieve consistent quality and the best possible outcomes for local people.
- 4.12 Contracts with national requirements can have unintended consequences when applied to particular circumstances. For instance, the national requirements and funding of Additional Roles Reimbursement Scheme (ARRS) roles for community pharmacists within PCNs, has on occasion exacerbated the problem of a general shortage of pharmacists, with some now preferring to work within primary care rather than remain in community pharmacies or acute hospitals, compounding the problem of community pharmacy closures and delayed discharges. The new responsibilities for ICBs provide an important opportunity, at place or system level, to integrate the whole primary care offer for communities, making the best use of both the staffing resource available and the premises.
- 4.13 The Quality and Outcome Framework (QOF) points that were an important and useful innovation twenty years ago are now out of date and are seen by GPs as well as ICBs as an inflexible and bureaucratic framework. This needs to be updated with a more holistic approach that allows for variation. The new approach must also recognize that, in order to allow primary care to refocus resources on prevention, outcomes rather than just activity need to be measured.
- 4.14 As the GP contract is now entering its fifth year of a 5 year agreement, and the government will be shortly considering its intentions for the next iteration of the contract, radical reform is needed, and this is the right time to make it happen.
- 4.15 I therefore recommend NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts. This partnership group should include a diverse range of GP partnership leaders currently delivering excellence across a range of different regions and demographics, as well as ICB primary care leaders, local government and - crucially - a number of patient and public advocates. As part of this work, NHS England and DHSC should, of course, engage with key stakeholders, including the BMA and the RCGP.

4.16 Although of course the final decision on policy and funding rests with ministers, I would suggest that this framework should enable systems to find the right solutions to fit their circumstances, including building on the partnership model, rather than sweeping it away entirely.

4.17 In particular, I would suggest that the work of this group should consider:

- the outcomes that we want from primary care as a whole. While it is not for this review to specify the outcomes, they should be developed closely with patients and the public over the coming months and include patient reported outcomes and experience as some of the measures for success
- the balance between national specifications and local flexibility and decision making - greater flexibility and appropriate local autonomy within a framework of national standards is needed to improve equity of access and care and to enable PCNs to take a greater role and responsibility in reducing health inequalities and population health management. ICBs, working with primary care partners at neighbourhood and 'place' level, need to join up the many different elements of primary care, including urgent care, making best use of clinical and other professional staff as well as premises and budgets, and taking account of the particular needs of their population and its geography and demography, to get the most convenient access and best outcomes for residents
- national standards or specifications should include clear expectations around digital and data, in line with the recommendations elsewhere
- how to incentivise and support primary care at scale. There are many different ways of achieving primary care at scale, within the context of integrated neighbourhood teams and wider place partnerships. These include: practices coming together as a single group; GP provider federations, owned collectively by partners and providing support to all member practices; free-standing practices working together within a PCN, where in future the contract (whether for core GMS services or enhanced services) might be held with the PCN rather than individual practices and partners; GPs working as part of a multi-disciplinary primary care division within a wider NHS trust and so on. The new contract needs to allow for different models, in particular allowing tailoring to local circumstances in the patient facing offer, while ensuring we capture the benefits of an 'at scale' model behind the scenes. This work should consider how the system can make it simple for partners who wish to move in this direction to do so, while also encouraging and incentivising others to move in this way
- how best to support struggling practices to improve. Practices that are not delivering at a high enough standard need to be supported to improve and,

where necessary, to be replaced so that residents in every community receive the support from primary care they need. This should include creating a centrally-held fund to buy out contracts or premises, or both, where that is essential to improve access, care and outcomes in a particularly disadvantaged community

Social care

- 4.18 I have heard a lot throughout the review about the need for social care to be better understood within the NHS. This is critical as appropriately embedding social care is essential for effective integrated working in systems, in particular at place and neighbourhood level.
- 4.19 Social care at its best can be described in the following terms: “We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing things that matter to us”.¹⁵ This definition is widely supported as describing the diverse range of support that social care offers to enable people to live as well and independently as possible. Social care is an important sector in its own right, employing around 1.5 million people, more even than the NHS, and making a significant economic contribution, estimated in 2021 to 2022 at £51.5 billion.
- 4.20 While local government has crucial commissioning and market-shaping responsibilities for social care, the provision of social care - both domiciliary and residential - is the responsibility of over 18,000 different organisations, mainly in the private sector, often small and family-owned, but including a small number of very large privately-owned providers as well as a significant number of not-for-profit, charitable and social enterprise organisations.
- 4.21 The social care landscape is complex. Many people in the UK currently do not know what level of care they are entitled to until they are faced with a family crisis. The government has published plans for social care charging reform, although implementation is currently paused.
- 4.22 As a society we need to face up to the challenge of providing a decent quality of care for everyone who needs it, including many of the most vulnerable people in our communities. It is not for this review to recommend the shape that any structural or financial reform of social care should take. Instead, we need a national conversation about what we expect from our care; and what we are willing to pay for it.

