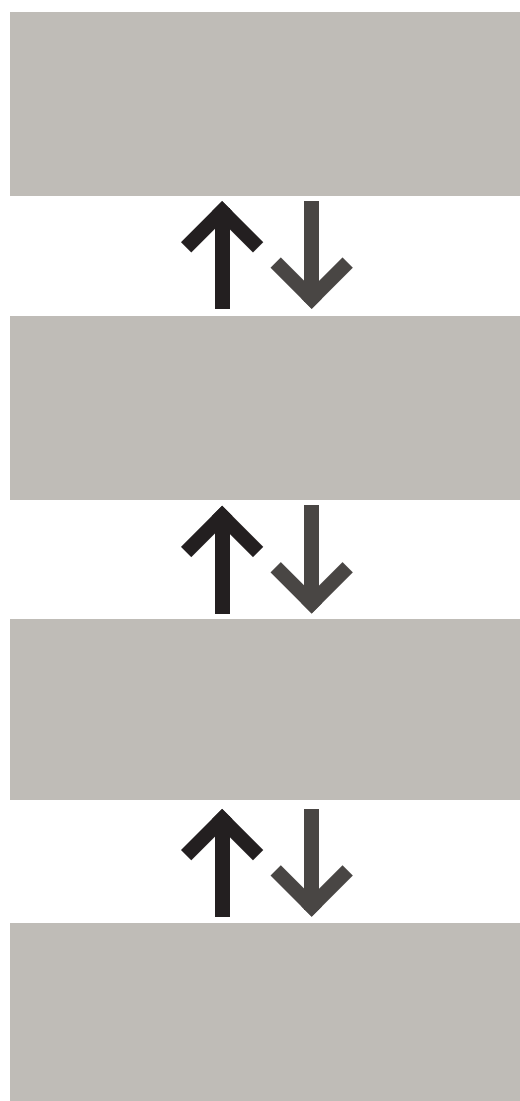


Simpler, clearer, more stable

Integrated accountability for integrated care

Andrew Hudson



About the author

Andrew Hudson had held senior roles in a number of different parts of the public services. He was Director General, Public Services at the Treasury between 2009 and 2011, leading the work on public spending through the general election and the first spending review under the coalition government, and overseeing the Treasury's work on financial management in government. Before that he was Chief Executive of the Valuation Office Agency (2004-09) and Deputy Chief Executive (Finance and Performance) at Essex County Council (2002-04) after a couple of years there as Assistant Chief Executive (1999-2002). Much of his early career was in the Treasury, ending as Head of the Health Team (1996-99).

Andrew now has a portfolio of roles. He is a non-executive director at Circle Housing, Volunteering Matters, and the What Works Centre for Wellbeing, and chairs two local charities, Hackney Winter Night Shelter, and The Old Church arts centre. In his spare time, he enjoys running and country walking, and is writing a book about the London to Holyhead road.

He was awarded the CB (Companion of the Bath) in the New Year's Honours 2012.

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As ever, any errors and omissions are entirely mine.

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Overview

The accountability framework for any service is the mechanism for determining priorities, allocating resources, monitoring progress, ensuring delivery and learning lessons. The details of reporting mechanisms and governance structures may be dry and dusty, but the implications are not: a poor accountability framework increases the risk of poor quality services for its users, and poor value for money for funders.

Getting accountability right is challenging at any time. It involves combining specific processes and structures with the right culture. The current context in England is particularly challenging in a number of ways: approaches to planning and organisation are changing, and new models of care emerging, with a lot of focus on increasingly integrated working. This is happening at a time when both finances and service delivery are under pressure in the NHS and local government alike.

In this paper, I identify the principles that should underpin a good accountability framework. I then look at how the present arrangements for accountability across health and care in England match up against these, with a particular eye on integrated working and new models of care, and suggests changes.

The good news about an accountability framework is that – unlike the development of a new drug or determining the best way to treat a particular type of cancer – the practicalities, at least, are in the gift of policymakers and can be changed relatively quickly.

Key points

- This paper identifies six principles that underpin an effective accountability framework. It should be:
 - comprehensive and joined up, spanning quality and finance
 - economical of time and money
 - clear and transparent
 - rigorous where it matters but encouraging towards innovation
 - stable over time and consistently applied
 - robust to the real world.
- The title of the paper identifies three condensed headline recommendations: accountability for health and care in England needs to be simpler, clearer and more stable.
- The paper is written at a time of significant change in the planning and delivery of health and care in England, with a strong emphasis on integrated working. All of this raises questions for the accountability framework.
- The paper concludes that more integrated ways of working will need an integrated approach to accountability which can reflect different local circumstances and changing ways of delivering care. The key components should be:
 - an overall framework for planning and monitoring, with the national elements set for the length of a parliament, and the local elements for a local authority term
 - a single set of outcome indicators, covering health care, public health and social care; this should comprise some key national indicators, plus a set of local indicators agreed by the relevant parties
 - a coordinated approach to planning at local level, including how planning and monitoring for individual organisations fits within this strategic, place-based approach
 - a high level financial plan also agreed at local level, as part of the process of setting service plans, which provides the framework for commissioning decisions
 - a common database for headline performance measures that is available to the public, which spans health and care, quality and finance
 - fully coordinated inspection regimes.

- This vision will take time to put into place. The following shorter-term measures should be taken to strengthen the current position:
 - Governance arrangements should be established quickly for all Sustainability and Transformation Plan (STP) footprints, bringing out the links to existing governance mechanisms.
 - The STP process, Joint Health and Wellbeing Strategies (JHWSs) and other existing mechanisms should be adapted to generate the integration plans required by the 2015 Spending Review, rather than starting a new process.
 - Clear statements should be published of how the health and care system works at all levels, including for new models of care vanguards. This should be done by the Department of Health (DH) for the overall system, and by appropriate local bodies, typically Health and Wellbeing Boards (HWBs).
 - There should be a simple but rigorous method of assessing the likely impact of making changes to the accountability frameworks and indicator sets, to make sure the benefits outweigh the costs.
- Before the start of the next parliament in 2020 there should be an independent review of the indicators set at national level, with a view to focusing on the key measures.

1. Introduction

Accountability can be a slippery concept. For some people, it can mean an intensive process, using formal techniques (eg a RACI analysis^{*}) that lead to a long list of powers, tasks and delegations. For others, it's simply knowing who to blame when something goes wrong – as a former boss of mine used to challenge us, 'Whose neck is on the line for this?'[†]

At root, an accountability framework is the means of ensuring that resources are translated into the best possible outcomes, for both the quality of treatment and services, as well as the value for money of the work done. It encompasses how people in governance and/or funding roles specify what they are looking for, how practitioners account to them for their performance, and how action is taken when performance is unsatisfactory. It therefore covers the initial process of setting a vision and more detailed objectives, right through to resourcing, delivery, monitoring performance, course correction and evaluation. So if, for example, a health or care organisation is persistently generating a low quality service, questions should be raised not just about the competence of front-line staff, but about the accountability framework. Who set the objectives, and were these demanding enough? Has progress been monitored properly, and why was no effective action taken to address the quality failings?

It is timely to be addressing this issue for England. I have been working on this paper for nine months or so, talking to range of people in both health and care. In this time alone, there have been significant changes to the wider accountability framework. The institutional architecture has changed, with Monitor and the Trust Development Authority merging into NHS Improvement. New planning arrangements are in place as a result of the advent of STPs, which require a range of organisations – all with their own accountability arrangements – to collaborate on a joint plan. The vanguard sites are setting up new vehicles for delivering services, bringing together different organisations (or parts of them) into new entities. Greater Manchester is pioneering an approach to integration through its devolution deal, which took effect from April 2016 (see the Appendix for more details).

Many of these developments cut across the lines envisaged in the 2012 Health and Social Care Act, which remains the statutory basis for the work of the NHS. This raises major questions for the accountability framework: it is risky, to say the least, for there to be too big a gap between the nominal accountability system and the real one. Who takes the final decisions on a service issue: the boards of the provider organisations, or the cross-agency steering board? If there is a service failure by people working for an acute trust, does

* A technique that asks, for a given set of activities, who is Responsible, who is Accountable, who is Consulted, and who needs to be Informed. There are a number of variants in project management literature.

† Reflecting his American origins, he often actually referred to a different part of the body.

responsibility rest with the trust, or with the multi-disciplinary team that shaped the new clinical pathway? Questions like this prompted the Chief Executive of NHS Providers, Chris Hopson, to comment in July 2016:

*'I think we're in danger of leaving the governance and accountability behind.'*¹

This paper is designed to assist those at the centre who are working on the answers to these issues, but to do so in a way that will be robust for the medium term, as models of care evolve, rather than just to address today's problems. It is structured into the following sections:

- **Section 2:** Starting with a bit of theory, what mechanisms for accountability are available, and what choices need to be made about different dimensions of the framework?
- **Section 3:** What principles should underpin a good accountability framework?
- **Section 4:** What is the context in England today? How do the features of the health and care system, both underlying and current, impact on accountability? What challenges do recent changes bring with them?
- **Section 5:** How do the emerging accountability arrangements match up against the principles of a good framework? What improvements could be made?
- **Section 6:** Pulling together the thinking, what would a good framework for health and care in England look like?
- **Section 7:** Concluding thoughts.

