The Association of Directors of Public Health and The Faculty of Public Health Consultation Response

Hewitt Review: Call for Evidence

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

About ADPH and FPH

The UK Faculty of Public Health (FPH) is a joint faculty of the three Royal Colleges of Physicians of the United Kingdom (London, Edinburgh and Glasgow). We are a membership organisation for approximately 4,000 public health professionals across the UK and around the world and our role is to improve the health and wellbeing of local communities and national populations. We do this by supporting the training and development of the public health workforce and improving public health policy and practice in partnership with local and national governments in the UK and globally.

ADPH is the membership body for Directors of Public Health, and is a collaborative organisation, working in partnership with others to strengthen the voice for public health, with a heritage which dates back over 160 years. ADPH works closely with a range of Government departments, including UKHSA and OHID as well as the four CMOs, NHS, devolved administrations, local authorities and national organisations across all sectors to minimise the use of resources as well as maximise our voice.

ADPH aims to improve and protect the health of the population by:

- Representing the views of DsPH on public health policy
- Advising on public health policy and legislation at a local, regional, national and international level
- Providing a support network for DsPH to share ideas and good practice
- Identifying and providing professional development opportunities for DsPH

Empowering Local Leaders

As the system moves towards new ways of working, we are keen to explore how we can empower local leaders within ICSs. Please share examples from the health and care system, where local leaders and organisations have created transformational change to improve people's lives. This can include the way services have been provided or how organisations work with residents and can be from a neighbourhood, place or system level.

Examples:

- Place-based examples such as work on Severe Multiple Disadvantage including upstream and healthcare integration of services eg Nottinghamshire ICS (details can be found below)
- Anchor institution examples eg assistance in travelling to hospital appointments
- Place based prioritisation linking with the broader Health and Wellbeing strategy eg Bassetlaw

Do you have examples where policy frameworks, policies and support mechanisms have enabled local leaders and, in particular, ICSs to achieve their goals? This can include local, regional or national examples.

Local example - Nottinghamshire

Nottinghamshire ICS has applied for and been successful in obtaining a Section 251 to allow data sharing for secondary use such as population health management. This has dramatically strengthened the use of data for planning and prioritisation and, for example, has allowed a much better understanding of health and care utilisation by patients and families with severe multiple disadvantage, allowing better targeting of available support.

Local example - North East and North Cumbria

In the North East and North Cumbria ICS (which is the largest in the country), the Public Health (PH) Community (DsPH in 13 Councils, OHID Regional Team, PH Consultants in NHS Trusts) have collaborated to streamline the PH contribution into the ICS. We wanted to avoid a parallel PH structure being developed but also utilise skills across the region. We engaged the Kings Fund to help facilitate sessions to:

- Gain a shared understanding of how we are currently supporting ICS workstreams
- Learn from other areas of the country on coordinating efforts to support the ICS
- Understand what the ICB wanted from the PH community (interviews with Executives)
- Develop principles for coordinated working, learning from what has/has not worked previously, reducing duplication and maximising expertise

As a result we:

- Reviewed the infrastructure for Population Health, Prevention and Healthcare Inequalities
- Agreed lead roles, including role description and secured agreement for lead DPH into ICB Executive
- Coordinated meetings to strengthen communication across the PH community
- Drafted the 'PH offer' to ICS, building on the previous 'core offer' to CCGs
- Arranged two annual meetings with ICB Executive to reflect on how the principles are used in practice

Do you have examples where policy frameworks, policies, and support mechanisms that made it difficult for local leaders and, in particular, ICSs to achieve their goals? This can include local, regional or national examples.

Examples:

- The inability to move resources from the criminal justice system across to health and care interventions (such as diversion schemes) that themselves reduce burden and benefit primarily the justice system efficiency and capacity
- Block contracts for services which can be a barrier to new developments in service organisation and delivery, or implementation of integrated whole pathways of care. Some flexibility for introducing change through/alongside the commissioning process is needed.
- Centralising decision-making at ICB level and then applying these to local places without prior engagement
- There is a significant issue around resourcing, which needs to be addressed. The question goes beyond the NHS; although health improvement and prevention are now higher up the NHS agenda, this is not matched by funding. Tackling health inequalities in the NHS is often seen as offering greater digital access rather than understanding communities, deprivation and why people don't access services

To achieve better outcome, six elements are required:

1. Redistribute resource upstream and make resourcing inequitable
2. Focus on all of the how factors as well as the what
3. Invest more in the programmes and interventions we currently have
4. Test ourselves against the best evidence bases and policy recommendations
5. Invest in better connectivity and coordination between policy and service areas
6. New vision for health: Beveridge report was the end point of decades of work by many civil society actors. With the NHS now over 75 years old, we need a debate on the nation's health, NOT about whether is time for a debate on health care model

What do you think would be needed for ICSs and the organisations and partnerships within them to increase innovation and go further and faster in pursuing their goals?

- A structural shift won't solve the problem of 'burning platforms' on delivery, quality and outcomes. However, more permissive guidance and flexibility for 'secondary use' of data to allow true population-level integrated planning of services and upstream prevention will help
- Greater use of outcomes-based commissioning to allow providers to manage more operational/tactical delivery
- Re-orientation of some performance targets for secondary care providers towards community health metrics eg so community stroke rates as important as in-hospital stroke mortality

What policy frameworks, regulations or support mechanisms do you think could best support the active involvement of partners in integrated care systems? Examples of partners include adult social care providers, children's social care services and voluntary, community and social enterprise (VCSE) organisations. This can include local, regional or national suggestions.