¹⁵ Routledge, M, [Social Care Future](#), Local Government Association. (Accessed: 17 March 2023).

- 4.23 It is clear, however, that if health and care are to be effectively integrated and delivered at ICS level, social care needs to be a national priority for investment and workforce development, enabling delivery of the reforms of the 2014 Care Act.
- 4.24 ICSs also have a vital role in supporting a more sustainable social care sector at system level, by taking an integrated approach to reducing the gap between demand for care and available supply, for example by encouraging the adoption of personalised, preventative and proactive models of care.
- 4.25 I would therefore urge an acceleration and expansion of existing work on understanding both need and the fair cost of care, before the proposed cap on adult social care costs is implemented. The fair cost of care work, commissioned as part of the government's now delayed implementation of charging reform, is a helpful model to move towards a fairer rate of care paid by local authorities to social care providers, and is helpful to understand the social care market - however, it is currently restricted to the older adults residential care market. While it will be beneficial to see the evaluation and assessment so far, it would also be helpful to expand this work to capture working age adults and potentially children's social care. It is vital we appropriately understand the cost of providing high quality care and support for those who need it. Whether this is paid for privately or through taxes and contributions, there is a clear need for this to be paid at a fair rate that reflects their vital role in enabling the dignity and independence of the people they support and their families.

Workforce

- 4.26 Further change will only be possible with a strong and supported workforce across both healthcare and social care.
- 4.27 The government is due to publish a long-term workforce plan for the NHS imminently. Given the interdependence of health and social care, I therefore recommend that the government should now produce a complementary strategy for the social care workforce as soon as possible. This plan should set the strategic direction for a more integrated health and social care workforce. This strategy can then support local authorities, who have responsibility for adult social care provision, and ICSs, who will play an increasingly key role in joined up workforce planning.
- 4.28 Shared training should be encouraged, together with the development of 'passports' reflecting qualifications and experience that make it easier for people to work within the whole health and care system rather than just one part of it.
- 4.29 The strategy should include integrated training and continuing professional development for social care and NHS staff, supporting the vital work of multi-

professional, multi-organisational teams and making it easier to integrate care around the needs of an individual. The strategy should also set out practical support for career pathways that include both NHS and social care.

- 4.30 Investment in workforce development in social care should be longer term, as a minimum based on a 3-year rolling planning cycle to support multi-year investment programmes.
- 4.31 The example of Derbyshire integrated care system shows the value of collaborative workforce planning:

In Derbyshire the integrated care system workforce team are working with Joined Up Careers, along with the Department for Work and Pensions, Jobcentre Plus and Futures for Business, to boost recruitment to the health and care Sector-based Work Academy Programme (SWAP). The programme, led by the local city council, prepares and places new entrants into the health and social care sector in Derby and Derbyshire, particularly targeting support to increase the employment rate for individuals unemployed and or on Universal Credit who are disabled, people aged 50+, ethnic minorities (BAME) and women. As a result of this programme, 299 participants signed onto the pathways into health and social care employment project, many of whom were previously unemployed or economically inactive.

- 4.32 Working in this way, at place or system level, ICSs can contribute to wider social and economic development - their fourth core purpose - as well as helping to solve immediate workforce challenges.
- 4.33 A similar partnership approach has been taken by the Suffolk and North East Essex (SNEE) ICS to the challenge of recruiting and training more NHS dental staff in a region that does not yet have its own university dental school. In collaboration with the ICB, the University of Suffolk have established a Centre for Dental Development, which will enhance local education and training opportunities in dental therapy and hygiene, apprentice dental technicians and post graduate dentists. The Centre will sit alongside a community interest company, created by the university, that will be able to bid for future locally commissioned dental services in line with usual NHS protocol. This initiative has the potential to improve the levels of NHS dentistry provision not only in SNEE but also in neighbouring systems such as Norfolk and Waveney. It is a further example of how an ICS has built an innovative local partnership solution to a major national challenge.

A joint venture community interest community has been established by Suffolk University and the ICB to create a dental training practice, where new recruits train as dental hygienists and dental hygienists can train as dental technicians, upskilling and expanding the existing workforce but also providing badly-needed dental care for local residents

under the supervision of qualified dentists and trainers. As in Derbyshire, the apprenticeship levy is a major source of funding for this work.