2. What do we mean by accountability in health and care?

Getting accountability right is inherently challenging

Getting accountability right in health and social care is intrinsically difficult. At its broadest, accountability is about how the behaviour of a large number of professional people can be influenced to maximise the health and wellbeing of a population. This depends both on deep-seated cultural and personal factors, and also on getting some technically complicated things right. And it is bound to be politically sensitive anywhere. Kenneth Clarke, who was both Secretary of State for Health and Chancellor of the Exchequer, commented recently:

‘Health is a political graveyard in every Western democracy... Political excitement and drama runs higher on the subject of health, than any other subject.’²

Another former Health Secretary, Patricia Hewitt, said:

‘Is the job impossible? No, it’s not impossible, but it is unbelievably demanding.’³

In Britain, this sensitivity is intensified by the deep national commitment to the NHS – as another former Chancellor, Nigel Lawson, commented:

‘The National Health Service is the closest thing the English have to a religion.’⁴

Alongside their accountability ‘up’ the line – it is hard to get away from these hierarchical terms – doctors, nurses and care workers feel accountable to the patient or service user in front of them. Quite apart from any medico-legal issues, they want to do a good job. Overwhelmingly, their intrinsic motivation means that they want to make their patients’ lives better, and this can easily be forgotten in designing accountability frameworks. Referring to the number of targets and processes in place in the 2000s – an issue which has not gone away – the former Labour special adviser on health, Robert Hill, commented in 2006:

‘the government has tended to talk as though professionals were knights... But it has tended to act as though they were knaves.’⁵

Health and care professionals also feel accountable to their professional standards, formally laid down by bodies like the royal colleges. Managers may feel accountable to their staff for their ability to win resources for their bit of the organisation. Trust boards feel a sense of direct accountability to the residents of their area, as well as to the people commissioning services. And politicians, national and local, are accountable to the electorate. Any successful framework needs to take account of these different motivations.

There are a range of mechanisms for accountability

Not surprisingly, given the difficulties and cultural dimensions, there is no one accountability mechanism for all health and care systems – for example, the four countries in the UK use somewhat different approaches.

There are different ways of driving better performance, with different accountability mechanisms to match. A 2011 study led by Peter Smith of Imperial College looked at the approaches to accountability used in seven countries.⁶ The authors identified the following four mechanisms:

- Market-based systems of choice, where patients or insurers exert pressure through the threat to take their business elsewhere.
- Elections, for the relevant authorities.
- Direct incentives, through managerial control, or payment mechanisms designed to improve quality or ensure minimum standards.
- Professional oversight and control.

Neither regulation (presumably part of professional oversight) nor transparency were pulled out separately, though the authors comment that they observed a move away from traditional trust in professional accountability towards more transparent approaches enabling public scrutiny.

Most, if not all, countries studied operate a mix of mechanisms. The study observed that a mix does seem to be the best approach as relying on a single method would create very stark incentives to move in particular directions. It also noted that many existing accountability mechanisms have developed through a mix of historical accident and political expediency, rather than careful design.

Accountability matters in the real world

A lack of attention to accountability is not surprising in one sense: most people would rather get cracking on introducing a new care pathway than worry about governance issues. But accountability is about far more than the detail of who sits on which board and how often performance is reported up the line. It has real-world implications in driving what people working in health and care seek to do, and how effectively the system performs as a whole. An accountability framework drives behaviour, for better or for worse, and hence impacts on quality and value for money. Complying with its requirements takes a lot of time and so it is important for everyone that the framework is effective. Some of the details may be dry and dusty, but the results aren't.

Some people are sceptical about the role of an accountability framework, because they argue it will always be trumped by the impact of personalities. It's certainly clear that individuals in key roles, nationally and locally, will have an important bearing on how successfully any framework operates in practice. But the importance of personalities is not a reason to give up on introducing better frameworks. On the contrary, the whole point of a framework is to avoid over-reliance on the behaviour of individuals in ensuring organisations are run well – and to limit the scope for individuals to do harm, without constraining their ability to add value.

The questions to answer

Designing any accountability framework involves balancing a number of considerations, as well as deciding on the main mechanisms. The following questions need to be answered:

- How far should the framework focus on outcomes, such as population health and wellbeing, compared to activity, standards of care, and processes? Is its focus short term or long term?
- How much of the framework will be set nationally and how much left to local discretion?
- How far should the framework be organisation-based and how far should it be place-based?
- How much focus should be on accountability to the hierarchies, and how much to patients and the local community?

These questions run through a number of issues in this paper, and Section 6 brings the answers together. However, the first step is to look at the principles that should underpin a good framework.

3. The principles of a good accountability framework

The delivery of health and care is changing rapidly, as new models are piloted and new planning regimes introduced. So rather than devise an accountability framework for particular organisational models, I have identified the following underlying principles which I believe should underpin any framework, and hence will stand the test of time.

- **Comprehensive and joined up:** a framework should cover quality and finance across health and care, with different ‘masters’ looking at the same data and not duplicating work. Bringing quality and finance together can help create a shared understanding of value – an important foundation for successful collaboration. Another key dimension here is a joined-up approach to monitoring and regulation: this should apply to organisations operating under traditional structures, and is all the more important under new models of care.
- **Economical of time and money:** accountability is important and work on it should not be skimped. However, there should always be an eye on whether the overall burden of the accountability framework itself is excessive or not. This is all the more important as resources are tight in all parts of the health and care system, not least the arm’s length bodies.
- **Clear and transparent:** stakeholders, from colleagues through to the wider public, should be able to understand who is accountable to whom for what. This will help to align power with responsibility: it is unrealistic to hold someone accountable for an event or a service if they are not in a position to have detailed knowledge of it, or to exercise control over those delivering the service.
- **Rigorous where it matters:** a framework should be firm on key issues such as safety, but should also be flexible enough to encourage innovation.
- **Stable over time and consistently applied:** rapid changes to the framework can be damaging towards accountability itself, as well as causing a distraction from service delivery.
- **Robust to the real world:** there is no point devising an accountability framework that is good in theory but that won’t fit in with political and service realities.

4. The accountability challenge in England

The nature of the NHS in England poses particular challenges for accountability. As well as the deep emotional commitment to the NHS in the country, our system is unusual internationally in being nearly 100% funded by the taxpayer and run by central government rather than local bodies. The commitment to a national service means that many aspects of an accountability framework must apply to 55 million people, looked after by 124,000 doctors, 377,000 nurses, midwives and health visitors, and nearly 900,000 others working for the NHS. It also has to cover a range of geographies and local circumstances. Working across health and care adds to the complexity. An accountability framework for integrated care will potentially apply to a further 1.5 million people working in adult social care.⁷ However, unlike health, social care is not centrally run but is overseen by 150 local authorities, separately elected and responsible to their own local populations. While the degree of local autonomy in England is currently low by international standards, it is set to grow. Changes to local government finance mean that by 2020, local authorities will raise significantly more of their own money. In addition, the growing number of devolution deals will bring more local powers, along with new combined authorities and elected mayors.

There is also a stark contrast between health and social care in terms of payment. Health treatment is free at the point of use, as is 'continuing care' from the NHS, whereas social care is means-tested. This can make for tensions both between different services and between the authorities and individuals and their families: looking after someone at home, with an intensive care package, will reduce costs in hospital or a nursing home, but will require more funding from the local authority and, depending on their means, the individual.

There is one other important difference between local authorities and the NHS: legislation provides that local authorities cannot run a deficit. A senior officer, known as the Section 151 officer, has the statutory duty to report a council's failure to set or keep to a balanced budget. By contrast, four out of five NHS trusts reported a deficit in 2015/16, and one clinical commissioning group (CCG) in five was also in deficit. For whatever reason, when push has come to shove, local authorities have made cuts necessary to stay within the financial parameters largely set for them (eg by tightening the criteria for entitlement to care). The NHS, by contrast, has allowed deficits to rise.

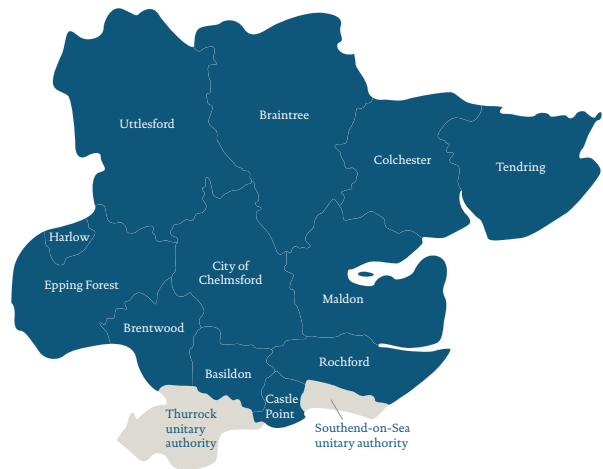
For all these reasons, there can be very different cultures of working between health organisations and social care organisations. The challenges increase in the many areas where the health and local authority boundaries are not coterminous. For example, in Essex, a big county with a population of 1.4 million, there is one organisation responsible for social care – the County Council. There are then two mental health trusts, three STP footprints, four major acute trusts and five CCGs. Twelve district councils carry related responsibilities, eg for housing. Figure 1 overleaf illustrates this mix of boundaries.

In addition, managers in the NHS and local government are accountable to a wide range of people, in different ways. Figure 2 summarises the position for the management of an acute trust, engaged in partnership working with the local authority. The blocks could be moved around to show the same complexity for other managers.

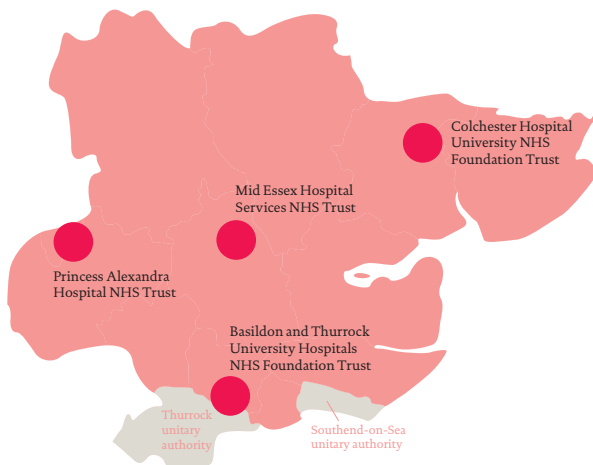
Figure 1: Health and care organisations in Essex

These maps illustrate approximate coverage of the main organisations responsible for health and care within the county of Essex.