- Locally, we could integrate/simplify commissioning processes so that providers share performance targets and can share (based on rational and evidence-based attribution) their own contribution to those targets where data exists to allow that
- Sign posting to relevant charities and their networks delivering support and guidance in the community and opportunities for engagement / inclusion in communities. This has to be backed up by investment in the sector, otherwise it feels very much like passing the buck. For example, all the NHS money that has gone into social prescribing has been spent on employing people to work in the NHS, rather than providing support and increasing capacity in the VCS sector that actually provides the support that patients need
- We don't need any more policy frameworks or regulations, but recognition that partners do not work for the NHS and also have priorities that could be better achieved in collaboration with the NHS. Partnership is a two-way relationship, but ICSs don't feel like that, so far

National targets and accountability

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?

- Move to outcomes-based targets (based on robust national modelling against evidence) but also taking account of disadvantage factors that operate in achieving effective interventions (for example in smoking cessation in SMI patients)
- Drop activity measurement where it provides no added value to a desired (and commissioned) outcome. Need better proxy / intermediate indicators if desired outcomes are difficult to measure or only change over long time periods
- Develop better indicators of clinical need reported alongside the relevant outcomes to truly assess impact of services on population health
- Introduce national targets specifically to assess health inequalities and health inequality related outcomes
- Make more and better use of patient reported outcome measures, including benchmarking against well-defined sets of PROMS, eg ICHOM

What mechanisms outside of national targets could be used to support performance improvement?

- Local workforce data will be critical - availability, retention, recruitment etc and the impact this has on service delivery, delays, effectiveness, safety. This allies with the need for reporting on understaffing of clinical rotas and patient safety issues
- The voluntary and community sector (VCS) is crucial – the sector is strong, but best described as surviving, not thriving. There is a vast wealth of expertise, insight and ability to shape statutory sector delivery to make it more community oriented. The VCS culture of using lived experience and community voices into the room to shape services should be embraced
- However, the sector needs stronger national coordination to be seen as central to strategy and policy, and not as part of the 'supply chain'
- There needs to be a better understanding of what good performance is - not based on arbitrary targets but defined and measured by outcomes at patient and population levels

Data and Transparency

We recognise that key to reaching greater local control and accountability is the transparent use of data, both at a local and national level. Do you have any examples, at a neighbourhood, place or system level, of innovative uses of data or digital services? Please refer to examples that improve outcomes for populations and the quality, safety, transparency or experience of services for people; or that increase the productivity and efficiency of services.

- Local trust dashboards identifying health inequalities (in access and intermediate outcomes) and outcomes collection of individual teams improves performance of teams over time for patient care (Nottinghamshire Healthcare Trust)
- Population health management analysis, including robust impact assessments, have allowed targeting of ICB and PCN activity on diabetes care (Nottinghamshire ICS)
- With the removal of the commissioner/provider split, the principle of sharing across all partners is laudable and should include LG and VCS partners; the data is there to drive quality and population health improvement

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?

- Use best existing examples of integrated primary, secondary, social care) databases (e.g. Nottingham GPRCC, North London, South Yorkshire Ecosystem platform) to advise on constitution and data standards for integrated databases
- Support efforts to improve intra-operability of different systems to enable data sharing across sector boundaries, between and within organisations. Intra-operability seems to have fallen off the list for digital solutions / EMR / platforms etc, but is often the single most challenging barrier to realising the benefits of sharing data for direct patient care, public health etc

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

- Revision and clarification of ICO rules for secondary data use where pseudonymisation (but not complete anonymisation) mechanisms are in place
- Extension of Section 251 permissions to all ICS's
- Stronger requirements on digital solution software industry to complete timely DCB 0129 Clinical Safety Case Reviews to help local Clinical Safety officers speed up implementation of innovative digital health solutions
- Intra-operability of data systems including private sector apps so collected information can be uploaded into EPRs for clinical and medicolegal safety

System oversight

ICSs are continuing to develop, and DHSC, NHS England and the Care Quality Commission (CQC) are still in the process of developing their working relationships with them. We recognise that there is significant variation in maturity, capability and performance between different systems and partner organisations,

including trusts. This will require an appropriate balance between autonomy, support, regulation and intervention. We are keen to explore whether there are any principles we can identify to help set that balance.

What do you think 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?

- Strong specialist public health has, through the history of the NHS, contributed to a highly efficient and logically prioritised health system. This input has waned over the last decade. We urge the centre to work rapidly to clarify how expert and experienced healthcare public health (including economic modelling) is mainstreamed in every ICS system in England
- To determine how the 90% of population health gain contributed by wider health determinants outside of the health and care system is both modelled into, and performance managed, in ICS arenas
- All of the strategic purposes of ICSs are important; subsidiarity needs to be a fundamental principle - not command and control, not anarchy, but somewhere in the middle
- Recognition that variation in a system is not always an inherent problem to be solved, rather a product of a system (and a series of systems) that are made up of multiple individuals serving a myriad of other individuals

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

- The use of expert facilitation and support teams to improve health gain (made up of experts in finance, public health, effective healthcare pathways, wider determinants opportunities, and health economics etc) to be able to provide short sharp assessments and future development needs (eg possibly like a slimmed down version of World Class Commissioning)

Additional evidence

Is there any additional evidence you would like the review to consider? See the Hewitt review terms of reference as a guide to what additional evidence may be relevant.

- There is greater understanding and respect of the DPH role and public health delivery since the Covid-19 pandemic. However, this comes with additional expectations of what is able to be delivered, and a tendency for LA public health teams to deliver NHS priorities at the expense of their broader role in local government
- We must guard against creating parallel systems, as has happened with smoking. The NHS has created smoking cessation services within a hospital context, often alongside services that have been in existence for 20 years. It will be critical for the ICSs to work with local stakeholders, requiring flex, local nuance and local investment to follow commissioning intention