

Accountability and autonomy in the NHS in England

Priorities for the Hewitt review

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Professor Sir Chris Ham

About us

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.

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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“In all public services we are making a radical shift from top-down, target-driven performance management to a more bottom-up, self-improving system built around the individual needs of service users and influenced by effective engagement with the public.”

Patricia Hewitt, Secretary of State for Health, 2006

“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.”

Jeremy Hunt, Health Secretary, 2015

Key points

- Progress has been made in acting on some of the recommendations in the NHS Confederation's report, *Governing the Health and Care System in England*.
- This is most evident in plans to create a new NHS England (NHSE), reduce staffing at the centre and regions, and co-produce the operating framework.
- More work is needed to reduce the number of national NHSE programmes, ensure greater consistency in how these programmes work, and bring an end to constant bidding for funds tied to specific priorities.
- The Department of Health and Social Care's (DHSC) 2020 report on *Busting Bureaucracy* should be revisited to release frontline staff to improve the delivery of care and enable senior leaders to look out more and look up less.
- High priority should be given to an organisational development (OD) programme to support the development of collaboration, mutual respect and trust and determine how peer support, shared learning and improvement collaboratives can play a bigger part in improving performance in future.
- Work is needed to define a high-performing integrated care system (ICS) and how data on performance can be used to stimulate improvements through transparent public reporting.
- The Hewitt review offers an opportunity for these and other issues to be addressed with priority being given to ensuring that planning guidance for 2023/24 is short and focused on a small number of national priorities, leaving scope for ICSs to add local priorities.
- Leaders in the DHSC and NHSE must recognise the exceptional pressures facing the health and care system and set out what a realistic set of medium-term objectives for ICSs looks like under current circumstances.

Introduction

The changes introduced by the Health and Care Act 2022 are designed to support a shift from competition to collaboration, streamline the national leadership of the NHS, and foster partnership working. ICSs – partnerships of NHS organisations, councils, voluntary and community sector agencies and others – are at the heart of these changes. ICSs have an opportunity to look and feel quite different to what has gone before in the way they work to improve health outcomes and the delivery of care for the populations they serve.

Integrated care systems were established on a statutory basis in July 2022. They comprise an integrated care board (ICB) which is a statutory NHS organisation responsible for managing the NHS budget and arranging for the provision of health services in the ICS area, and an integrated care partnership (ICP) which is a statutory committee jointly formed between the NHS integrated care board and all upper-tier local authorities that fall within the ICS area. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area.

Earlier this year the NHS Confederation published a report, [Governing the Health and Care System in England](#), outlining the conditions needed for ICSs to succeed. The report emphasised that ICSs had to develop the capabilities required to act as system leaders and take on mutual accountability for performance in their areas. It also described how the authorising environment in which ICSs operate had to change to make a reality of commitments by national bodies to devolve decision making and support partnership working.

The report was based on 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. The caveat is that the establishment of ICSs as statutory bodies must not result in duplication and additional bureaucracy in a system that is already heavily regulated.

The response to the pandemic by the NHS and its partners demonstrated the benefits that occur when the burden of regulation is relaxed. Many of the most important innovations in the NHS during the pandemic occurred because local leaders and staff had scope to improve how services were delivered based on their own experience of what needed to be done. This was recognised by DHSC in a report published in 2020, [Busting Bureaucracy](#), outlining actions that should be taken to create a culture that supports staff to lead improvements in care. The report argued that:

“...the success of the actions...will be impacted by how leadership at every level of the system embraces them. Each part of the system must question and call out organisational habits or local rules which increase excess bureaucracy. Everyone needs to play their part in busting bureaucracy, from national government to local providers and frontline staff.”

Department of Health and Social Care, 2020

As public services continue to recover from the pandemic, there is an opportunity to build on what worked and engage staff fully in improving care and health outcomes. High performing organisations are acting on this insight and delivering benefits for

the people they serve through the use of improvement methods. ICSs are well placed to amplify this work across systems and engage parts of the NHS not yet reached. This would help the NHS shift from a top-down performance-led culture focused on compliance to a bottom-up improvement-led culture based on commitment.