- 4.34 I support the Messenger Review's call for systems to improve mutual awareness and provide opportunities for staff to engage beyond their professional environment, to appreciate the totality of the system, and to value diverse professional approaches. For the NHS (itself a complex system within the larger complex system that is an ICS), there should be a clear expectation that part of the training and development budgets within each NHS entity (that is, 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. This is an essential part of creating the multi-disciplinary, multi-organisational neighbourhood teams (as well as the coherent system-wide leadership) that are at the heart of effective integrated care.
- 4.35 Professionals and practitioners should be offered formal and informal opportunities to develop their understanding of other parts of the system as part of their continual professional development.
- 4.36 Integration also goes beyond training, with a need for clear and standardised policies, governance and frameworks to enable flexibility across health and care roles. Blending some of the tasks of health and care roles can enable a better experience for the patient, increased continuity of care and a more efficient use of resource. Teaching a home carer how to dress a wound is an example of how transferring a healthcare intervention from a clinically registered practitioner to a non-clinically registered individual can potentially improve services by enabling closer alignment of different aspects of a person's care.
- 4.37 While delegation for certain interventions is becoming more common, it often takes place through informal agreements. This causes challenges for providers (for example around indemnity cover) and complications for regulators. Although published guidelines on delegation do exist, they are disjointed and not applicable across the whole health and care system. Without standardised governance and frameworks, it is challenging for individuals to feel supported and confident in delivering these interventions.
- 4.38 I therefore recommend that DHSC bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.
- 4.39 To speed up the onboarding of health and care staff and enable movement across the system where necessary, commissioners may consider requiring that providers maintain health and care workers DBS certification on the existing online database. This would mean there is no wait time when a person moves job as it is centrally stored and kept up to date, and therefore just minutes for agencies to

check, confirm or print a person's DBS certificate. Consideration should also be given to the passporting of training to reduce duplication and induction times.

The digital and data workforce

- 4.40 Although much of the focus and investment has been on digital and data systems within acute hospitals, it is essential that we level up basic digital infrastructure in all parts of the system, instead of expecting nurses, healthcare assistants and care workers looking after people with complex conditions and multiple needs to write down essential information on paper and then spend precious time going back to the office to input the data manually.
- 4.41 The skills needed to deliver data and digital transformation require a professional and highly skilled workforce at the system and provider level. Many health and care staff are well-versed in the use of digital tools; as the digitisation of health and care intensifies, staff at every level need to feel equipped and confident to use the tools available. As I heard frequently from clinical CIOs and other experienced leaders, new systems including electronic patient records are not primarily about technology: they are about transforming clinical and administrative processes to achieve better outcomes for patients, with digital tools enabling but not themselves delivering the necessary transformation. Major 'IT' programmes require substantial time and effort before, during and after implementation in culture, behaviours, and leadership, developing more medical, nursing and AHP CIOs and ensuring that all staff are comfortable with the tools they need to use.
- 4.42 The health and care system urgently needs to develop, train and recruit more specialists in fields such as data science, risk management, actuarial modelling, system engineering, general and specialized analytical and intelligence. Unfortunately, the Agenda for Change framework for NHS staff makes it impossible for systems to pay competitive salaries for these skilled professionals, with the result that too many ICBs and providers recruit the necessary staff on short-term contracts. I therefore recommend that ministers and NHS England work with the trade unions to resolve this issue as quickly as possible. National workforce planning needs to include steps to ensure that systems can build digital capability, upskill their current workforce and develop clear pathways for progression. ICSs themselves, working with local schools and further education providers, can create new routes into digital roles along the lines of the local academies that have successfully used apprenticeships to recruit and develop trainee nurse associates. As NHS England completes its own reorganisation, it would also be helpful if skilled staff could be seconded or transferred directly into those ICBs that need most support, with a specific focus on data science, cyber security, and analytical skills.

Chapter 4: recommendations

26. NHS England and DHSC should, as soon as possible, convene a national partnership group to develop together a new framework for GP primary care contracts.

27. The government should produce a strategy for the social care workforce, complementary to the NHS workforce plan, as soon as possible.

28. DHSC should bring together the relevant regulators to reform the processes and guidance around delegated healthcare tasks.

29. Currently 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.

5. Resetting our approach to finance to embed change

- 5.1 Instead of viewing health and care as a cost, we need to align all partners, locally and nationally, around the creation of health value. That shift is entirely in line with cross-government public spending principles, with their strong focus on public value and the outcomes that are being delivered for citizens.¹⁶ As individuals, there is nothing more valuable than our own health and wellbeing and that of the people we love. But good health also has a wider value to our society and economy. Recent analysis finds that every pound of public money invested in the NHS can generate £4 on average through gains in productivity and increased participation in the labour market.¹⁷
- 5.2 Today, however, we are not creating the best health value that we could from the current investment in the NHS. The evidence from other healthcare systems as well as our own demonstrates that there is a proven opportunity, whatever the total spend, to create greater health value by investing in primary and secondary prevention and by shifting care from acute to community and primary care settings ('allocative efficiency'). At the same time, within each element of healthcare, there are multiple opportunities to improve technical efficiency by enabling our most valuable resource - our people - to work more effectively (replacing paper systems with shared digital records, for example, or ensuring that every operating theatre session is fully utilised) and to significantly improve the use of our building and equipment.
- 5.3 Medicare, the publicly funded programme for people over 65 in the US, provides compelling examples of the improvements in outcomes, quality and value for money that can be achieved at scale through an integrated approach, with a single budget for the healthcare needs of a population group rather than fragmented payments to different providers. Such an approach typically involves earlier screening of older patients, with fewer ED visits and about 30% fewer hospital admissions. One of the Medicare providers demonstrating the value of this 'upstream' approach is the Florida-based group, ChenMed.¹⁸

Founded in Miami, Florida, ChenMed operates under the Medicare Advantage model, which as part of the wider government-funded Medicare programme specifically provides government funding to support those over 65 with more complex needs or in areas of high deprivation. ChenMed's care model invests heavily in primary care and prevention to

¹⁶ HM Treasury, [Managing public money](#), last updated September 2022

¹⁷ NHS Confederation, Carnall Farrar, Analysis: The link between investing in health and economic growth. 2022.

