NHS Confederation

Governing the health and care system in England

Creating conditions for success

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Professor Sir Chris Ham

About us

The NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

Palantir

Palantir is a software company that builds the world's leading software for data-driven operations and decision-making. Our platforms power critical operations for healthcare, government and commercial clients in dozens of industries worldwide. Founded in Palo Alto in 2004, today we have offices worldwide, including London, New York, Paris, and Munich.

Professor Sir Chris Ham

Chris Ham is currently co-chair of the NHS Assembly, emeritus professor of health policy and management at the University of Birmingham, and senior visiting fellow at The King's Fund, where he was chief executive between 2010 and 2018. He served as chair of the Coventry and Warwickshire ICS from 2019-2021.

During his career, Chris has worked at the universities of Leeds, Bristol and Birmingham, from where he was seconded to the Department of Health to work as the director of the strategy unit

between 2000 and 2004. He has also served as a non-executive director on the Heart of England NHS Foundation Trust and the Royal Free London NHS Foundation Trust.

Chris was awarded a CBE for his services to the NHS in 2004 and a knighthood for services to health policy and management in 2018. He was made an honorary fellow of the Royal College of Physicians of London in 2004 and an honorary fellow of the Royal College of General Practitioners in 2008. He became a companion of the Institute of Healthcare Management in 2006. He is also a founding fellow of the Academy of Medical Sciences.

Chris is an adviser to Carnall Farrar and a board member at New Local.

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Matthew Taylor
Chief Executive, NHS Confederation

When the NHS Confederation approached Professor Sir Chris Ham to write a paper on the role of the centre in the context of the creation of integrated care system, it raised a few eyebrows. After all, representing our members and supporting them to make the NHS the best it can be relies on close working relationships with colleagues at NHS England and NHS Improvement (NHSEI), the Department of Health and Social Care, and Downing Street. Was giving such a provocative brief to a nationally respected figure rather risky?

But as we publish Chris's excellent paper, we can be doubly reassured. First, it is clear that ministers and officials at the centre also recognise that the NHS's operating model needs to be re-examined. Second, with very little push back, we have won the argument that this re-examination cannot be a matter for only the centre to consider: it must be a debate for the whole service, indeed one that engages the NHS's partners, especially local government.

The issues addressed by Chris are central to the NHS Confederation's work. Self-improving systems need the right balance of top-down, sideways and bottom-up incentives comprising, principally, political accountability; national strategy and expertise; public service professionalism; a culture of challenge and support; and responsiveness to local partners, communities, patients and the public. Yet, nearly every NHS leader complains that they spend too much time looking up in response to the demands of national policymakers and regulators and, as a consequence, often lack the bandwidth or autonomy to be challenged and inspired by their peers and the people they serve.

Equally, as the membership organisation for ICSs, the NHS Confederation is deeply committed to helping leaders succeed. A centre reformed to support systems rather than control them is crucial.

In a few years the health and care bill could be seen as a game changer in improving health outcomes, or another failed health service reorganisation. At present, it still too often feels like the sponsors of that legislation in NHSEI and Whitehall have not fully understood or accepted the consequences of their own proposals. We hope and believe that Chris's excellent paper will make an important contribution to creating a centre than can truly enable and empower a system of systems.

Foreword from Palantir

Joanna Peller
UK Health Lead, Palantir

As we reflect on the last two years of pandemic response, little has proven more critical to our collective health and wellbeing than our ability to collaborate and mobilise locally, regionally and nationally.

In England, a striking example of such collaboration at scale was the COVID-19 vaccination programme. As it tackled one of the greatest logistical challenges of its kind, the NHS created a single source of truth through the enablement of a common, secure data foundation capable of underpinning the project in its entirety. From PPE availability at vaccination sites, to various storage requirements and available doses. Within days, the NHS was able to reconfigure facilities and services across the country to ensure vaccine availability for the patients who needed it most.

As outlined in this report, the future of integrated care systems (ICSs) will require the NHS to develop new ways of working. Ensuring a transparent, secure and federated data foundation across all levels of the organisation will become a critical requirement for scaling ICS capabilities and improving patients' lives.

Like the vaccination programme, ICSs are designed to empower decision-making in novel ways. By creating an intermediate layer of accountability, systems and trusts can begin to track and analyse

their unique decision-making, creating a virtuous cycle that will improve outcomes. Working across the unified network of ICSs, the health and care community can capture and better understand the various paths to decision-making in an operational, auditable way, providing insight and accountability into every step of patient care.

Whether operating locally or nationally, helping improve patient outcomes requires an integrated data foundation that enables insight into differences within populations served, identification of groups at risk and targeted support for those most in need. For ICSs, it also necessitates continued collaboration between public health teams, clinicians, and community organisations alike. The emergence of the ICS, even at its outset, thus represents a transformative opportunity for the future of patient care, allowing NHS organisations to work differently, but collectively, in harmony.

Key points

- The NHS has evolved from an administered to a managed service with a complex overlay of competition, inspection and regulation.
- Throughout its history, national leaders have expressed an ambition to devolve decision-making within the NHS even when relying on command and control to bring about change.
- Performance management has contributed to improvements in care but has had negative consequences, including disempowering staff and fostering a culture of compliance.
- There is an overreliance on regulation and an urgent need to value trust and restore respect between leaders at all levels.
- The NHS is a complex adaptive system and there are limits to the effectiveness of command-and-control methods in bringing about improvements in health and care.
- Central leadership is needed on some issues and local leadership on others, supported by peer challenge and support and the use of information on comparative performance.
- The partnerships that make up ICSs should draw on intelligence about the diverse populations served and harness community power* in discharging their functions.

*The term community power is used here and elsewhere to refer to the power of people and communities to improve health and care when they are fully engaged by the NHS and its partners, drawing on the work of the think tank, New Local.

Key points

- The number of staff working at the centre and in regions should be reduced substantially to enable ICSs to fulfil their potential as system leaders.

- The role of regions should be reviewed when ICSs have demonstrated their ability to act as system leaders, with a view to streamlining the organisation of the NHS.

- A major effort is needed to cultivate systems thinking and systems leadership and to build a ‘team of teams’ to underpin new ways of working.

- ICSs themselves should operate on the basis of subsidiarity and foster a culture of innovation and improvement in the neighbourhoods, places and organisations that make up systems.

- NHS leaders must engage in political management and push back on interventions that run counter to aspirations to devolve decision-making.

- A number of simple rules are proposed to support these developments; these rules should be tested and refined in the light of experience.

Introduction

Plans to establish integrated care systems (ICSs) as statutory bodies in the health and care bill foreshadow further changes to the organisation of the NHS. Unlike previous reorganisations, the changes expected to occur in 2022 have developed from within the NHS rather than being imposed by the government. Not only this, but leaders in the NHS have also played a major part in shaping the nature of these changes in partnership with the centre.

The emergence of ICSs from sustainability and transformation plans and partnerships (STPs) is unusual in this respect and also in the limited guidance from the centre, until recently, on how they should function. As a consequence, there is more ownership of the changes and commitment to making them work than in previous NHS reorganisations. In view of their genesis, ICSs have the potential to operate differently from any previous organisations through partners taking greater control of finances and performance under the proposed 'system by default' regime.