The NHS Confederation report argued that ICSs 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. Staffing levels in ICSs should be commensurate with their distinctive role in facilitating collaborative working and generating mutual accountability in place of hierarchical performance management. ICS leaders need to be skilled in enabling improvement, sharing learning, and promoting networking if they are to succeed. They should not seek to take on work better done by others in the health and care system.

In a publicly funded health service, autonomy needs to be matched by accountability for how resources are used. Mutual accountability within ICSs works alongside accountability through the hierarchy and the balance between the two is still evolving. The leaders involved in this work were clear that the role of ICSs is not to manage performance but to work with partners in taking collective responsibility for performance. Issues yet to be resolved include what happens when mutual accountability is insufficient and where it sits alongside national guidance on oversight and enforcement.

The principal changes proposed in the report were:

- There should be ever closer alignment between DHSC and NHSE 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.
- 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.
- 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 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.

The purpose of this short report is to assess progress in making these changes. It begins by noting key developments related to the recommendations made in *Governing the Health and Care System in England*. These developments include the Messenger/Pollard report on NHS leadership; plans to create a ‘new NHS England’ and reduce its staffing; proposals for an operating framework for NHS England; NHSE guidance on oversight and enforcement; the government’s announcement of the Hewitt review into oversight of ICSs; and the National Audit Office’s (NAO) report on the establishment of ICSs.

The report draws on discussions with leaders involved with ICSs and from other parts of the health and care system in two virtual roundtables convened by the NHS Confederation. These discussions provided valuable feedback on how national developments are playing out in different regions and how local leaders are experiencing policies developed at the centre. They also served as a reminder of the challenges of implementing major organisational changes at the same time as responding to the huge pressures facing health and care as winter approaches. The paper concludes by setting out priorities for the Hewitt review.

Key developments

The Messenger/Pollard report on NHS leadership

Published in June 2022, [this report](#) outlined a series of recommendations designed to tackle ‘institutional inadequacy in the way that leadership and management is trained, developed and valued’. These recommendations included putting in place unified standards for managers supported by training to meet these standards, creating a new talent management function, and encouraging top talent to take on some of the most difficult leadership roles.

From the perspective of this paper, it is pertinent to note the report’s criticisms of the ‘constant demands from above’ which created ‘an institutional instinct...to look upwards to furnish the needs of the hierarchy rather than downwards to the needs of the service-user’. The report also argued for a greater emphasis on collaborative leadership in place of an ‘ecosystem where personal, professional and organisational accountabilities flow vertically through distinct silos.’ This included developing a culture of teamwork in all parts of the health and care system.

The report identified the creation of a unitary NHS England and a new operating framework as opportunities to address these challenges and ‘to align responsibilities, accountabilities and authorities.’ It emphasised the need to embed inclusive leadership practices in order to improve equality, diversity and inclusion outcomes across health and social care.

The new NHS England and its operating framework

A major development in changing the authorising environment was the announcement on 7 July 2022 by Amanda Pritchard of plans to merge NHS England with Health Education England and NHS Digital and in so doing reduce the number of staff working at national and regional levels by between 30 and 40 per cent. In her statement, the NHS chief executive explained that part of the rationale of these changes was ‘to create the space to allow systems to lead locally’ by delegating functions to ICSs and resetting how NHS England works. She added that the operating framework for the new NHS England would set out more detail on future ways of working.

The operating framework was developed jointly with leaders from across the health and care system and published in October 2022. Its purpose was to explain ‘how we do things around here’ with the stated aim being to give system leaders ‘the agency and autonomy to identify the best way to deliver agreed priorities in their local context’. It emphasised the need for ‘a cultural and behavioural shift towards partnership-working; creating NHS policy, strategy, priorities and delivery solutions with national partners and with system stakeholders.’

Devolution was tempered by oversight of performance and intervention in organisations and systems facing challenges in recognition that NHS England retained statutory powers to act when serious concerns arose. This included a commitment to work closely with integrated care boards in the exercise of these powers. The letter accompanying the framework stated that: ‘Oversight and performance management arrangements within each ICS area will be proportionate and streamlined, avoiding duplication and unnecessary bureaucracy’.

