

BMA Briefing – Government Response to the HSCC Report and the Hewitt Review of Integrated Care Systems (England)

On 14 June 2023, the Government published its joint response to the [Health and Social Care Committee \(HSCC\) Report](#) on ICS (Integrated Care System) autonomy and accountability and the [Hewitt Review of ICSs](#). The BMA had submitted evidence to both.

This briefing provides a summary of [the Government's response](#), and sets out the BMA's views on its key aspects.

Background

In November 2022, it was announced that the Rt Hon Patricia Hewitt – former Health Secretary, and current Chair of the Norfolk and Waveney Integrated Care Board (ICB) – would lead an independent review of ICSs.

The review spanned various themes relating to ICS development, such as ICS oversight and governance, balancing autonomy with accountability, and a shift towards prevention. Its [final report](#) was published in April 2023.

The HSCC Report, published in March 2023, shares several key themes with the Hewitt Review, with oversight, autonomy and prevention again taking centre stage. Other overlapping areas included data sharing and the role of the Care Quality Commission.

The BMA submitted [written](#) and [oral evidence](#) to the HSCC inquiry and provided a comprehensive [written submission to the Hewitt Review's call for evidence](#).

Theme 1: targets and priorities for ICSs

Both the HSCC Report and the Hewitt Review recommended **reducing the number of national targets** set by NHS England (NHSE) and DHSC. Hewitt went a step further, advising that the mandate to NHSE contain no more than 10 national priorities – a recommendation that DHSC have already adopted ([the 2023 NHS mandate](#) published in June of this year features just three priority areas).

Hewitt also proposed that ICSs be granted the power to set locally developed targets, which would carry equal weight to national targets. The government was receptive to the suggestion, stating that it has already taken “meaningful steps” towards a less top-down approach. It cited recent reforms to the [Commissioning for Quality and Innovation \(CQUIN\) 2023/2024 guidance](#), which marks a pivot away from exclusively national targets and allows local areas to also prioritise locally and co-developed priorities.

In addition to this, DHSC have committed to publishing a shared outcomes toolkit, designed to support the development of local outcomes.

BMA View

We welcome the reduction in top-down targets and directives – something that the BMA called for in our own submission to the Hewitt Review and has lobbied for since ICSs were first introduced. Enabling ICBs to set their own targets based on local priorities, should encourage them to become

more responsive to the specific needs of their area and to more effectively drive improvements in population health.

Theme 2: autonomy, leadership, and support for ICSs

The HSCC report and Hewitt Review both recommend an improved **ICS leadership development offer**. Specifically, HSCC calls on government and NHSE to create and fund an ICS Leadership Development Programme; its aim would be to support the leaders of ICSs, providing them with the necessary skills for successful systems leadership. Hewitt is less prescriptive, proposing simply that NHSE work more closely with the Local Government Association (LGA), NHS Providers and NHS Confederation to deliver on a leadership support offer for ICSs.

Whilst the government recognises the value of a national leadership offer, there is no clear pathway for delivering on this. More promisingly, DHSC notes that a senior advisory group spanning health and care will help advise on and plan a 3-year roadmap of leadership and management support.

HSCC also proposes a **national peer review offer for systems**, building on the approach developed by the LGA. The government agree to giving this further consideration but advise that this should be developed by partners *within* systems. At least in this context, the government appears to favour a shift towards a “more bottom-up, autonomous model of improvement”.

BMA View

The government’s failure to mention clinical leadership in their response is particularly disappointing, as the BMA views this as central to making improvements in patient care and collaboration. We continue to lobby for significantly greater clinical representation and leadership within ICSs, including from GPs, secondary care doctors, and independent public health experts.

We are also disappointed by the minimal commitment to improved leadership development in the government’s response. This is not in line with the BMA’s view that it is critical for ICS leaders to be properly supported to develop, particularly as ICSs are still in their infancy as statutory bodies.

Theme 3: ICS governance, accountability, and oversight

HSCC recommended that the Secretary of State set out performance measures that would empower MPs to hold their local ICS to account. However, DHSC rejected this, stating that there is already publicly available data (such as CQC and NHSE assessments) to support analysis of performance at an ICS level, and that the creation of additional mechanisms would go against the spirit of the Hewitt Review. In this section, DHSC re-iterates its commitment to fewer national targets and directives.

In addition to this, Hewitt made the case for the creation of High Accountability and Responsibility Partnerships (HARPs) as a next step for the most developed ICSs. Under the proposal, the top ten performing ICSs (characterised by sustained performance improvement and effective financial management) would be subject to less central oversight and be awarded greater financial freedoms. While DHSC is supportive of the intent behind HARPs, it stops short of a commitment to implementing these in practice, noting that ICBs and ICPs are still in their infancy. Instead, DHSC states that it will undertake further work as ICSs mature to understand how models like HARPs might be introduced in the future.