> "There is more ownership of the changes and commitment to making them work than in previous NHS reorganisations."

Collective leadership and mutual accountability

ICSs across England are developing collective leadership and accepting mutual accountability for performance, as demonstrated in the response to the pandemic. Guidance from NHS England and NHS Improvement (NHSEI) (see below) suggests that this should mean less reliance on external oversight and intervention and more emphasis on subsidiarity and devolved decision-making. The statutory integrated care board (ICB) will be the leadership forum responsible for NHS functions and budgets within ICSs, and its members include leaders drawn from partner organisations.

ICSs are also expected to develop wider partnerships between the NHS, local authorities and others as they give more attention to improving population health and wellbeing. The integrated care partnership (ICP) operates as a statutory committee within ICSs and brings together all system partners to develop a health and care strategy building on the work of health and wellbeing boards. The ICB is required to take account of the strategy in carrying out its work.

Purposes and accountabilities

Working through the ICB and the ICP, ICSs have four purposes: improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and helping the NHS to support broader social and economic development. In pursuing these purposes, ICSs have to work with different accountabilities: upwards to national government via NHSEI in the case of the NHS, and outwards to local people in the case of local government.

How ICSs work in practice will hinge on the capabilities they are able to develop and the environment in which they operate. Much depends on the approach taken by national leaders and the regional offices through which they oversee performance and undertake planning. With a new operating model under development by NHSEI,* where will system leadership and partnership working fit into the model and will commitments to devolve decision-making be fulfilled?

“How ICSs work in practice will hinge on the capabilities they are able to develop and the environment in which they operate.”

*Work on the operating model has been commissioned by Amanda Pritchard and is being led by Mark Cubbon and Dominic Dodd.

About this report

This paper explores these questions, drawing on a review of the evolution of the centre and regions, research on how to improve healthcare, and interviews with leaders in the civil service, the NHS and local government. It focuses on the changes needed to create the conditions in which ICSs can improve outcomes for patients and the public and outlines a series of simple rules to guide those leading the reform programme. The ideas put forward are intended to provide a basis for debate with healthcare leaders and others in England about next steps.

The paper starts from the premise that a key role of leaders is to harness the intrinsic motivation of health and care staff and public health teams to perform to the best of their abilities. The distinctive contribution of ICSs is to work with partners in making use of all available assets and leading improvements in patient care and outcomes that require actions across the organisations and services that make up the health and care system. Staff must be fully engaged in this work as it is through their actions that patients and the public will experience improvements.

"Staff must be fully engaged in this work as it is through their actions that patients and the public will experience improvements."

"There would have been no theoretical difficulty – there is none now – in having from the outset a tightly administered centralised service with all that would mean in the way of rigid uniformity, bureaucratic machinery and 'red tape'. But that was not the policy which we adopted when framing our legislation. While we are now – and rightly I think – tightening up some of the elements of our financial control, we must remember that in framing the whole service we did deliberately come down in favour of maximum decentralisation to local bodies, a minimum of itemised central approval, and the exercise of financial control through global budgets."

Nye Bevan, Minister of Health, 1945-51[1]

"Ministers and the centre are finding it difficult to reconcile devolved accountability with the demand for detailed monitoring created by parliamentary interest in operational issues. In consequence, the centre is drawn into a whole range of issues, from hospital catering standards to the freedom of speech of hospital staff that it once expected to leave to the discretion of local management. The dilemma is that without substantial operating freedom, trust management cannot be expected to produce better performance than the old directly managed units, but that with such freedom there is bound to be a diversity of behaviour and performance. The existence of outliers is then seen – by the press, auditors and politicians – as a cause for central regulation."

Clive Smee, Chief Economic Adviser, Department of Health, 1984-2002[2]

“ It was relentless focus. The Prime Minister holding me to account, the delivery unit holding the department to account, me holding the department to account and the department holding chief executives to account – with the NHS knowing that this was the absolute top priority, because people were suffering and dying.”

Alan Milburn, Secretary of State for Health, 1999-2003[3]

“You are on a hiding to nothing if you pretend that the Secretary of State is not in the end responsible for everything. It is not a political dodge when I say that I am responsible for the problems that the NHS goes through in the winter period and I apologise to patients, and I also say it is unacceptable...I think the only way you can square the circle is basically being honest with the public. You take responsibility. It is down to you. But you don’t have a perfect ‘command and control’ structure...”

Jeremy Hunt, Secretary of State for Health, 2012-2018[4]

“Goals in the form of...targets can have an important role en route to progress but should never displace the primary goal of better care. When the pursuit of targets becomes, for whatever reason, the overriding priority, the people who work in that system may focus too narrowly. Financial goals require special caution; they reflect proper stewardship and prudence, but are only a means to support the mission of the NHS: healing.”

Don Berwick, Former President and CEO of the Institute for Healthcare Improvement; Adviser to the UK Government on Patient Safety[5]

> “Legislation of all kinds needs to be carefully calibrated to make only the necessary and proportionate changes. The risk of legislative overreach and of an excessive specification of detail, spelling out the exact conditions under which specific organisations can and cannot work together, can lead to burdensome bureaucracy and confusion for those faced with the task of implementation. As the pandemic has shown, there is a great deal of insight, commitment and innovation in local organisations. We need a legislative framework that builds on the trust we have for those within systems to understand and deliver what their populations need.”
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> **Department of Health and Social Care, 2021[6]**

Part one – The changing NHS landscape

> "Those who cannot learn from history are doomed to repeat it." (attributed to George Santayana)

The role of the centre

In the first phase of the NHS, the Ministry of Health worked primarily through exhortation and guidance, and its ability to influence decision-making within the NHS was limited. The Department of Health and Social Security, which replaced the Ministry in 1968, sought to strengthen its role after the first major reorganisation of the NHS in 1974 through the introduction of a national planning system supplemented by the development of performance indicators. The department stated that the aim was to achieve 'maximum delegation downwards, matched by accountability upwards.'[7]

A range of techniques drawn from new public management was introduced in the 1980s, including the NHS accountability review process involving national scrutiny of regional plans and performance, leading to annual review meetings. Regions in turn reviewed the performance of health authorities in their areas, as efforts to improve efficiency and reduce variations in performance gathered pace. The introduction of general management following the Griffiths Report was an important enabler of these changes and the development of performance management.

NHS internal market

Further changes followed with the introduction of the NHS internal market in the 1990s. They included the creation of 'self-governing' NHS trusts and general practitioner fundholding with the ostensible aim of enabling decisions to be taken locally by those responsible for care. In reality, moves to bolster upwards accountability remained important in response to growing pressures on NHS finances and performance. The dissonance between aspirations to devolve decision-making and the reality of central controls has become a recurring feature of NHS reforms.

"The dissonance between aspirations to devolve decision-making and the reality of central controls has become a recurring feature of NHS reforms."

Performance management was taken to a new level by the Labour government elected in 1997. Central oversight was reinforced by the establishment of the National Institute for Clinical Excellence, national service frameworks and the Commission for Health Improvement. The use of public service agreements between the Treasury and spending departments, and the establishment of the Prime Minister's Delivery Unit to help drive improvements in public sector performance, worked in the same direction.[8]

The decision to bring back many of the elements of the NHS internal market in 2001 appeared to be at odds with these centralising tendencies. This interpretation was supported by policy documents published at the time on shifting the balance of power in the NHS and developing 'a devolved and self-improving health service where the main drivers of change are patients, commissioners and clinicians, rather than national targets and performance management'.[9] In practice, the government continued to rely on command and control supplemented by inspection, regulation and competition.