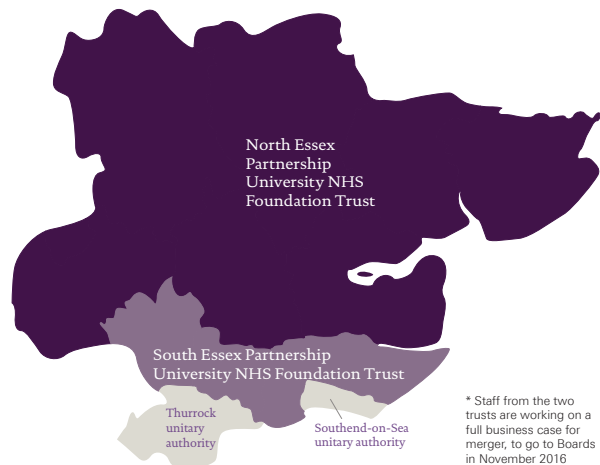
District councils



Major acute trusts



Mental health trusts*

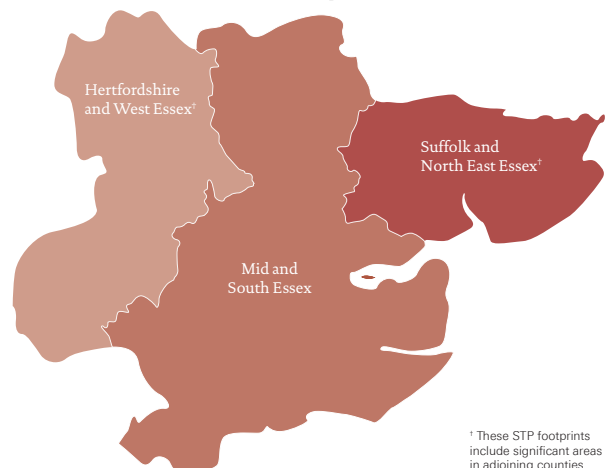


* Staff from the two trusts are working on a full business case for merger, to go to Boards in November 2016

Clinical commissioning groups

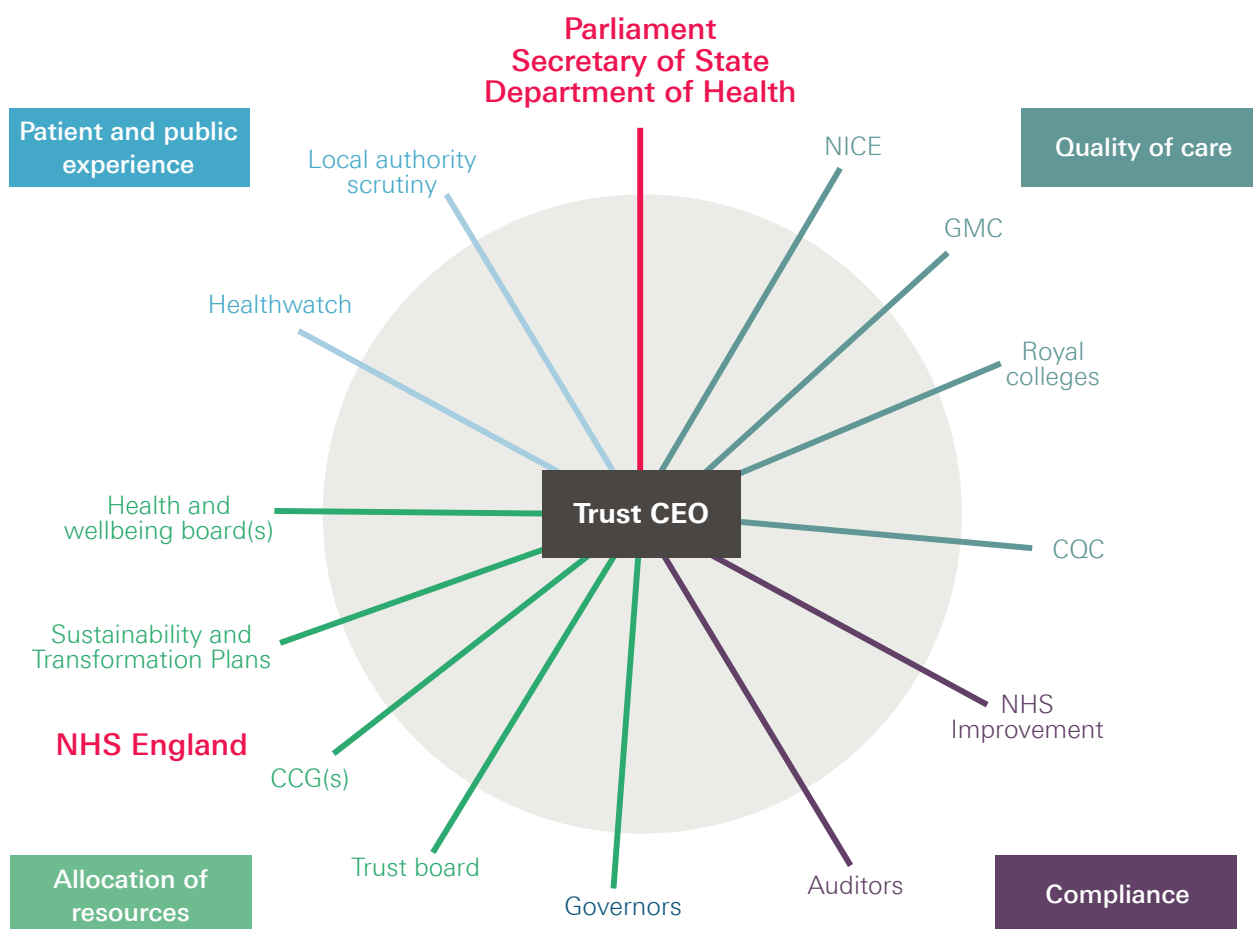


STP footprints



† These STP footprints include significant areas in adjoining counties

Figure 2: A complicated accountability map



The current context is driving change

The current context in England is driving changes to both the planning and delivery of health and care.

There is considerable momentum behind the implementation of the *NHS five year forward view* (Forward View). This was designed to tackle the ‘gaps’ covering health outcomes, service quality and finances, at the same time as delivering ministerial priorities such as seven-day working. These challenges are being addressed against a difficult backdrop.

NHS finances are in their worst state for at least 10 years. As the Health Foundation has put it, ‘the NHS in England is currently halfway through the most austere decade in its history’.⁸ The strain of this is being felt in a number of ways. Performance in early 2016 against the target for treating patients in A&E within four hours was the worst since records were first kept in 2004. Performance against some other waiting time targets is also drifting out. To try to address the deficits, a central cap has been put on the use of agency staff, although much of the increased use arose from central guidance/rules about staffing levels on wards. Meanwhile, junior doctors have recently been involved in a dispute lasting several months, including an escalating programme of strikes.

Local authorities have made cash cuts of well over 20% over the last five years, with much more to come.⁹ They also face extra cost pressures, some in common with the NHS, arising from changes such as the end of contracting out for pensions.

So arrangements are changing fast

New ways of doing business are being introduced, partly in response to these pressures. This has implications for accountability.

Within the NHS, the legislative position is still that of the 2012 Health and Social Care Act. Money flows from NHS England to CCGs, which it accredits. CCGs commission services from independent trusts, who account to them for their performance. Local authority services report to councils. There are also established arrangements for pooling budgets under Section 75 of the NHS Act 2006.

The 2012 Act was already a compromise. The incoming government in 2010, with Andrew Lansley as Health Secretary, published the white paper *Equity and excellence: Liberating the NHS* after a few weeks in office. A few phrases from the foreword and the executive summary capture the thinking:

'We will make the NHS more accountable to patients... We will free staff from excessive bureaucracy and top-down control...'

Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients...'

*The NHS will be held to account against clinically credible and evidence-based outcome measures, not process targets.'*¹⁰

Organisationally, commissioning was devolved 'to the health care professionals closest to patients: GPs and their practice teams'. Trusts were to become more independent and ministers would be less involved in decision making.

Drawing on the definitions of accountability mechanisms I introduced in Section 2, the 2010 approach put a lot of weight on market mechanisms, albeit with care remaining free at the point of use. Indeed the article itself, written in 2011, commented that while the Netherlands placed most reliance on markets, 'England appears to be moving in the same direction'. Strategic Health Authorities, which had represented the management oversight mechanism, were abolished.

By the time that article appeared, however, concern over aspects of the reforms outlined in the white paper had led the government to pause and rethink quite significantly. The changes included: making explicit that ministers were responsible for the NHS overall; introducing new safeguards against price competition and 'cherry picking'; promoting integrated care; and giving Monitor the core duty to protect and promote the interests of patients. The reliance on markets was toned down and balanced by more managerial control.

Even before the Act came into force in April 2013, the arrangements had come under further pressure. The two reports by Sir Robert Francis following the scandal at the Mid Staffordshire NHS Foundation Trust led to an extra focus on safety and quality, backed up by more central standards, eg for staffing levels on wards. The response to all this was in the hands of a different Secretary of State, Jeremy Hunt, who replaced Andrew Lansley in September 2012. The inspection regime for trusts has been tightened, partly in response to other scandals such as Winterbourne View. There is also greater transparency about other aspects of performance and focusing of accountability onto named clinicians.

More data is now being reported centrally. As more trusts have gone into financial deficit, there has been closer monitoring of financial management, and this was reinforced by concern over the potential impact of winter pressures in the winter of 2014/15. The combined effect has been a sense of much greater central control, compared to the philosophy of 2012, let alone 2010. In terms of accountability mechanisms, there is less reliance on markets and choice, and more on managerial control and professional control via regulation.

