



Hewitt review: call for evidence

About you

In what capacity are you responding to this survey?

On behalf of an organisation

Are you a member of an integrated care board or integrated care partnership?

Neither

What type of organisation are you employed by, or representative of?

If more than one of these statements applies to you, please select the option you feel is most relevant to your response.

National representative body

What is your job title?

Head of Policy and Public Affairs

What is the name of your organisation?

FODO – The Association for Eye Care Providers

If you are responding on behalf of your organisation, please provide your organisational email address. Your name and email address will not be shared with anyone outside of the department.

Are you happy to share your name and email address with the Department of Health and Social Care?

Yes

What is your email address?

healthpolicy@fodo.com

Name

Daniel Hodgson

Empowering local leaders

Integrated care systems (ICSs) are partnerships of organisations, including integrated care boards, NHS providers, local authorities, social care providers and voluntary, community and social enterprise organisations and other agencies with a role in improving health and wellbeing, that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

As the system moves towards new ways of working, we are keen to explore how we can empower local leaders within ICSs.

Question

Please share examples from the health and care system, where local leaders and organisations have created transformational change to improve people's lives? (250 word limit)

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.

Eye health providers and commissioners have worked together to improve access to enhanced primary eye care services for the benefit of patients – e.g.

- new pathways of care, including referral refinement schemes, to ensure people get the right care at the right time
- providing low vision services close to home, helping minimise the impact of disabling vision loss on individuals.

During the pandemic the sector created a new urgent eye care service known as [CUES](#). This collaboration resulted in

- patients accessing safe, high-quality urgent eye care services closer to home
- primary and secondary eye care working more closely together
- reduced pressure on busy hospitals with, at the time, higher risk of Covid transmission
- the use of technology for the benefit of patients, the NHS and taxpayer

The sector is now working in three ICSs with local leaders in Local Optical Committees (LOCs) and practices, to bring these benefits together under a banner known as [Optometry First](#). We know patients greatly value this local access, choice and convenience and have confidence in their local clinicians.

In all cases, as an NHS system, we have made most progress when we

- Maximise the use of local and national expertise to design and deliver integrated care
- Are supported by expertise within professional bodies who understand sector legislation, capacity and skills
- Collaborate and work on a no surprises basis

We therefore also support NHS England's operating framework commitment to support collaboration and work on a no surprises basis.

Question

Do you have examples where policy frameworks, policies and support mechanisms have enabled local leaders and, in particular, ICSs to achieve their goals? (250 word limit)

This can include local, regional or national examples.

There is an established three-tiered framework for NHS primary care services. In eye care this is known as Primary Ophthalmic Services (POS). This framework (provided for in legislation) strikes the right balance between nationally and locally commissioned services.

Parliament and the Government, advised by the DHSC and NHS England, through the Health and Social Care Act 2022, has wisely preserved national contracting, standards and nationally negotiated fees for core primary care services under the new structures.

The national core primary care contracts are also by far the most cost-effective route to reducing unwarranted variation, minimising NHS and provider transaction costs, ensuring consistent standards and equality of access are adhered to, and to avoiding access lotteries at the NHS front-door.

These provide an excellent starting point for ICBs in delivering the NHS Mandate, the Triple Aim and local priorities and strong foundations (which patients understand and value) which ICSs can build on to deliver locally commissioned enhanced services. This will help more care to be delivered closer to home and to transform overstretched outpatient services.

The new NHS Provider Selection Regime (PSR), supported by the NHS Standard Contract, provides a clear framework for efficient commissioning of locally enhanced primary care services (please also see our feedback below on funding for transformation).

Question

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? (250 word limit)

This can include local, regional or national examples.

In our experience longstanding challenges for NHS commissioning systems, and something to avoid with ICSs, have included:

- a plethora of frameworks and policies without sufficient support mechanisms to help delivery and execution of goals
- trying to balance budgets using blunt policy tools rather than strategic commissioning decisions – e.g. short-term underspend funding, restricting patient access to manage total cost rather than transforming services to deliver the maximum health outcomes within the available budget.

These risks might be greater in ICSs because of

- current NHS finances and system pressures
- new and more complex financial reimbursement models.

Given the tightness of NHS and social care resources, it is hard to see how ICSs will identify funds to invest in delivering the three arms of the triple aim – especially improving the individual experience of care and improving the health of population – without guidance. **It would be helpful therefore if this review could make recommendations about this.**

It may be that ICSs could top slice a proportion of funds to invest in transformation (for all three arms of the triple aim) or NHS England, DHSC and HMT could allow relaxation of a proportion of efficiency gains or 'cash releasing savings' targets for this purpose. **Otherwise, the key aspects of the reforms are unlikely to be delivered and the restructuring will have been in vain.**

Question

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? (250 word limit)

All system partners need to work together to maximise the benefits of innovation for patients and the wider NHS.

Sometimes this will be done most effectively at a very local – e.g. neighbourhood level – and at other times it will be best delivered at a system or even national level.

A guide to support ICSs and other organisations understand which types of innovations might be more suited to a neighbourhood, place, system or national level will help mitigate the risk of change programmes not being appropriately designed or funded.

