HFMA response
January 2023

Hewitt review

HFMA response to the call for evidence

Introduction

The terms of reference for the Hewitt review were published on 6 December 2022. The review considers 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 (DHSC), 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, the review 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.

Response

Question 1: What are the best examples, within the health and care system, where local leaders and organisations have created transformational change in the way they provide services or work with residents to improve people's lives? Examples can be from a neighbourhood, place or system level.

Some examples of effective transformational change may appear to be so logical or simple for those involved that they may not recognise them as being transformational. However, the cumulative effect of these changes can be significant. It is therefore vital that sharing of all experiences, however simple, is encouraged and supported.

The HFMA sees many examples of transformational change where finance teams have played a key role in facilitating the initiative. Our national finance awards[1] have recently recognised systems and organisations across the United Kingdom. Examples include:

- the Connect Programme in Mid and South Essex ICS that brings together 15 organisations in five interrelated projects across the entire non-elective pathway. It is jointly designed, led, and governed to achieve better outcomes for older people, as well as improving staff experience and providing financial benefits
- the combined finance teams across Staffordshire and Stoke-on-Trent Integrated Care System focus on patient pathways, rather than viewing activity and funding through an organisational lens. This allows them to allocate resources fairly and transparently across all partners
- Leicestershire, Leicester and Rutland Clinical Commissioning Group worked with primary care providers to develop a needs-based allocation formula for primary care that weights funding towards those practices who serve the population with the highest need, recognising that age (as traditionally used) does not always equate to health need.

Question 2: What examples are there of local, regional or national policy frameworks, policies, and support mechanisms that enable or make it difficult for local leaders and, in particular, ICSs to achieve their goals?

ICSs are in their early stages and there is still a cultural shift needed from the legacy approach of achieving efficiency through competition. Collaborative behaviours and relationships can be supported, or stymied, by national messaging and behaviour. An integrated approach at government level to reinforce shared goals, for example between the Department for Levelling Up, Housing and Communities (DLUHC) and the DHSC, would support local working.

National policies and frameworks should set out a clear minimum expectation which can then be implemented locally. The recent shift in the guidance relating to place – from local definition of places that were meaningful to their populations to more recent attempts to create a more homogenous approach has been unhelpful.

Goals for ICBs are long term – improving population health and reducing health inequality. The short-term nature of financial flows makes long-term investment challenging.

Recruitment and establishing new models takes time – in-year revenue allocations do not provide the funding certainty needed to make long term plans with confidence. When funding is unclear, individual NHS bodies will focus on internal need rather than working with partners.

The capital departmental expenditure limit (CDEL) remains an annual hard limit on the amount of capital expenditure the DHSC group can incur. This results in perverse behaviours at the year-end as supply chain and other issues outweigh other considerations when money must be spent or lost.

There is no simple process for transparently moving funds between NHS bodies meaning that funding flows can be a barrier to system working.

Question 3: What would be needed for ICSs and the organisations and partnerships within them to increase innovation and go further and faster in pursuing their goals?

NHS staff want to innovate and improve patient care – an aim shared nationally. However, the number of competing priorities (reducing waiting lists, staff recruitment, wellbeing and retention, digital development, the green agenda, and so on) leaves little capacity to address local priorities. Systems need space to develop, build relationships and trust to support collaborative behaviours, and understand what works for their population.

Significant financial constraints limit innovation as some double funding is required during the pilot and transition period. This limits the ambitions that can be realised. Long-term goals must be balanced with short-term operational issues. We have found that, ‘finance directors are concerned

[1] HFMA, *HFMA awards 2022,* December 2022

that longer term measures in relation to prevention, population health and health inequalities will be delayed as resources are spent on more immediate concerns.'

Workforce is a critical issue. There are insufficient staff to deliver current services at the level required, with significant vacancies in all sectors. New initiatives and service models can draw staff away from under pressure services to more attractive roles, exacerbating pressures on the day-to-day delivery of services. It is expected that more services and provision will move to community settings where appropriate – this needs to be supported by making staff movement between organisations and sectors easier.

Innovation within ICSs will involve multiple partners, which is a challenging context for decision making, with competing organisational priorities increasing the time that decision making can take. ICSs need support to find the most effective decision-making processes so appropriate action can be taken.