The NHS Commissioning Board

Reliance on a mix of policy interventions extended to the coalition government and the Conservative governments that followed

during the 2010s. The Health and Social Care Act 2012 established a statutorily independent body, the NHS Commissioning Board, now known as NHS England and NHS Improvement, as part of a programme of reforms seeking to 'liberate' the NHS. These changes built on previous attempts to create an NHS headquarters within the Department of Health known successively as the NHS Management Board, the NHS Management Executive, and the NHS Executive.

The development of the NHS headquarters resulted in many of the top roles in the department being occupied by NHS managers working alongside senior civil servants. The increasing focus of the department on the NHS gave the appearance of it becoming a 'department for delivery'.[10] This reflected wider developments in public services reform under the Labour government.

The relationship between the department and the NHS Commissioning Board since 2013 has been governed by a mandate setting out the government's priorities. This was meant to constrain the ability of ministers to add new priorities once the mandate had been agreed, a goal that has largely been achieved. Separating roles at the centre did, however, result in tensions that are discussed further below.

The role of the intermediate tier

The role of regions as the 'intermediate tier' between the centre and organisations delivering care has evolved alongside these changes. Regional hospital boards performed this function from 1948 to 1974 and were then superseded by regional health authorities from 1974 to 1996, responsible for overseeing hospitals and other services. The main function of regions during this period was planning the provision of services with the aim of achieving greater equity in access to care between different areas.

Regional offices of the NHS Executive in the Department of Health took over from regional health authorities in 1996 and were in turn replaced by strategic health authorities in 2002 until their abolition in 2013. They were superseded by regional offices of NHS England working alongside regional offices of NHS Improvement until the de facto merger of the two organisations under the leadership of Simon Stevens. During this period, the role of regions in overseeing performance became more prominent.

Manager accountability

The establishment of regional offices without their own boards removed the direct line between regional chairs and ministers and reinforced the accountability of managers to the centre through the NHS hierarchy. At its height, performance management was described as a form of 'targets and terror'[11] verging on bullying[12] as managers acted on behalf of politicians to deliver improvements in care. This contributed to a culture of micromanagement, described graphically in a report on the experience of chief executives working in the NHS.[13]

The resilience of the intermediate tier through successive reorganisations underlines the value of having a regional presence, in part because of the difficulty of overseeing an organisation as large and complex as the NHS directly from the centre. As well as planning and oversight of performance, regional offices are currently responsible for some other functions, such as the commissioning of specialised services. The question to be addressed is who should take on these and other functions when ICSs are established as statutory bodies alongside regional offices?

We return to this question below.

"The resilience of the intermediate tier through successive reorganisations underlines the value of having a regional presence."

The position today

At the time of writing, the Department of Health and Social Care (DHSC) combines the roles of a department of state supporting ministers, and a department that works with NHSEI in overseeing and managing the performance of the NHS.

As a department of state, DHSC is responsible for setting direction, developing and promoting legislation, negotiating funding for health and social care, accounting to parliament for the stewardship of resources, and working with other government departments and public bodies in developing and delivering health and social care policy. Its work is undertaken by around 4,000 career civil servants reporting to the permanent secretary and the chief medical officer, the latter also being the UK government's chief medical adviser.

Roles at the centre

The Secretary of State for Health and Social Care is accountable to parliament for the use of NHS resources. DHSC works with NHSEI to ensure that the government's priorities are delivered. The work of NHSEI at the centre and in regions is undertaken by around 11,000 staff* drawn from NHS and civil service backgrounds who report to the chief executive. Seven regional offices are responsible for the quality, financial and operational performance of all NHS organisations in their region.

The functions of NHSEI include allocating resources, leading on planning and operational matters, holding NHS organisations to account for their use of resources and delivery of priorities, and intervening to tackle performance challenges. Since 2013, NHSEI has become more involved in the development of strategy and health policy alongside DHSC. This includes producing the NHS Five Year Forward View[14] and the NHS Long Term Plan[15] as well as coming forward with proposals to change the organisation of the NHS in partnership with leaders in the NHS.

*c.10,000 more staff work in other national bodies like HEE.

The centre became increasingly crowded and cluttered after the Health and Social Care Act 2012. A shifting collection of national bodies with responsibilities for, among other things, the regulation of NHS foundation trusts and competition, health education, public health, NHS trusts, care quality, digital, and information technology worked alongside NHSEI and DHSC. These arrangements are currently being streamlined and simplified as NHSEI consolidates a number of other functions as part of changes in the health and care bill.

"The centre became increasingly crowded and cluttered after the Health and Social Care Act 2012."

'Behaviour trumps legislation'

In his analysis of the evolution of NHSEI following the Health and Social Care Act 2012, Nick Timmins shows how the aspiration to keep politicians at arm's length from the running of the NHS was frustrated by the imperative felt by Jeremy Hunt as Secretary of State to become involved in operational matters, as illustrated by the quotation from Hunt at the beginning of this paper.[16] Timmins concludes that behaviour trumps legislation while also emphasising, in a separate study, that the personalities and working preferences of ministers influence how they interpret the role.[17]

The behaviour Timmins is referring to includes that of NHSEI's leaders as well as ministers. The appointment of Simon Stevens as chief executive of NHS England in 2014 demonstrated the ability of public officials to shape the direction of the NHS even under an activist Secretary of State. NHSEI took on a more prominent role in making the case for additional funding for the NHS and the reform of social care under Stevens' leadership, as well as the development of strategy and policy. Stevens and Hunt both emerged as more influential, with DHSC 'disempowered' on many issues in the words of a senior leader interviewed for this report.

A former senior civil servant explained that the 2012 Act resulted in a reduction in staffing and capabilities in the Department of Health

at the same time as NHSEI took on its responsibilities. The latter is by some margin the biggest and most complex arm's-length body in England and the department found it challenging to act as an effective sponsor of NHSEI's work. The pandemic made more visible some of the underlying tensions between national bodies and their leaders. These tensions help explain why the health and care bill includes provisions to increase the powers of ministers and thus DHSC over NHS decision-making, suggesting that in some respects the pendulum is swinging back to the centre.

The future relationship between DHSC and NHSEI will have a major bearing on the issues addressed in this paper. Will the separation created by the Health and Social Care Act 2012 be sustained, or will there be increasing alignment of roles and responsibilities? If alignment does occur, will this entail ever closer coordination of the work of DHSC and NHSEI, or a reversion to the status quo ante with the NHS headquarters being taken back into the department? And what will be the impact of a new chief executive of NHSEI and a new Secretary of State on how these questions are resolved?

We return to these questions below.

Performance management

This high-level review of the changing NHS landscape shows that the centre has strengthened its oversight of the NHS, whatever the intentions of Nye Bevan at the outset. National standards and targets have become increasingly important in bringing about improvements in high-priority areas of care. Internal markets and inspection and regulation have also been used as part of an eclectic mix of policy interventions.[18] Among these interventions, performance management has proved the most resilient and as a result, England has arguably the most centralised healthcare system in the developed world.