Hewitt also suggested that NHSE and government work together to review and reduce the burden of approvals for ICB, Foundation Trust and Trust salaries, with the aim of allowing them to recruit into senior roles more easily. This recommendation has already been accepted by government and is in train. DHSC highlight its work with NHSE to develop a new very senior manager (VSM) pay framework, designed to improve the consistency and transparency of pay-setting processes.

BMA View

The BMA supports the continued theme of fewer top-down targets and directives and several elements of the government's response align with our call to give ICSs the time and resources they need to succeed. In particular, we agree with DHSC's decision to delay the introduction of HARPs – given that ICSs have only very recently come into force as legal entities, the addition of a new tier of ICS may be premature.

Theme 4: assessments and reviews of ICSs

Both HSCC and Hewitt recognise the important role of the CQC. HSCC called on DHSC to urgently provide a decision on ICS CQC ratings and to establish priority areas for inspection – a recommendation that has since been accepted in part (the Secretary of State has set out priorities, but an approach regarding ICS ratings remains to be seen). Hewitt stressed that any rating system should include a measure of ICS maturity, which itself would comprise factors such as quality, performance, and financial management. DHSC agreed that the highest ratings would not be awarded to ICSs where financial management was a concern.

Overall, there is also agreement between the government, HSCC and Hewitt that – as far as possible – NHSE's reviews of ICBs and CQC's assessments of ICSs should be complementary, mutually reinforcing, and non-duplicative. This should also apply more broadly to approaches to improvement.

BMA View

The government's approach to CQC assessments and NHSE reviews is broadly encouraging. In particular, we welcome the incorporation of Hewitt's recommendations on a new ICS rating system. In our own submission to the Review, the BMA emphasised the need to consider the numerous factors impacting ICS performance, including patient safety, collaboration, and leadership. The government's commitment to developing a more holistic (rather than transactional) form of regulation is, therefore, in line with the BMA's views.

Theme 5: prevention and promoting health

Both HSCC and Hewitt recommended a shift in focus towards preventative care and the promotion of healthier lives. In its response, DHSC was broadly supportive, re-affirming the need for systems to take a "life course" approach in order to tackle health inequalities. This would, for example, involve incorporating the needs of pregnant women, babies, and children into system plans. That said, the government did not commit to a refresh of the 2019 NHS Long-Term Plan, stating that its priorities were still the "right ones", and that these were being built upon through the [delivery plan for tackling the COVID-19 backlog of elective care](#), the [delivery plan for recovering urgent and emergency care services](#), and the [delivery plan for recovering access to primary care](#). DHSC's soon-to-be published Major Conditions Strategy is expected to further contribute to this.

However, concerningly, the government rejected HSCC's recommendation for all ICBs to include a public health representative. Though the need for a focus on prevention is acknowledged, the government makes the case for ICSs having full autonomy over appointments made to their board, with decisions based on an area's local priorities. This is with the implicit understanding that ICB decision-making still involves public health input.

The government also rejected Hewitt's recommendation of a 1% increase in the share of NHS budgets at ICS level going towards prevention over the next five years, which it describes as an 'arbitrary shift in spending'. DHSC instead commit to supporting investment in prevention, working with NHSE, NICE, ICSs and local government to develop practical information and evidence to help guide local decision-making.

BMA View

Whilst we welcome a greater focus on the prevention of ill health, the government's failure to embed public health expertise in ICBs is concerning. In its evidence submission to the Hewitt Review, the BMA had specifically called for this, highlighting the need for, and benefits of, strong public health leadership.

The government's decision to not increase the share of NHS budgets at ICS level that go towards prevention is more complex, as we recognise that this shift in resource could create significant pressure on NHS budgets, particularly without an injection of additional funding. The BMA believes that all parts of the health and public health system should be properly funded.

Theme 6: finance and funding

Hewitt recommended, where possible, **the end of small in-year funding pots**, particularly those with extensive reporting requirements; the Review instead advocates for **more recurrent or multi-year funding mechanisms**, as these grant ICSs greater financial freedom. DHSC accepted this recommendation, promising to make significant improvements to reduce the prevalence of in-year funding. In their response, DHSC point to examples where this is apparently already happening, including the multi-year funding awarded to build new hospitals via the beleaguered New Hospitals Programme.