¹⁸ Commonwealth Fund - Transforming Care: Reporting on Health System Improvement (March 2016)

improve outcomes, experiences and the time patients spend at home. This model uses rigorous risk stratification combined with high intensity proactive care to deliver these outcomes. Prioritising high frequency, longer GP visits enables GPs and core care teams to evaluate patients and conduct risk stratification to ensure they can focus on patients at highest risk of inpatient admission. This approach focusing on primary care and prevention has had remarkable results, generated significant value for those supported by ChenMed and resulted in a 40% reduction in inpatient hospital days compared to the Miami average.

5.4 There are many other examples of the value of this kind of proactive, prevention and outcome-focused care, reflected in the Fuller Stocktake as well as this report and elsewhere. Working at many levels - through place partnerships, integrated neighbourhood teams and provider collaboratives, as well as system-wide, ICSs provide the opportunity for urgently needed improvements in both allocative and technical efficiency.

Financial accountability

5.5 As mentioned earlier, integrated care boards (ICBs) are accountable for £108 billion of the £150 billion made available annually by parliament for the NHS.¹⁹ Ensuring that taxpayers' money is used to the best possible effect is a moral as well as a legal duty. Robust financial accountability, both to local residents and to parliament through NHS England and ministers, is therefore non-negotiable. But the creation of integrated care systems (ICSs) means that ICBs' accountability for NHS finances also needs to sit within a wider framework of local accountability for ICSs (including the mutual accountability of ICS partners to each other for achieving their agreed goals).

5.6 NHS England, DHSC and HM Treasury should therefore work with ICSs collectively, and with other key partners including the Office for Local Government and the Chartered Institute of Public Finance and Accountancy (CIPFA) to develop a consistent method of financial reporting that will give the public the information they need to hold their local systems to account, without creating burdensome new reporting requirements. Obviously much of local councils' budgets are devoted to responsibilities other than health and are therefore outside the scope of ICS-related work. We would also expect this group to review the implementation of recommendations related to greater financial autonomy and encourage proactive management of funds and good financial practice. Working across organisations and with ICSs in this way would provide a further opportunity to build in practice

¹⁹ Data refers to CCG and NHS England spending for 2021 to 2022 financial year - NHS Commissioning Board Annual Report and Accounts for 2021 to 2022 financial year [NHS Commissioning Board Annual Report and Accounts 2021 to 2022 financial year - for the period 1 April 2021 to 31 March 2022 \(england.nhs.uk\)](#) - to note £108 billion is the amount which ICBs were formally allocated in 22/23 the actual amount ICBs are responsible for is likely to be greater when considering funding streams from delegation or other one off in year funding packets.

the collaborative arrangements that are needed at national level to support those within ICSs.

- 5.7 The aim should be for an ICS to show its residents, local Health and Wellbeing Boards, oversight committees and Healthwatch, as well as national bodies, how much it is collectively spending from all public funds on prevention, population health management and reducing health inequalities; or on supporting mental health as well as treating mental illness; as well as, within the NHS, how effectively money has been spent for instance with respect to rates of operating theatre utilisation. As the financial framework for ICSs develops, this information should be transparent and enable a clear link between spend and health outcomes, as well as between quality, safety and productivity within the NHS itself.

Funding settlements

- 5.8 One of the main themes in the submissions received in response to the call for evidence was the perverse effects of ‘penny packets’ of funding in particular. Concern has been raised in relation to funding for discharge, and for investment in digital transformation.
- 5.9 An additional source of frustration and inefficiency is ‘non-recurrent’ money that is in practice ‘recurrent’ but that cannot be properly planned for because it is not in the baseline allocations. For instance, ‘winter funding’ is often provided (in October or November) in order to ramp up community health and social care beds, that will then be stood down in April, before being restored the following winter - when the ‘new’ beds simply return the situation to what it was a few months earlier.
- 5.10 Instead, funding should be largely multi-year and recurrent. The approach taken by the 2023 to 2024 priorities and operational planning guidance in converting some key non-recurrent funding into recurrent funding has been particularly welcomed in supporting planning over a longer term.
- 5.11 I therefore recommend ending, as far as possible, the use of small in-year funding pots with extensive reporting requirements. Additional funding pots should be considered only in limited, carefully considered exceptions rather than the rule. If they are required, funding should have:
- a reasonable turnaround time and duration to have a realistic impact. When setting the duration national organisations must consider the length of time needed to mobilise and wind down funding
 - restrictions and reporting requirements to be proportionate to the size and duration of the funds, to ensure they are not disruptive to system working, as well as to prevent non-take-up by some systems. In other words, small

amounts of time-limited money require maximum flexibility to get the best results