Performance management and associated initiatives such as the introduction of general management have contributed to improvements in care in some areas of health policy. Most obviously, reductions in waiting times and healthcare-acquired infections, and improvements in areas of clinical priority like cardiac and cancer care, were delivered through a combination of national standards and targets, a strengthening of upwards accountability, and extra spending. There were, however, negative consequences including gaming and misreporting of data to avoid penalties and sanctions for under performance.

"Scrutiny can of course act as a spur to improve performance, but may also undermine trust between leaders at different levels and demotivate staff if used inappropriately."

Avoiding blame and fear

Equally important is the danger that performance management fosters a culture of compliance and risk aversion that inhibits innovation and engagement with local people. At its worst, reliance on standards and targets has the effect of disempowering those working in the NHS, creating an over dependence on the centre and a substantial workload in responding to regulators. Don Berwick's report following the failures at Mid-Staffordshire NHS Foundation Trust was unequivocal in stating that blame and fear should be avoided and that continual learning, patient and public engagement, and transparency are the best way of improving patient safety.[19]

Performance management has grown in importance partly because of the salience of the NHS within British society and the greater interest shown by the media and government in its strengths and weaknesses. This has been accentuated by the centre having more rapid access to a wider range of real-time data through advances in information technology. Scrutiny can of course act as a spur to improve performance, but may also undermine trust between leaders at different levels and demotivate staff if used inappropriately.

Alongside performance management, inspection and regulation of providers have become increasingly prominent. Originally established as a by-product of the purchaser/provider split, inspectorates like the Care Quality Commission offer a means of providing information to politicians and the public on the performance of services. Their role has been strengthened in the wake of failures in care, as at Mid-Staffordshire NHS Foundation Trust, and a belief that inspection would be an effective means of improving patient safety and the quality of care.

> "Leaders in the NHS spend much of their time looking up at the expense of looking out to the communities they serve."

Burdens of bureaucracy

Taken together, performance management, inspection and regulation place many demands on NHS organisations. A recent report by DHSC identified diverse sources of 'excess bureaucracy' exacerbated by duplicative or disproportionate assurance systems. It also noted the burdens created by regulation of NHS organisations and healthcare professionals. Not surprisingly, the report observed that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow – a point to which we return.[20]

The impact of enhanced reporting requirements has been accentuated by duplication in requests for data from NHS providers by commissioners and regulators and lack of coordination between them. Leaders in the NHS spend much of their time looking up at the expense of looking out to the communities they serve. A new analysis of the impact of management on the performance of hospitals has noted the limited discretion available to NHS managers in how they undertake their role. The authors contrast the position of NHS managers with their private sector counterparts and question whether they have 'sufficient autonomy to make a difference'.[21]

Part 2 – Operating differently

> "We are graduating from the century of the molecule to the century of the system."[22]

Where do ICSs fit in and what approaches to improvement are needed?

The premise of this paper is that ICSs have the potential to operate differently from any previous NHS organisations. This is because ICSs are partnerships of NHS organisations and others who exercise collective leadership in accepting mutual accountability for performance in their areas. Early thinking on ICSs referred to 'system by default' as the organising principle, signifying that systems should occupy a pivotal position in the NHS in future.

In its guidance, NHSEI has argued that there will be 'increased freedoms and responsibilities for ICSs, including greater responsibility for system development and performance, as well as greater autonomy regarding assurance'.[23] NHSEI also stated that 'We are committed to ensuring that the principle of subsidiarity is applied in considering our own functions, that resources are devolved accordingly, and that the creation of ICS NHS bodies does not lead to duplication or create additional bureaucracy within the NHS'.[24]

Principles for system oversight

NHSEI has emphasised the leadership role of ICSs in oversight and assurance, while also noting that it would continue to be responsible for taking 'any formal regulatory action with providers'.[25] The proposed principles for system oversight are:

- working with and through ICSs, wherever possible, to provide support and tackle problems

- a greater emphasis on local priorities and on system performance and quality of care outcomes, alongside the contribution of individual organisations to system goals

- matching accountability for results with improvement support, as appropriate

- greater autonomy for ICSs and organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access

- compassionate leadership behaviours that underpin all oversight interactions.[26]

NHSEI has stated that the primary interaction of regions will be with the collective ICS leadership, adding 'regional teams will become 'thinner' as we move direct commissioning responsibility out to systems (individually and collectively). They will increasingly continue to enable systems to take on greater autonomy, working with them to identify their individual priorities and support needs'.[27]

Mandated support

Guidance on the system oversight framework outlines the use of mandated support 'for serious problems ...where there are concerns that the existing leadership cannot make the necessary improvements without support'.[28] Mandated support involves the use of NHSEI's enforcement powers including 'changes to the management of the system/organisation to make sure the board and executive team can make the required improvements'.[29] A key element in the system oversight framework is the recovery support programme which will be 'nationally led by a credible, experienced

system improvement director (SID) jointly appointed by the system, regional and national intensive support team'.[30]

These statements indicate that there remains a tension between aspirations to devolve decision-making and the continued use of hierarchical controls. On the one hand, NHSEI refers to an improvement-led approach, a learning system, and the use of peer review and support. On the other, the legacy of performance management and external intervention is evident in descriptions of mandated support, the recovery support programme, and the role of regions in activating these interventions. Much more space is devoted to the latter than to other approaches to improvement, raising questions about how far decision-making can be devolved in practice.

What kind of organisation is the NHS?

What approaches will be used to improve performance in a world of ICSs? Answering this question means taking a step back to ask what kind of organisation is the NHS and what approaches to improvement are likely to be most effective? And what lessons can be drawn from research into high-performing healthcare organisations?

In stylised terms, the NHS is often viewed as a single machine-like organisation run through a hierarchy based on command-and-control principles. The approach to performance management, inspection and regulation outlined in the first part of this paper is based, at least implicitly, on this view. It rests on a belief in planning and prediction even in the face of the uncertainty and complexity involved in providing healthcare.

An alternative view is that the NHS is a complex adaptive system made up of many different parts. Implicit in this view is the difficulty of managing a large service like the NHS through the hierarchy. Advocates of systems thinking like John Seddon[31] are critical

"The NHS is often viewed as a single machine-like organisation run through a hierarchy based on command-and-control principle...

...an alternative view is that the NHS is a complex adaptive system made up of many different parts."

of reductionist management models and set out an alternative approach based on securing commitment to change rather than seeking compliance with external targets and standards.

The limitations of viewing the NHS as a single organisation were emphasised by a senior leader interviewed for this report with experience of working at the centre and in the NHS. He argued that 'national levers aren't well connected to the NHS' and large NHS trusts could effectively ignore Whitehall. A local government leader added that many in the NHS laboured 'under the illusion of command and control' and were reluctant to recognise this.

> "The establishment of ICSs as statutory bodies involves a shift from power being exercised through a pyramid to being channelled through constellations."