The NHS's approach to the future was brought together in October 2014 in the Forward View. As well as stressing the importance of prevention, and more control for patients, this also pointed to breaking down barriers in the way care is provided, through better collaboration at a number of levels. In particular, the Forward View identified a small number of new care models, many of which are now being piloted and worked up as part of the vanguard programme. These are:

- multispecialty community providers (MCPs), combining groups of GPs with nurses, community health and others to create integrated out-of-hospital care
- primary and acute care systems (PACs), combining GP and hospital services
- urgent and emergency care networks, involving hospitals, primary care and others
- acute care collaborations, linking local hospitals together to improve clinical and financial viability
- enhanced health in care homes, offering better joined up health, care and rehabilitation.¹¹

Some local areas are planning to go a step beyond an MCP or PACS, towards an accountable care organisation (ACO). In these, all provider organisations would come together to deliver care against a capitated budget, with outcome objectives set for the health of the population. The most radical change actually in place is the devolution of health and care responsibilities to Greater Manchester (see Appendix).

These planned approaches to innovation have been accompanied by an increasing focus on the inter-dependency of organisations within a health economy, and a greater emphasis on integrated working. This started with the creation of the Better Care Fund in 2013, generating a single pooled budget to incentivise the NHS and local government to work more closely together.

The switch to a place-based focus was strengthened in 2015 in two ways. The government's Spending Review said that health and social care should be integrated across the country by 2020, with each area producing a plan for this in 2017. More immediately, in December 2015, NHS England, along with the other arm's length bodies,^{*} issued a new requirement for all areas to produce five-year STPs. These plans mark a major change in the approach to planning across health and care, creating new footprints – largely independent of those used for devolution deals – plus new organisational arrangements and a new multi-year approach. The guidance requires the involvement of both providers and local authorities.

^{*} NHS England, NHS Improvement, Health Education England, the National Institute of Health and Care Excellence, Public Health England and the Care Quality Commission.

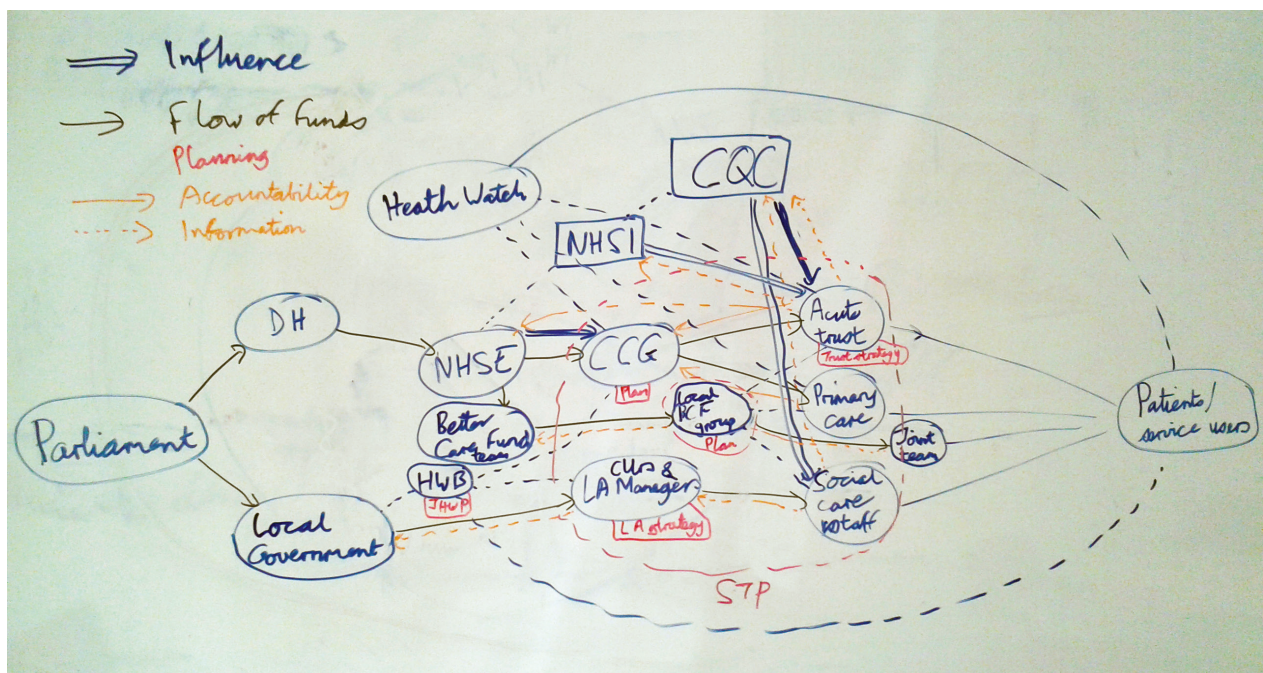
The lever for making all this happen is money: there is no statutory power, for example, to force foundation trusts or local authorities to take part in this process, but the supposition is that they will do so, as it is the gateway to funding running into billions of pounds to support financial recovery and transformation.

The greater focus on system-wide issues was reinforced when, for the first time, the government’s Mandate to NHS England for 2016/17 set objectives for the NHS as a whole, rather than just for commissioners.¹²

All this offers challenges to the accountability framework

The developments since 2012 – new institutions, new models, new planning regimes, new funding flows – have presented challenges to the accountability arrangements. Figure 3 is an – admittedly rough – whiteboard diagram of the different lines of planning and reporting. It demonstrates the complexity of the current.

Figure 3: Accountability flows sketch



We are a long way from the clean lines of accountability proposed in the 2010 white paper. NHS England, the regulators and others are having to work hard on solutions to the questions which are emerging.

In the next section I look at how the present position measures up against the six principles for a good accountability framework, outlined in Section 3, and suggest what would make for a stronger position.

5. How the present position matches up to the principles

Comprehensive and joined up

How does the present position match up?

Considerable efforts are being made to join up organisations and workstreams in a system that is inherently fragmented. However, these have some way to go to provide the best foundation for accountability in an increasingly integrated world.

Starting with the approach to **setting goals and priorities**, the Department of Health has for some time set outcomes frameworks which apply across the NHS, public health and adult care. For 2016/17, the NHS planning guidance, which launched the STPs, was signed off by the arm's length bodies. However, there was no explicit involvement from local government, even though participation from councils is an intrinsic part of real success, particularly given the stress on systems leadership and public health. Perhaps as a result, there is some scepticism in local government that STPs are (as one person I spoke to put it) 'a typical NHS thing', when they have the potential to be far more.

The STP process has the potential to generate a more comprehensive shared vision and sense of value at local level, though most local areas will need a lot more time to realise the benefits. The ambition is rightly set high, and the number of parties involved is also large. Building relationships between the various parties will take time, partly because many of the footprints are new, so some smaller areas which already have a high degree of integration are now having to work closely with other partners in the wider footprint.

At the same time, much of the planning will continue to take place at levels below the STP footprints, and a joined-up planning system will be important here too. The best building block may be the existing Joint Health and Wellbeing Strategies (JHWSs). The impact of the HWBs that oversee these strategies has inevitably been patchy so far. Improvements can and should be made by involving providers and the voluntary sector more, but creating a new organisation would bring disruption and still need most of the same people, covering much the same agenda.

Work is still needed on how to engage patients and the public more closely. This task will require some resource: most people I spoke to felt that Healthwatch had got off to quite a good start, but was short of the resources needed to play a part in the wide range of discussions under way among CCGs and trusts.

In terms of **monitoring and oversight**, there is substantial variation in arrangements at local level. There are good examples of areas which have had integrated working for some time, with shared indicators and common monitoring systems. For example, one approach focuses on a quarterly meeting involving the leader of the council, the chair of the trust and other senior representatives, which scrutinises a joint performance report and ensures

compliance with key standards, as well as looking ahead to new opportunities. Other areas have to report in multiple ways, eg where social care is run on a county-wide basis, but there are several CCGs, which sometimes find it difficult to agree a joint approach.

At the national level, the DH and the Department for Communities and Local Government (DCLG) produce separate Accounting Officer System Statements, explaining their statutory accountabilities. Producing two statements reflects the demands of Parliament, but will be increasingly distant from what is happening on the ground, not least because of the government's commitment in the 2015 Spending Review to integrating health and social care services by 2020.

The **regulatory architecture** is largely organisation-based and reflects the clear purchaser-provider split, first introduced in the early 1990s, that underpinned the 2010 vision set out in *Equity and excellence: liberating the NHS*.¹⁰ NHS England oversees commissioners. From 1 April 2016 NHS Improvement oversees trusts, and bringing Monitor and the Trust Development Authority together has the potential to provide useful streamlining. The CQC has across-the-board responsibility for quality regulation in health and care, which means that it can inspect and regulate new models such as PACS without radical changes in approach. Local authorities of course have separate regulatory systems altogether, with some overlap in public health, which is a local responsibility overseen by Public Health England as a DH arm's length body.

The increasing emphasis on place-based services and collaboration puts more onus on the various arm's length bodies to coordinate and streamline their work, and their leaders are making strenuous efforts to do this. NHS Improvement has recently published commitments to collaborate with colleagues in order to take a joined-up approach to oversight.¹³ This includes ensuring a shared definition of quality and efficiency with the CQC, and aligning with both the CQC and NHS England to create a single definition of success for providers. The CQC's strategy for 2016–21 similarly commits the organisation to developing 'a shared data set with partners, other regulators and commissioners, so providers are only asked for information about care quality once.'¹⁴ The three organisations have already been cooperating in the success regime work in the most challenged health economies. The CQC has also published the first prototype report looking at the quality of care in a place (North Lincolnshire), reflecting the need to be ready to adapt to changing models of care.¹⁵

Not surprisingly, it is taking time for this senior-level commitment to filter down to staff on the ground. I came across an example of separate inspections of acute and community work, when the services in question had already been working together for two years. As well as the waste of resources, this risks not picking up on either good or bad practice in the collaboration. What could be more awkward – if understandable, given the challenging context – is that both NHS Improvement and NHS England have a responsibility for getting the NHS's finances back to balance, and that is not always being approached in a collaborative way. For example, some local NHS Improvement (ex-Monitor) staff have been focusing overwhelmingly on getting provider deficits down, and acquiescing in behaviour which helps that process, but which may not necessarily be in the interests of the local health economy as a whole. The approach taken to reducing deficits is not just an accounting exercise about who takes how much of the strain, but will impact on decisions about services.