- 5.12 Further, the fact that funding settlements for the NHS, social care and public health are announced and allocated at different times throughout the year is a fundamental issue for the integration of services between and within the different parts of the system and impedes the ability of ICBs, ICPs and local authorities to plan effectively at system level. As well as this, differential approaches to funding across local authorities in the same ICB also impact on the system's ability to deliver equitable standards of care across an ICS.
- 5.13 I recommend that DHSC, DLUHC and NHS England align budget and grant allocations for local government (including social care and public health which are allocated at different points) and the NHS so that systems can more cohesively plan their local priorities over a longer time period.

Financial flexibility for intra-system funding

- 5.14 In order to facilitate greater self-governance, I recommend that systems should be given more flexibility to determine allocations for services and appropriate payment mechanisms within system boundaries, and the NHS payment scheme should be updated to reflect this.
- 5.15 Flexibility for intra system funding allocations should include the reduction in hypothecation of funding allocated to systems, either by provision or condition. This will enable local systems to allocate funding to maximise health value for their local populations.
- 5.16 While the reduction of hypothecation is crucial and should continue, I have heard mixed views over the course of this review as to how far this should be taken. On the one hand some called for an end to all hypothecation including mechanisms such as the Mental Health Investment Standard (MHIS) on the basis that local systems should be able to determine where and how monies should be spent to maximise health and care outcomes. On the other hand, much of the evidence I received identified the MHIS as an effective tool to incentivise spend in an area where there are clear issues in achieving parity of esteem and one which had been long underfunded. As such, at this stage I do not believe systems are in a place where we can remove all hypothecation, particularly the MHIS. However, where hypothecation remains there needs to be a clear focus on delivering outcomes for populations and moving spending upstream towards prevention within hypothecated budgets.

- 5.17 It is important to recognise the role for consistency, and as such I recommend national guidance providing a default position for payment mechanisms for inter system allocations should be further developed.
- 5.18 This will also require strengthened local analytical resource to assess what will deliver the greatest value for local populations. For smaller systems this analytical resource could be shared for instance across a regional footprint. This should be supported by national analysis drawing on national and international evidence.
- 5.19 These proposals do not imply a complete “letting go” by national organisations - rather, a move away from the volume of conditions that so often come with national funding and a move towards greater ICS autonomy, held to account by NHS England.

Simplifying and broadening delegation and pooled budget arrangements

- 5.20 As part of greater flexibility in managing funding within systems, pooling budgets allows local leaders to make holistic decisions about how best to allocate resources across their health and care systems - both to ensure better use of resources to address immediate needs, but also to support long-term investment in population health and wellbeing.
- 5.21 Pooled and aligned budgets have been routinely and successfully used across systems for some time; a minimum of £7.2 billion has already been committed to the BCF this year with 90% of local areas consistently agreeing that delivery of the BCF in other years has improved joint working between health and social care.²⁰ However, we have heard from the system that these methods for pooling budgets can be unnecessarily bureaucratic and narrow and do not allow for effective transparency.
- 5.22 Section 75 of NHS Act 2006 provides the legal mechanism for creating formal pooled budget arrangements between the NHS and LAs to carry out health and care related functions. I recommend that the government accelerate the work to widen the scope of s.75 to include previously excluded functions, (such as the full range of primary care services) and review the regulations with a view to simplifying them.
- 5.23 In the medium term reviewing the legislation would be helpful with a view to expanding the range of the organisations that can be part of s.75 arrangements to

²⁰ Department of Health and Social Care (2022) [Better Care Fund Framework 2022 to 2023](#). (Accessed: 30 March 2023).

include social care providers, VCFSE providers and wider providers such as housing providers.

Ensuring efficient delivery of care

- 5.24 While there is considerable scope to improve public value through shifting resources “upstream”, there is also scope to improve public value by addressing the costs of delivering care.
- 5.25 There is an opportunity to address unwanted variation in cost and opportunities to improve ways of working through improvements in technical efficiency. The increasingly urgent need to maximise value for public money is hampered by the continuing difficulty in establishing the real cost of delivering care (for example whether fixed costs are included, how administrative costs are applied and so on.) and the narrow focus on episodes of care, rather than complete pathways that include prevention, early intervention and support in the community (including from the VCFSE sector).
- 5.26 There are fundamental productivity challenges that systems, if using the appropriate tools, can address. For example, with the exception of the height of the pandemic, performance against the 4-hour A&E target has been declining for a decade, despite the fact that emergency medicine has been the fastest growing clinical specialty in the NHS and, in that time, there’s been a near doubling in the number of (full time equivalent) emergency medicine doctors.²¹ This combination of significantly more clinicians but declining productivity emphasises the need to move resources upstream (including by integrating appropriate specialist clinicians within wider neighbourhood teams) as well as rapidly improving productivity within emergency care and acute hospitals themselves.
- 5.27 Across all parts of the health and care system, there are many opportunities to use digital technologies to reduce administrative burdens on both clinical and other staff (for example moving to real time data dashboards rather than cumbersome paper based data collection); ensure that clinical and other staff are spending the maximum possible time on care and treatment (for example reducing journey times through smart scheduling or optimising theatre scheduling); and to support multidisciplinary working (for example using decision management tools to support a wider range of clinical staff to provide safe and effective care).
- 5.28 The 7-day-a-week, emergency ophthalmology service provided by Moorfields in partnership with the London Central ICB is a striking example of digitally-enabled, consultant-led transformation that has effectively eliminated waiting times for