Another leader invoked Matthew Barzun's work on leadership to argue that the establishment of ICSs as statutory bodies involves a shift from power being exercised through a pyramid to being channelled through constellations. Drawing on real-world examples and research on leadership, Barzun demonstrates the benefits of those in authority sharing power with others in order to achieve public or private goals. Constellations eschew both top-down and bottom-up mindsets by working as flexible and dynamic networks in which there is no single point of control.[32]

Nuanced understanding

These observations suggest that a more nuanced understanding of leadership and management is urgently needed. The starting point should be a willingness on the part of national leaders to build on learning from the pandemic response when local leaders and clinical teams had much more scope than usual to decide how services should be organised. There is also learning from the way in which the United States Army was transformed in response to new terrorist threats, drawing on systems thinking, discussed further below.[33]

The expectation that ICSs will develop partnerships with local authorities and other agencies to improve the health and wellbeing

of the populations they serve underlines the need to move beyond the view that the NHS can be run on a command-and-control basis. Equally important, the establishment of ICPs creates an opportunity for local leaders to listen to what matters to people and engage in dialogue with them. ICSs can enhance their legitimacy to push back on inappropriate top-down demands and find more effective ways of improving health and care by embracing community power.

Lessons from high-performing systems

Research into high-performing healthcare organisations in different countries has outlined the various routes taken to transform care.[34,35,36] Many of these organisations have demonstrated a sustained commitment to quality improvement by drawing on the intrinsic motivation of staff and demonstrating consistency in the pursuit of continuous improvement.

Changes to the Veterans Health Administration (VA) in the United States in the 1990s[37] illustrate the path taken by a large public healthcare system with particular relevance to the NHS. Under new leadership, the VA migrated from a failing, fragmented, hospital-centred system to a series of regionally based integrated service networks, reducing hospital use and strengthening out-of-hospital services. Independent assessments highlighted the achievements of the VA as a result of these changes.[38]

Achieving a new vision

Transformation centred on a new vision, a new structure to deliver this vision, and the appointment of new leaders to make it happen. Key changes encompassed a focus on quality and outcomes, a culture of measurement and reporting, devolved responsibility for implementing goals, and the use of comparative data to drive improvement. The guiding principle was ‘to decentralise decision-

making to the lowest, most appropriate management level and then to hold management accountable for their decisions'.[39]

The use of comparative data to drive improvement entailed the collection and reporting of performance in each of the integrated service networks responsible for delivering care. National leaders met regularly with network directors who were challenged by their peers in a system where there was internal competition to perform well. In his work on public services reform, Michael Barber describes this approach as 'devolution and transparency' and argues it has a role alongside other improvement mechanisms.[40]

Jeremy Hunt advocated this approach in his time as health secretary, arguing 'self-directed improvement is the most powerful force unleashed by intelligent transparency. If you help people understand how they are doing against their peers and where they need to improve, in most cases that is exactly what they do. A combination of natural competitiveness and desire to do the best for patients mean rapid change – without a target in sight'.[41] Plans to use a range of metrics in an integration index for ICSs offer an opportunity to test this belief.

It should be noted that after its transformation, the VA experienced challenges in holding onto the gains made. This is a reminder that the journey to high performance in a complex adaptive system is rarely linear and never one way.

Complementary approaches to improvement

The VA's story shows how complementary approaches were used to improve care. In the NHS, these approaches should include central leadership on some issues and local leadership on others. There is also a role for peer support, improvement collaboratives that include patients and service users, professional networks, and devolution and transparency. How these approaches are used and

how they are combined is what matters, recognising the risk that multiple initiatives may lead to confusion and incoherence – as noted in a review of the Labour government's quality strategy in the 2000s.[42]

Improvement must be led by staff

> "More needs to be done to encourage the uptake of proven innovations and deliver Nye Bevan's vision that the NHS should seek to 'universalise the best'. "

As stated at the outset, the starting point must be that most improvement work is done by staff providing services – in NHS trusts, primary care, local authorities, the private sector and the voluntary and community sector. The role of ICSs is to support this work and to ensure that systems are more than the sum of their parts by leading improvements that require action across the system. The use of mutual aid during the pandemic response, involving providers working together to deal with surges in demand and other pressures, is an example.

Within provider organisations, clinicians are best placed to lead improvements in care. Often this involves clinical teams sharing information about the patients they serve and removing barriers to communication. Experience in other countries demonstrates that care pathways designed by clinical teams bringing together expertise from different areas of care and working with patients is fundamental in realising the potential of integrated care.[43] Organisational and system leaders can unleash this potential by releasing clinicians to do this work and providing training and support.

Peer support and shared learning also have a role. The use of improvement collaboratives is an example, as is sector-led improvement in local government. A different example is the emergency care improvement support programme made up of experienced managers and clinicians able to advise NHS organisations on how to improve care by learning from what works in other areas and sharing best practice. More needs to be done to encourage the uptake of proven innovations and deliver Nye Bevan's vision that the NHS should seek to 'universalise the best'.

Professional networks and provider collaboratives have demonstrated the contribution they can make in supporting improvement across organisations. This is illustrated by changes in stroke care in London introduced a decade ago, involving the concentration of hyperacute stroke services in eight hospitals following a lengthy period of evidence gathering and consensus building. Evaluation showed that the new model of care delivered improved outcomes and costs were saved within two years of implementation.[44]

If greater emphasis is to be given to networks, collaboratives and similar improvement approaches, then the centre and regions need to focus on steering not rowing.[45] Steering includes setting direction, holding ICSs accountable for delivery, and ensuring that there is sufficient capacity and capability in place across the health and care system.[46] Chronic staffing shortages and the escalating costs of backlog maintenance in the NHS will continue to act as a brake on progress until the centre recognises its responsibilities in this regard.

"If greater emphasis is to be given to networks, collaboratives and similar improvement approaches, then the centre and regions need to focus on steering not rowing."

Elinor Ostrom and self-organising

Making a reality of complementary approaches to improvement requires the partners that make up ICSs to take joint responsibility for finances and performance by agreeing rules on resource use, applying these rules, and resolving differences collectively. Leaders in ICSs must be open to constructive challenge and be able to have hard conversations, without this undermining their ability to work together in the longer term. Mutual respect and understanding of the perspective of partners should be at the heart of the work of leadership teams.

Research into the effectiveness of integrated care contains a clear warning about focusing too much on structures and too little on relationships.[47] Leaders must exhibit integrity in everything they do and be willing to listen with an open mind to the views of others.

Likewise, clinical teams must recognise that the hard work of improvement 'is more sociological then technological' – a phrase I first heard articulated by a medical leader in an integrated care system in the United States over 20 years ago.

The right to self-organise

Nobel prize winner Elinor Ostrom's work on how 'self-organising' can avoid depleting common resources that nobody owns but many rely on, is a helpful way of framing the challenge facing ICSs. The design principles proposed by Ostrom include having the right to self-organise rather than being instructed by others how to do so, and allowing different arrangements to emerge in different communities. The challenge is how to apply these ideas in a large and highly visible public service like the NHS where there is an expectation of consistency across the country.

Although governance arrangements for ICBs have been prescribed in considerable detail by the centre, there remains latitude for the partners that make up systems to decide what other arrangements are needed. This is particularly the case in relation to place partnerships and provider collaboratives where most of the work of ICSs will be done. To avoid confusion, partners need to agree how decision-making forums within ICSs relate to each other and to established bodies like health and wellbeing boards.