Question 4: What local, regional or national policy frameworks, regulations and support mechanisms could best support the active involvement of partners, including adult social care, children's social care services and voluntary, community and social enterprise (VCSE) in integrated care systems?

Working as a health and care system across multiple sectors (including different finance and governance regimes) is primarily about effective relationships and trust between partners, which take time to build. Without this, national frameworks and regulations will have little impact. Work carried out in this space must promote transparency and sharing of information between partners and consider where there may be perverse incentives that work against this. For example, until section 41 of the VAT Act is reformed, VAT remains a barrier to NHS and local authority working arrangements.

It can be difficult to fully engage with all partners, particularly where the ICS model is seen as an NHS initiative that does not consider the priorities of other bodies. It is important to ensure that all voices are heard, which can require an active approach to engagement and partnership working. This is often most effective at a place-based level, as it is where relationships can be built most effectively.

Data sharing needs to be extended beyond the boundaries of the NHS. Local authorities hold significant information about their populations which can better inform the delivery of healthcare. Primary care information is often difficult to access but is essential in understanding population health and patterns of access. The VCSE sector is able to access communities that the NHS sometimes cannot. Bringing all of this together would dramatically improve the health and wellbeing of the population, start to address health inequalities and highlight the different skills and roles of all partners.

Question 5: What recommendations would you give national bodies setting national targets or priorities in identifying which issues to include and which to leave to local or system level decision making?

The key recommendation is to be clear on 'what' the national priorities are and allow local systems to develop the 'how'. The national role is to keep sight of the shared purpose. Priorities must be understandable, of limited number, and realistically achievable within current funding and timescales.

National priorities should be set in collaboration with local systems, who understand the realities of delivering services to patients and improving population health. The impact must be considered across the whole system – so priorities around acute activity acknowledge and fund the work created for other sectors such as community, mental health, or ambulance services.

When setting priorities, potential barriers to achieving them which are outside of the influence of the NHS, must be considered. For example, the impact of social care capacity on the ability of the NHS to reduce waiting lists, or the impact of poor housing on improving population health. Only the government can work across departments to address competing policies.

Local organisations need to be given time to make the changes required to achieve national goals. Priorities need to remain stable before assessing whether they have been achieved. For example, Lincolnshire County Council takes a multi-agency approach to preventing falls including fire and rescue responders, the ambulance service and voluntary sector organisations. It has taken them time to build relationships and develop a successful joined up working arrangement. There are clear benefits for service users from joined up working arrangements but those benefits may not necessarily be seen by the bodies involved.

Question 6: What mechanisms outside of national targets, for example peer support, peer review, shared learning, or the publication of data at a local level could be used support performance improvement? Please provide any examples of existing successful or unsuccessful mechanisms.

Sharing experience and learning is essential. The HFMA's ICB Finance Group, made up of over half of all ICB chief finance officers, noted that there was a need to share data and information across systems to both support development of ICSs and to support senior individuals who may feel isolated with an issue. The HFMA also enables peer support within the finance community through its networks across all sectors, creating a valuable resource to disseminate learning, share case studies, and discuss common challenges. These networks also support the NHS to develop relationships with other sectors and understand some of the pressures that they face.

The recent temperature check survey by the HFMA of directors of finance across all sectors of the NHS includes recommended actions for NHS bodies and national bodies to meet current financial and quality challenges.[2]

However, it must be recognised that building relationships through these networks, developing peer support mechanisms, and sharing learning all take time. The demands on the NHS mean that time is often precious with many conflicting priorities, which can limit the sharing of experience. The NHS also works in a culture where failure is hidden or punished, rather than used as a learning tool. This means that it is likely that multiple systems will repeat the same mistakes in trying to develop their approaches, wasting precious resources. Sharing examples of things that have not worked (for example, major IT projects), should be encouraged.

Question 7: What examples are there at a neighbourhood, place or system level, of innovative uses of data or digital services to improve outcomes for populations, improve quality, safety, transparency, or experience of services for people, or to increase productivity and efficiency?

As previously discussed, sharing case studies is an essential way of spreading innovation and learning. The One NHS Finance innovation library[3] includes a number of examples where data is being used to develop trust wide dashboards, for example at East Suffolk and North Essex NHS Foundation Trust. This enables all functions and clinical areas to understand how resources are being used and to anticipate the impact of any service changes that might be considered.