²¹ Rees, Sebastian, Hassan, Hashmath The A&E crisis: what’s really driving poor performance? Reform, (February 2023)

emergency care in one speciality. Equally, University Hospitals Birmingham has transformed its skin cancer pathway, using telehealth tools in the community and artificial intelligence support for diagnosis, significantly reducing the need for hospital appointments. By connecting primary, community, intermediate care and acute hospital teams through high-speed broadband networks, digital stethoscopes and similar smart diagnostic tools, we can bring the NHS to its patients.

- 5.29 Systems can play a crucial role in ensuring efficient delivery of care by their partners. Fundamental to this is improved data sharing accompanied by an actuarial approach to data and risk to understand how money is being spent and how effectively it can be spent across a system. The data sharing between NHS England, DHSC, ICBs and providers discussed previously helps to establish a 'single version of the truth' that will allow all concerned to understand the overall performance of the system and its component parts. There is already considerable benchmarking data available (for example GIRFT and Model Hospital Schemes) and this should be expanded to more areas, in particular in areas which are particularly data poor such as mental health, community services and primary care. Given this data, system leaders must feel empowered to work with partner organisations to drive improvements in productivity. Alongside such benchmarking and reflecting the fully integrated approaches of leading systems referred to earlier, it is also essential to adopt clean sheet design approaches or zero-based budgeting to set out what best practice care or processes should look like and calculate what different interventions should cost.
- 5.30 DHSC and NHS England should undertake work to share examples of pathway redesign where systems are moving to a 'could cost or should cost' funding model rather than what they 'do cost', based on efficient models of care and utilisation of staff or facilities - building on the analysis undertaken by GIRFT and others. These should increasingly look at the whole pathway, including the vital work of the VCFSE sector and local government, rather than individual episodes of care.
- 5.31 'Should cost' modelling should be indicative rather than compulsory, providing useful input for decision-making within ICSs as well as between ICS partners and helping to create the necessary level of ambition for multi-year transformation.
- 5.32 Further, to ensure effective and efficient care delivery, there needs to be improvement support for systems and the organisations within them. It is highly encouraging that NHS England's Recovery Support Programme has developed from a provider-facing programme to one that also supports systems facing the greatest challenges. The breadth of that programme - embracing financial challenges but also quality and productivity ones as well - is a very helpful reflection of the appreciation in NHS England and in systems of the interconnectedness of many of the challenges facing the health and care system. NHS England should ensure that systems are able to draw upon a full

range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities. This should include more robust productivity and sophisticated modelling tools which include but go beyond GIRFT and Model Hospital to enable all systems to understand their real productivity challenges and opportunities.

In NW London ICS, the ICB finance team are working closely with finance directors from across NHS trusts to understand the scope of productivity opportunities.

For example, the ICB supported the deployment of external support to quantify current utilisation of operating theatres across all 4 acute trusts and to work with clinicians and managers to realise this significant improvement opportunity. Work has also been funded to support community trusts to count and measure consistently to allow for productivity (costing, inputs and outputs) assessment and comparison beyond the historic approach that has focused mainly on the acute hospital productivity element of patient care. Similar work is being undertaken across mental health trusts and primary care providers. Across all local care providers the ICB is supporting local leaders to identify where the primary, community and mental health real estate could be used more effectively to allow poor quality buildings to be exited.

Across all areas of health and care, the ICB is supporting the wider system to drive consistency of approach by aligning commissioning decisions to standardise service specifications, and to simplify pathways and reduce variation.

Transparency of information enables more effective and consistent comparison and understanding of workforce and other cost inputs to an overall population- based approach to outcomes. This will, in turn, provide the means by which the ICB's ambition to redistribute resources and enable investment in prevention and targeting health inequalities can be realised.

Payment mechanisms

- 5.33 Financial flows and payment mechanisms can play an important role in ensuring improved efficiency in care delivery. Responses to the call for evidence exposed contrasting views about the use of a payment by results including concerns that it creates perverse incentives for organisations, encouraging overtreatment of patients, discouraging joint-working focused on shifting towards early intervention and undermining efforts to address health inequalities.
- 5.34 What is clear is that current approaches are not effective in driving value-based healthcare and while payment by results can help drive activity in a particular direction, it is important to recognise that it needs to be adopted in the context of wider system reform, incentivising prioritisation of resources on upstream activity.