Ostrom used the term 'polycentricity' to describe governance that involves multiple centres of decision-making each with a degree of autonomy, as is the case in ICSs. Polycentric governance is not a panacea and to function effectively requires leadership skills and practices that are relatively uncommon in the NHS. ICSs are acquiring these skills as they work as convenors and facilitators with their partners and in the process are learning what it means to exercise leadership in a non-hierarchical system.

The challenge of adapting to different ways of working

The inherent complexity of polycentric governance is one of the challenges faced by ICSs. Another is the ability of leaders to adapt to different ways of working. In their research on system leadership, Peter Senge and colleagues argue that 'transforming systems is ultimately about transforming relationships among people who shape those systems'. They add that 'many otherwise well-intentioned change efforts fail because their leaders are unable or unwilling to embrace this simple truth'.[48]

> "In the case of ICSs, progress will depend on whether leaders trust and respect each other sufficiently to leave behind old rivalries."

In the case of ICSs, progress will depend on whether leaders trust and respect each other sufficiently to leave behind old rivalries. Ostrom argues that trust develops through repeated interactions that demonstrate the credibility of shared commitments, and is undermined when there is a disconnect between what leaders say and what they do. For system leadership to function, leaders must be willing to compromise on contested issues if they are to avoid descending into stasis or chronic conflict.

System leadership must also reflect the diverse organisations and communities involved in ICSs. Leaders from different parts of the public sector need to work alongside leaders from the voluntary and community sectors with patient and community leaders being 'in the room' when decisions are made. Leadership teams should actively embrace diverse perspectives in their work and be open to innovations wherever they arise.

The experience of the United States Army in building a 'team of teams' to make a reality of system working is instructive here. An organisation run on command-and-control principles was transformed by leaders who recognised the need to break down silos, shorten lines of communication within the command structure, and decentralise managerial authority to enable 'the disciplined practice of empowered execution'.[49] The COVID-19 vaccination programme, in which the British Army was a key partner, was explicit in using a similar approach in its work.[50]

The role of culture and behaviour

In an important observation, Don Berwick's report following Mid-Staffordshire emphasised that 'culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime'.[51] Cultural change requires the NHS to strengthen capabilities for continuous improvement and learning, grounded in improvement science and enabled by an investment in education and training in quality improvement methods and partnership with patients and the public.

> "Real trust is fostered through positive organisational cultures that encourage calculated risk-taking and generate commitment rather than compliance."

The importance of cultural and behaviour change is reflected in the views of experienced NHS leaders. Ed Smith, the former chair of NHS Improvement, has criticised the growth of regulation in the NHS and a culture in which leaders are frequently replaced when things go wrong.[52] His views were echoed by a senior NHS leader interviewed for this paper, who reported that she only understood the extent to which unacceptable behaviours had become normalised, and the adverse impact on people and their performance, when she left the NHS.

Regulated vs. real trust

Richard Reeves and Ed Smith[53] argue that 'regulated trust' is much less effective than 'real trust,' which is based on a belief that leaders have a strong intrinsic motivation to perform to the best of their abilities. Real trust is fostered through positive organisational cultures that encourage calculated risk-taking and generate commitment rather than compliance. Reeves and Smith contend that these cultures support people to act in a way that is trustworthy and to do the right thing, starting with an assumption of positive intent.

Positive cultures take time to develop and require sustained effort by leaders and followers. Real trust emerges through the actions of

leaders who create the conditions in which people are supported to be effective. This requires leaders at all levels to work in this way, including politicians who set the tone at the top. A recurring theme during interviews was that politicians must lead by example if the aspirations behind current reforms are to be realised. Some interviewees questioned whether this would happen.

Relationships at the centre

Cultures and behaviours also matter in relationships between organisations at the centre. One interviewee argued that the formal separation between DHSC and NHS England resulting from the Health and Social Care Act 2012 was 'an aberration' from the established model of civil servants and NHS leaders working as partners and respecting each other's skills. As a consequence, relationships had become more fractious, reflected in behaviours on both sides. Bureaucratic rivalries were also evident in a reluctance to share information on some issues.

Interviewees reported that the co-existence of DHSC and NHSEI resulted in 'two sets of people doing the same thing.' In some cases, this was experienced as those at the centre 'marking each other's homework' and slowing down decision-making by requesting national approvals of decisions. In some cases, the involvement of the Treasury and No.10 added to the complexity, the New Hospital Programme being cited by one interviewee as an example.

Attitudes have to change

A widely expressed view was that the attitudes of the centre and regions to NHS organisations had to change if ICSs are to succeed. One NHS leader felt that 'the centre infantilises the front line all the time,' for example in the volume and content of guidance on planning and operational issues and the behaviour of some

regional office staff to those working in ICSs. In his view and that of others interviewed, the relationship needed to shift from 'parent to child to adult to adult' by valuing expertise at the front line and ensuring respect in ways of working.

An ICS chair reported that in his experience there was an 'assumed superiority' towards system leaders on the part of the regional office he worked with, illustrated by the tendency to find fault and focus on weaknesses rather than strengths. He also used the word 'infantilisation' to describe this and hoped that, over time, system leaders would be treated as 'grown ups'. Although these behaviours were manifest primarily in interactions with the regional office, he argued that they reflected the tone set by politicians and cascaded through the NHS hierarchy.

A senior NHS leader with experience of working at the intermediate tier felt there had been a significant shift in the last decade from regions working alongside the NHS to manage change, to regions 'marking and telling' organisations what to do. Whereas responsibility for improving care had once been shared, she felt the onus was now on organisations to take the lead with regional offices holding them to account. ICSs need to learn from this experience and develop or acquire the capabilities required to act as a trusted partner of the organisations that make up systems.

Some interviewees expressed frustration at the controls exercised by the centre and regions over communications with the public and the media. Systems and organisations with experienced leaders were unable to use their own judgement on these matters and felt that some leaders at the centre and regions were unwilling to engage in honest conversations about the realities of the NHS on the ground and be challenged by local leaders. Political interest in and oversight of the NHS was again at work here.

Regional performance variations

In making these points, it should be noted that regions vary in how they perform their roles. Interviewees reported that the north east and Yorkshire had taken an early lead in working in partnership with ICSs, including the regional director and his team meeting weekly with chief executives of the four systems in the region. Those involved comprise the collective leadership team for the NHS in the region and take shared responsibility for development sessions. The region operates on the principle that wherever possible, communications with NHS organisations should be by, with and through ICSs.

These comments are a reminder that analysis of form and function – the anatomy of the NHS – is necessary but needs to be considered alongside the physiology of the NHS, defined as 'the way things are done around here'. The NHS chief executive, Amanda Pritchard, has acknowledged this, arguing that NHSEI has to exemplify in its own work the behaviours needed across the NHS and be consistent in these behaviours.[54] This will not happen by accident and requires intention and commitment over the long term by leaders at all levels as work on a new operating model moves from planning to delivery.

"Analysis of form and function – the anatomy of the NHS – is necessary but needs to be considered alongside the physiology of the NHS, defined as 'the way things are done around here'."