Statements like this have been made many times in the past and it remains to be seen whether national bodies are able to reduce

oversight and enable ICS leaders to look out more and look up less. Growing pressures on the health and care system may result in even closer scrutiny of performance and make it difficult to fulfil commitments to devolve decision making. The behaviour of politicians will have a major influence on how these issues play out, especially if they choose to intervene directly in systems and organisations facing performance challenges.

System oversight and enforcement guidance

Arrangements for oversight and enforcement were set out in more detail in draft guidance documents published by NHSE in [June](#) and [October 2022](#). These documents reflect the establishment of ICSs as statutory bodies and learning from experience with the system oversight framework in 2021/22. Importantly they proposed that the oversight framework should be built around five national themes and local strategic priorities as a sixth theme underpinned by a set of high-level metrics.

ICBs are allocated to one of four segments based on a set of criteria used to determine their performance, and thus the scale and nature of support needs, ranging on a scale of segment 1 (no specific needs) to requirement for mandated intensive support (segment 4). Those in segments three and four are subject to enhanced oversight by NHSE and in some cases mandated support. ICBs in segment four – defined as those who are most challenged – are subject to the Recovery Support Programme. Memorandums of understanding have been put in place to clarify the role of NHSE's regional teams and ICBs in oversight and assurance.

As part of oversight arrangements, NHSE has a legal duty to annually assess the performance of each ICB. For 2022/23 the assessment will be in narrative form and encompass how ICBs have contributed to the wider local strategic priorities of the ICS.

Draft guidance on enforcement aligns intervention in ICBs with the approach taken with NHS providers following the transfer of functions previously carried out by NHS Improvement to NHSE.

The National Audit Office's report

This report, published in October 2022, focused on the way in which ICSs were introduced and the context in which they are operating. The NAO noted wide support for ICSs among stakeholders and for the approach taken by NHSE to their introduction. It also found that 'some aspects of the system for ICSs are still in their infancy or still being developed'. It added that it was important to be realistic about the time it would take for ICSs to bring about improvements in outcomes.

The NAO emphasised that ICSs were being introduced when the health and care system was dealing with longstanding financial and operational pressures, exacerbated by the pandemic. Thirty-one of the 42 ICSs have started their work as statutory bodies in deficit, and they are being asked to deliver extremely challenging efficiency savings. It is perhaps not surprising then that the NAO argued that 'there is a high risk that ICSs will find it challenging to fulfil the high hopes many stakeholders have for them'.

The report called on DHSC and NHSE to clarify 'what a realistic set of medium-term objectives looks like under current circumstances'. It also argued that their performance should be assessed on the basis of the effectiveness of joint working beyond the NHS and the delivery of local priorities, as well as core national NHS priorities. This required the oversight framework to be aligned more effectively with the strategic objectives of ICSs.

The Hewitt review

On 18 November 2022, the government announced that it had asked Rt Hon Patricia Hewitt, former Secretary of State for Health and chair of the Norfolk and Waveney ICB, to lead a review of accountability, targets and performance to help improve outcomes across the country. The press release that accompanied the announcement stated that the aim was ‘to empower local leaders to focus on improving outcomes for their populations’. This included ‘giving them more control and making them accountable for performance and spending, reducing the number of national targets, enhancing patient choice, and making the health care system more transparent’.

Patricia sent interim findings to the Secretary of State on 16 December to influence the annual NHS planning guidance and will produce a final report in mid-March 2023. The review is working in parallel with the ongoing inquiry into ICSs by the House of Commons Health and Social Care Committee.

Progress in the authorising environment

This high-level overview shows that progress has been made in responding to some of the changes proposed in the NHS Confederation’s *Governing the Health and Care System in England* report. This is most evident in plans to create a new NHSE, reduce staffing at the centre and regions, and co-produce the operating framework. There is also recognition of the need for ICSs to be held to account for a small number of priorities, including local priorities. Planning guidance for the NHS for 2023/24 will be an early test of this commitment.

Guidance on the oversight framework echoes the language of proportionate accountability and the need for rules-based intervention used in the NHS Confederation's report. It does, however, devote considerable space to mandated support and enforcement and is silent on peer support and the use of improvement methods. Similarly, while there is welcome recognition of the need to assess performance in relation to the four core purposes of ICSs, there is little evidence as yet of work to develop a shared outcomes framework with ICS leaders as proposed by DHSC in its white paper on integration.