- 5.35 Many health systems in other parts of the world, including those that are entirely or largely taxpayer-funded, are developing payment models that support and incentivise a focus on health. Meanwhile, NHS funding remains over-focused on treatment of illness or injury rather than prevention of them and ICS partners struggle to work around over-complex, uncoordinated funding systems and rules in order to shift resource to where it is most needed. There are lessons from other systems that we should draw on.
- 5.36 I therefore recommend that NHS England work with DHSC, HM Treasury and the most innovative and mature ICBs and ICSSs, 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. It should consider a number of potential models including:
- incentives for individuals or communities to improve health behaviours
 - an incentive payment-based model - providing payments to local care organisations (including social care and the VCFSE sector) to take on the management of people's health and keep people out of hospital
 - bundled payment models, which might generate a lead provider model covering costs across a whole pathway to drive an upstream shift in care and technical efficiency in provision at all levels
 - payment by activity, where this is appropriate and is beneficial to drive value for populations
- 5.37 This work should lead as quickly as possible to the testing of new models in practice within a selection of systems, enabling further development and refinement through collaborative learning and action.

Capital expenditure

- 5.38 The call for evidence repeatedly raised that a lack of capital, inflexibility in use of capital and the layering of different capital allocation and approvals processes from different departments and agencies are major barriers to improvement and productivity.
- 5.39 While ICS level CDEL allocations have been introduced to give greater ability to direct their operational budget in line with their systems priorities and local needs, there are still some issues around how providers work across system boundaries. In particular, accessing capital to support population need rather than just in their headquartered ICS. For instance, an ICS that urgently needs Tier 4 mental health beds within its own area for patients currently sent out of area finds that its mental

health partner trust is unable to develop the necessary provision simply because the trust is headquartered in a different system.

- 5.40 To take a different example, even with the hugely important Diagnostic Assessment Centres and Community Diagnostic Centres, some ICBs have found that the configuration that best meets the needs of their particular residents is rejected as not meeting the national specification. The laudable attempt by DHSC ministers to find faster, cheaper ways of creating urgently needed new services have, unfortunately, on occasion added further delays.
- 5.41 ICS leaders have the perfect opportunity to work together not only within the NHS but with local government partners to make the best possible use of the public estate and scarce public sector capital. I therefore recommend that 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.
- 5.42 This should build on findings from the independent review of the NHS capital allocation process conducted by Richard Murray in 2021, which I understand NHS England took forward in their planning guidance.
- 5.43 A cross-government review should consider:
- how government could move towards a 10-year NHS capital plan, with initial freedoms over larger sums for, say, 5 years tested and developed within more mature systems
 - reviewing delegated limits and approval processes across HM Treasury Cabinet Office, DHSC, and NHS England with a view to having a simpler more streamlined approval process and giving more mature systems greater responsibility for prioritizing and managing capital expenditure
 - how to allow greater year-on-year flexibility to support more efficient use of capital and support invest to save or save to invest
 - clarifying the government position in use of private finance and government involvement in primary care capital
 - how to enable providers working across systems (particularly mental health, specialised and ambulance providers) to access capital to support population need rather than just in their headquartered ICS
 - incentives for more efficient system-wide property management and considering reform of CDEL to enable void space to be filled and co-location across the NHS and local authorities

Strengthening and embedding a culture of research and innovation

- 5.44 Throughout this review, I have heard about the need to embed innovation throughout the health and care system. As care pathways as transformed across systems, it is essential that ICSs build a culture of importing and exporting “what works”, and that they innovate and transform in partnership with academia and industry. Academic Health Science Networks (AHSNs) should be seen as integral to that ambition, with ICBs ensuring that their AHSNs are aligned with local strategic priorities in order that best practice that meets the needs of their populations can be spread and adopted at pace and at scale.
- 5.45 To give just one example of this in practice, Imperial College Healthcare, itself an AHSN and part of the North West London Acute Provider Collaborative, has worked with primary care partners to transform its entire heart failure pathway. Equipped with a remote heart failure monitoring app to detect any abnormalities, patients are freed from multiple face-to-face follow-up appointments. Costly emergency hospitalisations have been significantly reduced. Above all, health outcomes have been improved.
- 5.46 Rather than each of the 42 systems to be constantly reinventing the innovation wheel locally, each investing relatively small individual budgets, ICBs can mobilise this expertise as a cost-effective and productive part of their contribution to system infrastructure. Regional AHSNs should work together, and with the national AHSN Network to identify and spread best practice, innovative pathways, enabling each system to import proven interventions including from academia and industry from elsewhere in the country, while ensuring that their own innovative approaches become part of the wider pool. Case studies such as West Yorkshire and South Yorkshire²² demonstrates how embedding an AHSN to deliver an “innovation hub” for an ICB provides the right expertise for the system, as well as allowing the AHSN to efficiently transfer best practice between systems and regions.
- 5.47 Systems should feel empowered to engage with AHSNs, National Institute for Health and Care Research (NIHR) as well as regional and national academic communities to proactively draw on their support and skills. This should align and support ICBs with the duty placed on them to facilitate and utilise research for the improvement of health and care services. Therefore, it is vital that we build a thriving research community which can easily access and utilise the wealth of data that systems collect to undertake well-developed and valuable research to support systems to drive transformation and enable wider economic growth.