A further potential rubbing point is in that in June 2015 the CQC was given responsibility to look at use of resources. This risks some confusion since most trusts expect NHS Improvement to major on that. Joining up these processes clearly fits with the accountability principle of comprehensiveness – it would be perverse for an organisation to be rated Outstanding by the CQC if it was running a huge financial deficit – but it does risk duplication of activity. In practice, NHS Improvement and the CQC are working together on how the assessment of use of resources can best be carried out.

Suggested ways forward

A comprehensive accountability framework should comprise the following:

- **A single set of outcome indicators for national purposes**, covering health and care. Currently the DH produces separate documents for the NHS, public health and adult social care. It would help to bring these into a single set.¹⁶
- **A coordinated approach to planning at local level**. This should be based on the STPs for larger footprints and the JHWSs for more local services, adapted as necessary to ensure they give full weight to social care, and to take account of other footprints (eg for specialist commissioning), in ways best settled locally. JHWSs should inform the STP process in advance. Once the STPs are agreed, local plans should be agreed by HWBs to give effect both to the conclusions of the STP and to local priorities. The aim should be for both providers and commissioners, across health and care, to have their say together at the planning stage, to seek to align their views and their requirements. This process will inevitably be imperfect for the first round of STPs in 2016/17, but should be refined for later years.
- **A broad financial framework** consistent with the service plans. This should also be agreed as part of the planning process. This, plus fully developed STPs and JHWSs, should provide a stronger foundation for the collaboration necessary in integrated working, and an agreed framework within which commissioning decisions take place. This process should be given time to realise its benefits, and the JHWSs will need more work.
- **Health and care leaders and staff must be seen as equal partners** at all levels. Specifically, the **NHS bodies should co-produce all relevant policies and documents** with the Local Government Association (LGA) and Association of Directors of Adult Social Services as fully as possible, bearing in mind that these are membership bodies that cannot order their members to take particular action.
- **Fully coordinated oversight and inspection regimes**. The leadership of NHS England, NHS Improvement and CQC should continue to work on integrating their inspections and information-gathering, so as to reduce duplication, and on making sure this commitment is reflected on the ground. This needs to be ambitious: there should be one coordinated monitoring regime for all national-level requirements, encompassing the following key points:

- **Alignment of planning and monitoring** around a common set of metrics and a common timetable.
- **A common database** for headline performance measures, spanning health and care, quality and finance, available to the public in an easily accessible format.
- **A more detailed database with local performance information**, where all organisations post their performance and all stakeholders can access the data.¹⁷ Some people I spoke with, though fewer than I expected, mentioned data sharing as a problem: if these rules do prove to be a real showstopper, this should be addressed nationally.
- **As well as data requests, inspection regimes should be coordinated.** Any risk of duplication between the work of the various arm's length bodies should be sorted out, especially as they too have to make cuts.
- **The current work to deliver a joined-up approach to regulating new models of care is a crucial enabler of success and should be pursued as a priority.** CQC's recent strategy document explains its approach. Its prototype report on the quality of care in a particular place is worth pursuing.
- **Common reporting requirements should be agreed locally, both for the indicators to be reported on and for the frequency and timetable for reporting.** These should be agreed on the appropriate footprint, typically that of the social services authority. This would mean that in most counties, CCGs should aim to use the same suite of indicators as the county, with scope for a few genuine local priorities; for example, if there was a particular problem in the north of a county that did not apply in the south. This would be preferable to having completely separate arrangements for each CCG area.

Economical of time and money

How does the present position match up?

As discussed in the previous section, the present system involves a lot of reporting up the various lines.

One person I spoke to said that their trust had to report on several hundred indicators every month, and nobody else has rubbished this figure. A number of people reported frequent ad hoc requests for particular pieces of information, in a way that has intensified over the last couple of years. Others complain of being asked regularly to respond to different requests for information at short notice, sometimes from different parts of the same organisation, and sometimes for information that has already been provided. The sense is that this aspect of the health system is suffering from the absence of a coordinating body playing the role of the old Strategic Health Authorities: with more layers, simple requests from senior levels can become steadily more involved as they filter down. More than one person said that they were sometimes having to report daily on winter bed status.

The counter to this is that large and complex organisations, spending substantial sums of money, are bound to have quite a long list of objectives, and should have systems to generate performance information economically. Nonetheless, it is hard to believe the present approach is a good use of time overall. Having too many measures can detract from giving priority to the most important points, as well as from actually using the data to drive improvement.

A similar conclusion was reached by Chris Ham and others in a 2015 report:

'we were struck by the number of different bodies involved in assessing performance... duplication in some of the work that has been done, and the competing frameworks that exist... There is a need for radical simplification and better alignment of this work. This is especially important at a time when the DH is proposing a new framework to add to those that already exist.'

We would particularly emphasise the need for alignment between the metrics used to assess local health system performance and those used in the CCG Assurance Framework from NHS England.¹⁸

The new CCG Improvement and Assessment Framework was introduced for 2016/17, to replace the existing CCG assurance framework and CCG performance dashboard. It contains 57 indicators, to be reported quarterly.

The new models of care could easily mean another layer of governance, if a new steering group or formal governance body, depending on the model, is added to existing arrangements. On the face of it, this is an extra burden, and attention should certainly be paid to avoiding duplication and aligning data requirements. However, one of the constant themes in successful collaborative working is the importance of building relationships, and spending time together is central to that – one of the features of Manchester's collaboration so far has been the time invested in working up structures and practices. So the key thing is to use the time together well, rather than to begrudge it.

Suggested ways forward

- **New governance structures should avoid unnecessary duplication, but focus on using time together well rather than minimising it.**
- **The Integration Plans for 2017, required by the 2015 Spending Review, should be incorporated into the STP process.** The February 2016 guidance on STPs says that, done well, they will 'mobilise local energy and enthusiasm around place-based systems of health and care, and develop the partnerships, governance and capacity to deliver'.¹⁹ This degree of ambition is admirable, but delivering it is not straightforward. As well as the familiar challenges of collaboration, the STP footprints are mostly different from the local authority areas responsible for social care, and a few authorities are split across two or more STPs. So rather than start another process for the integration work, the STPs and JHWSs should do the job.

- **There is a case for reviewing the indicator set and frequency of reporting independently.** This might best be done by someone with experience of performance monitoring in another sector, who will bring knowledge of the process but a fresh mind to the details. Given the importance of stability, however, any changes arising from the review should only be implemented for the next parliament, unless the work uncovers anything downright perverse. It's tempting to suggest that the cost of accountability itself should be monitored, but that would heap work on work – better to focus on reducing the cost rather than measuring it.

Clarity and transparency

How does the present position match up?

The central concern is that relationships are becoming blurred. Whatever its faults, the 2010 vision was clear on the accountabilities: commissioning would largely be done by GP-led local organisations, and the provider side would be in the hands of independent foundation trusts responsible to those commissioners and to GPs. There would be a lightish touch system of regulation to oversee safety and quality.

As it has transpired, there are now many more people potentially involved in decisions. More monitoring and more hands-on regulation may leave both commissioners and providers feeling less in control of their destiny. A number of people, in different parts of the system, have commented that the voice which trusts listen to most intensely is Monitor.*

As they bed in, the STPs will start to drive decisions, but there is no governance body for these plans as such. The guidance says that 'Each footprint will need to set out governance arrangements for agreeing and implementing a plan'.¹⁹ The absence of prescription is welcome in terms of local flexibility but risks the job being left undone.

The senior staff named as lead officials for STPs are in a range of different roles, though only a handful are in local government rather than the NHS. This spread underlines that there is no clear route for accountability to any oversight body or bodies. In a few cases, there may already be appropriate bodies whose footprints coincide well enough – for example one or more HWBs could be the foundation for the governance group. But in most cases the footprint of the STP is bigger than existing structures, and in some areas footprints have been imposed that do not match existing arrangements. This has led to tensions, and time for preparation and sign-off was very short – the lead officials were only confirmed publicly on 30 March 2016 (with three names to follow), with the STPs due to be submitted on 30 June.

In parallel with the nationwide implementation of STPs, the vanguards are developing new models in local areas. Most are setting up new groups to oversee their collaborative arrangements, reporting back to the parent organisations (trust board, local authority cabinet, etc). In the planning stage, this typically involves a steering group of the chief executives of the organisations involved. In some areas, they have been working together for some time; in others, this greater contact is already seen as a benefit of the new models.

* Most of the research for this paper was undertaken before Monitor formally became part of NHS Improvement on 1 April 2016.

When the vanguards move out of the pilot stage, most if not all will need to set up new vehicles, so that there is a legal entity for the commissioners to contract with – the point of both an MCP and a PACS is to create a new provider entity. Potential models include a limited liability partnership, a community interest company, a social enterprise, or a foundation trust. Clearly the commissioners will need to be satisfied that the type of entity chosen has sufficiently robust governance arrangements, but it will be using a model established in law, if not familiar in the health and care world. The position could be more complex if some but not all of the activities of a trust are within a PACS or MCP and others are carried out in a more conventional way.