Leadership and organisational development

How accountability works in future will depend critically on the maturity of ICSs and their ability to use resources effectively. At the time of writing, ICSs are at different stages of development as they work to strengthen both governance and relationships among partners. The starting positions of ICSs also vary in relation to their finances and performance on key NHS standards and targets.* An early test of the commitment of the centre and regions to work differently will be how they respond to these challenges.

*NHSEI published the first set of ICS ratings in November 2021, divided into four categories. The results showed only one system in the highest category, followed by 19 in the second highest, 17 in the third highest and five in the lowest.[55]

Proportionate accountability

Interviewees argued that a regime of earned autonomy, as proposed in national guidance, was an unhelpful way of describing what was being proposed. In their view, the starting point should be an assumption of autonomy with freedoms being constrained only when significant performance challenges were encountered. An alternative formulation would be to work towards proportionate accountability, involving light-touch oversight of well-performing systems and rules-based intervention and support of other systems.

> "A well-resourced leadership and organisational development programme to embed requisite values and behaviours among leaders is a priority."

Proportionate accountability would recognise the intrinsic motivation of staff working in the NHS to perform to the best of their abilities, by reducing the burden of regulation and creating opportunities for leaders to look up less and to look out more. Oversight and assurance would be tightened only when other forms of support had been exhausted. One ICS leader argued that there needed to be a shift from the NHS being performance led to becoming improvement led for system working to become a reality.

When intervention is needed it should take the form of support provided by peers from within an ICS or outside, with further measures used only in extremis. Freeing local leaders and staff from onerous reporting requirements will release time to develop capabilities in improvement skills and to cultivate the behaviours needed in an NHS committed to collaboration. A well-resourced leadership and organisational development programme to embed requisite values and behaviours among leaders is a priority.

The programme should extend from the top to the bottom of the NHS, with leaders and staff at all levels working together to develop and put in place the principles set out here. The wider ambitions behind ICSs relating to population health require active involvement in the programme by local authorities and other partners building on the foundations laid by joint strategic needs assessments and health and wellbeing boards. The focus should be on systems

thinking and the changes in mindsets needed to support the development of system leadership and 'shared consciousness'.[56]

Proportionate accountability can be facilitated by focusing on whether ICSs have the capabilities required to operate as system leaders. A number of interviewees referred to the role of capability reviews in Whitehall from 2005 onwards and advocated a similar approach in the NHS today. These reviews were led by peers and focused on the capabilities of Whitehall departments in leadership, strategy and delivery, including a critical assessment of the then Department of Health. They were later extended to strategic health authorities.

Improvement methods

An essential capability will be proven expertise in improvement methods. Many NHS organisations have invested in these methods in recent years and ICSs are well placed to work with partners to share the expertise that exists and to reach services that have not yet benefited from this approach. This includes drawing on the experience of the NHS Modernisation Agency, academic health sciences centres and networks and related initiatives in designing a coherent approach to quality improvement at all levels and encouraging the adoption and adaptation of proven best practices.[57]

Quality improvement requires an ability to collect, analyse and use relevant data and intelligence. An ICS chair argued that the centre should support ICSs by sharing data on comparative performance. This would facilitate the 'self-directed improvement' advocated by Jeremy Hunt as well as directing the 'disinfectant of sunlight' onto performance. The proposed integration index and the development of a shared outcomes framework proposed in the new integration white paper, may help facilitate this.

The power of data has been demonstrated in the delivery of the COVID-19 vaccination programme, where expertise from the public and private sectors was used to ensure effective delivery at scale and pace. Data from many sources were integrated into a tool known as Foundry to create a single view of what was happening available at every level.[58] The programme offers a model for population health management that can be adapted in the prevention of cardiovascular disease, cancer, diabetes and other conditions. Integrated data enables understanding of differences in the populations served, identification of groups at risk, and targeted support at those most in need. This requires close working between public health teams and clinicians as well as the involvement of community organisations.

Part three – What needs to happen now

> "A surprising finding from research on complex adaptive systems is that relatively simple rules can lead to complex, innovative system behaviour"[59]

What other changes are needed?

Interviewees suggested a number of other changes that are either necessary or at least deserve serious consideration.

First, the centre should identify a small number of national priorities covering improvements in care and health outcomes. ICSs should be held to account for delivering national priorities and should also agree a small number of local priorities as part of a memorandum of understanding (MOU) with regional offices. The MOU should set out a three-year rolling programme to be reviewed on a regular basis.

Local priorities matter because the issues facing ICSs vary and also because partners beyond the NHS must be able to see that the issues that are important to them are receiving attention. An ICS chair emphasised in particular the risk that local authorities would become disengaged if ICSs focus exclusively on NHS priorities determined by the centre. The latter cannot be ignored but need to be seen alongside local priorities identified by ICPs.

Both national and local priorities should be expressed as whole-system targets in recognition that the interactions among parts of

a system are often more important than the actions of individual parts. The focus should be on the core purpose of improving population health, working through a diverse asset-based partnership of local people and leaders. The Berwick report on learning from failures at Mid-Staffordshire NHS Foundation Trust cautioned against 'hitting the target but missing the point' and careful thought is needed to avoid this happening.

Recognise the drawbacks

The drawbacks of the current approach to NHS planning must be recognised. A recent example is guidance for 2022/23 published in 24 December 2021 which runs to 40 pages and outlines a very wide range of targets covering all aspects of care – itself supported by several other sets of guidance. Not only does this overestimate the ability of local leaders to tackle so many priorities at the same time, it also reinforces the culture of compliance that runs through the NHS. A senior leader with experience at the centre and in the NHS likened the guidance to 'something out of the Ark'.

Second, funding should be allocated to ICSs on a population basis and not tied to specific deliverables; another example of the centre appearing to not trust local leaders to use resources effectively. In turn, ICSs should devolve funding to place-based partnerships with resources only being retained by the system when agreed by partners. The principle of maximum devolution of funding will enable those responsible for delivering care to decide how best to use resources to improve outcomes. It will also reduce the work involved in bidding for funding and remove the 'straitjacket' (to cite one regional leader) of funding tied to specific purposes.

Third, a strongly held view among ICS leaders interviewed is that the number of staff in the centre and regions should be cut substantially, not least because of rapid recent increases.[60] These leaders argued that fewer more senior and experienced staff would

reduce work that adds little if any value and would enable more effective support to be offered when needed. Their views were echoed by a regional director who gave a positive account of this way of working in NHS Improvement's regional offices before they were merged with those in NHS England.

The same applies to the centre, where national programmes should be limited to the most important priorities. ICS leaders are clear that there should be much greater coordination of national programmes, which are often experienced as disjointed, overlapping and lacking in understanding of local pressures. There also needs to be greater clarity and consistency in how national programmes are executed as the new operating model is developed, including the scope for local adaptations of these programmes.

"ICS leaders are clear that there should be much greater coordination of national programmes."

Changing embedded ways of working

A number of interviewees questioned whether NHSEI was capable of making changes of this magnitude. The challenge it faces is how to alter long-established and often deeply embedded ways of working if the opportunities offered by ICSs are to be realised. One suggestion was that leaders in other parts of the public sector such as local government, where there is experience of how system thinking has been applied, should be invited to support these changes.