DHSC also agreed with Hewitt's suggestion that ICSs be given **greater flexibility to determine allocations for services, and over payment mechanisms** within their own boundaries. That said, the government highlights existing opportunities for flexibility, such as through the NHS Payment Scheme, and pushes back on the recommendation to limit ringfenced budgets, citing their necessity under certain circumstances (for example, the Mental Health Investment Standard).

However, **DHSC rejects the call to reconsider the 10 percent cut in ICB running cost allowance (RCA)**. It states that this forms part of the 30% real-terms reduction per ICB by 2025/2026 – an action that has been agreed to with government, and that forms part of the NHS financial plans.

Other key points include the government's commitment to **a review of the NHS capital regime**. Though the DHSC response points to the work already done in this area, such as the 2021 independent review of the regime, it supports a further review, with consideration given to areas that were not covered in detail previously. The government acknowledges the importance of **setting an overall strategic direction for NHS capital**, and **clarifying the position on new private finance**, promising to set out next steps in due course.

Most significantly, DHSC accept Hewitt's recommendation to create a working group, comprising NHSE, ICSs, local authorities and the Chartered Institute of Public Finance and Accountancy (CIPFA) to **develop a more consistent method for financial reporting**. The government's response acknowledges the need for this standardisation, agreeing that this will support spending on key policy areas within systems.

BMA View

Several aspects of the government's response are broadly positive, such as the commitment to more consistent and long-term funding arrangements for ICBs, and a further review of the NHS capital regime. The latter aligns with our criticism of capital investment, as set out in our report [Brick by Brick](#).

However, the refusal to reconsider the 10 percent cut to ICB running budgets is disappointing. We have been clear that ICBs need both time and resources to develop – this budget cut risks doing the exact opposite.

[Response to additional Hewitt review recommendations](#)

[Data and digital](#)

Hewitt recommended that NHSE, DHSC and ICSs collectively **develop a minimum data sharing standards framework** that is adopted by all systems, arguing that this would help improve interoperability and data sharing across organisational barriers. The government accepts this in principle, but it states that aspects of this are already being addressed through the plan for digital health and social care (June 2022) – for example, the plan includes milestones for setting standards on interoperability and system architecture.

In the same vein, the Review recommended **expanding the role of the FDP (Federated Data Platform)**, so that ICSs may have access to automated, accurate and high-quality data. This would enable health and care organisations to work together more closely and use data to drive improvements. DHSC supported the spirit of the recommendation and said that procurement of the Platform is currently underway.

[Primary and social care](#)

Hewitt advised that NHSE and DHSC urgently set up a national partnership group to **develop a new framework for GP primary care contracts** – a recommendation that the government has already put in train. In its response, DHSC promises to engage on 'the future of primary care,' working with key stakeholders such as patients, ICSs, and the profession itself to build on the Fuller stocktake report.

In addition to this, Hewitt recommended that the government develop a **social care workforce strategy**, akin to the NHS workforce plan. DHSC rejects this suggestion, stating that its 2021 white paper, People at the Heart of Care, already sets out the government approach to reforming adult social care.

BMA View

Although the BMA supports the use of data to deliver improvements, including a robust standards framework that supports greater data sharing across organisational boundaries, any further

expansion of the FDP must be approached carefully given the number of significant concerns about its development so far.

Chiefly, we are concerned that the development of an FDP may lock the NHS into a single supplier system, which could effectively outsource of the management of data for planning purposes and has not been developed with sufficient transparency to gain the confidence of clinicians and patients. This will be doubly concerning if the supplier who is ultimately selected to take the FDP forward has not been able to demonstrate a robust ethical framework for handling and sharing sensitive information. Furthermore, clarity on the sources of data that will flow to FDPs is needed to better understand the way in which they will function.

Regarding GP practices, we note the government's commitment to engage on the 'future of primary care'; the BMA has long voiced concerns over the existing GP contract and supports opportunities to reform this. That said, the BMA and GPC must be central to any discussions or negotiations, rather than merely consulted as one of several stakeholders.

Finally, we are disappointed by the government's failure to develop a social care workforce plan. The BMA appreciates the relationship between the NHS and social care workforce – which makes tackling issues in social care a priority. The social care sector is also experiencing a massive workforce crisis. For example, there are around 165,000 social care roles currently vacant. Projections indicate [that an extra 480,000 people may be needed to work in social care by 2035 to keep pace with demand](#).

These staff shortages are the result of poor pay, few training opportunities, and a sector suffering from a lack of workforce planning. It is crucial that a fully funded workforce plan for the care sector is developed and implemented to help reduce pressures within both the health and the care sector. This [should include ensuring social care workers are paid the Real Living Wage as a minimum](#), as well as introducing a standard work contract and improved training opportunities.