The direct answer to concerns about blurring is that the statutory accountabilities are unchanged. The vanguard bodies' plans will be approved by the governing bodies of trusts, the CCGs who subscribe to them, and by the cabinet of local authority partners. The vanguards will still involve the CCG commissioning services from a provider entity. And as to the alleged greater influence of the regulators, several people I spoke to argued that their role remains to regulate, not to line manage, and it should not be surprising that they are having more active involvement at a time of widespread deficits.

So how far does the current lack of absolute clarity matter? For the vanguards, the risks look manageable: there are a relatively small number of sites, and the participants are self-selecting enthusiasts. The process of delegating decision making and reporting back seems to be working in the areas I have talked to, though has arguably not been fully tested yet. But these are typically areas which are building on a track record of joint working, and this positive starting point is not transferable by itself. It will not be so easy to rely on goodwill in a less collaborative health economy.

The risks arising from the STP process are greater, partly because they apply nationwide. It is risky, to say the least, for there to be too big a gap between the nominal accountability system and the real one. The test of these arrangements will come when something goes wrong – either a significant service failure or a financial problem. Does responsibility rest with the boards of the organisations that are providing the services? Or with the cross-agency steering board who are really calling the shots? If there is a service failure by staff badged to an acute trust, does responsibility rest with the board and the management, clinical and executive, at the trust? Or with the multi-disciplinary team who shaped the new clinical pathway? So long as legal accountabilities remain where they are, parent organisations need to ensure they are sufficiently well informed to understand the risks they are running and what is being done to prevent those risks materialising.

My suggestions therefore recommend how to tackle both this concern about the gap between nominal and real accountability, and the lack of transparency that arises from the sheer complexity of the emerging arrangements.

Suggested ways forward

- **At every level, there should be an accessible summary of how the whole approach to planning and delivering services actually fits together.** This would enable the public to see who is responsible for what. The DH has produced an accountability statement²⁰ which actually provides a good foundation for this at

national level. However, this is aimed at the Public Accounts Committee and other such bodies rather than a wider audience, and the most recent version was produced in October 2014.

- **At local level, there should be a similar accessible summary of the arrangements in the local area, which could be produced by HWBs.** Some local bodies do produce such summaries already – for example, Bath and North East Somerset CCG has done a good job in getting a brief explanation of the STP process up quickly.²¹
- **DH and DCLG should begin work on a joint system accountability statement that covers integrated working, in addition to those for the rest of their work.**
- **Each STP footprint should specify and publish its proposed governance arrangements from approval of plans to monitoring, course correction and evaluation.** These arrangements do not need to be the same across the country: what matters is that they are fit for purpose and provide clear local accountability. The obvious vehicle to provide input at local authority level is the HWB.
- **The vanguards should publish their proposed governance structures,** once these are settled.
- **This transparency will also support direct accountability to the public, which is likely to become more important.** There is widespread commitment to the idea of public transparency among politicians and NHS leaders, partly because of the importance of engaging the public in the prevention agenda. In local government, it has been in the bloodstream for longer.
- **Lessons about accountability from the new models of care should be shared.** In organisational terms, as learning emerges from the new models, NHS England and the LGA should produce guidance on what works and what does not work at local level. This should include must dos, must avoids and good practice for accountability purposes – as well as for wider effectiveness.

These measures will help in the short term, but more fundamental changes are likely to be needed no later than the start of the next parliament (which means 2020, under the Fixed-term Parliaments Act). If the STPs are to be a permanent part of the system, as opposed to a vehicle for distributing a tranche of money, there should be a governance body to oversee them. The very inclusive approach Manchester has brought to the governance of its devolved health and care system could provide a model, though the experience there also shows that success takes time and effort (see the Appendix for more details).

I believe that new arrangements may well require new primary legislation, so the current allergy to this will have to be overcome no later than early in the next parliament. This will of course be a matter for the government of the day, but the point is not to have another top-down reorganisation, but rather an enabling exercise to put the emerging governance structures onto a firmer legislative footing. By 2020, there will also be a chance to learn lessons from the devolved arrangements in Manchester and elsewhere, depending on whether and how different areas choose to use potential freedoms.

Rigorous but encouraging innovation

How does the present position match up?

One of the key ambitions of the reforms proposed in the 2010 white paper was to move away from process targets towards a concentration on holding staff to account for outcomes. However, there has been a move in the opposite direction since, partly reflecting requirements introduced following the Francis reports about Mid Staffordshire. Some of these process standards have money attached: one high-performing trust reported having to do a thrombosis check on all inpatients, whether or not there was a clinical need, because there was a 'quality marker' with money attached. The checks therefore had to be reported to the trust board and the CCG.

There is always a tension in the NHS between national control and local discretion. Some of the issues deemed to be national priorities may not be particularly relevant in all parts of the country – even some well-known long-term conditions are not a major problem in all geographies, but all will have to report on them. Adding more national indicators also reduces the scope for local priorities – one area reported they only had space for one local CQUIN indicator*, meaning that the overall list will not provide the best focus on closing the health gap in that area.

The strong guidance on staffing levels is at variance with the principle of holding members of staff to account for delivering outcomes, partly by making data about these widely available. Standardising inputs such as staffing structures may inhibit innovation in some areas, although the evidence is that determined staff and managers have found ways to try out new organisational models and new methods of working.

An example of where the balance of rigour and freedom seems not to have worked is the Better Care Fund. This was introduced in 2013 as a way of directing more NHS resource towards collaboration with social care, thus supporting that service to keep people out of hospital. The aims command widespread support, but local staff in a number of places say that the implementation has often actually strained relationships rather than fostered them. The process has been bureaucratic – one county's original plan ran to 250 pages, and there are 33 pages of central guidance on the topic of working together. Reporting involves filling in a spreadsheet with nine sections every three months.

The Better Care Fund rules have made it difficult to build on some existing processes that worked. Generally, in trying to prescribe the system closely so that fairly specific objectives were met, policymakers have generated a lot of extra work and the Fund has not necessarily met its goals, partly because the pace of change required to meet the aims of the policy was extremely ambitious. Some lessons have been learned for the second year of operation, with some greater freedoms. However, the impact of that was offset by the fact that final guidance, which should have been issued early in 2016, eventually emerged in mid-March. Local bodies then had eight days to submit their plans, clearly constraining their ability to plan implementation effectively.

* CQUIN: Commissioning for Quality and Innovation, a payment framework linked to quality improvement goals.

If handled wrongly, using money as a lever to drive change can easily win minds but not hearts even among those who gain. Since the Better Care Fund money was diverted from the NHS in the first place, it risked losing both hearts and minds among some providers. It is important that the sustainability and transformation fund is used more effectively.

More generally, some people worry that integrated working by itself reduces rigour in accountability. To reduce the number of people visiting an elderly person at home, for instance, a genuinely integrated service will sometimes involve 'health' staff carrying out 'care' tasks and vice versa – this should be better for the elderly person, and more cost-effective, but it is demanding for staff and for councillors who may be pooling resources with a health body covering a wider area, with no certainty that every pound put into the pool will be spent on that council's residents.

The challenge is how to set an accountability framework that helps local leaders in both health and care to accept the loss of sovereignty that integrated working involves and to feel more comfortable with ambiguity. The managerial issues are a topic in their own right, but in accountability terms, the key things are:

- clarity over the positive outcomes sought for residents of the council – one senior officer said that a powerful argument with councillors was to see service users calling for the system to be better joined-up
- rigour over safety standards and propriety in financial management
- reliable and timely information about performance
- agreement in advance over risk and reward: how are savings shared, and who bears the risk of overruns
- a regular review process.

Suggested ways forward

- **The regulators need to keep a balanced view of the risks involved in new models.** It is important that a proper concern for safety and propriety does not put boards off from taking well-managed risks in the interests of better service and value for money. A risk-averse board, worried about a legalistic regulator taking a narrow view of its obligations, could back away from a joint venture. Clearly the regulator needs to ensure patient safety is not compromised, but that should not stand in the way of well-managed innovation.
- **More formal mechanisms are needed to weigh up the benefits of extra process requirements against the potential cost and distraction.** These mechanisms should be published.
- **There should be a conscious policy choice to ensure rules and regulations do not become more burdensome over time through gradual accumulation.** Something which starts fairly simple can become over-bureaucratic because a couple of new things are added each year and nothing is taken away.

- **Government should stand back and take an overview of the balance of rigour and scope for innovation.** This should be done at the start of the next parliament, when an incoming government will be setting its stance on running the health and care system.

Stable and consistently applied

How does the present position match up?

The Forward View says of the organisational structure that ‘there is no “right” answer... but there is a wrong answer, and that is to keep changing your mind’. The same applies to the accountability framework.

The ideal time to set out such a framework is at the start of a parliament. This was actually done in 2010 but, as explained earlier, the original philosophy did not prove sustainable. So since 2012, there have been changes in the planning regime, indicators, approach to monitoring and the organisational structure at national level, and in the finance regime for both the NHS (with the Better Care Fund) and for local authorities.

On the positive side, many of these developments do have a longer-term focus, including the Forward View itself. Some changes, such as the new finance arrangements for local authorities, are the result of the current government’s 2015 Spending Review, which is setting the direction for the current parliament. The then Prime Minister also boosted continuity in government more widely by leaving the Health Secretary, and many other Secretaries of State, in place after the 2015 general election – Jeremy Hunt was also one of very few to remain in the same job when the new Prime Minister took office in July 2016.

There are some further encouraging signs. The CQC has now set out its strategy for the five years to 2021.¹⁴ It has locked down its key lines of enquiry for a couple of years now, and will review them only once it has completed the first full round of inspections.

On the other hand, at a more practical level, there are examples where action has been delayed – which does not make for stability and good management. As well as the delays in the Better Care Fund guidance I have already mentioned, the tariff for 2015/16 was not agreed until well into the financial year. There is a contrast between the commendable scale of the ambition behind the STPs and the very short timescales local areas had to complete the first draft – the experience of the Better Care Fund more generally highlighted that time is needed to deliver the benefits of radical changes.