Fourth, the relationship between DHSC and NHSEI, referred to earlier, will have a critical bearing on how these issues play out. Organisational separation between DHSC and NHS England enabled Simon Stevens to take a public lead on some major issues and resulted in an unusual and welcome period of continuity in health policy. Set against this, separation, in the words of one of those most closely involved, led to 'duplication and second guessing' and generated much wasteful activity.

Going forward, there needs to be closer alignment between DHSC and NHSEI based on partnership and underpinned by trust and mutual respect among staff. The recent public spat between DHSC and NHSEI over value for money in the use of private hospitals to help tackle the elective care backlog has exposed underlying tensions at the centre. These tensions may increase as the government strengthens its grip over the NHS in other policy areas in its determination to demonstrate that it is taking the public's concerns seriously.

"Going forward, there needs to be closer alignment between DHSC and NHSEI based on partnership and underpinned by trust and mutual respect among staff."

Clarifying roles of the centre

The future operating model should make explicit the respective roles of DHSC and NHSEI in developing strategy and policy and overseeing NHS performance. The renewed emphasis being placed on delivery, including the establishment of delivery units in No.10, DHSC and NHSEI, risks sending confusing signals from the centre in the absence of a joined-up approach. The use of joint teams of DHSC and NHSEI staff is one example of how these risks are being managed.

NHSEI's guidance assumes that regional offices will continue to have a role, albeit in a slimmed-down form. Some interviewees questioned this assumption, pointing to the risk of adding another level of hierarchy if regional offices and ICSs co-exist, thereby adding to the challenge of excess bureaucracy.[61] Other interviewees argued that a much bigger risk would be losing the expertise that regional offices have demonstrated, for example in the pandemic response, before ICSs have developed the necessary capabilities.

A distant parallel can be found in the state of Victoria in Australia which adopted a model of devolved governance for its health services. In many respects this worked well, except when difficulties arose in the delivery of some specialist services. An independent review found that a contributory factor was the lack of capabilities in the state health department in the planning and oversight of clinical services. [62]

The value of the regional role

We emphasised earlier the enduring value of the regional role in the NHS during successive reorganisations. Accepting that reasonable people may disagree on the future of regional offices, more consideration needs to be given to their relationship with ICSs and the distinctive contribution they can make. As this happens, the pace of change should reflect the different starting points of ICSs and the time it will take for them to become fully established, as well as the need to reduce the burden of reporting requirements and approval-seeking throughout the NHS.

Work is already underway to devolve responsibility for specialised services commissioning from regional offices to ICSs, who are collaborating to operate at the scale required to undertake this function. An ICS chair reported that ICSs in his region were also working together on capital allocations and he envisaged similar collaboration on reviews of the provision of specialist services that cut across system boundaries. Devolution of these and other functions to ICSs should enable slimmed-down regional offices to refocus their work in line with the new operating model.

One way forward would be to establish a joint review by leaders from different parts of the NHS to work through these issues, taking account of regional arrangements for public health and social care and how they would relate to regional offices and ICSs.

Regional chairs

A different suggestion concerned the role of chairs. A regional director reported that he was expected to relate to chairs as well as chief executives and this did not feel comfortable. If regional offices are retained, he argued that regional chairs should be appointed with responsibility for working with ICS chairs. He also suggested that regional chairs should sit on the board of NHSEI to strengthen alignment between the centre and regions, a suggestion advanced independently by an ICS chair.

One ICS leader emphasised that staffing levels in ICSs should be subject to the same degree of scrutiny as staffing at the centre and in regions. The benefits of subsidiarity accrue when the organisations responsible for delivering care are released from the burdens of reporting and regulation discussed earlier. Substituting ICSs for regional offices will not achieve this result unless ICSs are themselves committed to devolution and foster a culture of innovation and improvement in organisations, places and neighbourhoods.

> "Making a reality of aspirations to devolve responsibilities to ICSs requires exceptional skills in political management."

Engaging with the authorising environment

Making a reality of aspirations to devolve responsibilities to ICSs requires exceptional skills in political management. The centre as defined in this paper – DHSC and NHSEI – exists in an environment in which the Treasury and No.10 take a close interest in performance. NHS leaders have a key role in engaging with the 'authorising environment'[63] in which they operate if they are to create public value in their work. Moore emphasises that strategic managers in the public sector have to embrace political management if they are to succeed and not see it as a threat to be avoided.

These observations are particularly pertinent to the NHS today. The quid pro quo for the additional investment in the NHS announced in the recent Spending Review will be closer scrutiny of how these resources are used and the improvements they are delivering. National NHS leaders must find a constructive way of engaging with these developments and pushing back on central interventions where appropriate. Demonstrating that ICSs are able to fulfil the expectations placed on them is an important safeguard against the tendency of the centre to micromanage, as is the legitimacy that derives from ICSs working in partnership with local authorities and the communities they serve and the mandate that that brings.

Rules to bring it all together

Research into complex adaptive systems cautions against over specifying change programmes.[64] The alternative is to focus on articulating a few simple rules to guide those leading these programmes as they grapple with the transition from established ways of working to an as yet unrealised future. Arguably, this is how ICSs emerged from sustainability and transformation plans and partnerships and it helped to create greater ownership and commitment to the changes now underway than has usually been the case in the NHS.

The following simple rules are proposed, starting from the premise that decisions in the NHS should be taken at the most local level possible, beginning in teams and neighbourhoods followed by places, systems and the centre, and that the role of leaders at all levels is to support staff to perform to the best of their abilities, drawing on their intrinsic motivation to improve outcomes:

- There should be ever closer alignment between DHSC and NHSEI based on a partnership of equals and mutual understanding of roles and responsibilities.

- Regional offices should become thinner as ICSs take on more responsibilities and should work with ICSs as equal partners and not senior members of the NHS hierarchy.

- The number of staff at the centre and in regions should be reduced substantially, with greater emphasis on senior and more experienced staff doing the work.

- ICSs should be held to account for delivering a small number of national and local priorities and should receive a population-based budget in order to do so.

- These priorities should reflect the core purposes of ICSs, including improving population health.

- A shared outcomes framework should be developed jointly by the centre and ICSs, reflecting the core purposes of ICSs.

- A regime of proportionate accountability should be used, based on light-touch oversight of well-performing systems and rules-based intervention and support of other systems.

- Intervention should take the form of support provided by peers within an ICS or outside, with further measures used only in extremis.

- Complementary approaches to improvement should be adopted, recognising the limitations of viewing the NHS as a single organisation.

- ICSs should demonstrate how they are using intelligence about the communities they serve and how they are harnessing community power in their work.

- A development programme should be put in place to foster the culture and behaviours conducive to the changes now underway, based on collaboration, mutual respect and trust.

- There should be a focus throughout the NHS on capability building and supporting leaders and staff to embrace systems thinking and create a team of teams.

- National leaders should work with the ICS leaders to develop the operating model for the NHS in future, with co-production of guidance and policy becoming business as usual.

- The role of regions should be reviewed when ICSs have demonstrated their capabilities as system leaders, to avoid creating unnecessary complexity and bureaucracy.

These rules should be tested and refined in the light of experience. In the spirit of a learning healthcare system, leaders at all levels should reflect on what is and isn't working as the reforms underway are rolled out and be willing to adjust course accordingly. Taken together, the proposed rules are the foundation on which the fundamental changes needed for success can be realised.

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