For example, IT connectivity between primary and secondary eye care has the potential to transform outpatient care, save millions of patient visits to hospital each year, release funds to invest in primary care services and reduce avoidable sight loss and its associated costs. To deliver this eye care providers and their representative bodies need to be invited to work with the NHS at all levels to find a solution that works across geographical boundaries. NHS England is currently working on these solutions, and these should be tested, funded and then rolled out nationally as a matter of priority.

This guide might include good practice examples (regularly updated), where ICSs, their organisations and partnerships can see what innovation is happening elsewhere in the country and replicate (if appropriate) rather than reinventing the wheel.

Question

What policy frameworks, regulations or support mechanisms do you think could best support the active involvement of partners in integrated care systems? (250 word limit)

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.

We welcome the recognition by Rt Hon Patricia Hewitt and this review that the NHS needs to mitigate the risk that ICSs become "a rebadged CCG or another layer of regulation and performance management."

One of the weaknesses of the CCG system was a lack of input from wider primary care (not just general practice). Yet primary care is the first point of contact for almost all NHS patients and where the vast majority of NHS care and prevention is still delivered.

As the Fuller review recognised, a major delivery challenge for ICBs is therefore how actively to engage primary care in strategic service planning and management through Integrated Care Partnerships (ICPs).

One GP place on an ICB cannot do this in isolation and genuine engagement mechanisms need to be found through ICPs to pool intelligence and agree effective local strategies supported by patients and the front-line primary and social care community.

Some ICBs have set up primary care commissioning boards, provider panels or other means to secure this engagement and channel, for example, Local Optical Committees (LOCs) input to the ICP's/ICB's strategic plan. The most successful models should be adopted by all ICSs and monitored for ongoing effectiveness.

ICSs and NHS England should consider provision of support (financial incentives, electronic communication/fora etc) to support involvement of partners across ICSs, making it easier for those who are hard to reach, who do not have the resource/ability, or who are traditionally less engaged, to become more actively involved and share their expertise and population knowledge.

National targets and accountability

Question

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? (250 word limit)

Priorities

We would like to see the NHS in England become the first health system to celebrate and support ageing well by prioritising quality of life issues which disproportionately impact our ageing population, for example

- seeing well and preventing avoidable sight loss
- hearing well, with early diagnosis and support for hearing loss
- helping people with vision and hearing impairment to live independently for longer.

Priority should also be given to enabling patient choice, something that has strong patient and political support, as evidenced by consultation responses during passage of the Health and Care Act 2022. As part of this, the NHS should prioritise

expanding patient choice where this is in the best interests of patients, the NHS and taxpayer and supported by evidence.

Targets

One of the concerns we raised during the passage of the Health and Care Act 2022 was how meaningful accountability would operate under the new system, so we welcome this review looking at this again.

National targets have their place in systems like the NHS – e.g. they send clear signals as to where attention is needed and are key to ensuring the NHS is appropriately prioritised.

We are agnostic therefore as to whether there should be more or fewer targets but, without them, there is a risk that serious service failures may be hidden for longer or go unchallenged altogether. We would therefore be opposed to any diminution of the standards which patients have the right to expect.

Question

What mechanisms outside of national targets could be used to support performance improvement? (250 word limit)

Examples could include peer support, peer review, shared learning and the publication of data at a local level. Please provide any examples of existing successful or unsuccessful mechanisms.

- **Patient choice.** For primary care and outpatient services, patient choice can be an effective mechanism to improve performance at all levels.
- **FutureNHS Platform.** As many reviews of the NHS have shown, we need to improve dissemination of best practice and information on models that work. One barrier is that individuals responsible for a particular service in one region cannot easily contact a person in another region who has already successfully implemented change. The [FutureNHS Platform](#) is an example of a tool that might help tackle this.

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.

Question

Do you have any examples, at a neighbourhood, place or system level, of innovative uses of data or digital services? (250 word limit)

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.

Digital innovation

Primary eye care in England is one of the most advanced in the world when it comes to access to advanced diagnostic equipment.

To date the NHS has not benefited from this because it has lacked an IT connectivity solution between primary eye care and secondary care.

This is now changing with new e-referral systems being tested. We hope NHS England will present a solution which can then be funded and rolled out at scale so that patients, the NHS and taxpayer can fully benefit from world class IT infrastructure in primary eye care settings.

Data

The [Model Health System](#) is an example of an innovative use of data which could be used more to seek out system improvements. As are [RightCare](#) data toolkits and Atlas of Variation. It is also possible to use NHS activity data (from reference cost and HES datasets) to obtain initial insights to drive continuous quality improvement.

It might be helpful to create a more user friendly 'data inventory' so that systems can explore what already exists and focus on improving data reporting, quality and analysis rather than reinventing new datasets which too often replicate or overlap with data that already exists.

Question

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? (250 word limit)

There is a longstanding challenge within the NHS system of setting excessive data reporting requirements, collecting more data than can be analysed and not using data that is collected.