Suggested ways forward

- **The national level accountability regime should be set for a five-year horizon, most obviously for a parliament, with a single light-touch mid-term review.** This should apply to planning requirements, indicator sets and inspection regimes. Local NHS bodies should also review their requirements on this timescale. Local authorities should have regard to this timescale too: they will obviously need to reflect their own electoral cycles, but should make any changes only once in each cycle.

- **In between these major reviews, policymakers should resist the temptation to make changes.** I understand the argument that indicators, for example, should be an improvement tool, and that if a clear improvement has been delivered in one area of work, that indicator should be dropped and replaced by something requiring more attention. But experience suggests that it proves easier to add indicators than to drop them, and change will typically take years anyway. A presumption in favour of ‘one in, one out’ would provide a discipline, as would a formal analysis of the costs and benefits of making a change in response to particular events. The DH did work to this principle, as far as possible, in its 2015 review of the Public Health Outcomes Framework, which had been left in place for three years previously to bed in. For the present government, this recommendation suggests leaving existing measures and initiatives in place, rather than changing or adding to them.
- **The authorities should stick to their timetables for producing guidance and regulations.** A more stable framework would automatically reduce the need for annual production of guidance and regulations. However, where these are needed, the timetable should be settled well in advance and the authorities must stick to it. Governments can make decisions quickly when needed.

Robust to the real world

How does the present situation match up?

The history of the last six years has arguably been a demonstration that the 2010 plans were not robust to the real world. They have been amended, successively, to reflect first the political pressure to protect some key features of the NHS, then the impact of severe failings in quality and safety, and now the need for a different approach to planning to deliver on the Forward View, including returning the NHS to financial balance.

By contrast, my suggested ways forward in this paper place a lot of stress on stability and focusing over the medium term.*

The classic rejoinder to many such recommendations is that they will never work in the real world. Politicians are easy targets here: the desire to announce new things ahead of an election or at a party conference can make for instability, leaving aside the impact of changes of political control. But it is not only politicians who change policies and approaches: new chief executives restructure their organisations, professional leaders reviewing an issue want to make a visible mark, and so on. Then there are the pressures from real-world events: some will be genuinely systemic, such as Mid Staffordshire; others will be tragic and highly sensitive but rare, such as young children dying from meningitis.

Rather than just accept that this is how the world is, it is worth examining why these developments happen: why health – not so much social care, here – seems to be more prone to them than other public services. This should help find ways to increase the chances of a long-term approach sticking.

* *Get well soon: reimagining place-based health*, a recent report by Collaborate and the New Local Government Network, also looks over a longer timeframe, calling for a 15-year forward view: www.nlgn.org.uk/public/2016/get-well-soon-reimagining-place-based-health/

It seems clear that health does attract more parliamentary attention, and generally more emotional pressure from the public, than other subjects. When faced with widespread riots following the shooting of Mark Duggan by police officers in Haringey, the Home Office did not respond by taking more direct control of law and order in that area. The Education Secretary is not held responsible for poor performance by schools in a particular town. There were changes locally when it was discovered that 1,400 children had been abused in Rotherham over a 16-year period, but imagine the nationwide measures that would have followed if those 1,400 had been found to have suffered from a physical illness ignored by the authorities.

There are two clear differences applying to health.

- First, there is no other level of democratic accountability. Citizens and their MPs cannot complain to their local councils, or to the Police and Crime Commissioner, or anyone else in an elected role. Nye Bevan famously commented that ‘if a hospital bedpan is dropped in a hospital corridor in Tredegar, the reverberations should echo around Whitehall’ – his remark has cast a long shadow!
- Second, more or less 100% of the funding for the NHS comes from the central taxpayer, and the Health Secretary is responsible for that. This goes some way to explaining the unique extent of central accountability in health, although for some years now, the vast majority of funding for schools and police has also come centrally. The difference seems to be cultural rather than intrinsic – research shows regularly that people care more passionately about health issues than other public services.

The risk of ‘real world’ pressure for sudden changes in health policy therefore seems likely to be with us for the foreseeable future.

Suggested way forward

- Use an impact assessment process to judge and explain where short-term changes can be damaging overall. As with balancing rigour and scope for innovation, the most practical way forward looks to be for practitioners and policymakers to get better at understanding where short-term changes can be actively damaging to service levels, and then explaining that more clearly when faced with pressures. This could be done through an impact assessment of the sort that applies to new regulations. Done well, this should be a useful support both to decision making and to explaining the approach. There is a risk, however, that impact assessments become a tedious box-ticking exercise, or are adjusted or ignored if they come to the ‘wrong’ answer. In the end, the outcome will still depend on the judgement of the people taking the decisions. To add to the rigour of the exercise, assessments should be done independently and published. DH, DCLG, the arm’s length bodies and the LGA should commission an independent study of how this should be done, though with a view to at least piloting the approach within months rather than years.

6. What should a good accountability framework for health and care in England look like?

Designing the framework

My analysis points to the following answers to the design questions for an accountability framework I set out in section 2.

- *Outcomes or activity or process? Covering standards of care or population health and wellbeing?* An increasingly complex delivery landscape fits better with a high level focus on outcomes, rather than activity and process, which have to be planned locally and can best be monitored at that level.
- *Short term or long term?* As many of the steps involved in delivering integrated care will take time to have their effect, it is all the more important to provide stability by focusing on long-term measures.
- *National or local?* Given the funding of the NHS and the nature of its work, there will always be a certain degree of national monitoring. However, many of the key success factors are dependent on local decision making and full-hearted engagement. A number of the themes in the Forward View emphasise the importance of local decision making, and the devolution agenda points in the same direction. A relatively small number of national outcome-focused priorities can provide the foundation for a wider range of locally set measures. To help those working on the front line, these sets should be aligned and not changed too often.
- *Organisation-based or place-based?* There needs to be a balance here. Integrated services presuppose working across organisations within a place, and the NHS has certainly taken steps towards more of a place-based focus. This also encourages a focus on the overall pattern of services to citizens and communities. However, so long as individual organisations retain their separate legal identity, they will need some governance apparatus of their own. Again, the key thing is to align effectively.
- *Focus on the hierarchies, or on patients and the local community?* Clinicians are always going to feel a tug of loyalties at times – where the patient, the manager and the royal college are asking for different things from them. But while short-term tensions are inevitable, in the medium term, the interests should be the same. So the best approach may be to strengthen engagement all round: of patients in their care; of the public in decisions about future services; and of clinicians in shaping the local vision for services in the area and the accountability arrangements which give effect to that.
- Any accountability framework will involve a mix of mechanisms and the balance will change over time. What is vital is that, at any one time, the choices taken are aligned and reinforce one another, rather than lead to conflicts.

Integrated accountability for integrated care

Drawing all this together, I believe that a more integrated way of working will need an integrated approach to accountability that can reflect changing ways of delivering care, and different local circumstances. The key components should be as follows:

- **An overall framework that is set nationally for the length of a parliament, and locally for a local authority term.** This would ensure that staff planning and delivering services have stability over goals and monitoring requirements. The Department of Health and the DCLG should take responsibility for this nationally, and each upper-tier local authority should be responsible locally.
- **A single set of outcome indicators for national purposes, covering health care, public health, and social care.** There should be a small number of these national indicators, focusing on top priorities, which the DH should put in place.
- **A coordinated approach to planning at local level.** This should be based on the STPs for larger footprints and the JHWSs for more local services, adapted as necessary to ensure they give full weight to social care, and to take account of other footprints (eg for specialist commissioning), in ways best settled locally. This is down to the people responsible for the governance of the STPs (see below) and to local authorities for the JHWS.
- **Agreement on how planning and monitoring for individual organisations fits within this strategic, place-based approach.** The starting point should be to align planning and monitoring around a common set of metrics and a common timetable. This needs to be agreed by the arm's length bodies nationally, and by local bodies for their monitoring.
- **A database for headline performance measures, spanning health and care, quality and finance.** This should be available to the public in an easily accessible format. Given the reach of this database, the DH and DCLG should take overall responsibility for making sure it is put in place, but the practical responsibility should lie elsewhere. The UK Statistics Authority, for example, has convened some relevant discussions on health statistics in 2016.²²
- **A more detailed database with local performance information.** All organisations should post their performance, with all stakeholders able to access the data. This should be part of the work above, though it is a much bigger exercise focused on practitioners rather than the public.

- **Fully coordinated inspection regimes.** These should be designed with an approach to regulation that is proportionate to the issue and the organisation or place, and set up to foster self-driven and sector-driven improvement, rather than as the main way of guaranteeing standards. This is the responsibility of the regulators.
- **An accessible summary of how the system of planning and delivering services actually fits together, at national and local level.** Central government should produce the national version, while local authorities should oversee the local one.