²² NHS England [Strengthening local partnerships and driving innovative solutions using innovation hubs](#)

Specialised commissioning or tertiary services

- 5.48 I wanted to note briefly, that during this review, several clinical and other leaders expressed concerns about the place of specialised services within the new landscape of ICSs. Unfortunately, it has not been possible in the timescale of this review to consider this issue in detail.
- 5.49 Specialist units, whether free standing or within larger trusts, are global leaders within clinical research and care. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS. As such they need to be viewed and supported as national assets within the context of the life sciences strategy and plans for delegation of the commissioning of the services they provide.
- 5.50 Following extensive engagement over the last 2 years, NHS England is in the process of delegating some of its responsibilities for specialised commissioning to the new ICSs from 2024. I have heard both from some specialist leaders who still have concerns with the new approach, as well as from others who are supportive of the proposed delegation and believe ICB pathways can deliver improved outcomes and more efficient delivery of care.
- 5.51 During 2023 to 2024 joint committees of ICBs and NHS England are being established to take on a subset of those specialised services. As these new arrangements are put in place, it is essential that they are kept under review to ensure the critical role of these specialist service providers is appropriately maintained through any new arrangements and these provider organisations continue to be engaged.

Chapter 5: recommendations

30. NHS England, DHSC and HM Treasury should work with ICSs collectively, and with other key partners including the Office for Local Government and CIPFA to develop a consistent method of financial reporting.

31. Building on the work already done to ensure greater financial freedoms and more recurrent funding mechanisms, I recommend:

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, and updating the NHS payment scheme to reflect this; and

c) National guidance should be further developed providing a default position for payment mechanisms for inter system allocations.

32. DHSC, DLUHC and NHS England should align budget and grant allocations for local government (including social care and public health and the NHS).

33. Government should accelerate the work to widen the scope of s.75 to include previously excluded functions (such as the full range of primary care services) and review the regulations with a view to simplifying them. This should also include reviewing the legislation with a view to expanding the scope of the organisations that can be part of s.75 arrangements.

34. NHS England should ensure that systems are able to draw upon a full range of improvement resources to support them to understand their productivity, finance and quality challenges and opportunities.

35. NHS England 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.

36. 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.

6. Annex A: the journey of the review

- 6.1 In November, during his autumn statement, the Chancellor of the Exchequer announced an independent review to consider the oversight and governance of integrated care systems (ICSs).
- 6.2 While the Secretary of State for Health and Social Care appointed me to lead this review, the report has only been possible due to the generosity of hundreds of individuals and organisations who have given up their time and engaged with us over the last 5 months.
- 6.3 During this review, I have engaged with over a thousand leaders from across ICBs, ICPs, local government, NHS trusts and foundation trusts, social care providers, VCFSE groups, academics and others with an interest in the success of ICSs.
- 6.4 We have also heard from over 400 respondents via our call for evidence - and we are grateful to everyone who responded from across the health and social care sector, patients, the public and wider voluntary sector. Throughout this review, we have been keen to capture the views of all partners involved in the day-to-day business of ICSs and their partners, and their responses has made this process richer and better informed at every step.
- 6.5 I am especially grateful to the work of colleagues who led and contributed to the 5 workstreams, that produced the majority of my recommendations. Colleagues from patient and service user groups, local government, the voluntary community faith and social enterprise sector and the social care provider sector, as well as the NHS, were included in the work streams, reflecting the partnerships that constitute ICSs.
- 6.6 Each workstream held a wide range of meetings in order to gather evidence from across the system. They reviewed the call for evidence responses, expert papers and data as well as a range of qualitative information from across the system.
- 6.7 From late January 2023, each workstreams also held a ‘town hall’ online event in which wider stakeholders were able to hear and contribute to the developing thinking of each workstream.
- 6.8 The review team also engaged with system partners more widely. This includes but is not limited to, engagement with:
- DHSC, NHS England and CQC
 - chairs and CEOs of ICBs and chairs of ICPs

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- trust and foundation trust leaders
- social care providers
- primary care providers (including general practise, dentistry, optometry, and community pharmacy) and leaders of primary care networks and partnerships
- a wide range of voluntary, community, faith and social enterprise stakeholders (including organisations representing children, mental health and the role of patient and public voice within health and care services)
- local government, including councillors, CEOs and directors of public health, adult social care and children's social care
- Healthwatch
- national trade union representatives

6.9 In engaging widely, and seeking a range of views, I believe that we have established a number of recommendations that can be widely supported, and which will enable ICSs to succeed.

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