Another example is at Leeds Teaching Hospitals NHS Trust where they built a dashboard that helped reveal health inequalities by using patient-level information, with postcode and other demographic details. The tool has helped to develop targeted services to support more effective service utilisation. This project links with national work to develop and share regional and ICS level health inequalities data.

Question 8: How could the collection of data from ICSs, including ICBs and partner, organisations, such as trusts, be streamlined and what collections and standards should be set nationally?

Data collections are a source of much frustration in the NHS. It is essential that local organisations understand why data is being collected, that they can see the benefits and can use the data to inform

[2] HFMA, *NHS financial temperature check*, December 2022
[3] One NHS Finance, *Innovation library*, ongoing

their own service transformation programmes. The time taken to share the results of national collections can mean the outputs are no longer useful locally.

The national cost collection is one such example. Costing data can give significant insight into clinical services, provide valuable benchmarking and can support local decision making, but this requires costing teams to have the capacity to analyse and present the data in a way which is useful locally. National and local needs should be complementary to one another – national guidelines are necessary so data is comparable between organisations but those guidelines should not be so complex and detailed, that following them draws attention away from the big picture by focusing on areas which are not material[4].

The automation of national data collection from routinely collected datasets should reduce the pressure on bodies but there is a danger that automation creates a new industry of local reconciliation to understand how national conclusions have been drawn from the data. The recent work allowing provider bodies to automate the population of provider finance returns (PFRs) is a good example of collaboration between national and local bodies to make improvements for everyone.

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

Sharing data across organisational boundaries is essential for the effective use of resources and improved patient care. It enables whole patient pathways to be reviewed and developed to optimise value to the patient and the system. During the pandemic, data sharing rules were relaxed for the purposes of tackling Covid-19. This clearly demonstrated the impact that sharing information can have on the ability of organisations to work together, which is a key aim of the ICS model.

National policy, on a robust legal basis and with appropriate national cyber-security features, should allow organisations to share data for the purposes of improving patient care through service development and transformation. This should include evaluation of implemented changes to ensure that systems and the wider NHS are able to learn from the work. It should be supported by robust guidance on the key considerations, from a legal and information governance perspective, organisations should make when sharing data. Interoperability of systems is a key component to make this work. This is an example of where a national approach is helpful and more efficient than developing local approaches.

Question 10: What are the most important things for NHS England, the CQC and DHSC to monitor, to allow them to identify performance or capability issues and variation within an ICS that require support?

National bodies need to evolve in the same way that organisations within the ICS are expected to. The emphasis of national monitoring should be on system outcomes to recognise the role of integration. If performance monitoring focuses on activity in individual organisations, it will work against the wider desire to encourage and promote system working. There is a danger that the oversight process could rebuild the barriers that the Health and Care Act 2022 seeks to remove.

It is accepted that there will be issues that require intervention by the appropriate oversight body. However, these interventions need to be mindful of the wider system purpose and pressures, not exacerbate challenges elsewhere through regulatory action with one partner. Regulators must be aware of the pressures on NHS bodies when making recommendations.

Question 11: What type of support, regulation and intervention would be most appropriate for ICSs or other organisations that are experiencing performance or capability issues?

Support, regulation, and intervention needs to be proportionate to the issue identified. It is also essential that the root cause of the issue is identified so that intervention is at the right stage in the pathway, otherwise any actions will only have a short-term impact.

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[4] HFMA, *What does good look like for costing in the NHS?,* September 2021

Local circumstances need to be considered at all stages so that support and intervention is effective; a one size fits all approach is unlikely to work for anybody. It is important to be clear, in advance, about the steps that will be taken and what the end point is. Clarity of roles is needed, particularly to avoid the risk of the ICB being seen as another layer of regulation, including how any intervention links with the wider NHS England operating framework and the system oversight framework.

About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For over 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

The association also analyses and responds to national policy and aims to exert influence in shaping the wider healthcare agenda. It has particular interest in promoting the highest professional standards in financial management and governance and is keen to work with other organisations to promote approaches that really are 'fit for purpose' and effective.

The HFMA offers a range of qualifications in healthcare business and finance at undergraduate and postgraduate level and can provide a route to an MBA in healthcare finance. The qualifications are delivered through HFMA's Academy which was launched in 2017 and has already established strong learner and alumni networks.

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