Governing the Health and Care System in England argued that there was a risk of duplication and mixed messages being communicated to ICSs and local leaders unless there was close alignment between DHSC and NHSE. The mandate for the NHS and NHS planning guidance both have a role in this regard and there needs to be clarity on respective roles and responsibilities of DHSC and NHSE in relation to the NHS. The personality of the Secretary of State for Health and Social Care will have a bearing on these issues.

Frequent changes in the individuals occupying this post in recent months may explain why little progress appears to have been made. The establishment of the Hewitt review suggests that this may be changing. The involvement of Jeremy Hunt as Chancellor of the Exchequer in setting up the review indicates the importance the government attaches to its work.

Work on the operating framework to date has focused mainly on the role of ICBs with little acknowledgement of ICPs and their role in leading work on health and care strategies. It would be detrimental if this were interpreted as ICPs being marginalised as NHS priorities take precedence in the work of ICSs. The core purposes of ICSs demand partnership with councils and others on the wider determinants of health and health inequalities.

Future iterations of the operating framework should give explicit recognition to the work of ICPs and their role in developing health strategies. More also needs to be done at a national level to establish a cross-government approach to improving health and wellbeing. Several government departments have a contribution to make and at present plans to work in this way appear to be in abeyance.

Governing the Health and Care System in England reported that NHS and ICS leaders often experienced national programmes as disjointed, overlapping and lacking in understanding of local pressures. There remains a strong case for reducing the number of these programmes, ensuring greater consistency in how they work, and limiting the proportion of resources allocated in this way. Work is ongoing in NHSE on these issues.

Linked to this, NHS and ICS leaders have expressed concerns at the way in which the centre uses funds for elective recovery, winter pressures and other high priority issues. A substantial workload is involved in bidding for relatively small amounts of money. Leaders involved in this work felt they should be trusted to use funds based on their assessment of local needs and plans agreed with partners instead of being subject to constant checking and marking.

These leaders welcomed the direction of travel set by NHSE but are concerned that aspirations to work differently and devolve responsibilities have yet to be realised. Staff who have become accustomed to working in one way – often those in more junior roles – take time to adjust. NHS leaders report continuing detailed oversight and incessant requests for information about performance, which risks undermining the credibility of commitments to work differently.

Work on cultural and behavioural change to date has focused on the merger of national bodies into new NHSE. There has been no national organisational development programme for the whole health and care system although some regions have initiated work with ICSs on new ways of working. An example is south west

England where the regional team led by Elizabeth O'Mahony has been working with the chairs and chief executives of ICBs to agree a compact setting out the behaviours they expect to see in their relationships and how the compact should be used in practice.

In the south west and other regions, discussions are taking place on how regional teams and ICBs should work with each other. In some cases, this may entail the delegation of functions to ICBs, individually or collectively, while in others, regional teams may continue to discharge functions on behalf of and in partnership with ICBs. Work on digital, workforce, service transformation and data analysis are examples. Differences between regions in the size and number of ICBs and their leadership capabilities mean that there can be no 'one size fits all' approach to these issues.

Cultural and behavioural change is essential to address concerns raised by ICS leaders of the 'assumed superiority' of some regional offices and a feeling of being in adult to child relationships in working with regional offices and the centre. There are also concerns about the 'poor behavioural cultures and incidences of discrimination, bullying, blame cultures and responsibility avoidance' described in the Messenger/Pollard report. Changing culture must be a high priority if the aspirations set out in the operating framework are to be realised.

Some chief executives involved in our work reported spontaneously that the leadership culture in the NHS had moved in a positive direction under Amanda Pritchard's leadership. Respect and trust in the chief executive community had been strengthened and there was a genuine commitment on the part of national leaders to engage with their peers in ICSs and NHS providers, as reported in the [Fuller Stocktake](#). There was also a willingness at the top to work compassionately with all leaders, particularly those facing difficulties.

A primary care network (PCN) leader expressed concern that ICBs had not always been willing to practice subsidiarity within their areas.

The Fuller Stocktake report on integrating primary care emphasised the need for national leaders to support and enable local systems to improve care and the same applies within ICBs. PCNs have a key role in working with general practices, community services and local people to streamline access to care, provide more personal care and help people to stay well for longer. ICBs need to devolve decision making and resources to PCNs and offer support in the development of new care models.