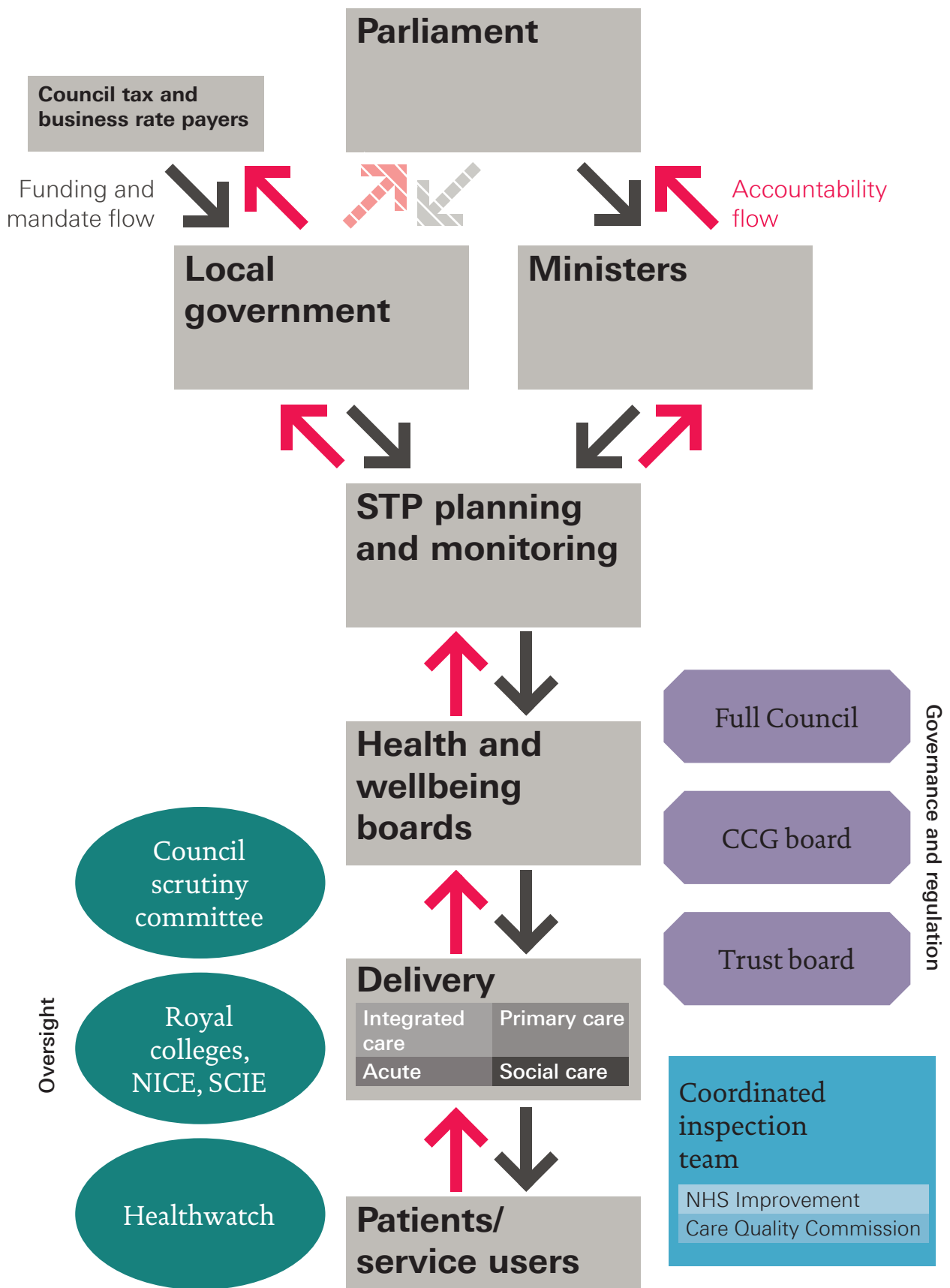
Figure 4 summarises the flows of funding and accountability under this integrated approach. Although local government of course has a separate electoral mandate, there is a link to Parliament through some central funding, for which the DCLG is accountable.

Improving the current position in the short term

This vision will take time to put into place. The following shorter-term measures could and should be taken to strengthen the current position:

- Governance arrangements should be established quickly for all STP footprints, bringing out the links to existing governance mechanisms. Each area should lead on its own arrangements, with NHS England making sure this happens.
- The STP process, JHWSs and other existing mechanisms, should be adapted to generate the Integration Plans required by the 2015 Spending Review, rather than starting a new process. This is an issue for central government to decide.
- Clear statements should be published of how the health and care system works at all levels, including for the new models of care vanguards. These should be produced by the DH and DCLG for the national picture, and HWBs locally.
- The national authorities should stick to published timetables for producing regulations and guidance.
- There should be a simple but rigorous method of assessing the costs and benefits of making changes to the accountability framework and indicator sets, starting with an independent study on how this should be done.
- Before the start of the next parliament, there should be an independent review of the national indicator set, with a view to streamlining and focusing this on the key national-level imperatives. This could be carried out under the auspices of the UK Statistics Authority.

Figure 4: New accountability system



7. Conclusion

The health and care system in England is under considerable pressure, and will need to continue to implement fast-paced changes to deliver services in new and better ways. This paper offers suggestions for how the accountability framework can facilitate this rather than stand in the way.

There is no perfect system of accountability, nor is there one which will eliminate all risk of either financial impropriety or serious clinical errors. But a price will be paid if too many rules, regulations and procedures are put in place in search of an extra ounce of assurance. There is a limit to the number of hoops that 700 NHS finance directors should go through in order to reduce further the risk that one will pay funds to a relative.

Similarly, the issue in devising a new accountability framework is not whether it is ideal, but whether it is better than what is happening at the moment, taking quality and value for money together.

The positive aspect of reviewing the accountability framework itself – as opposed to the cultural factors surrounding it – is that it is in the hands of policymakers. It is not, in the end, a religion, sent down by holy writ, but is man-made. Many things can be changed by administrative decision – the introduction of STPs is a good example. There are many challenges in health and care which policymakers cannot tackle directly or easily: persuading people to eat healthier food; finding a cure for dementia; or even securing genuine full-hearted cooperation between two hospitals that have been rivals for decades. But they can make very quick differences to the accountability rules within which staff on the ground have to work.

Ultimately, any accountability framework will only be as good as the people operating it. Good systems will not protect patients or drive better performance if they are implemented in an apathetic way. But the better the framework, the higher the chance that it will be effective.

The suggestions in this paper are designed to generate a framework that is simpler, clearer and more stable. This should enable stakeholders to have their questions answered, and staff at all levels to focus on the primary job of improving health and wellbeing.

Appendix

Greater Manchester: Devolved arrangements

Summary

In February 2015, as part of the wider ‘Devo Manc’ work, the 22 commissioners in Greater Manchester (GM), supported by the 15 trusts, signed an agreement with NHS England that provided a platform for the delegation of budgets, enabling the local health bodies and local authorities in GM ‘to take charge of health and social care spending and decisions’ in the city region. Greater integration of services is part of the plan. Their December 2015 document, *Taking charge of our health and social care*, says ‘Our focus must be on our people and our places, not organisations.’*

Formal delegation of functions and budgets took place on 1 April 2016. In 2016/17 NHS England remains legally responsible for its statutory functions. It is therefore formally ‘delegating’ responsibility to GM.

Within GM, a Strategic Partnership Board (SPB) sets the vision and strategy for health and social care in the area. It includes local authorities, CCGs, providers, and others. As this is a large body, it is supported by the SPB Executive – described as ‘the engine that drives delivery’ – and a Joint Commissioning Board. In terms of delivery approaches, they are taking ‘the best of local, national and international learning from Accountable Care Organisations’ and applying it to GM. Different models will apply in their 10 local authority areas, and there are four vanguard pilots within the city region, but all the local areas will be forming Local Care Organisations. There is an overarching Provider Federation Board.

How it works

Planning and resourcing: CCGs and local authorities will retain their statutory functions and their existing accountabilities for current funding flows. Some services will be commissioned on a GM-wide basis, but the subsidiarity principle means that joint spending plans will be agreed in each locality to deliver shared improved outcomes. Each locality will have a joined-up commissioning approach between the local authority and health partners, using pooled funds for ‘a substantive proportion’ of the health and social care spend.

Monitoring and course correction: The SPB Executive will receive regular reports on delivery. The aim is to generate metrics that monitor the outcomes set out in the Strategic Plan – which covers the city region as a whole – with a view to assessing system-wide performance.

Inspection and regulation: The aim in GM is to agree mutual assurance and regulation within the existing legal framework. That is under discussion with the regulators.

* Available from www.gmhsc.org.uk/gmhsc-downloads.

Comparison with the accountability principles

GM's approach is **clear and transparent**, in that a lot of material is published on how the system works. The University of Manchester has produced a two-minute video summarising the position for the general public. But GM recognises that engagement mechanisms for patients and the third sector need to be developed further.

The approach is in concept **comprehensive**, bringing together population outcomes, quality and value for money. As to appropriate **rigour**, there is an emphasis on working out new models, but no necessary weakening of existing mechanisms to ensure safety.

Stability is helped by a long-term focus in the city region, and the fact that this is the footprint for the STP. There is more of a question about how **economical** the arrangements will be: no doubt with a view to inclusiveness, there are a lot of groups and forums, with a lot of members – the (not untypical) December 2015 meeting of the SPB had 67 people in attendance, with apologies from a further 14 – evidence of the commitment to bringing so many different organisations together.

Finally, the arrangements should be relatively **robust to the real world**, in that a lot of political capital, national and local, has been invested in Devo Manc as a whole, including the health and care dimensions. There has also been a lot of planning. There will inevitably be tensions: GM has a substantial financial deficit, and is far from immune to cuts in local authority funding, both of which will put any collaborative arrangements under pressure.

Some people have commented also that providers are not as fully engaged as commissioners. However, they have formed a Provider Federation with binding collective governance arrangements, including 'Locked Gateways' to ensure that their collaboration is supported through robust joint decision making. An early test of GM's ability to sustain commitment to shared objectives against a challenge from an individual organisation was the decision of the Judicial Review on the Healthier Together plan, which ensured that a legal challenge from a professional group within one trust could not overturn the settled and shared commitment of the GM system overall.

Lessons and comments

GM is pioneering a number of ambitious devolved arrangements, and there will be plenty of lessons, whatever the outcome. Caution will be needed in assessing what is transferable. GM is building on a long history of collaborative working between local authorities, and has strong local leadership. Even so, these plans have been years in the making. Their arrangements are inclusive but time-heavy, and it will be interesting to see how the relationships – between NHS England and GM, between the SPB and the Executive, and between the GM-wide bodies and the localities – work out as they experience live running, and then move from delegation to devolution.

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