We would therefore support a set of principles which would see data collection limited to meaningful and proportionate reporting requirements and avoiding duplication in reporting.

We would also like to see an end to local modifications to data reporting when there is no scientific or reasonable methodological reason for doing so. For example, when CCGs changed data reporting requirements in a standard service specification based on local preference alone, it added cost for providers who worked across CCGs and meant data could not as easily be compared across regions.

It would also be helpful to provide guidance on avoiding collecting excessive numbers of KPIs at a service level, especially where KPIs might be strongly correlated and collecting additional data in fact adds cost and no scientific value.

Question

What standards and support should be provided by national bodies to support effective data use and digital services? (250 word limit)

Data use

- Reassure local systems therefore that they only need to collect meaningful data and avoid duplication of reporting requirements
- Collect data in a way that aids comparison locally and regionally where appropriate – e.g. collect data in a consistent way to agreed common definitions and standards
- Collect data in a way that does not add extra burden to providers, including without the need for providers to generate excessive reports/submissions.
- Use data to foster learning and collaboration. Often in healthcare, datasets need to be reviewed with a culture of continuous quality improvement rather than a blunt contract enforcement tool. This is more likely to improve patient outcomes and NHS efficiency in the long run.

Digital services

- Implementing digital services in healthcare can involve significant start-up costs. Hence it is often important to engage all funders, part-funders and the frontline at the development stage and seek economies of scale. For example, commissioning at a pan-ICs or national level can help investment decisions in primary care and accelerate transformational change, benefiting patients, the NHS and taxpayer
- Seemingly trivial local modifications to digital solutions can be costly and add unnecessary complexity without corresponding benefits – e.g. software modifications for local preference rather than improving patient outcomes. It can also make it much more costly to sustain a system and creates barriers to investing in improvements. This can be mitigated by supporting more standardisation across ICs.

System oversight

ICs 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.

Question

What do 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? (250 word limit)

We would assume the following would be helpful in this context

- national datasets which allow regional comparisons. For example, waiting list data matters to patients and families and can also provide early warning signs of system challenges and early indicators of system improvements
- patient feedback and complaints should continue to be a key part of ongoing systems monitoring
- data on impact on population health improvements and inequalities (within and across ICSs)
- regional variation in NHS Resolution data
- although reimbursement models might change, costing data should be collected as now as, matched with other datasets, it can be used to better understand variation and performance or capability issues across a system.

Question

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? (250 word limit)

One challenge with ICSs is that ICBs will include the largest local provider organisations. If a large provider is struggling it is highly likely the local ICSs will be too, given financial models and expectations in new systems. Added to this there is high probability (given current system pressures) that most NHS trusts and ICSs will not meet financial targets any time soon.

On balance it therefore seems sensible that in the initial years of ICSs more effort/resource is put into supporting and building capability.

As for established organisations like providers that are required to hold a provider licence, we think there needs to be clearer enforcement guidelines when performance issues are identified, and for these to actually be enforced. For example, it should not be acceptable for providers with a CQC inadequate rating to also fail to comply with patient choice conditions in the provider licence.

Additional evidence

Is there any additional evidence you would like the review to consider? (250 word limit)

See the [Hewitt review terms of reference](#) as a guide to what additional evidence may be relevant.

Local ICS leaders must move now to transform outpatient and hospital care if they are to achieve better outcomes and a more sustainable NHS.

NHS goals of prevention, early intervention, personalised care, long-term condition support and capacity management in health and social care all require the active engagement of primary care in pathway planning and service delivery.

There is a risk – as has happened in the past – that, without effective primary care input, essential prevention and quality of life issues (such as eye care) and management of chronic conditions (such as visual impairment and dry eye from medication), will be overlooked and deprioritised.

This is more of a risk when funds are as constrained as they are now and the system is dominated by the power blocks of Trust networks and local authorities, both of whom will rightly guard their patient and user resources.

This is why strategic plans, developed by ICPs with primary care input, around which all parties can rally, are such an important element of driving change.

It may be that ICSs could top slice a proportion of secondary care expenditure to invest in transformation (for all three arms of the triple aim) so that certain hospital activity can be transferred into primary care settings while controlling overall health expenditure. Alternatively, NHS England, DHSC and HMT could allow relaxation of a proportion of efficiency gains or 'cash releasing savings' targets for this purpose. Otherwise, the key aspects of the reforms are unlikely to be delivered and the restructuring will have been in vain.

You may upload a file to provide more details of this evidence. Upload a file

We have a few questions we would like to ask to help us improve future consultations.

How satisfied are you with the consultation process?

Satisfied

How did you hear about the consultation?

Received an email

Do you think we could improve this process?

The consultation opened in mid-December and closed in early January which made it difficult to compile evidence for each question in time. It would be helpful if consultations run at this time of year were run for at least two more weeks i.e the six-week minimum should apply. Nevertheless, we hope the responses we have provided are useful in helping ICSs realise the ambitions for patient and populations set for them and would be more than happy to meet with Patricia Hewitt or officials to discuss any aspects of our responses or to provide further detail if necessary.