Progress in ICSs

Research has shown that ICSs face different challenges in terms of the health needs of their populations and pressures on their services. This requires a nuanced approach to assessing their performance and intervening in systems in difficulty. It underlines the need to give higher priority to peer support, shared learning and improvement collaboratives in which well-performing ICSs are able to offer their expertise to ICSs facing the greatest challenges.

ICSs are at varying stages in developing the capabilities needed to operate as system leaders. Considerable time has been devoted to completing the transition from CCGs, putting in place new governance arrangements, and developing work in places and provider collaboratives. ICSs have also focused on working with partners in responding to the growing operational pressures affecting all parts of the health and care system. Other priorities have yet to receive the same attention in many systems.

The emphasis on transparency in the Hewitt review suggests that more attention will be given to publishing data on ICS performance. This is welcome but begs the question of how performance will be assessed. Now is the time to address this question and define what a high-performing ICS looks like. Publication of comparative information on performance can be a powerful means of improvement as long as care is taken to select the right measures and take account of the different contexts in which ICSs are working.

Where next?

An essential starting point is for national leaders in DHSC and NHSE to recognise the exceptional operational and financial pressures facing the health and care system. ICSs have inherited substantial deficits and are operating in a system that is missing key performance targets by a wide margin. There must be realism about the time it will take to tackle these pressures even with the additional funding for the NHS and social care announced in the autumn statement.

DHSC and NHSE should set out what a realistic set of medium-term objectives for ICSs looks like under current circumstances, as recommended by the NAO. Work on the NHS Long Term Plan update must also take account of the context in which health and care services are working. It was encouraging to see that planning guidance for 2023/24 contains a smaller number of national priorities. This should be built on in future and leave scope for ICSs to add local priorities.

National leaders should revisit the recommendations in DHSC's Busting Bureaucracy report and agree what further measures are needed to create time and space for local leaders and staff to innovate. This applies both to senior leaders who are subject to multiple reporting and regulatory requirements and to staff delivering care.

This is important because changes to the superstructure of the NHS, such as the establishment of ICSs as statutory bodies and the proposals in the operating framework, may be a necessary condition of success in the new NHS but they are far from sufficient. Supporting staff to improve care and health outcomes holds the key to progress which is why we have emphasised the need to invest in improvement methods and the development of cultures that value expertise at the frontline.

The Hewitt review offers an immediate opportunity for addressing some of these issues while others need to be tackled over a longer timescale.

The priorities now are to:

- Expedite work on a shared outcomes framework and ensure this is co-produced between DHSC, NHSE and ICS leaders. The framework should set out a small number of metrics aligned with national priorities. These must encompass the core purposes of ICSs including work on the wider determinants of health and health inequalities.
- Reduce the number of national NHSE programmes, ensure greater consistency in how these programmes work, and bring an end to bidding for funds tied to specific priorities. ICS leaders should be trusted to allocate population-based budgets appropriately in discussion with their partners and taking account of planning guidance.
- Clarify the place of mutual accountability within the NHS oversight and enforcement frameworks and codify how mutual accountability is evolving in practice. Ensure that the annual assurance process for ICSs is based on appreciative inquiry and supports work on cultural change.
- Revisit the eight priority areas identified in DHSC's 2020 report, *Busting Bureaucracy*, and progress in delivering these priorities to reduce the burden of reporting requirements. This should include releasing the time of frontline staff to innovate and improve the delivery of care as well as enabling senior leaders to look out more and look up less.



- Make recommendations for an OD programme for the health and care system to support the development of collaboration, mutual respect and trust at all levels and determine how peer support, shared learning and improvement collaboratives can play a bigger part in improving performance in future.
- Undertake work to define a high-performing ICS and how data on performance can be used to stimulate improvements through transparent public reporting.
- Ask DHSC and NHSE to set out how they will align their work in future and how they will collaborate with other government departments to provide national leadership on population health and tackling health inequalities.
- Agree how the findings of the Messenger/Pollard review should be used in developing system leadership.
- Assess what further changes may be needed to the number and role of NHSE's regions as ICSs demonstrate their capabilities as system leaders.

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